

The logo for NASMHPD is a white rectangular box with rounded corners, containing the text "NASMHPD" in a bold, blue, sans-serif font. The background of the entire cover is a textured, painterly illustration of blue water with a central orange life preserver floating on the surface, creating concentric ripples. The life preserver has three grey straps and a white rope is attached to it.

NASMHPD

CRISIS SERVICES

**Meeting Needs,
Saving Lives**

AUGUST 2020

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Crisis Services: Meeting Needs, Saving Lives

Debra A Pinals, MD

Project Support

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CRISIS SERVICES:



Meeting Needs, Saving Lives

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*First in the 2020 Series of Eleven Technical Assistance Briefs focused on
Beyond Beds: Crisis Services*



National Association of State Mental Health Program Directors

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ABSTRACT:

With COVID-19 as a constant stressor and new spotlights on the need to address structural racism in society, it is more important than ever to examine how mental wellbeing in the United States can be supported. Even prior to recent events related to these issues, national attention on alarming increases in suicide rates and opioid-related overdose deaths, homelessness, the over-representation of individuals with mental illness, intellectual and developmental disabilities and substance use disorders in the criminal legal system, all called attention to an urgent need for expanded prevention and intervention strategies for people in dire need of help. In 2017, the National Association of State Mental Health Program Directors (NASMHPD) and the Substance Abuse and Mental Health Services Administration (SAMHSA) partnered in advocating for policy makers to consider what it would take to look “Beyond Beds” in state hospitals as a single solution to all the challenges and instead develop a path toward a robust continuum of accessible, effective psychiatric care. Now, three years later, NASMHPD and SAMHSA highlight the first point of entry into that continuum of care- to prevent and manage crises in a way that offers an immediately accessible, interconnected, effective and just continuum of crisis behavioral health services. By enhancing crisis response, community needs can be met, and lives can be saved with services that reduce suicides and opioid-related deaths, divert individuals from incarceration and unnecessary hospitalization and accurately assess and stabilize and refer individuals with mental health, substance use and other behavioral health challenges. This paper, *Crisis Services: Meeting Needs, Saving Lives*, furthers the *Beyond Beds* strategy by describing this vision. By knitting together several bodies of work on crisis services, it sets the stage for the next iteration of a national dialogue for developing and expanding that much needed continuum of quality mental health and substance use care for all who need it, when they need it.

This working paper was supported by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services.



Background

Mental health and substance use services are increasingly recognized as critical infrastructure to help address a variety of societal concerns in the United States. In the throes of the COVID-19 pandemic and its emotionally tolling consequences, there is an even greater call to examine behavioral health practices, pivoting and adapting services to the needs of the population. Every aspect of the COVID-19 pandemic has shined a spotlight on the need to attend to mental wellness and make an accessible continuum of psychiatric care.¹ Demand has ranged from building access to disaster distress counseling to identifying where inpatient psychiatric services can best be delivered while minding infectious disease control. At the same time, tragic events showing violence, especially toward black men, and the disproportionate impact of COVID-19 on racial and ethnic populations have highlighted structural racism, healthcare disparities and unequal and unjust outcomes. Together, the need for comprehensive mental health supports for the population is a national imperative.

Even before the global pandemic, for persons with serious mental illness, prolonged waits in emergency departments² have been alarmingly long, and risks of arrest and incarceration, alarmingly high.³ Forensic services such as waits for competence to stand trial services have been increasingly in demand⁴, and they too are subject to the same disparities in care noted in other criminal justice landscapes.⁵ Through several initiatives spanning across decades, mental health advocates, government agencies, legislators, and providers have worked to push forward reform. The goal is to have a community system that is interconnected, effective, just and accessible, through well-coordinated services. With this as a reality, many lives could be saved, suicides averted, and even persons with serious mental illness could access quality care and avoid negative outcomes seen too often. In 2017, the National Association of State Mental Health Programs (NASMHPD) together with the Substance Abuse and Mental Health Services

SAMHSA Crisis Toolkit: A Roadmap for Crisis System Design

Earlier this year, the Substance Abuse and Mental Health Services Administration released its *National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit*, calling on crisis services that “are for anyone, anywhere and anytime.” This toolkit provides a roadmap for crisis system design.

Administration (SAMHSA) laid a foundational clarion call with the paper, *Beyond beds: The vital role of the full continuum of psychiatric care*⁶ in which the cry for “more beds” was questioned as the single system solution. Instead, that paper pointed to building an infrastructure of a continuum of mental health services and policies to ensure timely access to appropriate care to address serious emotional disturbances and serious mental illness. In subsequent years, NASMHPD put forth bold goals to achieve improved outcomes for mental illness,⁷ and in 2019, called for an exploration of nine areas as examples of lessons that could be drawn from the international community to enhance practices and services in the United States to achieve better outcomes for mental health overall.⁸

This paper offers a next step in looking *Beyond Beds*, providing an overarching view of crisis services for persons with urgent mental health and substance use needs and policy considerations for building that effective crisis service continuum. To give readers a more complete understanding of crisis services, this paper encompasses the following topic areas:

- The Crisis Continuum
- Examples of Effective Crisis Services
- Pathways in Crisis Services



- The Evolving Role of Law Enforcement and Mobile Crisis Response
- Person-Centered Crisis Care
- Supporting the Crisis Infrastructure, From Laws to Technology
- Crisis Services During COVID-19 and Beyond

As noted in SAMHSA's 2020 *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit*,⁹ a robust crisis system provides a gateway to mental health and substance use disorder treatment, and as a safety net more broadly for anyone and all who access it. In this way, crisis services support one end of the desperately needed continuum of psychiatric care.

The Crisis Continuum

The crisis continuum includes various crisis services for individuals with urgent behavioral health needs, the response to such crises and subsequent pathways toward more complete assessment and treatment when needed. According to the SAMHSA Crisis Care Best Practice Toolkit (henceforth the SAMHSA Crisis Toolkit),¹⁰ the role of crisis services includes addressing the acute suffering of persons when they are in an emotional crisis, as well as addressing mental illness itself, given it is one of the leading causes of disability.

