# READY TO RESPOND

## MENTAL HEALTH BEYOND CRISIS AND COVID-19

NASMHPD

Reimagining a Sustainable and Robust Continuum of Psychiatric Care

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# Ready to Respond:

## Mental Health Beyond Crisis and COVID-19


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## Disclaimer:

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## Abstract:

The current landscape of mental health services reflects both tremendous challenges and opportunities. With the impact of COVID-19 front and center in the national discourse, and the planning for a system involving a 988-crisis response, there is much work ahead. This paper, *Ready to Respond*, is the umbrella paper for the 2021 technical assistance coalition series developed through the National Association of State Mental Health Program Directors in partnership with the Substance Abuse and Mental Health Services Administration. It aims to lay out a roadmap as states emerge from the pandemic and need, more than ever, a full continuum of psychiatric care. As an outgrowth of a policy framework looking "beyond beds" within inpatient state hospitals as a single solution to improving mental health outcomes, the current discourse centers around access to crisis services. Yet, in order to best respond to demand, an entire array of services is needed both to prevent crises in the first place and to provide longer term supports beyond a crisis period for diverse populations of all ages with mental illness and substance use disorders, as well as those with co-occurring complex conditions. These services will require coordinated funding and planning with a broad group of stakeholders to address among other things equity and reducing the likelihood of suicide, overdose, criminal legal entanglements, homelessness, unemployment, or other untoward outcomes. The paper reviews recent behavioral health system demands and highlights seven key priority areas for consideration to build a sustainable, robust and more complete psychiatric care continuum.


## Highlights:

- There have been significant catalysts that have culminated in the focus on building out a more robust crisis continuum of care.
- The emotional toll of COVID-19 is an area that requires the attention of state mental health leaders
- Health equity may help shape future reductions in disparities in mental health outcomes
- Workforce challenges are highlighted as a major potential barrier to developing a more robust system of services, though the use of telepractices may help expand work opportunities and access to care.

## Recommendations for the Post-COVID-19 Future:

1. Expand and achieve a full continuum of crisis services.
2. Rebuild and reboot a robust, diverse, and well-qualified workforce.
3. Expand telehealth practices while ensuring ongoing quality and access.
4. Foster integration of disaster behavioral health into emergency preparedness and response.
5. Consider creative financial opportunities to maximize access to crisis response and other community-based mental health and substance use services with no wrong door.
6. Focus intentionally on diversity, equity and inclusion to reduce disparities in mental health outcomes.
7. Enhance interconnectedness with other systems and across borders for improved global responses

The National Association of State Mental Health Program Directors (NASMHPD), on behalf of the Substance Abuse and Mental Health Services Administration (SAMHSA), issued in 2017 a series of technical assistance papers on the need to shift the focus from building more state hospital beds to building a full and complete psychiatric continuum of care. The first paper in that series, B*eyond Beds: The Vital Role of a Full Continuum of Psychiatric Care*, laid a foundation from which national and international dialogue ensued.[1] The notion that psychiatric hospitalization is a key part of psychiatric care for those who need it has not shifted. However, there is increasing recognition that persons with serious mental illness, many of whom also have substance use disorders, need more than just psychiatric hospital beds. Just like in medical care, a complete continuum of services is necessary to meet the demands of persons with mental illness who may have any number of co-occurring complex conditions. In the four years surrounding the time of release of *Beyond Beds*, efforts around the country grew to examine and expand the behavioral health continuum, looking at models and goals both from the national and international literature. Each year, new NASMHPD technical assistance papers followed the theme of *Beyond Beds*, with approximately 10 papers and an overarching umbrella paper to establish a road map (Figure 1).[2,3,4,5]

Figure 1: NASMHPD Technical Assistance Coalition Series Umbrella Papers 2017-2020

**2017** *Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care*: set forth policy priorities of establishing a robust psychiatric continuum of care and looking beyond inpatient services as a single solution to the challenges for persons seeking services for mental illness.

**2018** *Bolder Goals, Better Results: Seven Breakthrough Strategies to Improve Mental Illness Outcomes*: delineated seven bold goals, from ending homelessness and suicide to getting immediate access to care, as a way to build a roadmap to better mental illness outcomes.

**2019** *Beyond the Borders: Lessons from the International Community to Improve Mental Health Outcomes*: examined nine key areas where examples from countries outside the United States have paved a way for improved mental health services.

**2020** *Crisis Services: Meeting Needs, Saving Lives*: built upon SAMHSA's Crisis Toolkit guidelines to help drive forward the need for a capacity for crisis services along its own continuum that is interconnected and equally accessible to diverse population.

In the years since the first paper in the *Beyond Beds* series was published, its tenets both reflected the national conversation and helped NASMHPD and state mental health leaders shape policy and planning. In 2021, the *Beyond Beds* dialogue calling for a complete continuum of psychiatric care is as important as ever, only it comes with the lessons learned from COVID-19 and a strong emphasis on continuing to enhance the crisis continuum of care. There are several reasons for this emphasis on prevention and crisis response that make these key considerations far beyond simply relying on "beds."

This paper, *Ready to Respond*, is the umbrella paper for the 2021 NASMHPD technical assistance coalition series and aims to lay out a roadmap for the years to come as we emerge from the pandemic and need, more than ever, a full continuum of psychiatric care. Although there are daily discussions

about crisis services, a complete continuum will need to incorporate integrated and interconnected services that can both prevent crisis and respond to them, as well as provide supports for individuals beyond crises. It will be critical to look ahead beyond COVID-19 and beyond inpatient psychiatric beds toward building out an improved, accessible and sustainable mental health service continuum that can be equally available across all demographics, in rural and urban regions, to meet what undoubtedly will remain growing demand.[6] The paper outlines the current landscape of the crisis response continuum and overall behavioral health system demands and finishes highlighting seven key priority areas for consideration.

## Catalysts for Enhanced Crisis Response as a Critical Aspect of the Psychiatric Continuum of Care

The activity of SAMHSA and NASMHPD along with countless interested stakeholders in mental health outcomes have been galvanized to pay attention and fund a growing number of programs for persons in behavioral health systems. Advocacy has played a key role, though demand for these services has also been borne out of the many failures and tragic negative outcomes seen across a depleted and fragmented mental health system. As such, several themes have been prominent in pushing forward a dialogue around crisis services that pre-date but have been heightened by COVID-19. Although the impetus for current system change is multifactorial, below six major themes are delineated as catalysts that have spawned planning for enhanced crisis response systems as a key aspect of the psychiatric continuum of care (Figure 2).

Figure 2: Catalysts Driving Toward Enhanced Crisis Response Systems

1. Suicide rates
2. COVID-19 and its impacts
3. Opioid overdose deaths
4. Jail diversion efforts and need to revisit the role of law enforcement in crisis encounters
5. Need for prevention and augmented services for children and adolescents with serious emotional disturbances
6. Litigation and regulation

One major theme that has catalyzed a discussion regarding crisis services as a vital part of the continuum of care is the rise in suicide rates across the country. Data from the American Foundation of Suicide Prevention showed 48,344 individuals died by suicide in America in 2018, and there were a recorded 1.4 million suicide attempts.[7] According to the Centers for Disease Control and Prevention (CDC), suicide was the second leading cause of death after accidents for individuals age 10 to 34 in 2019 and the fourth leading cause of death for individuals age 35 to 54.[8] Suicide rates between 2007 and 2017 increased 56% among people ages 10 to 24 years.[9] In response, the U.S. Surgeon General issued a report in 2021 outlining a national strategy for suicide prevention.[10]

Relatedly, as COVID-19's impact was increasingly causing distress, suicide prevention advocates had been pursuing a way to simplify the use of the National Suicide Prevention Lifeline. In July 2020, the Federal Communications Commission (FCC) announced that 988 would become Lifeline's designated number. This decision has jump-started a movement to help achieve its promise starting in July 2022. Many believe the need for a simplified crisis line access point could not be coming soon enough. Yet, as noted below, there remain challenges to achieving its implementation that will require ongoing diligent effort.

