Vibrant Emotional Health

988 Behavioral Health Crisis Care Continuum

Key themes from December 2020 working sessions and interviews

Contents

1. Executive Summary

More than ever, this is the time for us to update the behavioral health system to meet the needs of people in crisis and emotional distress. Approximately one in five people above the age of twelve has a mental health condition in the U.S. Suicide is the second leading cause of death among young people, and the tenth leading cause of death overall. More Americans died from mental health crises and substance abuse in 2018 alone than have died in combat in every war combined since World War II.

But we can change this. Suicide is preventable, and mental health conditions are treatable. Annually in the U.S., for every person who dies by suicide, 280 seriously consider suicide but do not kill themselves. But the crisis care continuum must evolve to better meet needs of people in crisis and distress, as well as prepare for the future mental health impacts of the pandemic and other events that may occur.

Vibrant Emotional Health and the National Suicide Prevention Lifeline, in partnership with RI International and the National Association of State Mental Health Program Directors, convened a series of four 2.5 hour working sessions over the course of December 2020. McKinsey's Center for Societal Benefit through Healthcare provided technical support including conducting stakeholder interviews and facilitating working sessions.

The purpose of these working sessions was to gather input to support planning and preparation across the behavioral health (BH) crisis continuum for the launch of 988 – the new three-digit number for suicide prevention and mental health crisis, designated by the FCC in July 2020. Vibrant and its partners turned to leaders from health care, public health, and public safety to get a pulse on current barriers to and goals for successful crisis care implementation. The series brought together over 110 stakeholders from mental health authorities, service providers, and state and local leaders in four working sessions.

This document presents key themes that emerged from the December 2020 series, and collectively emphasizes the need to shift the existing behavioral health crisis care continuum toward a system that is **inclusive, people-centered, and cross-collaborative.** The behavioral health care continuum should aim to be inclusive of different communities and geographies, integrated more fully into the existing healthcare system, and held accountable with new metrics. The barriers to meeting these goals are often related to infrastructure, accessibility, and accountability. This document outlines domains of activity that more specifically address those concerns, with examples of current programs and activities across the country.

We hope that these key themes can be drivers of future policies across states as they examine their behavioral healthcare needs and prepare for the launch of 988. We recommend that stakeholders and policymakers incorporate these themes and goals into their work, and seek to address these barriers to create a behavioral health crisis care system that is more accessible, inclusive, equitable and effective for all. For more specific policy recommendations regarding 988's implementation, please visit www.vibrant.org/988.

2. Barriers facing the BH crisis system

- Most local BH crisis care systems are underdeveloped due to underinvestment.
- The current BH crisis care system can elect who and when to serve, leaving everything else to law enforcement and hospitals.
- The system is often not set up to meet the needs of historically marginalized groups, such as the BIPOC population, LGBTQ+ population, and others.
- Peer support is often not fully integrated across the BH crisis care continuum.
- Lack of infrastructure makes it difficult for BH crisis providers to access many funding streams.
- Commercial payors often do not see a clear need to cover BH crisis care.
- Funding and services dedicated to children, youth, and families often sit outside of the BH system.
- Public safety processes and protocols are often not built with BH crisis providers in mind.
- Non-BH entities can be hesitant to refer outside of normal pathways for fear of liability.
- Metrics that demonstrate the effectiveness of the BH crisis system are often not tracked or communicated consistently across stakeholders.
- Accountability for a comprehensive BH crisis system varies widely.

3. Shared goals for a BH crisis system that meets community needs

- Individuals feel supported, respected, and in control of their own care.
- Lived experience is taken into account in every aspect of the system.
- Historically marginalized groups have a voice in the system and it is set up to meet their needs, with a specific focus on the BIPOC population, LGBTQ+ populations, and others.
- All involved entities work together in a trusted relationship.
- Solutions address the needs of the child and youth population, and the role of families is acknowledged and valued.
- Solutions address the varying starting points of different localities.