To understand the potential for an effective crisis care continuum, it is important to break down elements into understandable component parts. Although substance use services and mental health services have historically been set up on distinct parallel tracks, a robust crisis system must examine all aspects of needs for an individual. Integrated care opportunities should be incorporated, regardless of what issue is the "primary" one that presents itself. Individuals who present will represent diverse populations, diverse age groups and they may also have other medical issues. A crisis service array must appropriately address and triage real needs in real time.

SAMHSA Crisis Toolkit: Benefits of Good Crisis Care

1. An effective strategy for suicide prevention
2. An approach that better aligns care to the unique needs of the individual
3. A preferred strategy for the person in distress that offers services focused on resolving mental health and substance use crisis
4. A key element to reduce psychiatric hospital bed overuse
5. An essential resource to eliminate psychiatric boarding in emergency departments
6. A viable solution to the drains on law enforcement resources in the community
7. Crucial to reducing the fragmentation of mental health care.

SAMHSA Crisis Toolkit: Core Elements of a Crisis System

1. Regional or statewide crisis call centers coordinating in real time;
2. Centrally deployed, 24/7 mobile crisis;
3. 23-hour crisis receiving and stabilization programs; and
4. Essential crisis care principles and practices.



The definitions within the crisis services line-up can be important, especially as communities work to enhance the available of these services. To this day, there can be an alphabet soup of terms for levels of care. In the substance use services arena, the American Society of Addiction Medicine (ASAM) has advanced the delineation of levels of care, known as the ASAM Criteria. These help distinguish concepts of ambulatory services with and without extended onsite monitoring, non-medical but clinically managed services, medically monitored inpatient, and medically managed intensive inpatient levels.¹¹ Definitions like these, and needed definitions as pertained to crisis services for both mental illness and substance use disorders can help secure funding by establishing a clear goal and purpose of the particular program, whether it needs bricks and mortar buildings, or a billable service delivery design through Medicaid 1115 waivers, Certified Community Behavioral Health Center (CCBHC) activities, or straight Medicaid services to name a few. Also, policies, procedures and staff training needs will vary depending on the type of services provided. Without clear definitions across programs there can be ongoing confusion when comparing services.¹²

Beyond Beds

Recommendation #2: Terminology
Direct relevant agencies to conduct a national initiative to standardize terminology for all levels of clinical care for mental illness, including inpatient and outpatient treatment in acute, transitional, rehabilitative, and long-term settings operated by both the public and private sectors.

To date, there is no single federal definition for specific crisis services. For example, the Centers for Medicare and Medicaid Services, in its 115 Serious Mental Illness Availability of Services template offers some broad language in its definition of terms for “crisis stabilization units” and “coordinated community crisis response”, but leaves details up to states to define. It also leaves the term “crisis call centers” up to states to define.¹³ State by state definitions and programmatic nuances therefore can make comparisons challenging. Table 1 proposes working definitions of component parts of a crisis service continuum that are aligned with SAMHSA’s core service network features.¹⁴ Figure 1 depicts the flow through problematic crisis systems that are still too often seen and Figure 2 through a model interconnected crisis continuum.

Table 1: Types of Crisis Services across Systems

Crisis Continuum Component	Model Definitions	Additional Model Functional Components
Warm Lines/Peer Warm Lines	A call line that provides opportunities for talking, receiving support and referrals.	<ul style="list-style-type: none"> - Link individuals to crisis lines for calls that escalate - May be staffed and managed by peer-run organizations
24-hour Crisis Lines (telephone, text, or chat)	A communication system that provides screening, assessment, preliminary counseling, and resources for referrals for mental health or substance use services and suicide prevention pathways.	<ul style="list-style-type: none"> - Provide direct referrals for accessing emergency responses - Utilizes technology “air traffic control” routing, GPS locator and other data systems
Mobile Crisis Teams	A response system that utilizes behavioral health professionals to navigate within a region and at the scene of a crisis to complete mental health and substance use	<ul style="list-style-type: none"> - Work with law enforcement when needed and with appropriate protocols - Intervene as the crisis is occurring in any community setting - May provide follow up check-ins, wellness checks and other community-based interventions



	assessments or connect a person in crisis with services.	<ul style="list-style-type: none"> - Often designed for youth and adults through separate funding streams but may be linked
Crisis Intervention Teams (CIT)	Specially trained law enforcement officers who have undergone designated CIT training, adhere to policies for CIT officers and are linked to behavioral health designated crisis drop off points of access to care.	<ul style="list-style-type: none"> - More than just training, CIT programs are designed to improve police response and improve safety in dealing with individuals experiencing mental health crises - Can be successful in diversion of individuals with mental illness from the criminal justice system - Training emphasizes strategies for de-escalation and linkage to treatment - In addition to law enforcement training, the model includes partnering with drop off sites, robust community crisis care, behavioral health staff training, family, consumer and advocate involvement
Co-Response Teams	Coordinated behavioral health professionals and law enforcement teams who respond to emergency calls for emotional disturbances in the community together.	<ul style="list-style-type: none"> - May be embedded in police department staffing or may be worked out through protocol and funding with local behavioral health mobile crisis team - Practices involve simultaneous response and delineation of on the scene roles and responsibilities - Emphasizes diversion through on scene support, assessment and referrals rather than arrest
Crisis Hubs/Crisis Centers/Coordinated community crisis response center	Locations and systems that provide immediate in-person attention to any level of urgent to emergent need for mental health and substance use disorders and may include call centers, drop-in, and drop off sites.	<ul style="list-style-type: none"> - Includes virtual interconnected activities where the hub is through technology and routing - Allows walk-in clients in need of assistance and may provide urgent care assistance - Ideally offers combined management of substance use and mental health crises including withdrawal management and harm reduction strategies - Serves as drop-off center for law enforcement with the goal of diverting patients in a mental health crisis or with a substance use need away from the criminal or juvenile justice system - Manages crisis response across various community of crisis services - May manage calling centers to answer crisis calls
Psychiatric Urgent Care	Clinics with screening, assessment, brief intervention and prescribing capabilities that operate for walk-in visits with no appointment needed for immediate mental health and substance use support during day hours and limited weekends.	<ul style="list-style-type: none"> - Multidisciplinary staff including peers - Outpatient services and supports - Provide brief prescriptions - Withdrawal management and referrals - Provide linkages to longer term services
Transition or Bridge Clinics	Clinical therapeutic and medication management services made available for individuals moving from one level of care to the next (e.g., emergency department to long-term supports, or inpatient to community).	<ul style="list-style-type: none"> - Provide psychiatry access for medication prescriptions to avoid gaps in care while waiting for openings at regular outpatient services - Can be built to address medications and brief counseling to support opioid use disorder and other substance use needs
Crisis Stabilization Units (CSU) and	Brief, time limited (usually Up to 23 to 72 hours), medically monitored or supervised, observation units that	<ul style="list-style-type: none"> - Small facilities (less than 16 beds) for patients whose needs cannot be met in the community alone following a behavioral health crisis, sometimes licensed similarly