The second catalyst for change has been the impact of the COVID-19 pandemic on mental health. Although initial reports indicate there was no increases in overall suicide deaths during the pandemic,[11] survey data has shown more alarming rates of distress. The CDC's Monthly Morbidity and Mortality Weekly Report showed that in June 2020, the U.S. adult population reported experiencing increased levels of mental health symptoms including anxiety, depression, trauma-related symptoms, increased substance use and increased reports of serious suicidal ideation compared to earlier pre-pandemic data.[12] These findings were heightened for specific populations, including Black and Hispanic populations, essential workers and younger respondents.[13,14] Additionally, surveillance data has shown increased emergency department visits for youth between ages 12-17, especially girls, presenting with suspected suicide attempts.[15] Reger and colleagues noted that although there may be a "pulling-together" of additional supports that could reduce suicide risk post-disaster, they point to several factors that could increase the risk of suicides in the wake of the pandemic. [16] This includes the economic strain resulting from closed business, cancelled events and other economic downturns, social isolation, decreased access to community and religious supports, barriers to mental health treatment, illness and exacerbated medical problems, increased national anxiety, suicide rates among health care professionals, increased firearm sales, and shifting suicide rates across seasons. Thus, overall, as we move through and beyond the pandemic, attention to suicide prevention is a key component of needed services going forward.

The opioid crisis and the growing number of opioid overdose deaths represents a third catalyst for crisis service development. The increasing number of opioid overdose fatalities over the last half-decade or more created a need for intensive authorizations for funding through the State Targeted Response and subsequent Statewide Opioid Response discretionary grants and subsequent similar funding streams.[17,18] Although states were finally seeing some improvements in opioid overdose death rates through these funding initiatives and other avenues, with the impact of COVID-19, the overdose numbers are sadly on the rise again and efforts must be redoubled to get ahead of those curves that have contributed to reduced life expectancy of younger populations.[19] Methamphetamine associated deaths are also on the rise, which requires other specialized interventions.[20] The use of substances overall has increased while the percentage of persons of all ages receiving treatment has not.[21]

A fourth catalyst for change that produced some of the current press for system expansion to is the ever-increasing attention on jail diversion. It has long been recognized that individuals with mental illness and substance use disorders are over-represented in the criminal-legal system and juvenile justice system. In 2006, Munetz and Griffin proposed a strategy that emphasized the need to identify and divert individuals from criminal processes along multiple points of interception coalescing at five stages, from law enforcement contact, to courts to reentry and community probation or parole supervision, which became known as the Sequential Intercept Model.[22] In 2017, a sixth intercept, Intercept 0, was added with recognition that a more robust behavioral health crisis system might offer

*Beyond Beds*

**Recommendation #10: Partnerships**

Recognize the vital role families and non-traditional partners outside the mental health system can play in improving mental health outcomes and encourage and support the inclusion of a broader range of invited stakeholders around mental illness policy and practice.

opportunities for deflection and diversion from arrest altogether.[23] The Sequential Intercept Model was codified into the 21st Century Cures act, landmark mental health Federal legislation signed into law in 2016, driving grant programs and other initiatives.[24] At the same time, the Stepping Up initiative has helped county leaders and other stakeholders examine and reduce numbers of individuals with mental illness from jails.[25] In the wake of the murder of George Floyd, Breonna Taylor and others, anger over the disproportionate killing of black and brown people by police was raised to a feverish pitch, with one author calling the impact on emerging adults the "crisis within a crisis." [26] Resultant cries to "defund police" and to find better alternatives to manage crisis than a law enforcement response have contributed to re-examining partnerships and responses that can minimize police contact and maximize alternative approaches to managing community members in distress. Mobile crisis responses with alternative responders are a key part of these ideas. Examples such as the CAHOOTS model out of Oregon have gained increased attention for their crisis work uses models outside of police response.[27,28] A report by The Center for Law and Policy examined mobile response for youth with mental health issues and proposed key principles for effective mobile response programs as an alternative to law enforcement as first responders.[29] The key principles include ensuring responses do not include law enforcement, responders shouldn't always need professional degrees and should include peers and that the services should be reimbursable from Medicaid to promote equity. At the same time as the need to reduce excessive use of force in crisis response, the importance of jail diversion continues.

A fifth catalyst for change is with regard to children and adolescents and the growing and alarming trends for youth waiting in emergency rooms for psychiatric inpatient care.[30] Many states have faced litigation for failing to meet Medicaid's statutory Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirement for Medicaid beneficiaries.[31] This trend has shifted planning to create an intensive expansion of service arrays in many states to attempt to meet the needs of youth with serious emotional disturbances (SED). There is a large overlap with youth in the child welfare systems and the 2018 Family First Prevention Services Act now requires that treatment centers, known as Qualified Residential Treatment Programs for youth with psychological, behavioral or substance use challenges, must provide trauma-informed care and licensed staff that is more akin to a treatment model than a model that provides only structure and housing for youth involved in the child welfare system.[32] Often, EPSDT lawsuits incorporate an additional focus on youth involved in the child welfare and/or juvenile justice systems, given the propensity of those youth to be likely to have serious emotional disturbances stemming from any number of conditions. And remedies for these cases often include intensive mobile crisis services and follow up supports,[33] which again is a path that leads to expanded crisis services for Medicaid eligible youth. Although these are youth-focused programs, their design creates other discussion that can support adults in crisis as well as other populations, including those with complex needs such as those with intellectual and developmental disabilities.

Media reports and litigation against states and jurisdictions have been a sixth catalyst for change. Pivotal cases have called for remedies for waitlists of individuals found incompetent to stand trial waiting in jail[34,35] and other forensic populations.[36] Recent cases in Washington[37] and New Hampshire[38] have sided with plaintiffs against the states related to the boarding of patients in emergency departments with findings that states are failing to meet constitutional r standards by leaving individuals languishing in emergency departments when they have been determined in need of psychiatric hospitalization.[39] The case in Washington supported advocacy for additional funding for more robust services with the state

legislature.[40] In addition, *Olmstead v. L.C.* (1999), a case often used in litigation to drive improved services, has catalyzed shifts for state mental health systems to help prioritize the terms of the Americans with Disabilities Act by providing adequate constitutional protections for persons with disabilities that require them to be served in the least restrictive environments and appropriate community-based services.[41] These cases dovetail the Final Rule that was set forth in 2014 related to Home and Community-Based Services Waivers, that was aimed to enhance the quality of these services and provide additional protections such that Medicaid beneficiaries receiving these services have full access to the benefits of community living.[42] Home and community based services rules and associated new dollars that are being made available through the American Rescue Plan Act related to COVID-19 have fostered states to spend resources building out these types of services.

Together, these examples of change drivers have called for system transformation and development of a more accessible and complete psychiatric crisis care continuum. Many of these issues predated COVID-19 and culminated in February 2020 in the release by SAMHSA of the *National Guidelines for Behavioral Health Crisis Care-Best Practice Toolkit,*[43] which called for practices that would yield better outcomes for individuals in acute need while reducing unnecessary hospitalizations and arrests. This was followed by the 2020 series of *Crisis Services: Meeting Needs, Saving Lives*[44] as well as the National Council for Wellbeing and the Group for the Advancement of Psychiatry's *Roadmap to the Ideal Crisis System*.[45] Unimaginable as it was, however, as the original SAMHSA Toolkit was being written, on January 20, 2020, the first case of COVID-19 infection was reported in the United States,[46] and by the time of *The Toolkit*'s release, the world was facing a global pandemic.

Much has happened since those first COVID-19 cases were identified. As the virus spread around the world, everything as society knew it quickly and forever changed. The emotional toll of this pandemic, comingled with a tragic spotlight on the murder of George Floyd and other Black and Brown men at the hands of police as well as general healthcare disparities seen in the pandemic's impacts, has no doubt further driven the need for preparedness and availability of adept crisis responses.

*Beyond Beds*

**Recommendation #1: The Vital Continuum**

Prioritize and fund the development of a comprehensive continuum of mental health care that incorporates a full spectrum of integrated, complementary services known to improve outcomes for individuals of all ages with serious mental illness.