- Solutions address the needs of different geographies, including rural, frontier, and tribal communities.
- BH crisis care is viewed and funded as an extension of the healthcare system.
- High quality and evidence-based crisis care is delivered across the BH crisis care continuum.
- BH crisis care providers uniformly acknowledge accountability for outcomes.
- Emergency rooms and detention facilities are not the de facto solutions to BH crises – people are treated in the most collaborative environment possible.

4. Domains of activity

Note: Examples provided are non-exhaustive

4.1 Enhancing the capacity and robustness of the BH Crisis Care Continuum

- Building capacity across the BH crisis continuum to ensure the system can identify and meet demand in line with SAMHSA's National Guidelines for Behavioral Health Crisis Care, e.g.,
  - Arizona's crisis response model, which has crisis call center hubs, mobile crisis units, and crisis stabilization facilities linked and working in coordination with local first responders. *Contact: David Covington, RI International; Erica Chestnut-Ramirez, La Frontera Arizona, Shelley Curran – Aetna/Mercy Care Health Plan, Alex Herrera – AHCCCS*
- Creating accountability structures at all levels to incentivize coordination, connection, and outcomes measurement
- Creating system-wide mechanisms for involving and effectively integrating the perspectives of specific groups, including:
  - Individuals with lived experience, e.g., building off the work of:
    - California Peer-Run Warm Line. *Contact: Eduardo Vega, Humannovations, formerly of Mental Health Association of San Francisco*
    - NYC Well's large network of available Peer Support Specialists. *Contact: Kelly Clarke, NYC Well*
    - Utah Mobile Crisis Outreach Teams, which pair clinicians with individuals with lived experience. *Contact: Kim Myers, Utah Division of Substance Abuse and Mental Health – Crisis Expert, Leanne Huff - Program Administrator, Utah Division of Substance Abuse & Mental Health – Mobile Crisis Outreach Team Expert, Doug Thomas, Utah Mental Health Commissioner, Steve Eliason – UT State Representative*
  - Caregivers and family support systems

- Historically marginalized populations, such as BIPOC, LGBTQ+, rural, and others, e.g., building off the work of:
    - Trans Lifeline, which is dedicated to building and maintaining trust with the transgender community with a model anchored on lived experience and empowerment. *Contact: Elena Rose Vera, Trans Lifeline*
    - The Gathering of Native Americans and Gathering of Alaska Natives training and technical assistance offered through the Tribal TTA Center, which provides a potential model for a culture-based planning process. *Contact: Pamela End of Horn, Indian Health Services*

- Integrating substance use prevention and addiction treatment into the BH crisis support structure, e.g.,
    - Baltimore Crisis Response, which provides services for detoxification as part of the crisis stabilization model. *Contact: Edgar Wiggins, Baltimore Crisis Response, Inc.*

4.2 Coordinating effectively across entities involved in crisis care

- Working with relevant entities – including hospital emergency rooms, 911[1], schools, and law enforcement - to create protocols (including shared definitions) and incentives that support coordination, e.g., building off work such as:
    - Embedding BH resources into 911 call centers in Harris County, TX. *Contact: Jennifer Battle, The Harris Center for Mental Health and IDD*
- Embedding crisis response into the school system, both operationally and financially, e.g.,
    - Baltimore County School System, which implements mental health training for school security officers and funds an Expanded School Mental Health Network in coordination with Behavioral Health System Baltimore. *Contact: Sharon Hoover, Co-director of the Center for School Mental Health (CSMH) at the University of Maryland School of Medicine*
- Integrating with social supports and community resources such as support for housing and food security, e.g., building off the work of:
    - Washington Foundational Community Supports, a supportive housing and employment benefits program that coordinates closely with the BH crisis system. *Contact: Kevin Martone, TAC*
- Establishing mechanisms for effective coordination.
    - Establishing a group to plan for 911 and crisis response coordination and 988 scale up across Federal, state, and local entities.
    - Putting in place technology that connects entities across the crisis care continuum, e.g.,
        - SAMHSA, through NASMHPD's TTI project, has funded 23 state mental health agencies to build or expand crisis bed registry systems. Crisis bed registries are databases designed to show "real-time" availability of psychiatric crisis services, including inpatient beds, and

