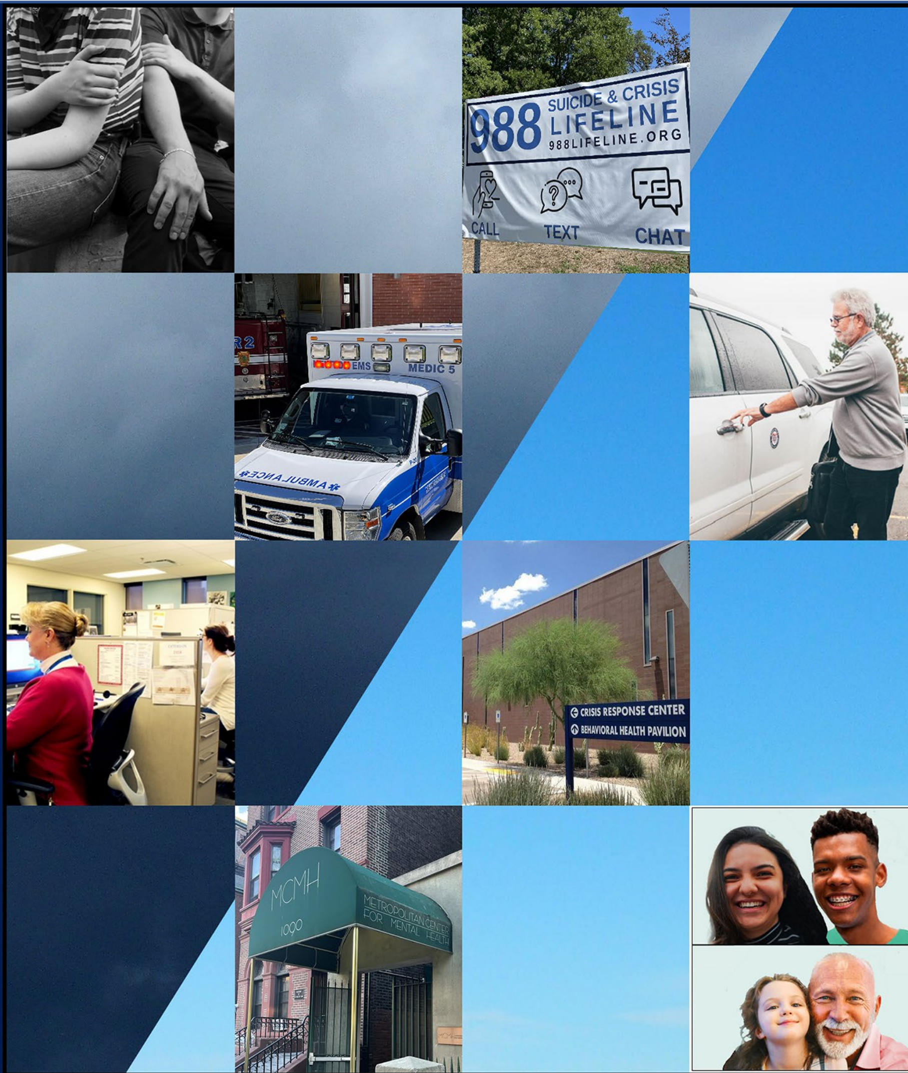


FROM CRISIS TO CARE

Building from 988 and Beyond for Better Mental Health Outcomes

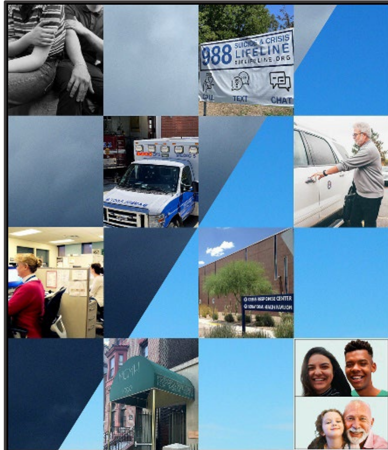
NASMHPD

September 2022

Key elements to help individuals and systems move from crisis to care

Paper No. 1 in the *From Crisis to Care* Series

From Crisis to Care: Building from 988 and Beyond for Better Mental Health Outcomes



