THE ROLE OF SUPPORTIVE HOUSING, CASE MANAGEMENT, AND EMPLOYMENT SERVICES IN REDUCING THE RISK OF BEHAVIORAL HEALTH CRISIS

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The Role of Supportive Housing, Case Management, and Employment Services in Reducing the Risk of Behavioral Health Crisis

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Abstract:

There is significant momentum among state behavioral health authorities (SBHAs) nationally to develop accessible and responsive crisis services that will meet the needs of adults, children, and families when mental health emergencies occur. These important efforts should strengthen the crisis response capacity of behavioral health systems, expedite access to care, lower suicide rates, and reduce encounters with law enforcement. As states continue to plan and implement strategies that support more effective behavioral health crisis response systems, attention must be paid to integrating and providing access to other critical services and supports that both reduce crisis risk and support recovery. This paper builds the case for the importance of evidence-based and best practice supportive housing, case management, and employment services as integral components of a behavioral health system that help with crisis prevention, mitigation, and recovery — and offers strategies for supporting their effectiveness in doing so.

Key Points:

- Supportive housing, case management, and employment programs that use evidence-based and best practices provide critical opportunities to recognize the early warning signs of a behavioral health crisis and take steps to prevent it.

- High-fidelity supportive housing and supported employment programs serving individuals with mental illnesses and co-occurring disorders, including those who experience homelessness, integrate crisis prevention and intervention into their service models. When implemented effectively, these services can help reduce the severity of crises that do occur and can facilitate post-crisis recovery.

- Case management services that incorporate evidence-based and best practice interventions can function as a critical hub for engaging individuals, facilitating self-direction, and choice. Linkages to these and other services and supports can help reduce crisis risk and assist in recovery.

- SBHAs can strengthen the role of supportive housing, case management and supported employment in crisis prevention, mitigation, and recovery through policy, funding, and practice support. SBHAs can also help ensure effective coordination between upstream services that address social determinants of health (SDOH) and crisis services.

Recommendations for the Future:

1. As states enhance their behavioral health crisis response systems to support successful implementation of 988, SBHAs should commit to making supportive housing, case management, and supported employment services more available and accessible within their systems to address SDOH, reduce crisis risk, and support individuals in their recovery.

2. Policies, regulations, service definitions, and performance monitoring should reinforce key features of these services that make them effective in crisis prevention, mitigation, and recovery, and ensure their alignment and coordination with the crisis response system.

3. SBHAs should work in close coordination with state Medicaid agencies to ensure sufficient funding and coverage to support effective implementation of supportive housing, supported employment, case management and integrated peer supports, and advocate for adequate provider rates in their states.

4. Supportive housing, case management, and employment services providers should be equipped with guidance, tools, and protocols, and offered training and technical assistance to ensure they can effectively assess, plan for, and intervene to prevent or resolve crises as needed. They should also be trained on protocols for accessing local crisis systems and services.

5. SBHAs and providers should invest in recruiting and retaining a diverse, culturally competent and responsive workforce, and should partner with trusted community leaders in order to more effectively engage people of color in upstream services that improve SDOH and reduce crisis risk, and in crisis services as needed.

The ability of behavioral health crisis services to meet demand and successfully resolve crises is largely dependent on the ability of the behavioral health system to help prevent crises in the first place and to effectively manage and resolve a crisis when it does occur. As states continue to plan and implement strategies that support more effective behavioral health crisis response systems, in conjunction with the implementation of 988, attention must be paid to integrating and providing access to other critical services and supports that both reduce crisis risk and support recovery. Access to upstream services can help address social determinants of health (SDOH) like housing and employment which are general factors that play an important role in improving mental health and wellness, and also facilitate recovery among people with a mental illness and/or substance use disorder (SUD). Conversely, lack of access to these and other resources can both increase the risk that a person will experience a behavioral health crisis and affect their ability to recover from one.

Structural and systemic racism in the U.S. have contributed to behavioral health services often being inaccessible to people of color and to significant disparities in SDOH. Recent estimates are that African Americans represent only 13 percent of the general population but account for nearly 40 percent of people experiencing homelessness, and account for more than 50 percent of homeless families with children.[1] Black Americans also experience poverty[2] and unemployment[3] at elevated rates. Mental illness and/or SUD can contribute to, as well as be exacerbated by, homelessness and unemployment. Making housing, employment, and other supports more accessible to people of color can help address important SDOH, reduce crisis risk, and support recovery.

