NASMHPD

SUPPORTING LOCAL DESIGN OF COMMUNITY DIVERSION CENTERS: MONTANA

"A crisis system has to be inclusive and serve everyone rather than a small subset of people."

–Wyatt McAlpine, Project Director

VISION

The lack of a cohesive, evidence-based crisis system had become evident to the Montana Addictive and Mental Disorders Division (AMDD) and to stakeholders in communities across the state. People in behavioral health crises were often detained in jail or hospitals after encounters with law enforcement. Sequential Intercept Mapping workshops convened in municipalities had repeatedly identified the need for receiving centers (crisis stabilization units) as alternatives to emergency rooms and jails. Hospitals reported that behavioral health visits accounted for 30-40% of emergency department visits, more than double the national average of 15.7%.[1] Communities were struggling to shift from a rigid reliance on emergency departments and detention and move to a model of care that utilizes community-based alternatives. Three counties in western Montana: Lewis and Clark, Missoula, and Cascade agreed to participate in a regional crisis stabilization planning and implementation process to advance system innovations for diverting individuals from the Montana state hospital, jails, and hospital emergency departments. The state provided support to convene stakeholder groups, map resources, collect and analyze data, and develop a strategic plan. Throughout the process, they encouraged stakeholders to design and implement a "no wrong door" approach to crisis care including crisis care facilities such as peer respite, short term residential, 23-hour urgent and longer-term crisis stabilization units. At AMDD's request, NASMHPD provided technical assistance to the three counties through a contract with WICHE (Western Interstate Commission for Higher Education). WICHE consulted the three counties on consensus building within their communities and effective crisis and diversion models.

JAIL DIVERSION APPROACH

The project encourages stakeholders in three counties to establish crisis diversion facilities (crisis stabilization units) that will accept anyone that law enforcement transports there due to a behavioral health crisis.

MEASURING PROGRESS

Both the communities receiving TTI funds and WICHE prepare and submit quarterly reports on their progress to AMDD. The volume of hospital emergency department behavioral health visits will continue to serve as a measure of progress. A sub-goal of the project is to develop a data dashboard that can reflect the

level of utilization of crisis diversion centers and their integration with other crisis services.

INTEGRATION WITH CRISIS SYSTEM

Counties have mobile crisis teams and with the implementation of 988, will have 24/7 access to call centers. The third component of the continuum, crisis stabilization units, are not easily accessible to rural and frontier areas of the state and not fully utilized where they are accessible. Through this process, AMDD is working with community stakeholders to determine how to improve their utilization and where best to locate them.

BEHAVIORAL HEALTH EQUITY

Since launching the TTI project, four more communities have been added that represent rural and frontier areas of the state including the Blackfeet Indian Reservation of Montana. American Indians and Alaska Natives represent about 6.5% of the population of Montana and reservations comprise 9% of its land. According to SAMHSA's TIP 61: Behavioral Health Services for American Indians and Alaska Natives[2] "American Indians and Alaska Natives have consistently experienced disparities in access to healthcare services, funding, and resources; quality and quantity of services; treatment outcomes; and health education and prevention services. Availability, accessibility, and acceptability of behavioral health services are major barriers to recovery for American Indians and Alaska Natives."

PROJECT LEGACY

Based on the progress of this TTI funded effort, AMDD sought and was awarded additional funds from a CMS planning grant to support expansion of mobile crisis services.[3] As project funds to support community development and implementation end and plans are completed, the ADMM anticipates supporting community implementation of regional crisis diversion centers designed by and for the communities that they serve.

WHAT HAS STATE LEVEL SUPPORT FOR COMMUNITY DIVERSION CENTERS TAUGHT US?

Community stakeholders are not all at the same level of readiness to embrace change that challenge conventional structures and procedures. Projects such as this one provides support to communities as they build consensus and design more flexible, community-based approaches to crisis care that best fit their environments. AMDD is finding that engaging community stakeholders early in the design and implementation of crisis systems has encouraged adoption of community-based crisis care and led to growing consensus and action.

For more information on this project, contact Wyatt McAlpine at *wyatt.mcalpine@mt.gov*.

[1] QuickStats: Emergency Department Visit Rates Related to Mental Health Disorders, by Age Group and Sex — National Hospital Ambulatory Medical Care Survey, United States, 2016–2018. *MMWR Morb Mortal Wkly Rep 2020*; *69*:1838. DOI: http://dx.doi.org/10.15585/mmwr.mm6948a13externalicon.

[2] TIP 61: Behavioral Health Services for American Indians and Alaska Natives 2019 https://store.samhsa.gov/product/TIP-61-Behavioral-Health-Services-For-American-Indians-and-Alaska-Natives/SMA18-5070

[3] More information on CMS planning grants can be obtained at https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/state-planning-grants-for-qualifying-community-based-mobile-crisis-intervention-services/index.html

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