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First in the 2022 From Crisis to Care Series of Ten Technical Assistance Briefs Focused on Building from 988 and Beyond for Better Mental Health Outcomes

National Association of State Mental Health Program Directors
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September 2022

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Acknowledgements

Setting the stage to help state policymakers move their systems and the people they serve from crisis to care has special meaning these recent years given the unprecedented stressors we have all faced in the context of the COVID-19 pandemic. Despite these difficult times, incredible efforts have realized major gains with the initiation of 988 and more. For that, on a personal level I am grateful to those who lead this country's reform efforts who have informed the content of this paper, whether working in government, provider agencies, community mental health, advocacy, research, professional capacities, direct care, payor systems, or as peers and family members with lived experience. Through their work, the lives of people with behavioral health challenges can be lived better and longer, and as a result we all stand to gain. To that end, my colleagues in the Michigan Department of Health and Human Services and representatives from each of those sectors are part of that collective whole that help inform this work, and I offer my thanks and appreciation. I am also grateful to Brian Hepburn, M.D. for his kind and steady stewardship for positive change, along with Meghan Haupt, and the work of the entire NASMHPD team who continue to push for better practices and more resources to those individuals challenged by behavioral health needs. This year, Nili Ezekiel, took on the role shepherding these papers to completion on behalf of NASMHPD, and we could not have finished this series without her "air traffic control" skills, further refined while the papers were already in flight…She took on the job with grace, a smile and an assertive "how can I help?" attitude despite the press of deadlines. Kudos to you, Nili for a job well done! Also I want to give a humble nod to my ever-patient family, who offer help when they see me writing at many odd hours, and support me in ways that transcend words…And finally, I am also and ever especially grateful to Elizabeth Sinclair Hancq, MPH, who continues to provide a steady and able hand researching facts and figures and in constructing these papers to make them better than I could ever do alone.

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Abstract:

Alarming rates of suicide, opioid overdoses, arrest and incarceration, homelessness, waits in emergency departments to access psychiatric hospitalizations, along with heightened social strains are now intersecting with a depleted workforce amidst the waxing and waning COVID-19 pandemic waves. In this context, policymakers have recognized the need to look beyond psychiatric inpatient beds as a single solution for youth and adults in need of psychiatric care. The discourse among mental health leaders is now centered around immediate access during crises, while moving individuals, including those with serious mental illnesses, substance use disorders, intellectual and developmental disabilities and other conditions, from crisis response to ongoing and interconnected care. The July 2022 transition of 988 as a three-digit number for behavioral health emergencies is among the new bold strategies for improving crisis response. It has already catalyzed significant changes for state behavioral health systems, including creating new partnerships with 911 and other stakeholders. The Certified Behavioral Health Clinic (CCBHC) model for comprehensive services and improved fiscal infrastructure for community mental health systems is expanding with increased funding at the federal level. The Substance Abuse and Mental Health Services Administration (SAMHSA) has been leading the nation on standards and expectations on all these fronts. Yet, to yield an accessible, interconnected, effective, and just behavioral health crisis services continuum that ultimately achieves better mental health outcomes, strategic priorities will be critical. This paper provides an overview of seven key elements to move individuals and systems from *Crisis to Care* that are needed now.

Highlights:

- The transition to 988 offers opportunity to grow crisis response services along a continuum. This transition should be leveraged to ensure careful attention to the full continuum of psychiatric care.
- There are exciting opportunities to better develop a network of effective community services that will be responsive to the needs of people at risk of behavioral health crises.
- Attention to timely access to services and needed funding will be important to move to a crisis-to-care continuum.
- A strong behavioral health workforce is the necessary ingredient for strengthening the system.

Recommendations:

1) Leaders should make every effort to examine existing strategies to strengthen the behavioral health workforce for recruitment, retention and nurturance.
2) Home and community-based services that foster the implementation of emerging evidence-based practices for out-of-hospital care to support individuals with complex behavioral health needs should be a national priority.
3) Leaders should make every effort to foster timely access to care.
4) Policymakers and behavioral health leaders should make every effort to enhance engagement and other strategies to maximize retention in treatment.
5) Leadership should facilitate access to the rapid advances in technology that came about through the COVID-19 pandemic while also carefully reviewing various applications of technology to maximize its most robust and effective use while minimizing ineffective use.