SBHAs play a critical role in determining the types of behavioral health services that are available in a system, including how they are funded and regulated, and for ensuring equitable access for all who need them. SBHAs and providers can help make services available in ways that help reduce unnecessary crisis services use and costs, and improve individuals' recovery outcomes.

Background

As discussed in the National Association of State Mental Health Program Directors' (NASMHPD) 2018 report, *Bolder Goals, Better Results: Seven Breakthrough Strategies to Improve Mental Illness Outcomes*, ending homelessness among individuals with serious mental illness (SMI) — using interventions tailored to their unique needs — is critical to strengthening behavioral health systems and improving individual-level outcomes.[4] Individuals experiencing homelessness are at increased risk for experiencing a behavioral health crisis by myriad risk factors, such as high rates of abuse and trauma, higher prevalence of suicidal ideation and attempts, and untreated physical health conditions, as well as increased likelihood of being arrested and incarcerated, which leads to a cycle of disconnection from the behavioral health system and recurrent homelessness.[5] The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) has recognized **housing** as the "cornerstone" to recovery for individuals with mental illness and co-occurring disorders (CODs) who experience homelessness.[6] SAMHSA has also recognized the importance of pairing community-integrated, affordable housing with supportive services for this population through its endorsement of the evidence-based permanent supportive housing (PSH) model.[7]

> The U.S. Substance Abuse and Mental Health Services Administration has recognized housing as the "cornerstone" to recovery for individuals with mental illness and co-occurring disorders who experience homelessness.

PSH services can help prevent an individual from experiencing a behavioral health crisis and can also reduce the likelihood that if a crisis does occur, it will lead to eviction or a return to homelessness. Research has found that individuals experiencing homelessness who also have behavioral health conditions experience improvements on housing stability and behavioral health measures and a

reduction in emergency department and hospital admissions when served by PSH.[8,9,10] PSH has been adapted to serve individuals with a broad range of behavioral health and housing needs, including families with children and persons exiting jails and prisons.[11] Supportive housing interventions have also been shown to reduce child welfare involvement and to help keep families together,[12] while the rate of incarceration in jails and prisons has been significantly reduced among PSH participants with prior histories of incarceration.[13]

Supportive Housing combines decent, safe, affordable, community-based housing with flexible, voluntary services and supports to help individuals achieve stable housing and community integration.

Case Management includes a range of services provided to assist and support individuals in developing their skills to gain access to needed medical, behavioral health, housing, employment, social, educational, and other essential services and supports.

Supported Employment assists with obtaining competitive, integrated employment opportunities consistent with individual choice, and offers ongoing customized supports to maintain employment.

By helping those who frequently use emergency departments, psychiatric and medical inpatient units, and other emergency services to quickly access PSH, not only are their crisis risks reduced, but also the costs associated with recurrent services utilization.[14] To be successful, PSH service providers must be linked with crisis systems and services to ensure early intervention, coordination, and post-crisis handoffs back into housing and services.

Case management services for individuals with behavioral health needs may either stand alone or be combined with other services or housing, and they may be offered either by behavioral health systems and providers or by non-behavioral health entities such as those within the homelessness system. Case management models serving behavioral health populations vary in intensity, focus, and duration — ranging from those such as Assertive Community Treatment (ACT), intensive and clinical case management models, which use small caseloads and provide ongoing services for individuals with chronic behavioral health conditions, to more generalist models characterized by larger caseloads and basic linkage and coordination with services and supports for longer-term care.[15,16] Both ACT and Critical Time Intervention (CTI), which provides continuity of care to individuals with SMI during transitions from homelessness, psychiatric hospitals, or other institutions into community housing, are evidence-based case management models associated with reductions in negative psychiatric symptoms, length of psychiatric hospital stays, and emergency department visits.[17] CTI has also proven effective in reducing recurrent homelessness[18,19,20,21,22] and has been shown to be cost-effective.[23] MISSION is another model that incorporates and has been shown when combined with PSH to help improve housing retention, mental health outcomes, and access to care.[24] Many features of these and other evidence-based interventions such as motivational interviewing, trauma-informed care, and harm reduction can be adapted to help case management programs effectively serve individuals who have one or more risk factors for experiencing a behavioral health crisis.