[1] E.g., Major 911 protocol providers include ATCO, Power Phone, and IAED. Contact: April Heinze, NENA

often also include less intensive crisis services. NRI has been working closely with the funded states to assist their work and document their progress and lessons learned. A NRI/NASMHPD report highlighting this initiative will be available in the Spring of 2021. *Contact: Ted Lutterman, NRI; Brian Hepburn, NASMHPD*

- Behavioral Health Link in Georgia uses an electronic bed registry to enable crisis line staff to see available beds and refer individuals. *Contact: Wendy Tiegreen, Georgia Department of Behavioral Health and Developmental Disabilities; Debbie Atkins, Georgia Department of Behavioral Health and Developmental Disabilities*

— Creating regular cross-system convening points within communities, e.g.,

- Arizona Crisis Community Collaborative weekly meeting to support cross-system planning for 988. *Contact: David Covington, RI International*

— Organizing ongoing cross-sector trainings to increase awareness of BH crisis services and build relationships across entities, e.g., building off the work of:

- Crisis Intervention Team (CIT) training for law enforcement. *Contact: Ron Bruno, CIT International*

4.3 Financing BH crisis care continuum services and supports

- Making strategic investments in BH crisis services
  - — Developing guidance and approach to braiding funding across different sources
  - — Using state and local dollars to primarily fund infrastructure, not ongoing services
- Removing barriers to billing insurance for BH crisis care
  - — Establishing standard codes and processes to bill Medicaid, Medicare, and commercial insurance, e.g., building off the work of:
    - Developing guidance for other states on Medicaid billing. *Contact: David Covington, RI International*
  - — Investing in third-party billing capabilities, including infrastructure and personnel, e.g.,
    - Funding support provided by the Colorado Department of Human Services to enable ongoing billing to support Colorado Crisis Services. *Contact: Michael Allen, Rocky Mountain Crisis Partners*
  - — Accelerating accreditation process for BH crisis providers
- Increasing available funding streams
  - — Establishing 988 coordinators in every state to work with the 988 Administrator and SAMHSA to assess resources that exist in the community and identify gaps
  - — Investing in research and technology to build the evidence base around realized savings
  - — Building relationships with state, community, and healthcare associations to educate stakeholders and increase financial support

- Creating additional funding streams to cover operational costs associated with 24/7 crisis care
- Disseminating example legislation for states interested in implementing 988 cell phone fees
- Developing shared perspective on how philanthropy can invest strategically in the BH crisis care continuum, e.g., building on large philanthropic investments such as:
    - Philanthropic investment in the Crisis Text Line by Melinda Gates, Balmer Foundation, Pierre Omidyar, and others. *Contact: Ken Zimmerman, The Mental Health Strategic Impact Initiative*