6) State behavioral health leaders should continue to foster partnerships and coordination with traditional and non-traditional partners and consider where funding and workforce can be braided and catalyzed for more meaningful access and outcomes.
7) Policymakers should promote sustainable and adaptable practices and identifying funding that can meet the growing demand for care across the behavioral health system.

July 16, 2022 was a historic date in the United States. On this date, “9-8-8” as an easy to remember, three-digit dial was established for the National Suicide Prevention Lifeline. And 988 goes further than the original Lifeline and has evolved into a broader “crisis line.” To get to this point, many things had to happen, not the least of which was the July 2021 approval by the FCC for 988.[1] With a global pandemic and years of rising suicide rates, the time was ripe to catalyze this shift. With this transition to 988, State Behavioral Health Authorities (SBHAs) and other policymakers continue to work hard to build out the mental healthcare system beyond 988 to further establish a robust psychiatric continuum of care, recognizing that crisis care must link to services that provide more than crisis resolution, while the full continuum must continue to support individuals to avert crises in the first place. This paper reviews seven key elements needed to move the behavioral health system forward, *From Crisis to Care*, both for the people served, and for the system itself. Given the increasing demand for mental health services, counterbalanced with depleted staff and the sense of global fatigue from all that has been endured with the COVID-19 pandemic, only through this ongoing pursuit of a strengthened and expanded array of community services will there be improved mental health outcomes.

Taking a Step Backwards to Help Look Forward

Taking a step backwards to help look ahead, in 2017, the National Association of State Mental Health Program Directors (NASMHPD), on behalf of the Substance Abuse and Mental Health Services Administration, commissioned a review of what seemed to be growing demand for psychiatric beds, leading to the publication of *Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care*. All too often public discourse centered on building more beds—often state hospital beds—as a single solution for needed mental healthcare. Some of this push was in response to numerous system challenges. Emergency department boarding of psychiatric patients, for example, has been a growing phenomenon that many were and are recognizing as highly problematic.[2,3] At the same time, arrest and incarceration of persons with serious mental illness has for many years been a constant point in need of problem-solving. Waits for individuals found incompetent to stand trial became a source of strain on systems and even pointed litigation at SBHAs revolving around individuals waiting in jails for psychiatric beds.[4] For youth, states were facing calls for reform to shift services to more in-home supports by creating a network of community-based systems of support and infusing new models of care for youth with serious emotional disturbances, all while youth boarding in emergency departments awaiting psychiatric admission was increasing. Since the COVID-19 pandemic, the cry to address youth behavioral health has only gotten stronger and louder.[5] Today, the message in *Beyond Beds* continues to resonate. It remains clear: “the rush to ‘more beds’ needs to be tempered with illumination and clarity about patient need, the kinds of beds best suited to meet those needs…[and that]…only a complete continuum of psychiatric care can reduce the human and economic costs associated with mental illness.”[6] In alignment with that call for a continuum, the American Psychiatric Association recently produced its own analysis, offering a model for assessing psychiatric bed need in a given community.[7]

2017 Beyond Beds Key Recommendations

- The vital continuum
- Terminology
- Criminal and juvenile justice diversion
- Emergency treatment practices
- Psychiatric beds
- Data-driven solutions
- Linkages
- Technology
- Workforce
- Partnerships

After the *Beyond Beds* messaging took hold, subsequent NASMHPD papers spoke of setting bolder goals for better outcomes, and even looking beyond the borders at international practices to enlighten progress.[8,9] In more recent years, the confluence of many different voices and advocates looking across the continuum of care has made a laser focus on crisis services as the gateway to care. In that context, in February 2020 SAMHSA, issued its *National Guidelines for Behavioral Health Crisis Care: Best Practices Toolkit.*[10] Just as this was released, the world was hit with an unbelievable challenge—the global COVID-19 pandemic. Suddenly SBHAs were working on disaster preparedness at new levels—not only ensuring that individuals in public behavioral health services had access to proper COVID-19 protections (including personalized protective equipment, viral testing, contact tracing and ultimately vaccination access), but also that emotional supports to the general population were available.