As the world sorts through the massive disruption and loss of life caused in this moment, policy makers in mental health and other public services are called to the task of developing and building back a sustainable and improved mental health continuum of care that is more adept at meeting the needs of more people, including those with more complex presentations. Too many people with serious mental illness remain homeless, unemployed or incarcerated with insufficient access to services. With the roll out of vaccines comes the hope of having COVID-19 immunity more widespread including for vulnerable populations. Yet, the Delta variant has produced a trail of viral spread and new questions. With all these factors coalescing, there is so much to do to help ensure that access to mental health and substance use services are robust and immediate. The calls for enhanced crisis services that arose prior to the

pandemic have only been heightened. It is important to take stock and continue pursuit of policies and programs to realize improved outcomes for all.

## Taking Stock: Key Areas of Focus that Will Shape Future Outcomes

*Moving from Beyond Beds to Beyond Crises and to a Full Continuum of Psychiatric Care*

NASMHPD polled state mental health leaders in June 2021 asking for their perspectives in reviewing the 10 key original recommendations from the 2017 *Beyond Beds* paper. A self-selected group of 25 respondents provided feedback on which of the recommendations had yielded accomplishments and which were needed to be prioritized in the coming years to ensure an infrastructure of a continuum of mental health services achieved (Table 1). In addition, this same group of state leaders who are enthusiastically and diligently working on the development of the 988 infrastructure were also forthcoming about barriers that exist today that will need additional attention and focus (Table 2).

Table 1: Top Three *Beyond Beds* Recommendations from State Mental Health Leaders

| | **Recommendations where significant progress has been made** | **Recommendations where more progress is needed** | **Recommendations more important after COVID-19** |
|---|---|---|---|
| **First** | The Vital Continuum | The Vital Continuum | Workforce |
| **Second** | Criminal and Juvenile Justice Diversion | Workforce | The Vital Continuum |
| **Third** | Partnerships | Criminal and Juvenile Justice | Technology |

Table 2: Identified Barriers to 988 Implementation from State Mental Health Leaders

| | Count | % of respondents |
|---|---|---|
| Workforce shortages | 16 | 64% |
| Rural/geographic concerns for mobile crisis | 13 | 52% |
| Technology/IT | 9 | 36% |
| Not enough crisis system infrastructure | 9 | 36% |
| Lack of funding | 8 | 32% |
| Meeting needs of diverse populations and geographies | 6 | 24% |
| Insufficient crisis bed capacity | 4 | 16% |
| Ensuring 24/7 availability | 3 | 12% |
| Limited collaboration across law enforcement, emergency medical and mental health systems | 3 | 12% |
| Legislative barriers | 2 | 8% |

The results of this informal survey of state mental health leaders is telling and helps set the stage for areas of emphasis needed as states navigate new budgets and plan for future directions. Other information available about the public's well-being further helps inform priorities.

*Surveys Regarding the Emotional Impact of the COVID-19 Pandemic*

As leaders in behavioral health systems examine what is needed for the future, part of planning must include information about the emotional impact of COVID-19. In March 2020, Brooks and colleagues published a rapid review of the psychological impacts of quarantine from prior outbreaks such as SARS, Ebola, and the H1N1 influenza pandemics.[47] Their findings synthesized 24 papers examining these issues and found negative emotional effects including post-traumatic stress symptoms, confusion, and anger especially related to longer quarantine duration, fears of infection, boredom, frustration, insufficient information and supplies, and financial strain. During the COVID-19 pandemic, similar findings were seen, including from the CDC showing marked increases in mental distress and suicidal ideation compared to the previous year.[48]

Regular household "pulse" surveys (HPS) of persons across the U.S. over the age of 18 during the pandemic were conducted through the CDC in partnership with the U.S. Census Bureau. A report on the findings of the HPS data showed that between August 19, 2020 and February 1, 2021, there were significant increases (from 36.4% to 41.5%) of adults who reported symptoms of anxiety or depressive disorders during the past seven days.[49] This increase in symptom reporting also corresponded with increased reports of needing mental health counseling but had not received it (9.2% to 11.7%), with findings of the greatest increases for those individuals between 18 and 29 years old and those with less than a high school education.

New data is consistently emerging from around the world looking at the emotional impact of the pandemic on populations. For example, Pieh and colleagues[50] examined the mental health of high school students in Austria during social distancing and remote schooling and found, compared to similar data from 2018, increased symptoms of depression, anxiety, insomnia and disordered eating and suicidal ideation. One third of respondents also reported suicidal thoughts. In addition, the authors found increased smartphone use associated with worse mental health.[51] Findings in adults treated for high blood pressure showed that the stress and anxiety during the COVID-19 pandemic lead to a worsening of blood pressure control.[52] A study by the American Psychological Association reported that more than 50% of respondents reported "re-entry anxiety," which was a term used to explain the emotional distress associated with opening back up and returning to work and social events after so many months of staying at home.[53]

Prior studies also showed healthcare workers reporting post-traumatic stress symptoms during outbreaks that pre-dated COVID-19, with depression, insomnia and anxiety sometimes lasting for one to three years afterward.[54] Frontline workers dealing with COVID-19 patients directly may be particularly impacted emotionally with burnout.[55] The behavioral health workforce has had similar strains in dealing with the demand for services in the face of limited supplies and numerous resource challenges.[56] More recent data with responses from over 26,000 state, tribal, local and territorial public health workers suggest that 53% reported symptoms of at least one mental health condition in the prior two weeks, with worse symptoms for those who did not take time off work or worked more than 41 hours per week.[57] Although suicide rate data has not yet shown marked increases, this is an ongoing concern.

Taken together, these trends inform policy makers that the need is now and the demand for mental health services is likely to rise further.

*Diversity, Equity and Inclusion Call to Action*

Disparities in how COVID-19 impacted populations galvanized action to more intentionally focus on health disparities. History teaches us that the disparities in how diseases spread is not new (Figure 3).[58,59,60] The magnitude of COVID-19's impact was, however, new to this century, and called out more about potential vulnerabilities, including those to specific underserved populations. In addition to how COVID-19 impacted persons of color and other ethnic groups, in the field of behavioral health, there were other disparities of note. Studies found individuals with substance use disorders[61], serious mental illness[62] and intellectual and developmental disabilities[63] have been at disproportionate risk of acquiring COVID-19 and its related impacts.

In the context of increased awareness of the uneven distribution of COVID-19, in May 2020, the murder of George Floyd created outrage and protests that transformed the dialogue to an even broader one related to diversity, equity and inclusion across the board. State and federal leaders have focused on more inclusion in hiring key positions with diverse backgrounds at the highest levels. The election of the Biden-Harris Administration embodies this priority, with Vice President Harris representing the first person of color-- and the first woman-- to be elected to this powerful position. Diversity has been a hallmark of President Biden's selection of key leaders. Some states have mirrored these activities.

Figure 3: Lessons from History on Disparities in Health Outcomes During Prior Pandemics

Studies examining previous pandemics indicate that persons of the lowest socioeconomic status had the highest mortality rates from pandemics in 1918 and in 2009. Although there was some indication that there were two waves, with the first hitting the poor, and the second hitting the rich. Another study of the influenza pandemic of 1918 showed that Black Americans had lower morbidity but higher case fatality rates for unclear reasons.

*(Mamelund et al 2019; Mamelund et al. 2018; Økland et al 2019)*

In addition to leadership selection, policies and practices have focused on issues related to diversity and equity. President Biden issued an executive order on January 21, 2021, titled *Ensuring an Equitable Pandemic Response and Recovery,* which established a COVID-19 Health Equity Task Force to provide government-wide efforts to "identify and eliminate health and social disparities that result in disproportionately higher rates of exposure, illness, hospitalization and death related to COVID-19."[64] This has been true among behavioral health leaders and in behavioral health policy making around the country. On behalf of SAMHSA, the 2020 Compendium of technical assistance coalition papers, *Crisis Services: Meeting Needs, Saving Lives,*[65] had a focus on structural racism and the need for health equity. One of its papers solely focused on how crisis services needed to attend to diverse populations if crisis services were to truly be able to serve anyone, at any time, as directed in the SAMHSA Best Practice Toolkit.[66]

The importance of attending to diversity and equity is not only just the right thing to do. It is increasing clear that outcomes for mental illness, substance use disorders and serious emotional disturbances are tied to social determinants of health.[67] The social determinants themselves are clearly impacting populations such as persons of color or Native Americans disproportionately. Not only were these

populations disproportionately impacted byCOVID-19,[68] but data on the emotional impact of COVID-19 seen in the health pulse surveys also show these differences.[69] Suicide rates, drug overdoses and access to care all must therefore be priorities for populations for whom there are differences and disadvantages today.