5. Appendix

Exhibit 1: Participants vision for how people will feel using future 988 system

# of responses: 39
The size of the word corresponds to the number of individuals who shared that word.

Exhibit 2: Crisis and emergency services care continuum

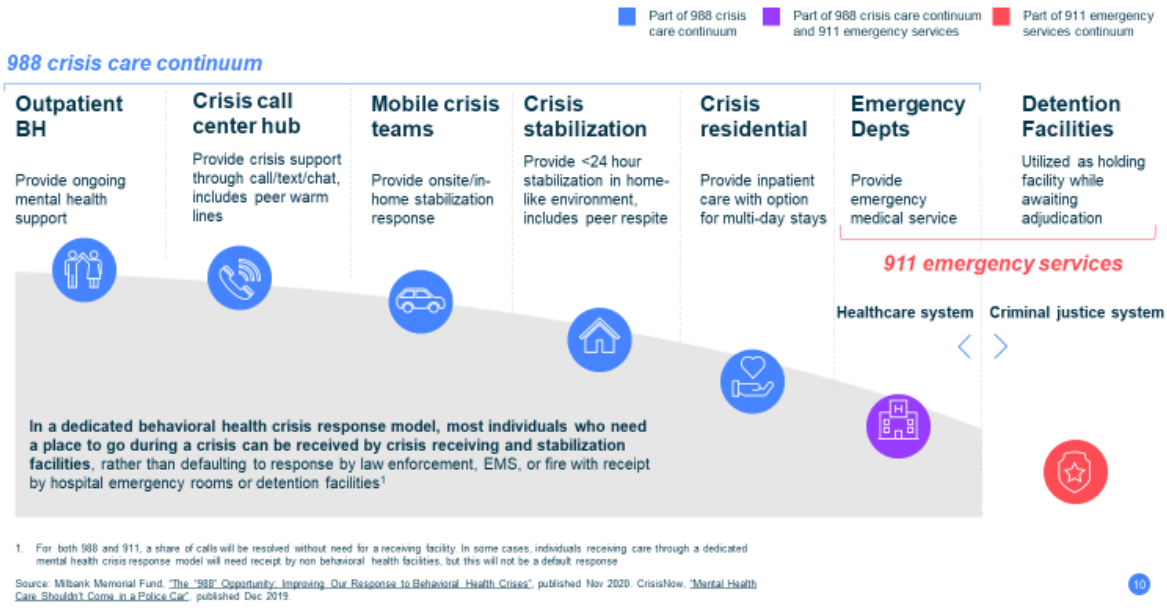
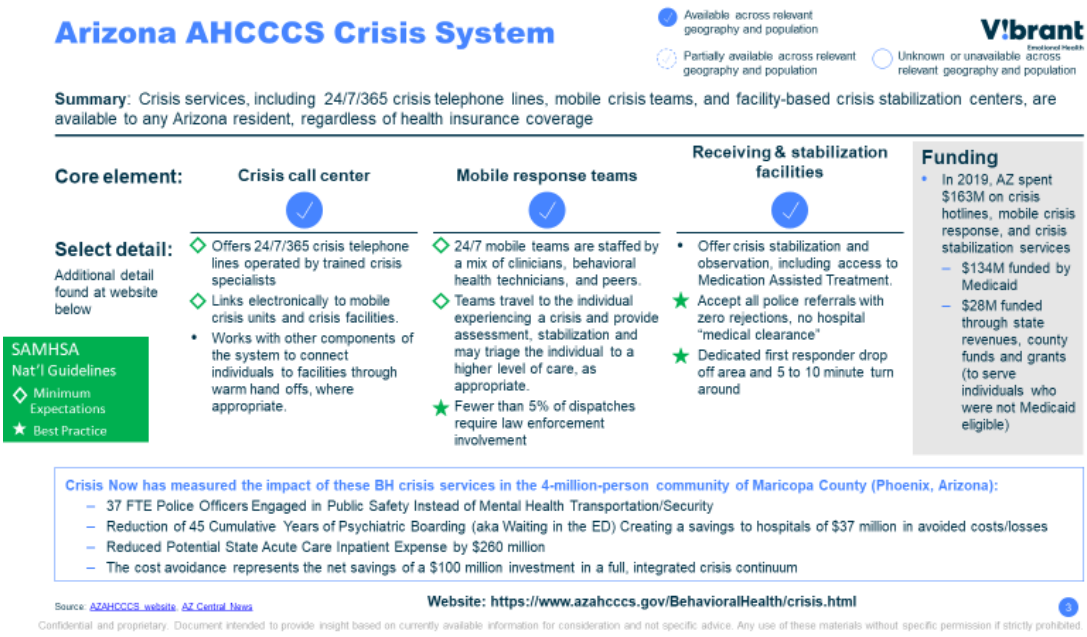