In August 2020, the Centers for Disease Control (CDC) released results of a survey from late June of that year showing that 40% of U.S. adults reported struggling with mental health or substance use, including 11% who had reported seriously considering suicide.[11] The Disaster Behavioral Health hotline saw an 891% increase in calls in the early months of the COVID-19 pandemic.[12] In response to this growing demand, Crisis Counseling Assistance and Training Program (CCP) grants were issued throughout the United States as a partnership between SAMHSA and the Federal Emergency Management Agency (FEMA).[13] Many states took advantage of these federal opportunities and launched campaigns under the CCP programs to foster mental well-being even beyond the pandemic. In Michigan, for example, the Stay Well initiative (Michigan.gov/staywell) continues to produce an array of resources from a call-line to online group supports and videos that remains active to help provide free supports to all who may be struggling emotionally in the context of the pandemic.[14] Utah built a crisis intervention chat line through SafeUT (https://safeut.org/),[15] and Maine built out the StrengthenMe (https://strengthenme.com/) approach to provide free stress management and resiliency resources for anyone in Maine experiencing stress related to the COVID-19 pandemic.[16]

The COVID-19 pandemic provided further clarity that crisis services needed to be more firmly established everywhere. To that end, NASMHPD, on behalf of SAMHSA, again commissioned bodies of work with collections of papers along the crisis services themes, issuing in 2020, *Crisis Services: Meeting Needs, Saving Lives*,[17] and in 2021, *Ready to Respond: Mental Health Beyond Crisis and COVID-19.*[18]

Though the vision of a crisis services continuum has centered around the rollout of 988, to keep moving forward, it is also important to recognize that a crisis response that only deals with the issues of the moment will not have the same promising impact as one that moves the individual "*From Crisis to Care*," and does so through a coordinated and interconnected system that can support the individual over time. Such a system must prioritize helping individuals from diverse backgrounds with any number of challenges, including mental illness, serious emotional disturbances, substance use disorders, intellectual and developmental disabilities, or other conditions or circumstances. This system should help those individuals achieve their maximum potential beyond the crisis, in their home environments and outside of institutions, while offering supports, as well as places and spaces that foster recovery and return to community settings or relief that can be brought into the home. At the same time, such a system must coordinate across multiple sectors, integrating 911, 988 and an entire array of resources.

Putting the pieces together of a true and robust continuum of psychiatric care from the lens of the crisis system is a key theme of this paper, *From Crisis to Care*, and is supported by a number of individual papers as part of a 2022 compendium to help policymakers and mental health advocates forge ahead with the latest information to continue to improve upon the mental health services delivery system. Themes for those papers have helped inform this one (see Text Box). This overarching "umbrella paper"

highlights seven **key elements** that are necessary to move the behavioral health system towards the vision of a sustained and robust continuum. These include:

1. A strong behavioral health workforce
2. Effective home and community-based services
3. Timely access to care
4. Engagement and strategies to foster retention in care
5. Strategies for routinizing and developing effective technology
6. Old, new, and improved partnerships
7. Sustainable and expandable services

Just as 911 is baked into the fabric of American society, 988 is the next frontier in mental health crisis response. There is no doubt that many lessons will be learned along the way in its growth and development. History will look back on this exciting era of change and opportunity as a remarkable time, and today's behavioral health leaders are shaping that history.

From Crisis to Care: Papers in the 2022 Series

1. *From Crisis to Care: Building from 988 and Beyond for Better Mental Health Outcomes*
2. *Trends in Psychiatric Inpatient Capacity, United States and Each State, 1970 to 2018*
3. *Telling the Story: Data, Dashboards, and the Mental Health Crisis Continuum*
4. *A Safe Place to Be: Crisis Stabilization Services and Other Supports for Children and Youth*
5. *Innovation and Determination: How Three States Are Achieving Comprehensive, Coordinated and Sustainable Behavioral Health Crisis Systems*
6. *Climate-Related Disasters: Understanding Causes, Consequences, and Interventions to Protect Community Mental Health*
7. *Crisis in Services: Self-Care, Self-Directed Care, and the Use of Technology Supporting All*
8. *The Role of Supportive Housing, Case Management, and Employment Services in Reducing the Risk of Behavioral Health Crisis*
9. *Responding to and Preventing Crises: CCBHCs, Urgent Care and an Example of One Health System in Maryland and its Approach to Crisis Services within an Accessible Psychiatric Care Continuum*
10. *Lending Hands: Improving Partnerships and Coordinated Practices between Behavioral Health, Police, and other First Responders*