As a SDOH, **employment** plays a critical role in promoting recovery, while also reducing social exclusion, isolation, and poverty. Adults with SMI are more likely to be unemployed or underemployed, contributing to economic hardship that can further affect behavioral health.[25] Despite low employment rates, the majority of people with SMI are capable of and interested in working if connected with appropriate jobs and supports.[26] Supported employment (SE) services provide individuals with mental illness and CODs with specialized assistance in choosing, acquiring, and maintaining competitive employment. The evidence-based, SAMHSA-recognized Individual Placement and Support – Supported Employment (IPS-SE) model, which has been adapted for working with people who are experiencing homelessness and those who have been involved in the criminal justice system,[27] has been shown to increase access to competitive employment and income; reduce symptoms of mental illness, inpatient

hospitalizations, and psychiatric crisis visits; and improve self-esteem and overall quality of life.[28,29] Assisting individuals to achieve employment enables them to improve their social integration and networks as well as their living situation,[30] which can reduce crisis risk in addition to having positive impacts on other SDOH. Evidence also suggests SE as an important component of programs designed to support persons experiencing an early episode of psychosis, affecting community stability and recovery through sustained employment, improved quality of life and lower hospitalization rates during the early stages of psychotic illness.[31,32] However, relatively few people with SMI served by SBHAs receive SE services, due largely to lack of sustainable services funding. More can be done to promote employment as an achievable outcome during recovery at both the system and provider levels.

Reducing Crisis Risk through Effective Services Implementation

Below are key features of supportive housing, case management, and employment programs that can help to reduce crisis risk. Common barriers to effective crisis prevention within these programs are also explored, along with strategies for increasing their effectiveness.

Supportive Housing Services

Supportive housing services focus on proactively engaging and assisting participants in building the skills to access and maintain housing, and connecting them with treatment, supports, and community resources that support recovery. High-fidelity PSH programs that make services available on a 24/7 basis and integrate behavioral health services are perhaps most effective in reducing crisis risk. By maintaining low caseload sizes (e.g., 1:15) and routine face-to-face contact with tenants where they live, PSH providers are able to recognize the early warning signs of a potential crisis, and to adjust the frequency and intensity of services as needed to help avert a crisis.

Potential barriers to effective crisis prevention within PSH programs may include a lack of 24/7 service availability due to funding or workforce challenges; larger caseloads that limit the ability of staff to effectively monitor tenants for crisis risk; and lack of behavioral health services integration, such as when PSH is funded and operated within local homelessness systems. In these instances, PSH programs tend not to be naturally connected with behavioral health systems and services, and staff may not be equipped to recognize crisis risk factors.[33] Staff capacity and training in this regard may be lacking regardless of whether the program sits within or outside of the behavioral health system. Thus, PSH provider agency staff need training to identify risk factors and to proactively and effectively engage individuals in planning to reduce crisis risk.

PSH services are delivered based on individualized plans that assess tenant needs and preferences and ensure access to services and supports to address those needs. Ideally, this assessment includes consideration of the types of crises that may occur (e.g., psychiatric, substance use, medical, housing- or family-related). Plans should include monitoring these risk factors and engaging individuals in services and supports that specifically reduce risk. Some PSH programs require providers to develop a specific crisis prevention and intervention plan for tenants as a means of effectively planning for and intervening in the event of a crisis.[34] Plans are developed with tenants as workers are assessing housing-related strengths, barriers, and service needs prior to tenancy, and are updated throughout tenancy to reflect changing needs. Copies are given to the tenant and to the service provider.

Many providers embed peer workers into PSH service teams; these team members bring their own personal experience with mental illness, recovery from an SUD, homelessness, and/or justice system involvement. In addition to assisting PSH program participants with resource navigation and linkage, peer workers' expertise may be called upon when the PSH team is having difficulty engaging with a tenant who is at heightened risk for experiencing a crisis. Peer workers can effectively engage

participants in unique ways that help meet basic needs, build trust and rapport, and gradually gain voluntary participation in services, while also helping to de-escalate and divert potential crisis situations.

Case Management Services

Case management services have the potential to address many of the risk factors associated with a behavioral health crisis. At a basic level, case management focuses on assessment, planning, linking, advocacy, and monitoring. ACT case management services use low caseload sizes (e.g., 10:1) in addition to directly delivering psychiatric and SUD treatment, employment, and rehabilitative services specifically for those with SMI and CODs who have the most acute behavioral health needs and are most at-risk of crisis (e.g., those with frequent hospital admissions, frequent use of emergency services, experience of homelessness, or involvement with the criminal justice system). ACT services are intensive, highly individualized, and delivered by multidisciplinary teams on a 24/7 basis to people wherever they are in the community, enabling providers to monitor and titrate service intensity to manage crisis risk. Funding and staffing limitations may challenge the ability of ACT teams to effectively prevent crisis, particularly where 24/7 service availability is lacking. Modifications may also be needed for ACT teams to effectively respond to SUD-related crises, homeless individuals in need of outreach and engagement, and for those also needing housing supports.[35]