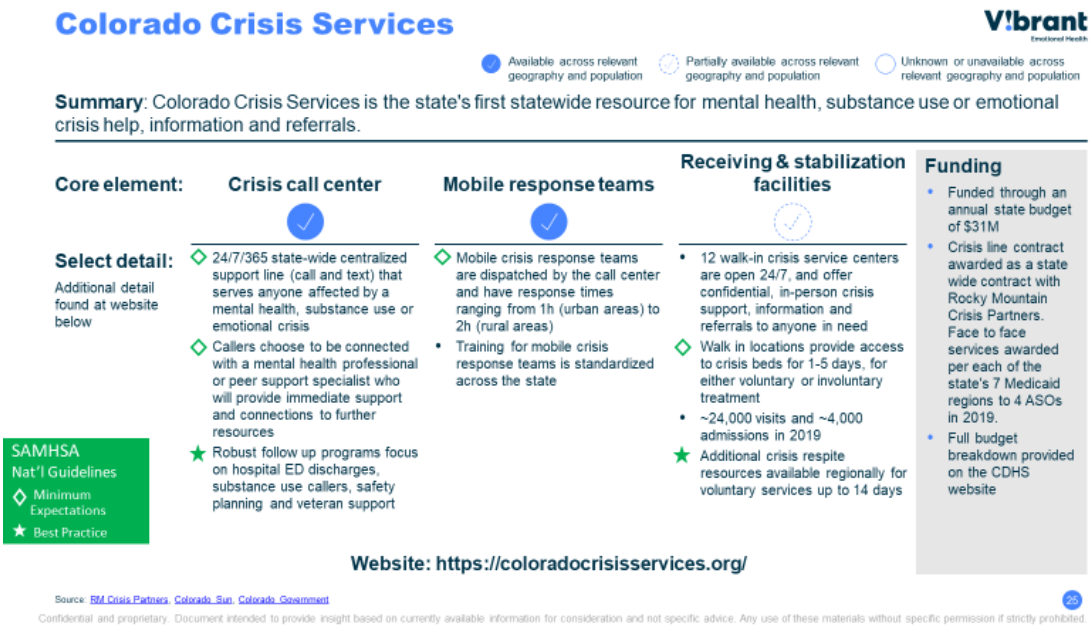
Exhibit 3: Exemplars

3.1 Arizona AHCCCS Crisis System



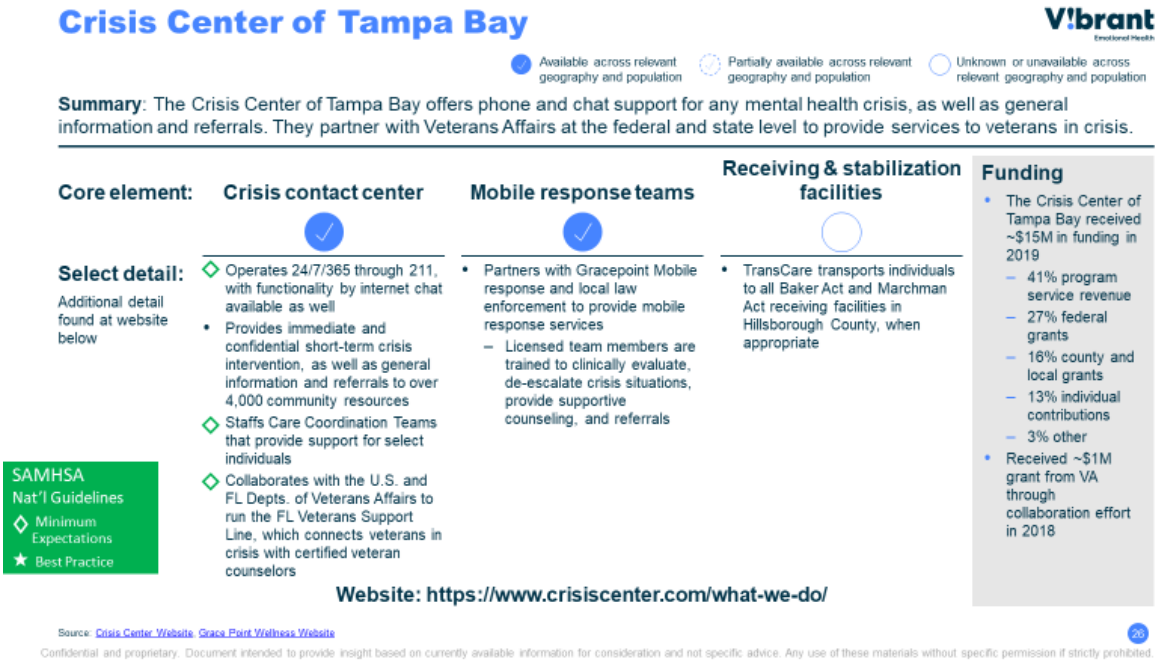
Contact:
Alex Herrera – AHCCCS;
Tom Betlach, formerly of AHCCCS - tombetlach@gmail.com;
Erica Chestnut-Ramirez, La Frontera - Erica.Chestnut-Ramirez@LaFrontera-EMPACT.org;
David Covington, RI International - David.Covington@riinternational.com;
Shelley Curran – Aetna/Mercy Care Health Plan