The Key Elements:

1. A Strong Behavioral Health Workforce

In June 2022, the Bureau of Labor Statistics of the U.S. Department of Labor reported a slight gain in non-farm payroll employment, including professional and business services, leisure and hospitality, and health care as well as an overall unemployment rate of 3.6%.[19] And yet, worker shortages and supply chain disruptions in 2022 are among the top concerns among businesses with "millions more job openings than workers to fill them," according to a CNBC report.[20] Ironically, the impact of children's behavioral health on the adult workforce is also devastating, with one 2021 study from On Our Sleeves showing that 53% of working parents have missed work at least once per month to support their children who had mental health needs.[21,22] The American Hospital Association examined workforce challenges for the health care system, which is an industry that provides care and services to hundreds of millions of people annually and is a major consumer of supplies and community resources. In their strategic analyses published even before the full impact of the pandemic in 2020, they identified professional shortages, financial pressures, burnout among professionals and workplace violence as key areas of concern that needed addressing to help foster a robust and skilled workforce.[23]

The behavioral health workforce is facing too many of these concerning realities. Yet, demand and need for behavioral health treatment is only increasing. Critical trends in behavioral health needs in the context of rolling out 988 and related services include high suicide rates, relentless opioid and other fatal drug overdose rates and substance use, astounding levels of houselessness, arrests and incarceration among people with serious mental illness, co-occurring substance use disorders and other behavioral health conditions, and families in despair regarding their children with emotional health needs who wait long periods for appropriate services.[24] These realities are only more highlighted by data from Mental Health America showing that over half of those who need mental health services are not receiving them.[25] It is clear that what is needed—and yet in critical short supply—is a strong workforce, and one that can meet the needs of complex populations.

It may be that at no point in history has the behavioral health workforce been sufficient to meet the needs. In fact, as part of the 21st Century Cures Act that went into effect in 2016 at the end of the Obama Administration, the Health Resources & Services Administration (HRSA) was mandated to study the behavioral health workforce. In its report examining projections from 2017 to 2030, certain behavioral health providers (psychiatrists and addiction counselors) were projected to experience shortages by 2030 if there were no changes in behavioral health utilization.[26] Although the same report indicated that other behavioral health workers would be in adequate supply, current data are quite different. A recent report produced by Health Management Associates and the National Council for Mental Wellbeing spoke of the national crisis related to the behavioral health workforce.[27] In that report they surveyed 260 behavioral health organization members of the National Council for Wellbeing in the fall of 2021 and found that the demand for services has increased, waitlists for services are growing, and yet nearly all respondents (97%) reported they are having difficulties recruiting and retaining employees, with too few qualified applicants, non-competitive salaries, and high burnout after COVID-19 as among the top reasons. Other reports highlight the geographic maldistribution of America's behavioral health workers.[28] With the trends across almost every sector of the labor market showing depleted resources, these workforce needs are creating critical levels for vulnerable populations who depend on people to support their needs, mitigate risks, address disabilities, and foster recovery. Moreover, given studies

showing that Black and Indigenous People of Color (BIPOC) report higher levels of behavioral health distress than white counterparts,[29,30] efforts are necessary to address the diversity of the behavioral health workforce in addition to general workforce needs.[31] Addressing the workforce from a diversity perspective will also require careful analyses and intentional approaches. As an example, states like Hawaii have specifically called out in their Workforce Innovation and Opportunity Act State Plan an effort to target services specifically for Native Hawaiians.[32]