Extended Observation Units	provide care to assist with de-escalating the severity of a crisis and/or need for urgent care.	<p>to inpatient units, sometimes licensed with separate regulatory schemes short of inpatient level of care</p> <ul style="list-style-type: none"> - Provide prompt assessment, medical monitoring, stabilization and determination of next level of care needed - Considered less restrictive and an alternative to traditional inpatient psychiatric hospitalization - May allow for either voluntary and or involuntarily holds under mental health statutes similar to civil commitment provisions depending on state statutes and regulations - Involuntary medications usually only administered in an emergency context
Crisis Residential Services	Services where individuals in crisis can voluntarily reside for brief periods (usually up to 14 days) and receive behavioral health supports in a less intensive setting than inpatient level of care.	<ul style="list-style-type: none"> - Can be used as a step-down or diversion from an inpatient hospitalization - Can be used to assist in de-escalating a person's level of distress and/or need for urgent care associated with a substance use or mental health disorder by providing continuous observation and clinical support - Can include access to multidisciplinary treatment including treatment with medications and therapeutic supports
Living Room/Peer Run Crisis Centers	Comfortable non-clinical space that provides an alternative to emergency rooms for adults for short-term stays where individuals have available recovery support staff such as peers to help resolve crises.	<ul style="list-style-type: none"> - Provides a calming and safe environment - Short term stays (days to weeks)
In-Home Supports/Family-Based Crisis Home-Based Support/Respite Services	Short-term intensively supported services where individual may stay with their own family or other qualified local family or provider-based locations with add-on supports.	<ul style="list-style-type: none"> - Includes regular contact and home visits with mental health professionals and other support staff, parent peers or mentors
Emergency Rooms with or Without Dedicated Behavioral Health Sections	Embedded hospital-based service for medical emergencies, including psychiatric emergencies, especially where safety related to psychiatric illness, medical management of substance use or medical co-occurrence may be an immediate concern.	<ul style="list-style-type: none"> - More appropriate when medical issues or uncertain diagnostic complexity need careful monitoring - More appropriate for severe drug use or alcohol use where medical monitoring is indicated - Increasingly able to induce medication assisted treatment for opioid use disorder - May be more appropriate for extreme behavioral dysregulation challenges
Partial or Day Hospitals	Community-based day mental health services with full multidisciplinary team with groups, therapies, medically monitored, and access to prescribers who can adjust medications while the individual resides at home.	<ul style="list-style-type: none"> - Appropriate for individuals with ongoing symptoms of mental illness but low safety concerns - Individuals typically sleep at home and come to hospital during daytime hours - May be used as a transitional treatment site when moving from inpatient to outpatient care



<p>Acute Psychiatric Hospital Units</p>	<p>Hospital level of 24-hour care for psychiatric illnesses for a person who needs intensive, multi-disciplinary treatment with medically managed intensive and round-the-clock nursing, usually addressing safety and complex care-management needs.</p>	<ul style="list-style-type: none"> - Typically, a locked setting - Typically, a length of stay days to weeks - May allow voluntary and involuntary patients - Treatments provide maximum diagnostic assessment, observation, medication adjustments, and address risk of harm to self and/or others - May allow ECT administration - Considered the highest medically necessary level of care - May be found in critical access hospitals as small facility that have 24-hour emergency care, outpatient and inpatient services - May be found in general hospitals, freestanding private, or, in some places, within state psychiatric hospitals still accepting acute patients
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*Adapted from: [Crisis services](#). National Alliance on Mental Illness; [Crisis services: Effectiveness, cost effectiveness, and funding strategies](#), 2014, SAMHSA; Saxon V, et al. [Behavioral health crisis stabilization centers: A new normal](#), 2018, *J Mental Health & Clin Psychology*; [National guidelines for behavioral health crisis care best practice toolkit](#), 2020, SAMHSA; [Getting to the ideal behavioral health crisis system: Essential elements, measurable standards and best practices](#), 2020 (draft under review), Group for the Advancement of Psychiatry. Centers for Medicaid and Medicare Services 1115 Waiver Definitions of Terms used in the Availability Assessment, 2020.