Not all individuals need the level of service intensity provided by ACT, and case management programs offering less intensive supports tend to focus on service linkages that can prevent crisis risk, rather than on providing services directly. These programs can adapt principles and strategies from and train case managers in evidence-based interventions like motivational interviewing, trauma-informed care, and harm reduction to help strengthen their ability to engage individuals with behavioral health needs. This ability, in combination with good assessment and planning, is essential to creating effective linkages with the community-based treatment, services, and supports that may reduce an individual's crisis risk.

CTI is intensive, time-limited, and focused on assisting individuals with SMI to achieve housing stability; however, it has several elements that can be adapted by case management programs serving a broader range of individuals with behavioral health needs to help prevent crisis. During each phase of CTI services, staff focus on connecting individuals with treatment and community resources in one or two key focus areas that include: psychiatric treatment and medication management; substance use disorders management; life skills training; money management; housing crisis management and prevention; and family intervention. Case management assessments can be aligned with many of these focus areas, which are also tied to crisis risk. Other CTI elements that can be adapted include its emphasis on early engagement and ongoing relationship-building; planning to address risk factors through linkages with community providers and resources that promote stability; and gradually shifting responsibility for crisis prevention to longer-term treatment providers and other formal and natural supports. Regardless of program model, large caseloads may inhibit effective planning, monitoring, linkage, and coordination by case managers to reduce crisis risk. Training is needed for case managers in crisis risk assessment and planning, client engagement, and coordination with treatment and other service providers.

Supported Employment Services

Supported Employment (SE) services promote competitive employment in the community based on program participants' interests and available choices, with service coordination and ongoing monitoring that can help reduce crisis risk. SE services may be standalone or integrated into other service models. When implemented to fidelity with the IPS-SE model, services emphasize the integration of employment services within clinical treatment teams and the provision of ongoing follow-along supports to help an individual maintain employment. By working in partnership with program participants' other behavioral health providers, such as psychiatrists, therapists, and case managers, employment specialists can

monitor for symptoms and stressors that may affect an individual's ability to find and keep a job while also being informed of any changes, events or circumstances that could lead to a potential crisis. Where required, elevated risk of crisis can signal a need for modified employment supports, including more intensive on-site job coaching, mediation between an employer and the individual, or sometimes, assistance in exiting a place of employment and finding a job that is a better fit. Where employment specialists are not viewed as part of or able to regularly participate in clinical treatment team communication and planning, efforts to recognize crisis risk may be hampered.

SE service providers should ensure that employment specialists are trained to identify crisis risk factors, to assertively engage individuals and offer adjustments to employment supports as needed, and to have structures and protocols in place that ensure regular and effective communication between SE staff and clinical treatment providers. Yakima Neighborhood Health Services, an SE provider based in Washington State who also delivers supportive housing and health care services, allows SE and behavioral health clinical staff to share an electronic database in order to more effectively coordinate services.[36] This type of shared data system can allow for rapid communication between SE staff and the clinical treatment team to better support with recognizing and responding to situations involving elevated crisis risk. SE and behavioral health treatment providers could also codify partnerships using memorandums of understanding (MOUs) and operationalize integration by inviting employment specialists to weekly treatment team meetings; sharing employment and treatment/services plans between providers; and meeting jointly with program participants to ensure service coordination.

Crisis Mitigation and Recovery

Just as supportive housing, case management, and employment programs can engage in approaches that help reduce crisis risk, many of the same strategies noted above can also help in mitigating and resolving crises when they do occur, as well as assist with post crisis recovery as defined in Figure 1.

Figure 1: Effective supportive housing, case management and employment services have a role in:	
Crisis Prevention →	Identifying crisis risk factors, intervening to reduce the risk of crisis occurring.
Crisis Mitigation →	Intervening to reduce the severity of a crisis, and to resolve it once it occurs.
Crisis Recovery →	Post-crisis connection with and return to services/supports that promote recovery and prevent recurring crises.