3.2 Colorado Crisis Services



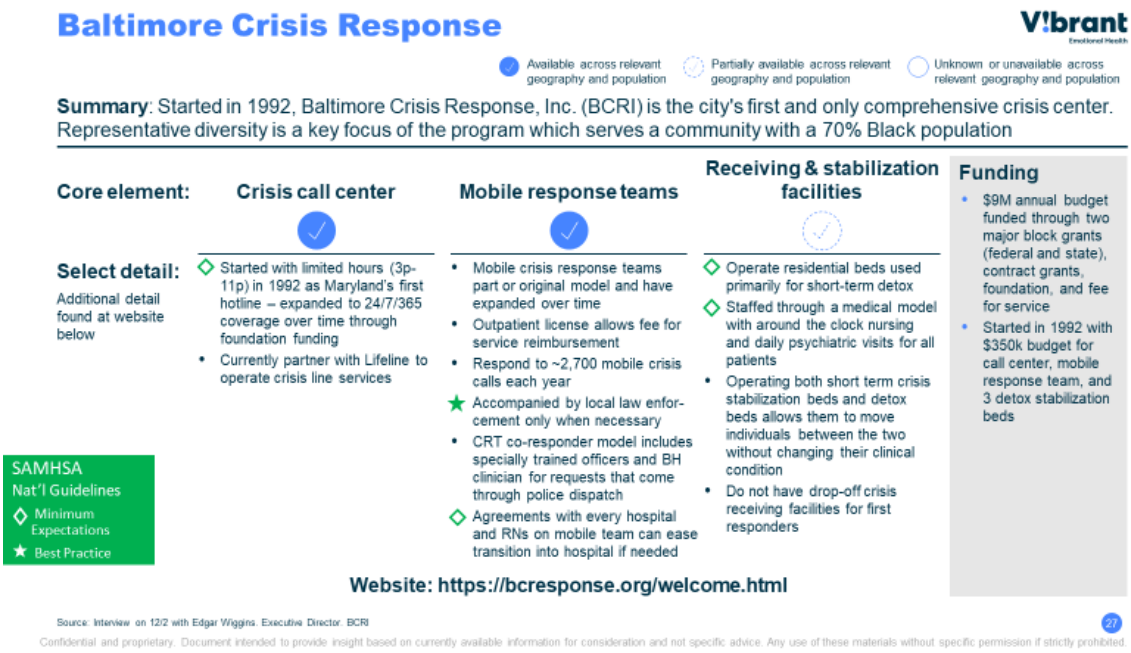
Contact:
Michael Allen, Rocky Mountain Crisis Partners - MICHAEL.ALLEN@CUANSCHUTZ.EDU