Figure 1: Flow of the Current Problematic Crisis System

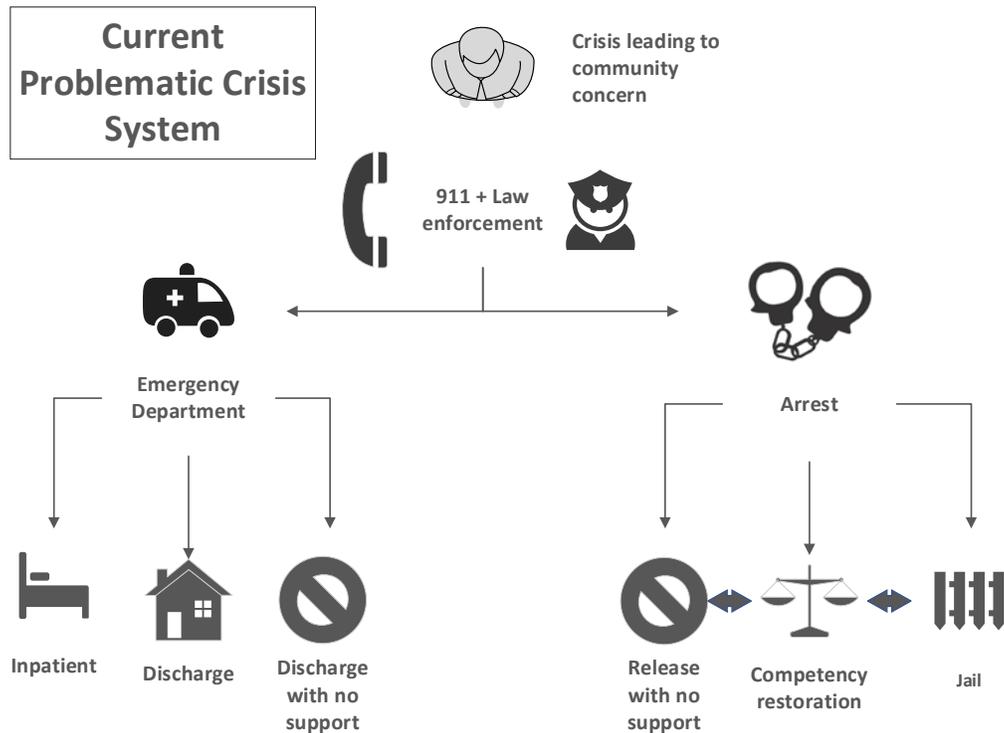
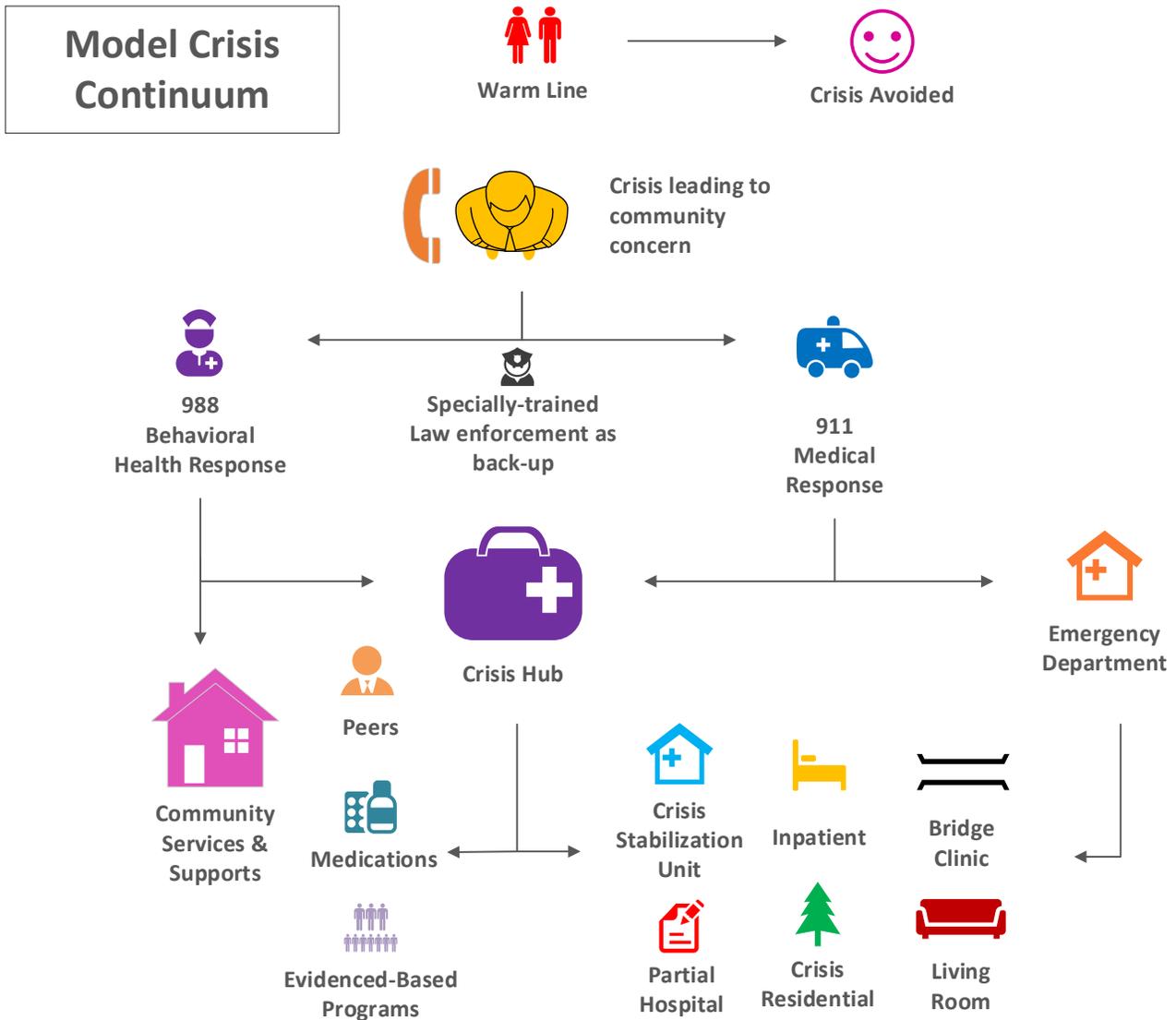


Figure 2: Flow of an Interconnected Model Crisis Continuum



Examples of Effective Crisis Services

In some parts of the country, the work of building out crisis systems has been long standing or recently begun in earnest. One example of such effort has been realized through the Crisis Now model, which was started in Phoenix, Arizona. The model incorporates technology, crisis centers, case processes, suicide prevention, and more improved management of persons in distress than had been available through traditional medical emergency department response, and a methodology that de-emphasizes routing individuals to psychiatric inpatient beds as a single option.¹⁵ The Crisis Now model has gained tremendous traction and was described in a well-circulated 2016 report spearheaded by two behavioral health thought leaders.¹⁶



In 2014, National Public Radio aired a story of the “Restoration Center” in San Antonio, Texas, that helped it gain national attention.¹⁷ This center was designed as a community crisis resource and as a “police friendly” drop off site to help improve jail diversion initiatives for persons with mental illness and substance use.¹⁸ People from around the country traveled to visit the site to learn about its vision and mission and to see how it could be adapted to their local communities. More recently other centers and models have gained national attention, such as the Pima County, Arizona Crisis Response Center, which was developed through local partnerships and funded in part through a ballot initiative.¹⁹

