May, 2021

Region-VIII SAMHSA Structured Listening Sessions:

State Crisis Services Profile

Description: With guidance from a model developed in the state of Arizona, SAMHSA Region-VIII has been working closely with SAMHSA-HQ and the National Consortium on Crisis Services to take a closer look at the standards for behavioral health crisis services. Structured listening sessions with behavioral health officials and crisis services experts in five Region VIII states (Colorado, Montana, South Dakota, Utah, and Wyoming) were held in March and April of 2021. These sessions examined crisis services systems throughout Region VIII in comparison to SAMHSA's National Guidelines and recommended best practices for behavioral health crisis care services[1]. In efforts to appreciate the unique nuances of what is considered to be "best practice" in this region, behavioral health crisis services provided in frontier and rural communities were emphasized during these sessions.

Objective: This report is a regional comparative analysis of crisis service systems. This report captures current Region VIII state crisis services planning and program implementation efforts. The report findings and executive summary will be shared with Region VIII state behavioral health officials, as well as SAMHSA HQ in order to further support their crisis service system development as well as implementation of the new National Mental Illness and Suicide Prevention Crisis line, *988.

SAMHSA's National Guidelines for Crisis Care: Core Services & Best Practices

As defined by SAMHSA's National Guidelines for Crisis Care and recommended best practices for behavioral health crisis care services[1], the following represent the "essential elements" of a "no wrong-door integrated crisis system":

Tier 1 - Regional Crisis Call Center: Regional 24/7 hub/crisis call center that is clinically staffed to provide crisis intervention capabilities (telephonic, text and chat). Such a service should meet National Suicide Prevention Lifeline (NSPL) standards for risk assessment and engagement of individuals at imminent risk of suicide and offer quality coordination of crisis care in real-time.

Tier 2 - Crisis Mobile Team Response: Mobile crisis teams that are available to reach any person in the service area in a timely manner (e.g., their home, workplace, or any other community-based location of the individual in crisis).

Tier 3 - Crisis Receiving and Stabilization Facilities: Crisis stabilization facilities providing short-term observation (e.g., less than 24 hours) and crisis stabilization services to all referrals in a home-like, non-hospital environment.

Structured Listening Sessions: A Region-VIII Behavioral Health Crisis Services Profile

General Themes: Preparing for the transition to *988 will "force the conversation that may not have ever happened; a conversation that is long overdue."

- Crisis Services has gained a lot of momentum recent years, particularly with current initiatives related to development and upcoming implementation of the national 988 system.
- First responders (e.g., law enforcement, EMS, 911 dispatch centers) appear to be critical partnerships for developing, implementing and evaluating behavioral health (BH) crisis response systems throughout Region VIII, particularly in rural and frontier communities.
- Common barriers or challenges related to BH crisis services systems appear to include:

[1]SAMHSA (2020). *National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit*.
https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

- The lack of a comprehensive and cohesive statewide BH crisis services system (i.e., "currently a regional system of care; not statewide system of care").
- Integration of crisis services, both within and between levels of crisis care (i.e., Tiers 1-3), as well as with other relevant statewide and national systems providing BH crisis services (e.g., 911, 211, National Crisis Networks).
- A need for increased broadband and access to appropriate technology.
- Access barriers to BH crisis stabilization services for certain populations (e.g., SMI, tribal nations, children/adolescents, high acuity, substance intoxication/detox, etc.).

Tier 1: Behavioral Health Crisis Call Centers

General Themes

- Variation among Region VIII states of what resource is used as the primary BH Crisis Call Center (e.g., statewide crisis call center, 211, etc.).
- Integration with other relevant statewide and national systems providing BH crisis services.
  - Majority of state BH Crisis Call Centers seem to be connected to the National Suicide Prevention Lifeline.
  - Some state BH Crisis Call Centers are not 24/7/365.
- Working towards real-time/air-traffic control model
- Variation in efforts to tracking or collect data on BH-related calls.
  - Some states collaborate with state 911 centers or other relevant national call systems (e.g., National Crisis Network, National Suicide Hotline) to track these calls, while others are not currently collecting this data.
  - An emphasis on implementing data collection/analysis of BH-related crisis calls seemed to be a trend in discussions related to the implementation of 988.