To be successful, PSH service providers must be able to respond on-site, by phone, or virtually to intervene with a developing crisis. Team-based case planning and service delivery helps ensure that any responding PSH service team member has an ongoing relationship with and can support the individual in accessing additional care as necessary. This can in turn help alleviate any feelings of anxiety or symptom presentation that a response from an unknown individual like a mobile crisis worker may exacerbate. Barriers to mitigating crises within PSH programs may occur where 24/7 ability to respond, team-based service delivery, and/or integration with behavioral health services, including crisis services, is lacking. PSH program staff need training in order to effectively intervene and deescalate a crisis, regardless of whether the program sits within or outside of the behavioral health system. Further, many PSH programs lack policies and procedures and clear protocols for *how* to call for backup when crisis intervention is needed beyond the scope of a PSH programs or provider's resources. Providers must

have an understanding of the crisis response process in their community and know when and how to call on crisis services. PSH programs should establish policies and procedures outlining protocols for crisis response, supported by regular staff training on these processes and on services that can support ongoing coordination of care in the event of a behavioral health crisis.

Managing a behavioral health crisis is inherent to ACT which assumes this responsibility. Thus, these services should also be available to respond to crisis on a 24/7 basis, and all team members should be familiar *with and to* the individual experiencing a crisis to facilitate effective resolution. While workers in less intensive case management programs may not have primary responsibility for crisis intervention, they should receive training in de-escalation and have protocols in place for coordination with primary treatment providers, crisis services, and other supports equipped to intervene in the event of a crisis.

The integration of SE service providers with the mental health treatment team can improve opportunities to deescalate a crisis, help individuals stabilize, and avoid interruptions to their employment should a crisis occur. Where employment specialists are not integrated with the clinical treatment team, protocols should be in place that ensure timely communication between SE and treatment providers, including emergency notification to SE providers, in the event of a crisis.

When an individual comes into contact with crisis services, there is a need for post-crisis coordination and connections with services and resources, both in the immediate aftermath of a crisis experience and to sustain long-term recovery while minimizing the risk of a recurrence. This includes not only providing quick linkages with care following contact with any part of the crisis services continuum (call centers, mobile crisis, or crisis stabilization), but also to housing and employment services and resources.[37]

Figure 2: Key Program Features & Strategies that Support Crisis Prevention, Mitigation & Recovery
✓ **Crisis risk assessment and planning**
✓ **Proactive and ongoing engagement**
✓ **24/7 community-based availability**
✓ **Low caseload sizes**
✓ **Integration with behavioral health services**
✓ **Team-based case planning and service delivery**
✓ **Peers integrated as team members**
✓ **Ability to monitor and adjust service intensity/frequency**
✓ **Protocols for coordination with crisis services**
✓ **Timely post-crisis referrals and warm handoffs**

For those already participating in housing, case management, and employment programs, post-crisis coordination means ensuring these programs have protocols in place for receiving warm handoffs from crisis services providers and for quickly reengaging them into housing and services in order to promote stabilization and prevent future crises. Workers in these programs can assist individuals in navigating any challenges that may arise as a result of a crisis with landlords or employers, for example, and with any necessary disclosures or reasonable accommodation requests.

Figure 2 above offers several key program features and strategies that support crisis prevention and mitigation, as well as post-crisis recovery.

While behavioral health systems and providers may be inclined to recommend additional treatment (e.g., partial hospitalization, crisis residential program) to mitigate a crisis, a person's return to their housing, work, and other activities (e.g., school) as soon as possible may be their first choice and more likely to facilitate rapid re-stabilization and a return to one's recovery goals. Some crisis systems have infrastructure in place to support follow-up by existing behavioral health providers, including supportive housing, case management and employment services providers, when an individual accesses crisis services. For example, Georgia's Crisis and Access Line (GCAL) allows call center staff to identify ongoing behavioral health service providers and request provider follow-up at the time of the initial crisis call.[38]

In Washington, D.C., staff across the crisis continuum have access to a centralized database which allows staff to identify and coordinate with existing providers at the time of crisis.[39]

In order to secure post-crisis connections for individuals who are not already accessing housing and employment programs or resources, crisis providers need processes in place that ensure timely engagement, referrals, and warm handoffs to these connections on the back end of crisis services. Case management and care coordination play a significant role in supporting individuals coming out of crisis, and crisis programs should coordinate with or directly provide these services in order to facilitate linkages to appropriate supports. Most crisis stabilization units (CSUs) provide social workers and case managers to facilitate connection to behavioral health providers and coordinate care with existing providers. Connections Health Solutions in Arizona incorporates transitional case management services into the acute crisis stabilization unit it manages, in order to connect individuals with services and supports that prevent reemerging crisis.[40] States and providers have also utilized "peer bridgers" to assist individuals in making strong connections with resources and quickly integrating back into the community after crisis stabilization.[41] Tennessee has embedded peer support services like these into its CSUs.[42] Washington State's Peer Pathfinder Program assists individuals who have experienced a substance use-related crisis with peer engagement and connection with behavioral health and other services including supportive housing and supported employment following utilization of hospital emergency rooms.[43,44]