### *The Promise of 988 and Crisis Best Practices to Service Anyone, Anywhere, at Anytime*

As described above, in July 2020, the FCC approved rules that established 988 as the three-digit number that would serve as the national suicide prevention lifeline to aid callers to get access to supports and services.[70] This paved the way for the October 2020 passage of The National Suicide Hotline Designation Act, touted as a landmark piece of legislation that will change the landscape of crisis response. The signing of this suicide prevention bill was celebrated by many stakeholders, including diverse communities far and wide, such as LGBTQ+ communities,[71] and has been celebrated as a way to reduce police violence toward persons of color by creating alternative pathways to respond to crisis.[72]

There is a recognition that 988 is more than just a suicide prevention lifeline but an entry point for any needed crisis response for any type of behavioral health crisis including suicide, mental health, or youth in distress. The implementation of 988 and a robust crisis continuum of care will require vigilant stakeholder buy-in, appropriate funding, and infrastructure development.

Funding of the future of crisis services is an important area of consideration. In a report to Congress by the Medicaid and CHIP Payment Access Commission (MACPAC), a non-partisan legislative branch agency that provides policy and data analysis to make recommendations to Congress and the U.S. Department of Human Services, the Commission analyzed government datasets to create a series of recommendations regarding access and Medicaid payment of mental health services.[73] The authors highlighted the unmet need of mental health services, including that 50% of Medicaid beneficiaries with serious mental illness said they needed but did not receive treatment and that access to treatment is affected greatly by the extent of which states cover services and the willingness of providers to accept new Medicaid patients. It is estimated that one out of every four individuals with serious mental illness are covered by Medicaid, and one out of every six individuals with a substance use disorder,[74] and as such Medicaid remains a big player in the infrastructure of a robust behavioral health continuum of care.

*Beyond Beds*

**Recommendation #3: Criminal and Juvenile Justice Diversion**

Fund and foster evidence-based programs to divert adults with serious mental illness and youth with serious mental illness or emotional disorders from justice settings to the treatment system. These programs should operate at all intercept points across the sequential intercept framework and be required to function in collaboration with correctional and other systems.

With regard to funding crisis services, many states are working toward legislation that taxes citizens to collect funding support 988 similar to how 911 is funded, with Virginia being the first state to pass such legislation.[75] NASMHPD has been working with state leaders to help in these efforts. In addition, since many crisis service recipients receive their behavioral health care through Medicaid or are individuals with serious mental illness or substance use disorders, SAMHSA and the Center for Medicaid and Medicare Services (CMS) have major roles in developing funding pathways. This includes significant set asides in federal block grant dollars, including those that are coming to the states via the American Rescue Plan Act (ARPA) as well as other funding mechanisms. Yet there will also be the need to engage

with private insurers and other funding streams to help ensure the success of crisis services, since they will be accessible to all.

Another consideration is that it is believed that the implementation of 988 will increase the demand for crisis services. Although Medicaid programs can play a critical role in financing them, states have little guidance on how to implement funding to support this work. To that end, MACPAC recommends that joint sub regulatory guidance from the federal government should address how Medicaid and CHIP can be used to fund a crisis continuum for beneficiaries experiencing mental health crises. An analysis published by Vikki Wachino and Natasha Camhi for the Well Being Trust provides five policy pathways through Medicaid, referred to in their paper as building blocks, in how Medicaid can help states pay for and build robust crisis systems. These include 1) expanding benefits to cover crisis services through state options, 2) using waiver authorities to increase access to home and community based services (HCBS), 3) using managed care delivery systems to provide crisis services, 4) expanding crisis services through 1115 demonstration waivers and 5) financing administrative spending for Medicaid beneficiaries in call centers.[76] These guiding recommendations may serve as a roadmap for states as they also balance funding coming in through the ARPA funds and the provisions for enhanced Home and Community Based Services (HCBS).

The expectation of the authorizing legislation for 988 is that it be operational by July 2022. As such, states are working to ensure that they are ready for the 988 launch. To help foster collaboration and inspire the development of 988 activities, SAMHSA, NASMHPD and other partners have helped develop a weekly virtual "Crisis Jam" that has been hosted through RI International, in partnership with the National Action Alliance for Suicide Prevention, the National Suicide Prevention Lifeline, Vibrant Emotional health and NASMHPD, where leaders from around the country inform each other on best practices and next steps for 988 roll out. Each week more than 200 individuals attend. As part of this effort, NASMHPD also helped launch #CrisisTalk,[77] which provides a wealth of information and news-type reports related to crisis services role out.

The promise of 988, envisions high call volumes responded to via crisis call centers with full GPS information on a caller's location. Through this technology, call responders will help inform individuals about local behavioral health resources and be able to deploy a mobile crisis team if necessary.

### *Workforce Needs*

A robust continuum of psychiatric care requires the workforce infrastructure to make it effective. There are major concerns that workforce shortages will impede the ability to respond to the tsunami of mental health needs. In 2018, the National Council for Mental Wellbeing Medical Directors Institute put forth a report titled *Psychiatric Shortages: Causes and Solutions*,[78] highlighting years of psychiatric workforce shortages and the need to expand care to integrated multi-disciplinary care teams to help ensure access to services. Direct care workers and direct support professionals have also been highlighted as a priority area of need.[79,80,81] The General Accounting Office noted in 2001 of the need to attend to critical shortage areas of direct care workers, including those that work for older adults and others.[82]

All levels of care in the continuum seem to be impacted, and in some places, staffing is at a critical level. Take Oregon, for example, where its state hospitals were found to be in dire conditions with more than 45% of its direct care staff taking leave, necessitating in the spring of 2021 the state to call in the National Guard to assist.[83]

*Beyond Beds*

**Recommendation #9: Workforce**

Initiate assessments to identify, establish, and implement public policies and public-private partnerships that will reduce structural obstacles to people's entering or staying in the mental health workforce, including peer support for adults and parent partners for youth and their families. These assessments should include but not be limited to educational and training opportunities, pay disparities, and workplace safety issues. The assessments should be conducted for the workforce across all positions.

Several states and legislators are attempting to create solutions to workforce shortages. For example, faced with new legislation that was expanding an autism benefit, Michigan worked to expand the availability of board-certified behavior analysts by expanding certification programs to ten universities throughout the state.[84] As another example, although the state declared a staffing crisis in its state hospitals, CareOregon is making a major investment of $7.5 million in 25 behavioral health provider organizations to help them recruit and retain staff as part of the CareOregon Emergency Behavioral Health Workforce Stabilization Fund proposal.[85] In Congress, Representative Debbie Dingell (MI) proposed the Better Care Better Jobs Act to help stabilize and expand the workforce providing home and community-based services.[86] These efforts are important steps forward. However, as noted by the survey of Commissioners outlined above, workforce shortages represent one of the most significant concerns for state mental health leaders and will remain a key priority area of focus in order to meet the demands for mental health services.

### *Advancing Technology*

Expanding and strengthening telepractice was highlighted as another significant priority area in the Commissioners' survey. Even before the pandemic, the use of telepsychiatry was gaining traction and studies were showing positive outcomes.[87] In the massive transition to address the COVID-19 pandemic, the use of technology become an imperative. Mental health and substance use services saw remarkable shifts in care delivery to almost total video or telephonic use in order to facilitate access and social distancing related to the pandemic.[88] During the pandemic, the federal government assisted in the transition by supporting polices that helped to minimize disruptions to care delivery during the emergency declaration.[89] As the workforce got comfortable with virtual platforms, many organizations attempted to provide guidance regarding the provision of telepractices.[90] A review of the literature synthesized from international experiences highlighted practical guidance and the need to understand hybrid approaches in the post-COVID-19 world.[91]

*Beyond Beds*

**Recommendation #8: Technology**

Create and expand programs that incentivize and reward the use of technology to advance care delivery, promote appropriate information sharing, and maximize continuity of care. Policymakers should require as a condition of such incentives that outcome data be utilized to help identify the most effective technologies, and they should actively incorporate proven technologies and computer modeling in public policy and practice.