Other types of supports are being built to help individuals access outpatient services outside of traditional models where there may be waits for appointments. For example, psychiatric urgent care clinics have opened, some inspired by demand and complexity related to COVID-19.²⁰ There are several on-demand mental health clinics available in Massachusetts,²¹ and envisioning the continuum of tomorrow, advocates have called for same-day access while considering the challenges to funding services of this nature.²² Even in addiction care there has been much done around the country to get immediate access to medication assisted treatments (MAT). The Certified Community Behavioral Health Clinics model also is setting forth a path given that the model requires easy access to care and 24/7/365 crisis services and is being examined as a model in various states.²³

Pathways in Crisis Services

One of the critical elements of crisis service continuums is the importance of understanding the flow, or pathways that individuals may follow as they move from the initial crisis response through the rest of the array of services.²⁴ The pathways an individual will follow can look very different depending on that person’s needs, with continuous treatment and supports that can last hours to days to months. For example, for someone with a serious mental illness, an individual in crisis may ultimately only need time to be re-stabilized on medication. Others might need significant medication changes or supports that address housing needs. Ultimately, an individual’s treatment should be geared specifically to their needs.²⁵ Moreover youth, older adults, or persons of diverse backgrounds should have equal access to crisis supports that are capable of meeting their needs, and the crisis service continuum will need to be able to equally and adeptly serve everyone.²⁶

Beyond Beds

Recommendation #7: Linkages Recognize that the mental health, community, justice, and public service systems are interconnected, and adopt and refine policies to identify and close gaps between them. Practices should include providing “warm hand-offs” and other necessary supports to help individuals navigate between the systems in which they are engaged.

Crisis call lines and “warm” lines function as an important entry point into the crisis service continuum. These types of systems connect individuals calling in to specialized counselors or peers on the other end of a phone line. Some individuals prefer outreach in a moment of distress through text or online chat. At times, an individual may call or text just to connect or to seek information, but during the contact, the individual may reveal information that raises more urgent concern. Some individuals are calling in a suicide crisis or looking for urgent support to help with substance use, or they may have any number of other distressing concerns. With the expansion of these types of call services, there is an increasing need for them to be streamlined and readily accessible with the responders knowledgeable about the rest of the



continuum of mental health and substance use care. Regardless of the modality or context, access to them as part of an interconnected range of responses across modalities is critical.

Crisis call lines have in fact proven to be a critical part of the crisis system infrastructure during the COVID-19 pandemic. The National Disaster Distress Line quickly saw a rapid rise in utilization as societal distress over this disaster spread throughout the country. States have responded by attempting to coordinate crisis services more broadly. Take for example the Michigan “Stay Well” initiative,²⁷ which was launched after the statewide stay home order in response to COVID-19 went into effect, and has been sustained even after the lifting of the restrictions.²⁸ The state’s efforts put forth several options to persons in need of emotional supports, including a peer warm line that has received thousands of calls,²⁹ crisis counseling with “Stay Well” counselors, video resources, and written guides for the public managing stress and anxiety pertaining to COVID-19. With the support of SAMHSA and Federal Emergency Management Agency (FEMA), additional staff have been deployed to a call center in Michigan.

Throughout the United States, these types of call centers are connected to the National Suicide Prevention Lifeline and the National Disaster Distress Helpline. At the federal level, there has been growing advocacy to make the pathways to crisis supports even easier with a simpler national suicide prevention lifeline number. The Federal Communications Commission voted in July 2020 for “988” to serve as the nation’s forthcoming new number to connect people to the National Suicide Prevention Lifeline or other types of crisis counselors.³⁰ This new number has far-reaching implications. Though further development and implementation details would need to be worked out, it could presumably differentiate a mental health crisis in need of mental health support from those requiring a law enforcement response.

Psychiatric bed registries are another example of a means to build better linkages to psychiatric services in a crisis context. These have been developed in an effort to curb emergency department boarding times. The idea behind them is that individuals coming for acute assessments who need a psychiatric hospital bed could be sent to one without delay. With the passage of the 2016 21st Century Cures Act came grants to help foster psychiatric bed registries around the country. A 2017 report by NASMHPD Research Institute of existing bed registries showed 16 states had some type of bed registry and eight states were in some phase of planning for one.³¹

For individuals in crisis due to substance use, there may be a need for a crisis response that includes robust withdrawal management practices, even including the induction of medications to assist with treatment during the initial response, and then a linkage to a community prescriber as part of the crisis response pathway. There may be individuals who are not yet ready to embark on their recovery journey after the crisis, so regardless of their readiness, crisis services staff should be adept at motivational interviewing, as well as techniques such as Screening, Brief Intervention, and Referral to Treatment to help point individuals to treatment appropriate to their need beyond the crisis period.³²

The Evolving Role of Law Enforcement and Mobile Crisis Responses

The Sequential Intercept Model, a framework for helping systems develop strategies to identify and intercept an individual with mental illness and/or substance use away from criminal justice involvement and toward treatment, expanded its focus to include examination of the crisis care continuum with the addition of “Intercept 0” in 2017.³³ The Department of Health and Human Services Assistant Secretary for



Planning and Evaluation (ASPE) in 2019 also examined early diversion activities around the Country at “Intercept 0 and 1” of the Sequential Intercept Model.³⁴ These reports pointed out service gaps that needed to be filled at the law enforcement interface and even before law enforcement are called in response to a behavioral health crisis. Several recent tragic violent incidents between police and persons of color have brought these issues under the spotlight even more. They inspired community support for the Black Lives Matter movement and a cry to re-examine police practices. This has included calls from some advocates to defund law enforcement and examine shifting the allocation of resources between law enforcement and other systems. With these conversations, the role of law enforcement in behavioral health crisis response has also emerged as part of the conversation.