Some states have also implemented short-term, intensive case management services, similar to CTI, as a bridge to support individuals with significant behavioral health and other challenges (e.g., high crisis service use, homelessness, justice system involvement) with community reintegration and connection to appropriate services post-crisis. Georgia's High Utilization Management program offers short-term intensive care coordination, service linkage, and referrals for individuals who have a history of high crisis services utilization and are disconnected from community-based services and supports.[45] Following acute hospitalization, the Pathway Home program in New York connects individuals with significant behavioral health challenges who are not otherwise linked with behavioral health services to intensive short-term and mobile case management in order to help with the transition back to the community and ensure ongoing connection to supports to address SDOH, including rapid connection with housing.[46]

Strategies for SBHAs and Providers to Strengthen the Role of Supportive Housing, Case Management & Employment Services in Reducing Crisis Risk

Both SBHAs and providers can support many of the strategies noted above. SBHAs must emphasize the importance of supportive housing, case management and employment services and their role in preventing, mitigating, and helping people to recover from behavioral health emergencies through policy, funding, and practice support. Systems should ensure the availability of these services, and work with providers to better promote the idea that people with high needs and complex conditions can live in independent, affordable housing in the community with the appropriate services and supports, and likewise that work can be part of their daily routine.

SBHAs can work with Medicaid agencies (if separate) to design and finance these services in ways that reinforce the key features and strategies highlighted in this paper and ensure their coordination with crisis services. Practice support is needed in order to help providers operationalize program standards, and workforce training and development efforts can help ensure that program staff have the critical skills necessary to effectively assess for crisis risk factors, and to plan for and intervene as needed.

Collaborative partnerships are also necessary to ensure effective coordination between behavioral health services, including those along the crisis services continuum (call center, mobile crisis, crisis

stabilization), and upstream services that address SDOH like housing and employment to ensure access to the services and resources individuals want and need, post-crisis and for long-term recovery.

Policy, Regulations, and Program Standards

SBHAs should commit to supporting access to upstream services that address SDOH and are critical to preventing, mitigating, and recovering from behavioral health crises as the crisis system is developed. Policies and regulations should affirmatively articulate the role of these services in relation to the crisis response system. Since SBHAs generally have a direct or indirect oversight role in crisis services as well as in supportive housing, case management, and supported employment, they are uniquely positioned to ensure alignment and coordination of these services through regulations and service definitions.

SBHAs should also ensure that these services have the capacity to meet individual needs. Service definitions in and across regulations (e.g., SBHA and Medicaid regulations, if separate) should align and specify caseload sizes consistent with best practices; staffing that reflects the role and type of workforce needed, including peer support; and an adequately trained workforce to meet the diverse needs of service recipients. Service definitions should also address how these services support 24/7 access and provide the level of flexibility and intensity needed to be responsive to individuals.

Additionally, standardized tools could be encouraged or required that support the development and implementation of crisis prevention and intervention plans alongside individualized services plans. North Carolina's managed care organizations assess the capacity of PSH service providers to do this as part of provider readiness assessments.[47] Crisis plans should identify what constitutes a crisis; precipitating factors; support systems, individuals, or agencies the person wants contacted should a crisis occur; and, as appropriate, authorization to allow ongoing coordination between supports to mitigate potential crisis. Programs can also be encouraged to have protocols for ongoing assessment of an individuals' changing needs relevant to common crisis risk factors — such as unmet mental health or SUD treatment needs, medical concerns, lack of income, or risk of eviction — in order to adjust the frequency with which an individual is engaged based on their regularly assessed level of crisis risk.

Importantly, SBHAs must ensure reasonable quality and performance monitoring of these services. SBHAs should establish meaningful performance indicators and data metrics related to crisis prevention and intervention (e.g., crisis planning, ability to respond to or see individuals within reasonable timeframes, interaction with crisis programs, warm handoffs); evaluate compliance with minimum standards (e.g., caseload size, services, training); and engage in system- and provider-level evaluations against standards and benchmarks. Metrics should examine whether the expected outcomes of these programs are achieved in terms of connections with and sustainability of housing, employment, and other services and supports that can reduce crisis risk. In particular, SBHAs and providers can monitor to make certain that programs in which crisis prevention or response are inherent to the model do not overuse external crisis services. SBHAs and providers should talk with crisis programs to understand whom they may be mutually serving based on data and observation, and plan collaboratively to help those individuals stabilize. This may help providers take steps to proactively intervene early, particularly with individuals who present with multiple risk factors, helping to alleviate the feeling of always operating in "crisis mode." Additionally, metrics should be evaluated across demographics and regions to examine and address disparities in accessing services that address SDOH and assist with crisis prevention, mitigation and recovery, particularly among disadvantaged and rural communities.