Although virtual platforms helped maintain a specific level of service, certain areas where broadband access or for populations for whom access to cell phone minutes were more limited created disparities in access.[92] In addition to these types of challenges, there have been ongoing questions about whether telephone-only services will yield the same payment structures as video-based clinical interventions.

More work is also needed to examine whether the shift to emphasize virtual technology over in-person over the long-term will have the same positive benefits it seems to have had during the crisis.

## Key Areas for Priority in Behavioral Health Services Beyond COVID-19 and Beyond Beds

Mental health services are rapidly shifting and have proven both nimble and resilient in the face of unprecedented demands and a fluid environmental context with the emergence of COVID-19. At the same time, mental health and substance use challenges remain, and their development requires ongoing vigilance. Now is the time to be ready to respond to need and to anticipate avenues that can support a sustained, improved, and robust continuum of psychiatric care. The recommendations from the 2017 *Beyond Beds* remain relevant today. It is clear that psychiatric inpatient services, although necessary, are not sufficient as a single solution to the mental health needs of the population. In the COVID-19 recovery period, key priority recommendations must be highlighted-- some as spin offs from the 2017 recommendations, and some with a newer focus. Details surrounding these recommendations are delineated in this 2021 *Ready to Respond* compendium's individual technical assistance papers as outlined in Table 3. Each theme helps shape aspects of a reimagined sustainable and robust continuum of psychiatric care.

Table 3: 2021 NASMHPD *Ready to Respond* Compendium of Technical Assistance Coalition Papers

| No. | Compendium Topics |
|---|---|
| 1 | Ready to Respond: Mental Health Beyond Crisis and COVID-19 |
| 2 | Disaster Behavioral Health Through the Lens of COVID-19 |
| 3 | Suicide Prevention and 988: Before, During and After COVID19 |
| 4 | Law Enforcement and Crisis Services: Past Lessons for New Partnerships and the Future of 988 |
| 5 | Strategies and Considerations for Providing a More Equitable Crisis Continuum for People of Color in the United States |
| 6 | The Effects of COVID-19 on Children, Youth and Families |
| 7 | Mental Health System Development in Rural and Remote Areas during COVID-19 |
| 8 | Funding Opportunities for Expanding Crisis Stabilization Systems and Services |
| 9 | Technology's Acceleration in Behavioral Health: COVID, 988, Social Media, Treatment and More |
| 10 | Using Data to Manage State and Local-level Mental Health Crisis Services |

Within this "Ready to Respond" framework, key areas of priority have emerged across the various topics. These priority policy recommendations are highlighted below:

***1. Expand and achieve a full continuum of crisis services.***

Through the crisis of the pandemic, a greater push for crisis response enhancement has been achieved. Important changes are on the horizon with the revamping of the National Suicide Prevention Lifeline number to an easy-to remember 3-digit number, 988, expanding the Lifeline network for better coverage across the states, and making investments in quality assurance to improve the provision of quality care. The Lifeline will provide expanded capacity for a surge of calls during any future disaster/emergency.


Given that the launch of 988 is less than a year ahead of this writing and the growing demands for improved responses from law enforcement and behavioral health supports, prioritization of the crisis work must continue. This will mean the expansion of interconnected lifeline centers, bringing together 911 and 988 activities, as well as the launch of an increased number of mobile crisis intervention (MCI) and mobile crisis services (MCS) for persons of all ages. There is a need for increasing research and empirical evidence for what types of mobile response are best for which populations, what types of staffing models are ideal, and what roles behavioral health staff play when emergency medical services and law enforcement are each called to a scene. The role of peers and recovery coaches will need to be expanded and further refined for these services. Crisis text lines, peer warm lines and information about resources such as domestic violence, grief support, housing and employment services must all be available for callers to receive. High risk situations during a crisis, including working with armed individuals, though rare, must also be triaged addressed with the most appropriate and least restrictive interventions without compromising safety. And persons in crisis must be linked to care, whether its MAT for opioid use disorder, or psychotropic medications for acute psychotic conditions, there must be immediate access to evidence-based therapies available through the crisis network.

***2. Rebuild and reboot a robust, diverse, and well-qualified workforce.***

*Rebuild and Reboot a Robust Workforce*

As noted above, burnout rates of frontline workers are profound, and the gaps in workforce seem to be at an all-time alarming rate. With the needs for mental health and substance use services on the rise, now is the time to regenerate a workforce that is ready, willing and able to serve in the public and private behavioral health systems and provide care for each other. Just as in the *Beyond Beds* recommendations, this includes expanding the workforce beyond the traditional professionals, integrating expanded roles for peer supports, recovery coaches and even lay staff to help support some of the infrastructure of services for individuals to help them remain. Highlighting the need for greater education and pay for direct care workers and direct support professionals is also going to be necessary to support the home and community-based services tenets. As the workforce is being developed, they will also need a greater intentional focus on their own well-being, and flexible job options such as flex schedules and virtual options where feasible. Working with schools to grow and develop workforce is another avenue that warrants further exploration, along with loan repayment programs and attention to health professional shortage area designations. Innovation to grow the workforce will be needed, and many states are already embarking on dialogue to implement new ideas along these lines.

***3. Expand telehealth practices while ensuring ongoing quality and access.***

*Expand Telehealth*

The pivot to the use of technology in response to the COVID-19 pandemic catalyzed major changes in the workplace that will likely never return to pre-COVID-19 operations. Technological advances in providing care will continue to require research and innovation as the technology develops still further. Hybrid approaches that allow for some in-person connections as well as telehealth activities need to be studied to help determine best practices for particular individuals, settings and conditions. Given the workforce challenges, the use of telehealth has allowed for expanded crisis responses in more remote

areas. The potential for increasing broadband access to regions currently less served opens a myriad of possibilities for enhancements. Lessons learned from the COVID-19 experience should be taken to help shore up responses to future disasters, and future enhancements should be driven by data. Telehealth has proven lifesaving, both because it allowed for mitigation of viral spread at the height of the early pandemic outbreak, and because it helped keep people in mental health services who may have otherwise been at risk of decompensation or suicide. The effort now should be focused on how to sustain the most impactful aspects of telehealth and continue to enhance quality and access not as a replacement for all in-person services but as another quality tool in the array of services available.

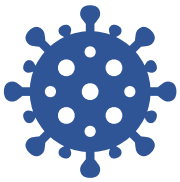
***4. Foster integration of disaster behavioral health into emergency preparedness and response.***

Although COVID-19 has caused immeasurable pain and loss, it has catalyzed opportunities to improve the behavioral health system's integration into emergency preparedness and to assist in future continuity of operations. Disaster behavioral health (DBH) should continue to be implemented with three immediate foci:

- Ensure that vulnerable populations with serious mental illness, serious emotional disturbances, substance use disorder, persons with intellectual and developmental disabilities, neurocognitive conditions and traumatic brain injuries who require additional supports are well served without disruption during emergencies.
- Coordination of DBH requires efforts to address the general emotional impacts of emergencies on the population as a whole.
- DBH activities should also center around serving the emotional needs of the public health and behavioral health workforce as a separate and focused effort.

Planning as part of disaster preparedness should include developing culturally and linguistically tailored messages to provide information and identify supports for diverse populations. The benefits of self-care, the skills of peers and peer navigators, the willingness of faith-based messengers and influencers, and the value of warmlines, telehealth and provider mutual aid agreements locally or with neighboring states became more evident during COVID-19, and these resources should be augmented. The SAMHSA Disaster Distress Helpline and Crisis Text Lines handled substantial increases in volume, reflecting anxiety and distress brought on by COVID-19's many uncertainties and the critical importance of these types of assets. Grants available through FEMA's Crisis Counseling Program (CCP) for short-term support to states and special grant opportunities[93] and increased Medicaid matching helped states to cover service needs related to COVID-19, and advocacy and access to these resources proved invaluable and should continue.