Rural/Frontier Considerations

- Residents may call local community hotlines or law enforcement rather than call a statewide (or National) crisis call center.

Common Challenges/Concerns

- Variation in integration of state BH Crisis Call Centers with 911. For example, some are not directly connected to 911 vs. forwarding (i.e., caller hang up and call 911).
- A need for increased integration between crisis hotlines and mobile dispatch services.

Tier 2: Behavioral Health Mobile Crisis Teams

General Themes

- Activation of Behavioral Health (BH) Mobile Crisis Teams appears to occur in a variety of ways, and varies significantly dependent on the state and area within a state (e.g., activation by local MHC crisis hotlines, state crisis lines, 911 dispatch, and/or law enforcement).
- The structure of BH Mobile Crisis Teams varies significantly between and within Region VIII states
  - The structure is often dependent on geographic area or availability of local resources to support/provide a BH Mobile Crisis Team.
- Some states' BH Mobile Crisis team efforts are regionalized, while others report initiatives developed at the local/county level. Some Region VIII BH Mobile Crisis Team models include:
  - BH clinician-only response (law enforcement, and/or EMS may offer back-up coverage)
  - Co-Responder Model: Paired response of law enforcement and BH clinician
  - Law-enforcement response (e.g., CIT-trained officers)

- Variation in BH Mobile Crisis Team response time and method of transportation for BH Mobile Crisis response to patient/scene (i.e., own vehicle vs. transported by law enforcement).

Rural/Frontier Considerations

- Law enforcement identified as a critical partner for BH Mobile Crisis Team response,
- High interest in exploring and piloting virtual responder models with law enforcement (e.g., pairing law enforcement with remote BH clinician for virtual evaluation and crisis management).

Common Challenges/Concerns

- Workforce (e.g., rate of pay, retention/turnover rate).
- Safety concerns can influence Mobile Crisis Team activation or Mobile Crisis Response efforts (e.g., intoxication, perceived aggression).
- Transportation
    - A need for secure transportation services for BH Mobile Crisis Team.
    - A need for systematic protocol for who transports, how the person in crisis is transported, and to where they are transported.
- Insufficient funding or lack of local resources to implement an appropriate BH Mobile Crisis response system to fit the unique needs of rural and frontier areas.
- A significant need for updated technology and broadband in order to enhance efforts to support virtual BH Mobile Crisis response in rural/frontier areas.

Tier 3: Behavioral Health Crisis Receiving/Crisis Stabilization Center

General Themes

- Trend of developing or established regional crisis stabilization centers.
    - Inter-facility variation in types of services available (e.g., detox, beds for 24hr stabilization periods), admission criteria, and services offered to support population-specific needs (e.g., children/adolescents, high acuity, psychosis).
- Variation in how patients are transported to crisis stabilization facilities (e.g., law enforcement, EMS, BH co-responder, assistance of family or community member).
- Many states reported working towards creating a comprehensive crisis stabilization services registry for a "real-time" inventory of available BH services (e.g., beds, etc.).

Rural/Frontier Considerations

- Emergency Departments and/or local jails serving as initial entry points or "holding" areas while a plan is formulated for proper patient assessment and transportation to crisis stabilization.
- Location and cost management of Crisis Stabilization Center (e.g., bed utilization to justify/support cost of service)

Common Challenges/Concerns

- Access barriers to BH crisis stabilization services for certain populations (e.g., SMI, children and adolescents, high acuity, intoxication/detox)
- Secure transportation to/between crisis stabilization facilities.
- Location of facilities throughout the state (i.e., transportation distance and capacity).
- Some reports of safety/liability concerns related to patient intoxication level, perceived aggression, or acuity level influencing access of crisis stabilization services.
    - A need for workforce development around managing safety concerns and high acuity populations, as well as crisis services for children and adolescents.