Provider fidelity reviews and performance improvement processes can also reinforce important features of evidence-based practices that influence crisis prevention, mitigation, and recovery so they are operationalized — such as 24/7 service availability, team-based services that are integrated with behavioral health treatment, low caseloads, face-to-face contacts in the community, and ability to

titrate services based on changing needs. Providers may additionally require guidance that allows for specific adaptations to address co-occurring SUDs; the needs of homeless individuals, children, and families; and the particular risk factors of persons with a history of criminal justice system involvement.

Finally, SBHAs must work closely with state Medicaid agencies and managed care organizations to equip providers to offer these services consistent with best practices and compliant with standards, with additional attention to their role in crisis prevention and intervention.

Funding Upstream Services and Supports

SBHAs, in close coordination with state Medicaid agencies, must ensure adequate funding and coverage to support these services as established in policy and regulation, with additional attention to their role in behavioral health crisis. SBHAs should also work with state Medicaid agencies to evaluate the ability of current state plan or waiver services related to supportive housing, case management, and employment to provide prevention, mitigation, and recovery supports. SBHAs and Medicaid agencies must be clear about the spectrum of services needed in each of these types of services, which ones Medicaid will pay for, and which ones SBHAs or other sources should pay for. SBHAs and Medicaid agencies should proactively address braided funding approaches so that the services needed are reimbursed, regardless of payer.

SBHAs must also work with state Medicaid agencies so that managed care contracts articulate the need to pay for services related to preventing, mitigating, and recovering from behavioral health crisis. Additionally, provider rates for supportive housing, case management, and employment services must factor in services for crisis prevention, mitigation, and recovery, including additional staffing, increased face-to-face or virtual supports, and collateral contact time. Given the significant role that peer support services play in mitigating crisis and promoting recovery, SHBAs should work with Medicaid agencies to evaluate reimbursement rates so that peer support staff are adequately compensated. Geographic considerations, such as transportation time or the need to support technology for crisis and non-crisis program staff to communicate with service recipients, particularly in rural areas, should be accounted for as well. SBHAs should make sure that funding is available for these services to actively plan and coordinate with crisis providers about issues like 24/7 availability to connect, data- and information-sharing, linkages to services, and warm handoffs. Providers should have adequate funding to allow for equitable access to these services through provision of bilingual staff, virtual remote interpretation services, and telehealth capabilities.

Workforce Training and Development

SBHAs should support supportive housing, case management, and employment programs so that staff can effectively assess for crisis risk factors, and plan for and intervene as needed to prevent, mitigate, and resolve crises. In addition to training providers on the types of program guidance, tools, and protocols that support this goal, SBHAs can offer training and technical assistance to supportive housing, case management, and employment provider agencies and staff operating both within and outside of the behavioral health system to equip them with basic skills for recognizing and responding to behavioral health crises. This education can be accomplished by creating a common curriculum, like Louisiana created for its PSH service providers[48], or a centralized online training platform to enhance quality and access to training supports on a regular basis. For example, Washington is creating an online training platform for peer support staff responsible for responding to crisis.[49]

Training topics can include:

- Recognizing the signs and symptoms of mental illness and substance use/intoxication
- Psychiatric medications and side effects

- Crisis risk assessment and planning
- De-escalation
- Proactive engagement
- Motivational interviewing
- Trauma-informed care
- Harm reduction
- Cultural sensitivity

Staff working within supportive housing, case management, and employment programs also need training on the local crisis system and services, as well as protocols to follow during crisis situations and instruction in how to access those services when needed. Staff working in crisis services, including call centers, mobile crisis teams, and crisis stabilization programs, need working knowledge of the housing and employment programs and resources available within their community and how to access them. Some of this training can be provided internally within provider agencies, whereas some lends itself well to cross-training between provider types. This type of cross-training can be encouraged and supported by SBHAs, and providers can directly initiate it in their communities as well.