*Emergency Preparedness*



In 2019, *Beyond the Borders: Lessons from the International Community to Improve Mental Health Outcomes* examined the experience of other countries in responding to disaster and building sustained improvements in mental health services.[94] Similarly, Yox reviewed the lessons learned about global health, and called out some of the global health conceptualizations as placing priorities on improved health and achieving equity in health worldwide.[95] She describes work of the National Association of County and City Health Officials (NACCHO) and local health departments (LHDs) and the importance of focusing on global health, allowing and shifting to bidirectional learning so that those LHDs in the United States can also learn from the experiences of other countries in dealing with local health crises. She

notes that given the inherent risks of long-term impact of COVID-19 on social isolation, mental health and substance use the need to look beyond one's borders and continue to improve in a global sense is paramount. By focusing on global health, and examining physical and mental health simultaneously, there may continue to be evolving strategies that can foster greater healing and recovery from disasters.

***5. Consider creative financial opportunities to maximize access to crisis response and other community-based mental health and substance use services with no wrong door.***

Funding streams for crisis services will likely be needed from a variety of sources, including Medicaid, CHIP, general funds, new tax levies on 988 calls, federal discretionary grants such as block grant dollars, private insurers and more immediate funds coming through the American Rescue Plan Act. The challenge is that each of these sources of funding have their own mandates, limitations and requirements. They also are managed at state and local levels by different entities which can create barriers to uniform planning for a service that cuts across all sectors. Even outside of the traditional mental health and substance use state authorities, there is the need to serve individuals with intellectual and developmental disabilities, older adults, schools, child welfare, juvenile justice, criminal legal and court systems who send referrals either in a moment of crisis or as part of the full array of supports needed. This will include leveraging waiver options for Medicaid services to maximize federal dollars, as well as considering options to manage finances through population based initiatives such as health homes, accountable care organizations or managed type entities, as well as using demonstration opportunities for community level comprehensive services such as in the Certified Community Behavioral Health Center Model. Opportunities for creative options exist for states to help serve individuals that did not exist previously, and policymakers therefore are given a golden opportunity to use the funds wisely.

*Financial Opportunities*

***6. Focus intentionally on diversity, equity and inclusion to reduce disparities in mental health outcomes.***

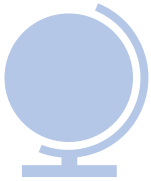
Tragically, disparities in healthcare have not dissipated. In fact, the impact of COVID-19 has made them only more apparent. Leadership at the highest level of the federal government has recognized the critical importance of ensuring diversity of representation and intentional efforts to study health outcomes from an equity lens. In the space of crisis services and the broader continuum of psychiatric services for all ages, attending to diverse populations and their unique needs is critical. The needs of Black and Brown persons, Latinos, American Indian and Alaska Natives, among individuals with serious mental illness or other behavioral health type condition, just to name a few, require and deserve targeted approaches to eliminate the disparities in mental health outcomes such as suicide rates, overdose rates, child welfare removals, and others that can lead to downstream consequences and impact generations. Policymakers should take every possible action to eliminate needless tragic outcomes associated with law enforcement encounters with persons of color and persons with mental illness that all too often are reported. Still, it is important to recognize that law enforcement will remain a partner in the crisis response system, and therefore efforts will be needed to engage them and focus those responses on the right situations and with attention to equity in access to jail diversion and reduced use of force as much as possible. Equitable, accessible, and just quality care must be front and center and cultural humility should enter service delivery. Much work is needed to reduce disparities. Calling these issues out is only the first step.

*Focus on diversity, equity and inclusion*

### *7. Enhance interconnectedness with other systems and across borders for improved global responses*

State mental health authorities have a unique role to play in expanding the crisis continuum, but they cannot do this in isolation. Collaborations are needed and bringing in stakeholders as advisors in program development aligns with federal funding requirements, such as is seen in mental health advisory bodies at state and local leadership levels. Collaborations between behavioral health and public health has been critical in addressing the COVID-19 pandemic and brought out the need to integrate these efforts in a sustainable way. As noted above, global health now has meaning and relevance to the human experience. Shifts away from traditional law enforcement responses in many cases, and ongoing needs of jail diversion and reentry supports, juvenile justice diversion remain key priority areas. Work must continue building bridges between child welfare, schools, and children's behavioral health services. Local hospitals must be interconnected with community-based services. Persons with substance use disorders require warm handoffs and MAT must be available because it can literally save lives. Persons with traumatic brain injuries, intellectual and developmental disabilities and other challenges often appear in the behavioral health systems. Given these needs, establishing and enhancing interconnectedness has never been more important. Network analyses should demand policy makers to make sure that they have all the partners at the table and that they get input from various perspectives to roll out the best services possible.

*Interconnectedness for Global Responses*



## Conclusions

Although there have been many advances in improving mental illness outcomes, too many people with serious mental illness, serious emotional disorders, and co-occurring substance use disorders are still waiting too long to receive needed services. Too many are homeless, too many are being arrested, are incarcerated or in the juvenile justice settings, too many are overdosing and dying by suicide. With COVID-19 so many lives have been lost, and many people are in need of emotional support. Now, as COVID-19 vaccines roll out, and new funding is being distributed, there is hope on the horizon. Yet, while the virus continues to be present, there are even broader population mental health needs that will require immediate access through no wrong door policies. The daily dialogues are replete with ideas about how to build crisis services along a continuum Looking beyond COVID-19 and beyond crisis, there continues to be a need for interventions across a continuum of care, the funding to support them, and a workforce to deliver them. *Ready to Respond* aims to provide a level-setting overview of the current landscape and highlights areas needed for prioritization. The resilience of our communities is profoundly humbling given what experiences have come through this pandemic. Taking that strength forward, there is no better time than now to collaboratively pursue improved services for better outcomes.

## References


[1] Pinals DA, Fuller DA: Beyond beds: The vital role of a full continuum of psychiatric care. Alexandria, VA, National Association of State Mental Health Program Directors, 2017. https://www.nasmhpd.org/sites/default/files/TAC.Paper_.1Beyond_Beds.pdf

[2] Ibid

[3] Pinals DA, Fuller DA: Bolder goals, better results: Seven breakthrough strategies to improve mental illness outcomes. Alexandria, VA, National Association of State Mental Health Program Directors, 2018. https://www.nasmhpd.org/content/ta-coalition-assessment-working-paper-bolder-goals-better-results-seven-breakthrough

[4] Pinals DA: Beyond the borders: Lessons from the international community to improve mental health outcomes. Alexandria, VA, National Association of State Mental Health Program Directors, 2019. https://www.nasmhpd.org/sites/default/files/TAC_Paper_1_508C.pdf

[5] Pinals DA: Crisis services: Meeting needs, saving lives. Alexandria, VA, National Association of State Mental Health Program Directors, 2020. https://www.nasmhpd.org/sites/default/files/2020paper1.pdf

[6] Pinals DA, Hepburn B, Parks J, et al: The behavioral health system and its response to COVID-19: A snapshot perspective. *Psychiatr Serv* 2020; 71(10):1070–1074

[7] Suicide statistics. Washington, DC, American Foundation for Suicide Prevention, 2021. https://afsp.org/suicide-statistics

[8] Hedegaard H, Curtin SC, Warner M: Increase in Suicide Mortality in the United States, 1999-2018. Centers for Disease Control and Prevention, National Center for Health Statistics Data Brief, April 2020. https://www.cdc.gov/nchs/data/databriefs/db362-h.pdf

[9] Abott B: Youth suicide rate increased 56% in decade, CDC says. *The Wall Street Journal,* 2019m Oct 17. https://www.wsj.com/articles/youth-suicide-rate-rises-56-in-decade-cdc-says-11571284861

[10] 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. Washington, DC: U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012. https://www.ncbi.nlm.nih.gov/books/NBK109917/

[11] Pirkis J, John A, Shin S, et al: Suicide trends in the early months of the COVID-19 pandemic: an interrupted time series analysis of preliminary data from 21 countries. *Lancet Psychiatry* (Epub ahead of print April 13, 2021)

[12] Czeisler MÉ, Lane RI, Petrosky E, et al. Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. *MMWR Morbidity and Mortality Weekly Report* 2020; 69:1049–1057

[13] Ibid.