3.3. Crisis Center of Tampa Bay



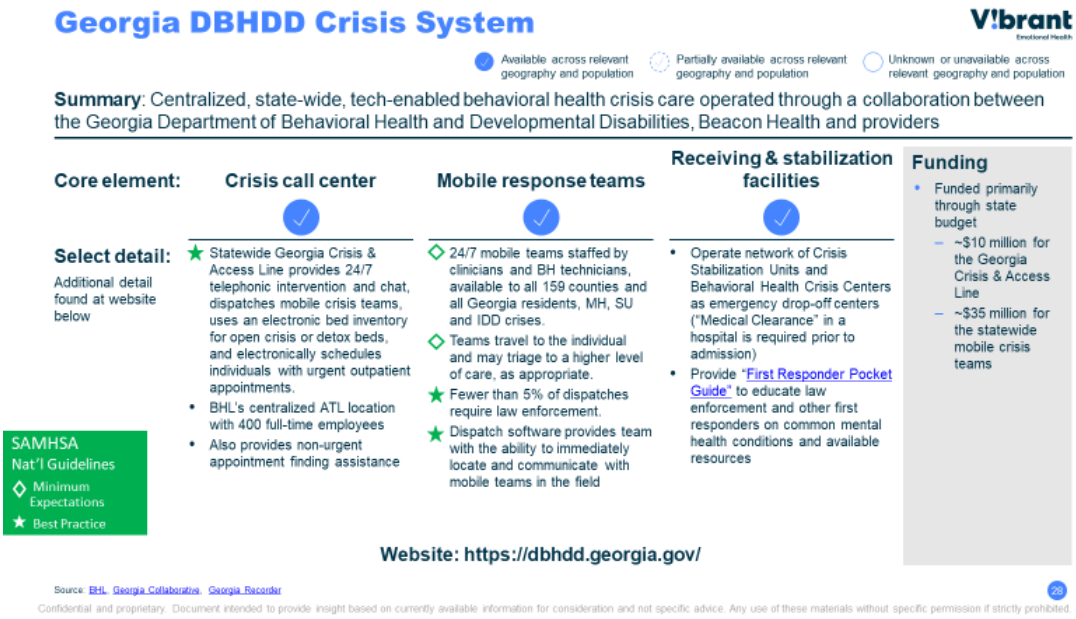
Contact:
Eric Hebert, Crisis Center of Tampa Bay- ehebert@crisiscenter.com

3.4 Baltimore Crisis Response



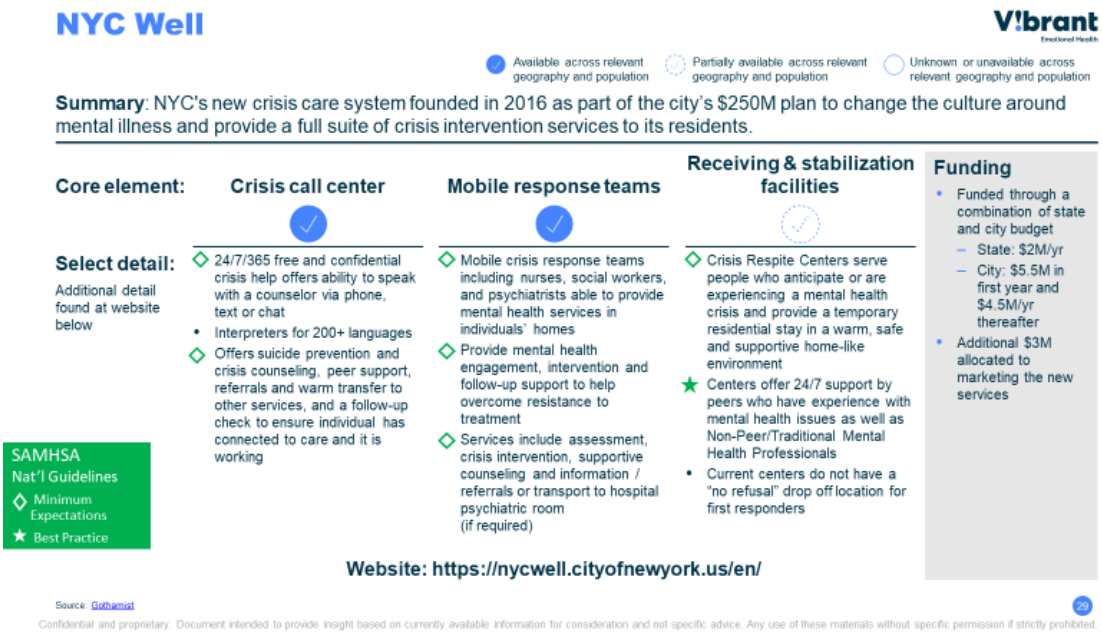
Contact:
Edgar Wiggins, Baltimore Crisis Response, Inc. ewiggins@bcresponse.org