The interface of law enforcement and mental health response has a long history, and over the last several decades has been increasingly developed. The Council of State Governments Justice Center, for example, has put together several resources, for example, to help communities enhance collaborations between police and mental health systems.³⁵ The International Association of Chiefs of Police also launched the One Mind campaign.³⁶

In the literature, the collaborations have generally been described by three main designs.^{37,38,39} “Police-based specialized police response” includes law enforcement officers who are specifically trained to manage behavioral health crises and have knowledge of and access to the system to help support their response. In a second model of police response, behavioral health clinicians are hired by police departments for a “police-based specialized mental health response.” Their job is to accompany officers on calls where an individual might be in a behavioral health crisis or for calls where a behavioral health specialist might be helpful (e.g., death notifications, follow up visits). A third model of coordinated law enforcement and behavioral health specialized crisis response is a “mental health-based specialized mental health response,” which includes services also known as mobile crisis services, where a mental health unit, staff person or team of staff respond directly at the scene of the crisis, and link to law enforcement on site to jointly respond to an incident when needed. A fourth, design of crisis response includes mobile crisis teams, a non-law enforcement-based response that allows mental health clinicians to respond to crises directly. These mobile crisis response teams may have protocols where law enforcement serve as back-up but are designed to be a distinct non-law enforcement-based response.

The Crisis Intervention Team (CIT) is an example of a police-based specialized police response strategy. A core component of the model is a 40-hour curriculum of specialized training on mental health and systems issues to law enforcement officers. The curriculum generally includes topics such as an overview of mental illness and de-escalation strategies, and typically incorporates individuals in recovery as lecturers as well as tours to their living facilities to help law enforcement understand these issues firsthand.⁴⁰

Studies have shown positive impact with CIT interventions with regard to diversion to treatment, reduced use of force and officer injury.^{41,42,43} The model has gained international support. Yet, a review of the literature found the strongest evidence on the effectiveness of CIT showed its ability to enhance officer cognitive and attitudinal outcomes, but the same review indicated

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.



more research is needed to determine if the change in officer beliefs results in changes in behavior.⁴⁴ Rigorous studies of racial breakdown of outcomes is also not yet available for CIT. Data on the effectiveness of CIT also shows that volunteers who sign up to become CIT officers seem to show greater benefits and positive outcomes than those who are assigned.⁴⁵ Although the CIT model is very well-respected, this should be a cautionary note for departments that have taken on wholesale adoption of one-time CIT training to all officers as a single policy solution to address the intricacies of crisis response in the behavioral health context. Here, the crisis service behavioral health system, which is called for as an integral part of a robust CIT model, becomes increasingly relevant.

Models where behavioral health and law enforcement are designed to co-respond in some fashion also show promise and several have highlighted that consumer experience is positive.^{46,47} An example of an effective police-based specialized mental health response is the Crisis Response Team in Seattle, WA.⁴⁸ Starting in 2010, the police department contracted with the local mental health agency to have mental health clinicians work directly with CIT officers. A qualitative study of the program found that the model improved encounters between law enforcement officers and people experiencing mental health crises as well as better utilizing police department resources.⁴⁹ In Massachusetts, the provider organization Advocates launched a co-responder model in 2003, partnering with the state Department of Mental Health and other stakeholders and has continued to grow across the state, showing successful outcomes for jail diversion, cost savings and shifts in police culture and attitudes about managing mental health crises by embedding a clinician in local police departments to ride with police and respond to crises⁵⁰ In addition to having specialized behavioral health staff assigned to work within local police departments to jointly respond to crises, they were able to leverage the entire mobile crisis service to help the communities they serve.

A third design is a “mental health based mental health co-response” designed specifically to have a behavioral health mobile crisis provider co-respond with police to a scene without necessarily being stationed in the police department or riding in the police car. However, separate from law enforcement, mobile crisis services have expanded in many states based on a variety of policy shifts and intentional program design. These mental health crisis response models serve as a growing fourth, non-law enforcement, model of crisis response. One program gaining national attention recently is the CAHOOTS (Crisis Assistance Helping Out on the Streets) program run out of a Federally Qualified Health Center. CAHOOTS was established in 1989 as a community policing initiative in Eugene and Springfield, Oregon to help with managing mental health crisis, addiction and homelessness in the community.⁵¹ It involves the deployment of two-person teams consisting of a medic (such as a nurse, paramedic or EMT professional) and a mental health crisis worker who can provide a trauma-informed response to help diffuse crises. A recent report showed that in 2019, out of approximately 24,000 CAHOOTS calls, police backup was requested only 150 times.⁵²

In some jurisdictions, mobile crisis response was enhanced in response to class action litigation and other system developments. For example, in Massachusetts, the landmark Rosie D litigation centered on Medicaid eligible youth with serious emotional disturbances whose needs were historically addressed with an over-reliance on out of home settings. The remedy catapulted an entire systemic response to youth in need, including the establishment of an array of services that included

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.



more robust mobile crisis intervention (MCI), defined as “on-site, face-to-face crisis response” 24/7/365 for youth in a behavioral health crisis, and includes the ability for a comprehensive behavioral health assessment, intervention, stabilization and coordination.⁵³ This has allowed crises to be addressed where they occur—be it at home, in schools, or elsewhere in the community. The services even include in-home follow up after the crisis. As another example, Connecticut’s youth mobile crisis service has demonstrated significant reduction in emergency department visits and positive outcomes.⁵⁴ Typically, the mobile crisis clinicians also have specific safety protocols that help determine when back up law enforcement response is needed and how it should be coordinated. Models such as these offer guidance to other jurisdictions considering expanding strategies of non-law enforcement-based crisis response.

Person-Centered Crisis Care

Crisis services require the ability to serve all populations that access them.⁵⁵ To adhere to the principles outlined in the SAMHSA Crisis Toolkit, this will include addressing individual recovery needs, utilizing peers and being trauma informed.⁵⁶ Related to these goals, there is increasing attention to the importance of engagement as a way to help drive person-centered care.⁵⁷ One review of several studies demonstrated that interventions to improve mental health knowledge, attitudes and reduce barriers helped improve retention in psychiatric services.⁵⁸

SAMHSA Crisis Toolkit: Principles of a Crisis Service Continuum

1. Addressing recovery needs
2. Significant role for peers
3. Trauma-informed care
4. Zero suicide/suicide safer care
5. Safety/security for staff and people in crisis
6. Crisis response partnerships with law enforcement, dispatch and emergency medical services