[14] Twenge, JM, Joiner, TE: Mental distress among U.S. adults during the COVID-19 pandemic. *Journal of Clinical Psychology* 2020; 76:2170-2182

[15] Y Yard E, Radhakrishnan L, Ballasteros MF, et al: Emergency Department Visits for Suspected Suicide Attempts Among Persons Aged 12–25 Years Before and During the COVID-19 Pandemic — United States, January 2019–May 2021. *MMWR Morbidity and Mortality Weekly Report* 2021; 70(24):888-894

[16] Reger MA, Stanley IH, Joiner TE. Suicide Mortality and Coronavirus Disease 2019—A Perfect Storm? *JAMA Psychiatry.* 2020;77(11):1093–1094.

[17] Statewide opioid response grants. Rockville, MD, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/grants/grant-announcements/ti-20-012af

[18] State targeted response to the opioid crisis grants. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2016. https://www.samhsa.gov/grants/grant-announcements/ti-17-014

[19] Ahmad FB, Rossen LM, Sutton P: Provisional drug overdose death counts. Centers for Disease Control and Prevention, National Center for Health Statistics Data Brief, 2021. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

[20] Han B, Cotto J, Etz K, et al: Methamphetamine overdose deaths in the US by sex and race and ethnicity. *JAMA Psychiatry* 2021; 78(5):564–567

[21] Results from the 2019 National Survey on Drug Use and Health: Detailed tables. Rockville, MD, Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, 2020. https://www.samhsa.gov/data/

[22] Munetz MR, Griffin PA: Use of the sequential intercept model as an approach to decriminalization of people with serious mental illness. *Psychiatr Serv* 2006; 57(4):544–549

[23] Abreu D, Parker TW, Noether CD, et al.: Revising the paradigm for jail diversion for people with mental and substance use disorders: Intercept 0. Behav Sci Law 2017; 35:380–395

[24] H.R.31–21st Century Cures Act (2015-2016). https://www.congress.gov/bill/114th-congress/house-bill/34

[25] The Stepping Up Initiative. Washington, DC, National Association of Counties. https://stepuptogether.org/

[26] Schindler M, Kittredge J: A crisis within a crisis: Police killings of Black emerging adults. Washington, DC, The Brookings Institute, 2020. https://www.brookings.edu/blog/how-we-rise/2020/12/02/a-crisis-within-a-crisis-police-killings-of-black-emerging-adults/

[27] Climer A, Gicker B: CAHOOTS: A model for prehospital mental health crisis intervention. *Psychiatric Times* 2021; 38. https://www.psychiatrictimes.com/view/cahoots-model-prehospital-mental-health-crisis-intervention

[28] Gerety RM: An alternative to police that police can get behind. *The Atlantic,* 2020, Dec 28. https://www.theatlantic.com/politics/archive/2020/12/cahoots-program-may-reduce-likelihood-of-police-violence/617477/

[29] Bunts, W: Youth Mobile Response Services: An Investment to Decriminalize Mental Health. Washington, DC, The Center for Law and Policy, 2021. https://www.clasp.org/sites/default/files/publications/2021/04/Youth%20Mobile%20Response%20Services_0.pdf

[30] Bebinger M: Kids in mental health crisis can languish for days inside ERs. *National Public Radio,* 2021 Jun 23. https://www.npr.org/sections/health-shots/2021/06/23/1005530668/kids-mental-health-crisis-suicide-teens-er-treatment-boarding

[31] Perkins J: Fact Sheet EPSDT Litigation Trends & Docket. Washington, DC, National Health Law Program, 2020. https://healthlaw.org/resource/fact-sheet-epsdt-litigation-trends-docket/

[32] Intensive/Qualified Residential Treatment. Washington, DC, Children's Bureau. https://www.childwelfare.gov/topics/outofhome/group-residential-care/intensive/

[33] Rosie D: Reforming the mental health system in Massachusetts. Northhampton, MA, Center for Public Representation. http://www.rosied.org/

[34] Fuller DA, Sinclair E, Lamb HR, et al: Emptying the "New Asylums": A Beds Capacity Model to Reduce Mental Illness Behind Bars. Arlington, VA, Treatment Advocacy Center, 2017

[35] Pinals DA, Callahan L: Evaluation and restoration of competence to stand trial: Intercepting the forensic system using the sequential intercept model. *Psychiatr Serv* 2020; 71:698–705

[36] Trueblood v Washington State Department of Social and Health Services, 101 F Supp 3d 1037 (9th Cir 2016)

[37] In re the Detention of: *D.W., G.K., S.P., E.S., M.H., S.P., L.W., J.P., D.C. and M.P.*

[38] Baker R: State loses mental health lawsuit over emergency room boarding. *The Laconia Daily Sun* 2021, May 20. https://www.laconiadailysun.com/news/local/state-loses-mental-health-lawsuit-over-emergency-room-boarding/article_63d7c5b2-b29d-11eb-993b-5b2ce3601178.html

[39] Ramer H: Court rules against New Hampshire in emergency room boarding case. *Associated Press* 2021, May 12. https://www.seacoastonline.com/story/news/2021/05/12/top-court-rules-against-new-hampshire-emergency-room-boarding-case/5052818001/

[40] Mental health boarding: In re detention of DW and the legislative response. Seattle, WA, Washington State Hospital Association. https://www.wsha.org/policy-advocacy/issues/legal-issues/mental-health-boarding-in-re-detention-of-dw-and-the-legislative-response/

[41] Olmstead v. LC, 527 U.S. 581 (1999)

[42] Mann C: Final rule – CMS 2249-F – 1915(i) State Plan Home and Community-Based Services. Baltimore, MD, Centers for Medicare and Medicaid Services, Department of Health and Human Services, 2014. https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-10-14.pdf

[43] National Guidelines for Behavioral Health Crisis Care, Best Practice Toolkit. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2020. https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

[44] Pinals DA: Crisis services: Meeting needs, saving lives. Alexandria, VA, National Association of State Mental Health Program Directors, 2020. https://www.nasmhpd.org/sites/default/files/2020paper1.pdf

[45] Roadmap to the Ideal Crisis System. Washington, DC, The National Council for Mental Wellbeing, 2021. https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwiamNzBobPyAhWfVTABHWNjACEQFnoECAMQAQ&url=https%3A%2F%2Fwww.thenationalcouncil.org%2Fwp-content%2Fuploads%2F2021%2F03%2F031221_GAP_Crisis-Report_ExecutiveSummary-final.pdf&usg=AOvVaw2tzC8q5KhXolgmeGkbklyV

[46] Holshue ML, DeBolt C, Lindquist S, et al: First Case of 2019 Novel Coronavirus in the United States. *N Engl J Med* 2020; 382:929-936

[47] Brooks SK, Webster RK, Smith LE, et al: The psychological impact of quarantine and how to reduce it: rapid review of the evidence. *Lancet*. 2020; 395(10227):912-920

[48] Czeisler MÉ, Lane RI, Petrosky E, et al. Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020. *MMWR Morbidity and Mortality Weekly Report* 2020; 69:1049–1057

[49] Vahratian A, Blumberg SJ, Terlizzi EP, et al: Symptoms of Anxiety or Depressive Disorder and Use of Mental Health Care Among Adults During the COVID-19 Pandemic — United States, August 2020–February 2021. *MMWR Morb Mortal Wkly Rep* 2021; 70:490–494

[50] Pieh C, Plener PL, Probst T, et al: Assessment of mental health of high school students during social distancing and remote schooling during the COVID-19 pandemic in Australia. *JAMA Netw Open* 2021; 4(6):e2114866

[51] Ibid.