The situation is so dire, that states have called for emergency provisions to protect certain behavioral healthcare systems, such as occurred when the Oregon State Hospital turned to the National Guard to assist with a staffing crisis in fall of 2021.[33] In order to tackle the behavioral health workforce needs, there must be an "all hands-on deck approach" and many leading scholars and policymakers have been working in partnership with local and national entities to help develop strategies. In a broad effort to improve the workforce, a Health Workforce Research Center was established with federal funding in 2015 and is housed at the University of Michigan's School of Public Health. That work spawned a report looking at the need for data to help plan for the behavioral health workforce.[34] To improve trends and the health of people who are underserved, HRSA, with initial funding support in partnership with SAMHSA, moved further in this direction with the development of their Behavioral Health Workforce Education and Training (BHWET) program that provides opportunities for providers through education.[35] Training programs supported by BHWET for the first three years grew to almost 150 according to its recent report, supporting over 9,000 trainees, including pre-doctoral interns to master's level practicum trainees and peer paraprofessionals, 40% of whom upon graduation indicated an intent to work in a rural or underserved area and 72% indicated an intent to work with children, adolescents and transitional-age youth.[36]

Beyond Beds

Recommendation #9: Workforce

Initiate assessments to identify, establish, and implement public policies and public-private partnerships that will reduce structural obstacles to people's entering or staying in the mental health workforce, including peer support for adults and parent partners for youth and their families. These assessments should include but not be limited to educational and training opportunities, pay disparities, and workplace safety issues. The assessments should be conducted for the workforce across all positions.

The U.S. Department of Health and Human Services produced a further report through the Office of the Assistant Secretary for Planning and Evaluation (ASPE) in 2021 that identified three models showing some promise for increased workforce efficiencies, including utilization of psychiatric mental health nurse practitioners, behavioral health mobile applications and development of crisis services.[37] Several states, like Nevada, Illinois, Indiana, Colorado, Wisconsin, Tennessee, Massachusetts, New Jersey, and Washington State were spotlighted for innovations in using American Rescue Plan Act (ARPA) dollars to enhance their direct care workforce in innovative ways.[38]

The National Governors Association highlighted the children's mental health provider workforce shortage[39] considering reports from the CDC showing that one in five children may have a mental health issue, but only 20% of them receive care.[40] Individual states have also done their own analyses regarding workforce capacity and developed state level approaches to overcome staffing gaps. For example, the Ohio Council of Behavioral Health & Family Services Providers identified shortages in every one of eight disciplines in 2016, and projected even deeper shortages in six of them (except for certified nurse practitioners and social workers) by 2030.[41] On a local level, these projections created an advocacy pitch to seek immediate investments in the state budget to support workforce development and provide

funding to behavioral health organizations to offer recruitment and retention initiatives as well as support for supervision lines. In Oregon, the State's Oregon Health Authority issued approximately $132M to 152 provider organizations as grantees for awards to shore up workforce gaps.[42]

As noted, many recommendations have been set forth to date, and they can be divided along different organizing frames of reference, which for policymakers can make it somewhat overwhelming to consider what direction to go or where to begin. In one review, Beck and colleagues argue for establishing a consensus process as an immediate first step in arriving at solutions for the workforce development needs across the country.[43] They suggest that there be an examination of workforce *production*, *distribution*, *resilience* and *maximized potential*, with concomitant planning, evaluation, policy development and practice approaches that can be built around these four frames.

Though an exhaustive review of strategies to rebuild a workforce in behavioral health is beyond the scope of this paper, given the imperative needs right now, promising recommendations suggested by others are highlighted in the text box below. Many of these ideas harken back to the 2017 *Beyond Beds* recommendations calling for attention to the workforce and building non-traditional partners to help augment it. In 2022, those recommendations are just as important, and workforce rebuilding and rebooting will be a key element in moving *From Crisis to Care*, addressing the workforce crisis within the behavioral health system while shaping services so those in need can access care across a robust continuum.

Recommendations related to workforce development from various contributors

Recommendations from Beck, Manderscheid, and Buerhaus:[44]

1. Continue to foster the development of a minimum data set as a foundational step for standardizing collection of workforce data to inform workforce planning efforts.
2. Foster policy development that reduces barriers to address shortage issues.
3. Reduce burnout for workers.
4. Enhance training workers through initiatives that foster integrated care and access specialists.
5. Build in peer provider workforce development

Recommendations from ASPE:[45]

1. Expand partnerships and their capabilities within crisis services.
2. Address funding barriers.
3. Expand workforce with the use of peers.