One strategy to maximize individual voice in their care is through Psychiatric Advance Directives (PADs) (sometimes also referred to as Behavioral Health Advance Directives).⁵⁹ For crisis service providers, it is important to know if the individual has a psychiatric advance directive and then to understand what it means and how to honor it. The 1990 Patient Self-Determination Act codified the need to have certain healthcare facilities make patients aware of opportunities for advance directives. In the mental health area, these are legal documents that an individual executes typically during a period of

wellness that codify their specific behavioral health treatment decisions that then could be enacted when their mental health deteriorates to the point where their decision-making is compromised.⁶⁰ Decisions might include determining a surrogate decision-maker who can help interpret the individual’s preferences during a crisis. In addition, decisions that are spelled out might include authorizing or declining particular medications or somatic treatments (including electroconvulsive therapy) and preference for particular psychiatric hospitals, to name a few. Several resources are available to crisis service providers that provide further details about PADs (see for example, the Psychiatric Advance Directive Resource Center at <https://www.nrc-pad.org/>).⁶¹ SAMHSA has also funded further information about PADs through its technical resource site for providers, individuals and family members dealing with serious mental illness at www.SMIAdviser.org. This resource site offers an app available for furtherance of individual psychiatric advance directives. Although some individuals who encounter psychiatric services may be under an assisted outpatient treatment court order or brought in by police,⁶² PADs may be one strategy that can ultimately



reduce coercive interventions.⁶³ It is important to consider all forms of engagement through voluntary service provision and individual voice to help improve retention over time.

Person-centered crisis care requires a service array to address the whole person, and this means helping them with needs regardless of whether their primary issues are situational, related to severe mental illness, substance use challenges, or a combination of these. The call for nimble service provision to address this vast array of considerations is a tall but necessary order. For example, it is well established that incorporating medication assisted treatments for withdrawal management for opioid use disorder can be lifesaving,⁶⁴ yet access to prescribers and high overdose mortality remains a critical issue that requires analyses of geographic differences and other factors to improve outcomes.⁶⁵ To leave a gap in time risks an individual returning to substance use and overdosing. The crisis service continuum must be prepared to adroitly address all needs, including those that are not traditionally in the wheelhouse of “mental health” services.

Creating a culture of welcome-ness is another way to enhance person-centered care. One study identified numerous challenges faced by individuals with mental illness as they described their experiences in emergency departments, including a lack of privacy, long waits, professionals who are less adept at relating to the individual’s distress on a person-level, lack of prioritization during triage, minimal family support available, and shame and stigma associated with mental health conditions as felt during the emergency department experience.⁶⁶ Numerous reports have begun to elucidate the important role of peers in the crisis continuum. This can include their participation in low intensity supports, such as through warm lines where individuals provide a listening ear, all the way to the deepest parts of the crisis continuum, such as through peer-run or peer-led respite centers.⁶⁷

The Living Room models are perfect examples of fostering the core principles highlighted in the SAMHSA Crisis Toolkit of including peers, being recovery oriented and trauma informed. One Living Room model found in Skokie Illinois addresses some of the barriers that individuals might face in going to a traditional emergency department when in psychiatric care by providing immediate, client-centered, and recovery-oriented services, as well as being embedded into a home-like setting in the community, promoting autonomy, respect, hope and social inclusion.⁶⁸ In this way, models such as these foster what it truly means to create crisis services that can be person-centered. Individuals seeking crisis services, by their very nature, will be at risk of being further traumatized if these principles are not incorporated.

The importance of having all staff trained appropriately on safety and security, as well as Zero Suicide principles is critical given that the crisis service itself can result in a critical lifesaving opportunity. Accessibility to medical services when needed should be part of proper linkage supports. The 2020 NASMPHD Series of technical

assistance papers focused on *Beyond beds: Crisis Services* includes examination of crisis services for diverse populations including individuals with substance use disorders,⁶⁹ children and adolescents,⁷⁰ homeless

2020 NASMHPD *Beyond Beds: Crisis Services* Technical Assistance Briefs

1. Crisis services: meeting needs, saving lives
2. Crisis services and homelessness
3. Technology to address suicide
4. Substance use disorders
5. Legal issues
6. Best practices
7. Funding
8. Diverse Populations with unique needs
9. Child/Adolescent
10. Rural crisis services
11. Police partners in crisis response



persons,⁷¹ among others.⁷² Each of these areas of focus helps enhance the ability to respond to individual needs across the crisis continuum.

Supporting the Crisis Infrastructure, From Laws to Technology

At the core of the crisis continuum are a host of details that must support the infrastructure. Funding will likely be generated from various federal, state and even local resources.⁷³ Billable time may be based on volume or time, with bundled rates or per service rates for different elements of the crisis service. In addition, enabling legislation may be needed in states that do not allow for specific aspects of crisis care, such as crisis stabilization units. Licensing rules in each state will need to be considered to determine which parts of the crisis care continuum will need specific certifications. As these are developed communities will need to consider the applicability of the Emergency Medical Treatment and Labor Act (EMTALA) for these types of services, some of which might hold themselves out as emergency providers sufficient enough to risk Medicare funding if individuals are not stabilized prior to transfer.

Beyond Beds

Recommendation #4: Emergency Treatment Practices

Monitor hospitals for adherence to EMTALA in their emergency departments and levy sanctions for its violation, including the withholding of public funding. Hospitals with licensed psychiatric beds that refuse referred patients should similarly be sanctioned if monitoring shows they have a record of refusing referred patients without legitimate cause.

Legal and regulatory considerations in crisis centers where evaluations are conducted are complex.⁷⁴ Strategies for engagement in voluntary services should be maximized, but depending on the jurisdiction, crisis stabilization and evaluation sites may be regulated to allow for both voluntary and involuntary holds. Even when there are these options, individuals should be served in the least restrictive settings possible. In states that have assisted outpatient treatment laws, there may be arrangements with the courts regarding the ability to bring people to a crisis center to determine if a higher level of care is needed. In addition, individuals may only be legally held in a crisis center for a finite number of days or hours based on the statutory provisions in the state, after which the individual may need a further assessment, admission to a psychiatric unit, or discharge. Due process and other rights of individuals served- especially in involuntary contexts- are critical and most state laws provide for mechanisms to support this aspect of the legal regulation of behavioral health practices.