[52] Celik M, Yilmaz Y, Karagoz A, et al: Anxiety Disorder Associated with the COVID-19 Pandemic Causes Deterioration of Blood Pressure Control in Primary Hypertensive Patients. *Medeni Med J*. 2021; 36(2):83-90

**[53]** Pappas S: Why the pandemic's end spurs anxiety. Washington, DC, American Psychological Association, 2021. https://www.apa.org/topics/covid-19/pandemic-end-anxiety

[54] Preti E, Di Mattei V, Perego G, et al: The Psychological Impact of Epidemic and Pandemic Outbreaks on Healthcare Workers: Rapid Review of the Evidence. *Curr Psychiatry Rep.* 2020; 22(8):43

[55] Lai J, Ma S, Wang Y, et al: Factors Associated With Mental Health Outcomes Among Health Care Workers Exposed to Coronavirus Disease 2019. *JAMA Netw Open*. 2020; 3(3):e203976

[56] Pinals DA, Hepburn B, Parks J, et al: The behavioral health system and its response to COVID-19: A snapshot perspective. *Psychiatr Serv* 2020; 71(10):1070–1074

[57] Bryant-Genevier J, Rao CY, Lopes-Cardozo B, et al: Symptoms of Depression, Anxiety, Post-Traumatic Stress Disorder, and Suicidal Ideation Among State, Tribal, Local, and Territorial Public Health Workers During the COVID-19 Pandemic — United States, March–April 2021. *MMWR Morb Mortal Wkly Rep* 2021; 70:947–952

[58] Mamelund SE, Dimka J: Tuberculosis as a risk factor for 1918 influenza pandemic outcomes. *Trop. Med. Infect. Dis.* 2019; 4(2):74

[59] Mamelund SE: 1918 pandemic morbidity: The first wave hits the poor, the second wave hits the rich. *Influenza Resp. Viruses* 2018; 12(3):307–313

[60] Økland H, Mameland SE: Race and 1918 influenza pandemic in the United States: A review of the literature. *Int. J. Res. Public Health* 2019; 16(14):2487

[61] Melamed OC, Hauck TS, Buckley L, et al: COVID-19 and persons with substance use disorders: Inequities and mitigation strategies. *Subst Abus.* 2020;41(3):286-291

[62] Volkow N: Study reveals adults with mental disorders are at significantly higher risk of COVID0-19 and have poorer outcomes. New York, NY, Brain and Behavior Research Foundation, 2020. https://www.bbrfoundation.org/content/study-reveals-adults-mental-disorders-are-significantly-higher-risk-covid-19-and-have-poorer

[63] Turk MA, Landes SD, Formica MK, et al: Intellectual and developmental disability and COVID-19 case-fatality trends: TriNetX analysis. *Disabil Health J.* 2020;13(3):100942

[64] COVID-19 Health Equity Task Force. Washington, DC, U.S. Department of Health and Human Services Office of Minority Health. https://www.minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=100

[65] Pinals DA" Crisis Services: Meeting Needs, Saving Lives. Alexandria, VA, National Association of State Mental Health Program Directors, 2020.

[66] Pinals DA, Edwards ML: Crisis services: Addressing unique needs of diverse populations. Alexandria, VA, National Association of State Mental Health Program Directors, 2020.

[67] Alegria M, NeMoyer A, Falgas I, et al: Social determinants of mental health: Where we are and where we need to go. *Curr Psychiatry* Rep 2018; 20(11): 95

[68] Racial data transparency. Baltimore, MD, Coronavirus Resource Center, Johns Hopkins University of Medicine. https://coronavirus.jhu.edu/data/racial-data-transparency
[69] Household pulse survey. Atlanta, GA, Centers for Disease Control and Prevention, 2021. https://www.cdc.gov/nchs/covid19/pulse/mental-health.htm
[70] Implementation of the National Suicide Hotline Improvement Act of 2018. Washington, DC, Federal Communications Commission, 2020. https://www.fcc.gov/document/designating-988-national-suicide-prevention-lifeline-0
[71] 988 officially becomes law. West Hollywood, CA, The Trevor Project 2020, October 19. https://www.thetrevorproject.org/2020/10/19/988-officially-becomes-law/
[72] Rankin K: New national mental health crisis line can save black lives. *Health Central* 2020, December 9. https://www.healthcentral.com/article/mental-health-hotline-black-lives
[73] Access to Mental Health Services for Adults Covered by Medicaid. Washington, DC, Medicaid and CHIP Payment Access Commission 2021. https://www.macpac.gov/wp-content/uploads/2021/06/Chapter-2-Access-to-Mental-Health-Services-for-Adults-Covered-by-Medicaid.pdf
[74] Results from the 2019 National Survey on Drug Use and Health: Detailed tables. Rockville, MD, Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, 2020. https://www.samhsa.gov/data/
[75] Hepburn S: Virginia is first state to pass 988 service fee legislation. Alexandria, VA, Crisis Talk 2021, May 4. https://talk.crisisnow.com/virginia-is-first-state-to-pass-988-service-fee-legislation/
[76] Wachino V, Camhi N: Building Blocks: How Medicaid Can Advance Mental Health and Substance Use Crisis Response. Well Being Trust, May 2021. https://wellbeingtrust.org/news/how-medicaid-can-advance-mental-health-and-substance-use-crisis-response/
[77] Crisis now. Alexandria, VA, National Association for State Mental Health Program Directors. https://talk.crisisnow.com/
[78] The psychiatric shortage: Causes and Solutions. Washington, DC, National Council for Mental Wellbeing, 2018. https://www.thenationalcouncil.org/wp-content/uploads/2017/03/Psychiatric-Shortage_National-Council-.pdf?daf=375ateTbd56
[79] Retooling for an Aging America: Building the Health Care Workforce. Washington, DC, National Academies Press, 2008. https://www.ncbi.nlm.nih.gov/books/NBK215393/
[80] Yorkunas R: A workforce in crisis: Disability services are seeing a shortage of direct support staff. *Fox 43* 2021, June 12. https://www.fox43.com/article/news/local/direct-support-professionals-workforce-crisis/521-46f28311-b88f-43cf-b0dc-3f7f9349b715
[81] 2019 Direct Support Professional Compensation Study. Blue Bell, PA, Moving Agencies toward Excellence, 2020. https://www.paproviders.org/wp-content/uploads/2020/01/2019.1219-2019-DSP-and-Frontline-Supervisor-Compensation-Study.pdf
[82] Health workforce: Ensuring adequate supply and distribution remains challenging. Washington, DC, United States General Accounting Office, 2021.
[83] Wilson C: 'Dire' staffing situation at Oregon State Hospital prompts call for National Guard to assist. *OPB,* 2021, August 13. https://www.opb.org/article/2021/05/27/oregon-state-hospital-staffing-issues-national-guard-assistance/
[84] Lt. Gov. Calley: Michigan autism progress includes top 10 ranking for certified behavior analysts. Lansing, MI, State of Michigan, 2018. https://www.michigan.gov/som/0,4669,7-192-29701_74909_74922-484306--,00.html
[85] CareOregon to invest $7.5 million in 25 behavioral health provider organizations to improve processional recruiting & retention. *Open Minds* 2021. https://openminds.com/market-intelligence/news/careoregon-to-invest-7-5-million-in-25-behavioral-health-provider-organizations-to-address-clinical-professional-burnout/?utm_source=mailchimp&utm_medium=email&utm_campaign=weekly-news&utm_content=2021-07-02
[86] 117th Congress 1st Session. https://debbiedingell.house.gov/uploadedfiles/hcbs_01_xml.pdf
[87] Hubley S, Lynch SB, Schneck C, et al: Review of key telepsychiatry outcomes. *World J Psychiatry* 2016;6(2):269-82
[88] Pinals DA, Hepburn B, Parks J, et al: The behavioral health system and its response to COVID-19: A snapshot perspective. *Psychiatr Serv* 2020;71(10):1070–1074

[89] Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency. Washington, DC, U.S. Department of Health and Human Services, 2021. https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

[90] Telepsychiatry toolkit. Washington, DC, American Psychiatric Association. https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/toolkit

[91] Smith K, Ostinelli E, Macdonald O, et al: COVID-19 and Telepsychiatry: Development of Evidence-Based Guidance for Clinicians. *JMIR Ment Health* 2020;7(8):e21108.

[92] Neylon KA: *Using Technology to Improve the Delivery of Behavioral Health Crisis Services in the United States.* Alexandria, VA: National Association of State Mental Health Program Directors, 2020. https://www.nasmhpd.org/sites/default/files/2020paper3.pdf

[93] Crisis Counseling Assistance and Training Program. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2019. https://www.samhsa.gov/dtac/ccp