SBHAs can also offer programs and providers training and guidance in other areas, including sample policies and procedures that identify clear processes for specific activities, such as:

- Accessing program or provider agency on-call supports in the event of a crisis, as well as how and when to access crisis services, including clear protocols on when to call 988 or 911
- Handling crises that pose a safety risk, including reporting of critical incidents, processes for programmatic debrief, and protocols for engagement after a safety incident
- Information-sharing and care coordination with other providers during crisis
- Modification of crisis plans and care coordination meetings with treatment providers during crisis
- Post-crisis support, including with transitions back into housing, employment, and other services and supports

Many SBHAs are currently identifying levers to incentivize recruitment and retention efforts to address the behavioral health workforce shortage, which has been exacerbated by the COVID-19 pandemic.[50] To ensure more equitable access to quality upstream and crisis services, SBHAs and providers should invest in recruiting and retaining a diverse, culturally competent workforce that represents the communities being served in order to bridge the cultural gaps that can deter service engagement. Potential strategies include using financial incentives and scholarships, recruiting from local institutes of higher education, including historically Black colleges and universities, training providers in the National CLAS Standards, and evaluating barriers to retention among current providers of color.[51,52]

Collaborative Partnerships

As SBHAs plan for and build out their crisis services continuums to help ensure the success of 988, they can encourage and support cross-sector collaboration in several ways to reinforce effective coordination between crisis and upstream services. SBHAs can encourage — and providers can directly initiate — the establishment of MOUs that, for example, define roles and responsibilities of partnering entities during and after crises; facilitate communication, warm handoffs, and referrals; and outline processes for the sharing of resources (e.g., training) and information such as data on frequent users of crisis services who are commonly served between entities.

Current investments in creating more responsive behavioral health crisis systems, including enhanced federal matching for Medicaid Home and Community Based Services provided under the American Rescue Plan Act (ARPA), can be leveraged to forge cross-system partnerships to address SDOH and increase access to housing and employment supports.[53] The importance of SBHAs and providers partnering with trusted community (e.g., religious) leaders and offering supportive services that improve SDOH such as housing and employment has also been cited as an effective way to engage more people of color into crisis services.[54] As SBHAs plan for 988 implementation, states should regularly convene key stakeholders inclusive of these community leaders, as well as the systems and providers responsible for making housing, case management, and employment services available, as connection to upstream services such as these will be necessary to reduce the potential additional burden on crisis services.

SBHAs should also take steps to ensure that crisis providers not only assess immediate crisis, but also evaluate needs related to SDOH like housing and employment. This approach is particularly important for mobile crisis and crisis stabilization programs in order to ensure coordination with available programs and services that address these needs to further promote community stability. SBHAs could also require post-crisis follow-up within a certain time period (e.g., 48 hours) after an individual comes in contact with crisis services and could support infrastructure that ensures connections with existing upstream service providers.[55] SBHAs can also enhance peer support services across the crisis continuum to work with upstream service providers to support an individual's community stabilization and reintegration post-crisis.

Further, SBHAs can incentivize and set expectations for partnerships between behavioral health providers and other systems and services, including HUD-funded homeless Continuums of Care which provide access to housing resources for homeless individuals and families, as well as mainstream housing providers (such as public housing authorities) that serve people with disabilities including behavioral health conditions. ARPA provided an additional $1.5 billion in Mental Health Block Grant dollars to be utilized over the next several years, money which SAMHSA has encouraged states to use to develop partnerships among critical stakeholders of the crisis services continuum.[56] Given the limited funding and availability of IPS-SE within states, consideration should be given to forging partnerships with employers and with employment resources outside of the behavioral health system as well, such as with Vocational Rehabilitation and Department of Labor programs and services (e.g., Career OneStop, American Job Centers, Workforce centers, WorkSource).

Conclusion

Nationally there are unprecedented investments being made into the behavioral health crisis system; however, connection to upstream services plays a significant role in making sure the crisis system is not overwhelmed. As state crisis planning moves forward, systems should also focus on providing access to upstream services like supportive housing, case management, and employment services, including the coordination of these with crisis systems and services. Given the particularly detrimental impact of crisis on individuals who have inadequate access to high quality, responsive care, strategies to expand upstream connections should address disparities in access. SBHAs play a vital role in strengthening access to crisis services as well as addressing SDOH that have a role in crisis prevention, mitigation, and recovery. SBHAs and providers can support the strategies discussed in this paper to advance policy, funding, and practice in order to integrate and coordinate the two and produce better outcomes for individuals experiencing or at risk of experiencing a behavioral health crisis.

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