Recommendations from the National Governors Association:[46]

1. Align curriculum between 2-year community colleges and 4-year colleges for seamless credit transfer to promote mental health-related degrees.
2. Offer creative incentives to participate in higher education, receive certification and attract workers.
3. Adapt apprenticeship models to support the social services and mental health workforce.

Recommendations from the National Council on Mental Wellbeing and Health Management Associates:[47]

1. Leverage strategies that states have used for emergency preparedness and disaster response, which allows for funding expansion and relief through disaster declarations that could expand access to Crisis Counseling Assistance and Training Program Grants.
2. Increase funding and financial incentives to attract and retain the workforce, leveraging stimulus funds, legislative remedies for rural areas, and innovative financing models, while promoting partnerships, loan repayment, waiver of HRSA residency requirements for J-1 visa holders, and partnerships with the Department of Labor and Employment.
3. Optimize access to the available behavioral health workforce, through promotion of payment and regulatory adaptation and training and support for physical health providers to conduct routine behavioral health screenings, reducing administrative and regulatory burdens for behavioral health working in primary care, and supporting psychiatric consultation models, as well as shifting mid-level staff ability to perform functions previously reserved for other professionals and expand telehealth capabilities and policies, while developing paraprofessional staff such as non-specialists and peers.
4. Waive burdensome documentation and administrative activities, such as waiving elements of comprehensive psychosocial assessments, extend deadlines for treatment plans, eliminating separate treatment plan documentation and allow payment and regulations that foster brief encounters prior to full intake completion.
5. Maximize use of Medicaid graduate medical education (GME) for training the behavioral health workforce, by expanding Medicaid GME, which does not have the same limitations as Medicare GME, and could benefit from CMS guidance to enhance flexibility for states to structure and pursue policy goals.

Recommendations identified in *Psychiatric Times*:[48]

1. Expand collaborative care models.
2. Expand the use of telehealth.
3. Prioritize recruitment, retention, mentoring, and hands-on training experiences.
4. Reduce stigma associated with psychiatry by partnering further with primary care.
5. Improve upon insurance reimbursement opportunities and willingness for mental health professionals to accept insurance.
6. Reduce regulatory barriers and opportunities.

Recommendations by Beck, Spitz, Frogman, et al:[49]

1. Production (policies that examine population needs, recruitment and training strategies with a focus on diversity)
2. Distribution (specialty right-sizing, community worker shortages, need for primary care, broad investments that are not disproportionate to certain settings such as rural and acute care),
3. Resilience (safer working conditions, attending to the mental health of healthcare workers, decrease burnout),
4. Maximize potential (flexible regulations for billing, interstate mobility and licensure, cross discipline work)

Recommendations to address diversity in the workforce from the National Academy of State Health Policy:[50]

1. Engage BIPOC Communities.
2. Use Data to understand workforce needs.
3. Incorporate diversity, equity, and inclusion into state workforce planning.
4. Align efforts across state agencies.
5. Prioritize behavioral health in health care workforce recruitment and retention.
6. Create increasingly culturally inclusive workplaces to facilitate and nurture BIPOC professionals.
7. Leverage funding opportunities to invest in a diverse workforce.

2. Effective Home and Community-Based Services

A crisis is a temporary challenge, yet critical infrastructure for crisis care must encompass a community system that is effectively able to provide care for people who experience crises and also provides necessary supports to prevent crises from occurring altogether. Thus, as noted in *Beyond Beds,*[51] a robust and effective, tightly linked community-based service system is a foundational element of a complete continuum of psychiatric care. Across the United States, efforts to establish more robust community-based services are underway for both youth and adults. Take for example, the work being done in children's crisis services, where an important ingredient for crisis response includes in-home stabilization.[52] In the years after the rollout of the Rosie D remedy, based on a lawsuit regarding Medicaid eligible children in Massachusetts, in-home stabilization and support of youth with complex behavioral health needs has only expanded further in the state.[53] Overall trends in youth crisis work include longer periods of in-home stabilization services after the crisis, as described in detail in *A Safe Place to Be: Crisis Stabilization Services for Children and Youth.*[54] This work with youth can set up important examples of what may be needed now for adults. Home and Community-based Services in the most generic sense are simply those that take place in home environments and in communities—rather than in institutions, jails or other non-integrated settings. Regulatory and legal mandates have formalized the term "Home and Community-Based Services" or HCBS, and these laws and regulations are driving change in behavioral health system offerings. As policymakers build services beyond those directly attached to 988, it will be important to develop best practices along both the formal and informal meanings of HCBS. For this to occur, there are many lessons and considerations for development of that robust community-based continuum.