3.5 Georgia DBHDD Crisis System



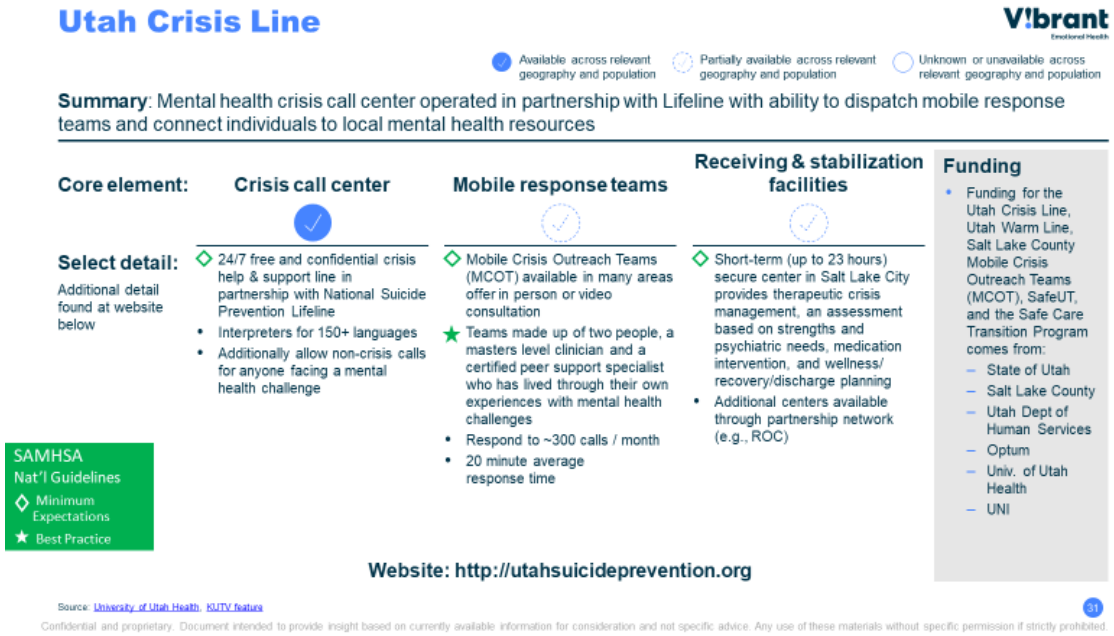
Contact:
Wendy Farmer, formerly of BHL Wendy.Farmer@beaconhealthoptions.com ;
Wendy Tiegreen, Georgia Department of Behavioral Health and Developmental Disabilities - Wendy.Tiegreen@dbhdd.ga.gov ;
Debbie Atkins, Georgia Department of Behavioral Health and Developmental Disabilities - Debbie.Atkins@dbhdd.ga.gov

3.6 NYC Well



Contact:
Kelly Clark, NYC Well - kclarke@vibrant.org

3.7 Utah Crisis Line



Contact:
Kim Myers, Utah Division of Substance Abuse and Mental Health – Crisis Expert - kmyers@utah.gov;
Leanne Huff - Program Administrator, Utah Division of Substance Abuse & Mental Health – Mobile Crisis Outreach Team Expert;
Doug Thomas, Utah Mental Health Commissioner;
Rep. Steve Eliason – UT State Representative