Partnerships will be another key element in the crisis care continuum. Schools, local hospitals, senior housing centers, law enforcement, sheriffs and with other state agencies that work with veterans, older adults, persons with developmental disabilities, native populations, immigrants, and those with serious mental illness, are just some examples of the types of partnerships that are beneficial to establish as a crisis system. Organizations through provider networks, peer organizations, and advocates will all benefit from participating in the enhanced crisis continuum. Non-traditional partners who will be a resource in building out these services include those in faith-based communities, local tribal leadership, small businesses and others.

Many crisis services already rely on technology, but reliance on technology will only expand overtime, especially with the emergence of COVID-19. Beyond bed registries described above, use of other



technologies is also going to be necessary. For example, as the Crisis Now technology demonstrates, the concept of an interconnected dispatch system “air traffic control” will allow persons in crisis to be efficiently, empathically, and effectively routed to the most appropriate response. GPS technology that can identify the location of an individual caller through geo-mapping who may need a rescue response, or who simply may need a referral for services nearby, attached to databases that will show where services exist and are available hold promise that in many ways is as yet unimagined. In addition, a single call to a call center that has exceeded its capacity will be able to be routed to the next available call center, though ideally, calls will be responded to locally with knowledge of local resources. The importance of hearing a voice on the other end also means that when needed, overflow capacity can be handled anywhere. With the right connectivity, individuals will still be able to be immediately directed to the resource and level of support needed following the initial crisis contact.

Workforce development to effectively manage the crisis continuum is a key component to its success.⁷⁵ Clinical staff responding to distress calls all should be well-versed in healthcare disparities, areas of vulnerability to negative bias in response to persons of color or other minorities. Ideally staff diversity will also reflect diversity in the community. Training will be required on the critical importance of engagement into voluntary substance use disorder and mental health treatment, as well as the legal regulations of practices in crisis services that might require intervention even when the individual declines it. Such training would need to help clarify statutory requirements for the criteria that usually include risk of harm to self or others that could permit involuntary holds and referrals when needed to inpatient services, and issues of confidentiality. Staff working in crisis services therefore need to be adept at understanding and operationalizing the legal and regulatory provisions of the crisis continuum. Since crisis services are for anyone, anytime, staff should be equally trained across shifts for this 24/7/365 operation. In addition, these staff will require intentional trainings and support on what it truly means to serve anyone and everyone with a welcoming and engaging attitude.

Crisis Services During COVID-19 and Beyond

Perhaps one of the most recent catalysts for the need of a robust crisis care continuum has been the responses needed to manage the COVID-19 pandemic. As the pandemic swept through the states, societal stress and distress over this newly emerging type of disaster has created the need for nimble and evolving policy and planning in crisis services. Early on as the COVID-19 pandemic was spreading through the United States, there was an astounding increase by over 890% of calls to the National Disaster Distress Helpline.⁷⁶ This level of need occurred amidst an already alarming rise in suicide rates with 2018 showing the highest age- adjusted suicide rates since 1941.^{77,78} Although some states were seeing promising evidence of improvement prior to the COVID-19 pandemic, the opioid crisis had already been reaching new levels and claiming more lives than motor vehicle accidents.⁷⁹

Disaster behavioral health is increasingly recognized as mission-critical to overall disaster response. For the National Incident Management System (NIMS)⁸⁰, which operates out of FEMA, specific regional responses are important to allow operations to continue without disruption.⁸¹ Continuity of Operations Plans (COOP) are designed to further delineate smooth transitions without interruption in core functions. Many states sought to plan for surge capacity initially, as medical beds were being deployed to take care of patients needing ventilator support from the novel coronavirus. In the behavioral health crisis context, dramatic shifts in demand of psychiatric crisis services and volume made planning challenging.



There are continuing ongoing demands for needed supplies such as personalized protective equipment (PPE) and testing for the behavioral health population and the staff that care for them. States have worked hard to satisfy the shifting demand to best help the needs of vulnerable persons in the behavioral health system including those with mental illness, intellectual and developmental disability and substance use disorders. Crisis counseling and crisis prevention through outreach activities have been supported through SAMHSA and FEMA funded grants. The pandemic has only highlighted the needs for a coordinated and adept crisis continuum that will likely be utilized even more as the pandemic evolves along with the strain on the economy and social networks.

Especially with COVID-19, much has also shifted with new reliance on video and telephonic technology for clinical services.⁸² Even in mobile crisis response, the use of tele-health practices has expanded. Jurisdictions have begun to use telephonic or video connections with emergency medical workers or law enforcement to help navigate complex situations in the community. In order to protect hospitals from excessive traffic during times of high community penetrance of COVID-19, much of these technologies were born out of necessity. Additionally, crisis hubs also developed video and telephonic access to help screen individuals to focus in-person visits only on those that could not be triaged through technology connections. With the COVID-19 pandemic and the ongoing community behavioral health challenges likely to be seen in its aftermath, services developed through these changing practices will continue. They will likely evolve further as providers learn more about best practices in the long run. This includes how to balance in-person contacts with telepractices while mitigating risk of viral illness in crisis support contexts.

Conclusions

Crisis services sit at the “crossroads” and must be adept at serving the needs of all individuals immediately at the time they need support. Some of these individuals may be in their darkest hour, in suicidal crisis, psychotic, intoxicated, recently in contact with law enforcement, or recently victimized. The crisis continuum offers an opportunity for life-saving intervention. It is impossible to quantify how many more lives could be saved and how many better outcomes could be achieved with access to a robust and well-developed crisis continuum.

The current fragmented system has too many gaps to appropriately address the needs of all individuals, regardless of age or the severity of the individual’s needs. As well, all individuals in a community, regardless of background, race, ethnicity, or prior mental health history may experience an emotional or suicide crisis.

As noted in the SAMHSA Crisis Toolkit, services must be available to anyone at any time, and this means that bias and racial inequities must be eradicated. This means that although they must incorporate technology at its highest capability to interconnect the crisis continuum with a host of other services, they must also provide human responses in real time. Building out a complete crisis services array represents one step in fully realizing an integrated and complete psychiatric care continuum that has been the vision of behavioral health for well over 50 years. Although there is much work ahead, the global pandemic and recent strains related to racial issues in society serve as reminders of the critical importance of supporting each other through difficult times. The possibilities of providing effective, interconnected, just and accessible crisis services that can save lives and improve mental health outcomes should provide the inspiration to take on the challenges ahead.



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