Beyond Beds

Recommendation #1: The Vital Continuum

Prioritize and fund the development of a comprehensive continuum of mental health care that incorporates a full spectrum of integrated, complementary services known to improve outcomes for individuals of all ages with serious mental illness.

Lessons from the International Community Regarding Potential Home and Community-Based Supports

As described in "#CrisisTalk," there are innovations to look at internationally related to home-based crisis response and stabilization.[55] For example, a study out of the Netherlands of individuals and family members with acute psychotic or manic symptoms found that their first interactions with a mobile crisis

team had challenges with communication and cooperation, the feeling of being stigmatized especially when police were needed, and a lack of reliance on personal crisis plans, demonstrating that there is more to learn about mobile responses.[56] At the same time, Intensive Home Treatment is a program based in the Netherlands where multidisciplinary teams, known as Crisis Resolution Teams, work in people's homes to help resolve psychiatric issues.[57] Thus, there is work that could be developed to address the gaps that people experience in home-based care.

Another study out of Switzerland is examining crisis resolution and home treatment (CRHT) teams that represent a community-based mental health service as an alternative to hospitalization to care for people with severe and acute mental disorders who might otherwise be considered for admission to hospitals.[58] Early results just published in 2022 showed that CRHT was comparable to standard hospitalization in terms of psychiatric symptom reduction and readmission rates, though had a longer first treatment period, even though the latter trend appeared to be shifting with experience in the model.[59] A study out of France revealed that home-based psychiatric mobile team services showed promising effects including responding to calls, home visits, coordination of meetings, clinical assessments of patients, and utilization of crisis resolution teams and Assertive Community Treatment (ACT) models.[60] What this suggests is that there will be increasing innovations and evidence likely to address the underlying conditions and challenges faced by individuals who present in crisis with increasing community-based and at-home care.

Evidence-Based Practices as Part of the Home and Community-Based Service Array

Expanded access to community practices that are evidenced based is essential to meet the growing need, as well as is the development of new practices that maximize engagement and support for people in community settings. The role of Permanent Supported Housing (PSH) and employment services will continue to be key service components to support individuals who may utilize crisis services.[61]

Other essential models include ACT, a service delivery model that became known as the "hospital without walls," with multidisciplinary teams that provide care and support to individuals with histories of multiple psychiatric hospitalizations. Experienced policymakers and behavioral health leaders likely resonate with the important findings of a recent study that identified, after 45-years of working with the model, implementation challenges with ACT related to evolving psychosocial factors for clients, barriers to clinicians' developing competencies, and shifting mental health systems.[62] Although a gold-standard for a community-based service, it will be important to continue to understand how to promote its use most effectively. Programs and services that rely upon the model, such as Forensic Assertive Community Treatment (FACT) were designed to support individuals who have some of the same histories as ACT clients but allow for an additional focus on prevention of arrest and incarceration.[63]

Additional services that expand community supports include those that are targeted to address important transitions. Critical Time Intervention (CTI) has received much attention as an intervention designed to help individuals transition from institutions or homelessness to more permanent community-based services.[64] It was designed as a shorter-term transitional case management model with a phased approach that focuses on building connections in the community as staff work to develop and hand-off the client to more permanent supports. One study showed that CTI participants were less anxious and felt more supported across their transition to have a home.[65] CTI also improved engagement with community mental health teams compared to controls at six weeks (53% vs. 27% with control group), with continued engagement at six months in one study of 150 male prisoners with serious mental illness.[66] There is an entire infrastructure of training and support through the Center for

the Advancement of Critical Time Intervention to help in its implementation.[67] New Hampshire's Department of Health and Human Services launched in July 2022 a statewide initiative to offer CTI to help individuals transition out of psychiatric hospitalization as part of its 10-year mental health plan.[68] Models of transitional supports for individuals with co-occurring mental illness and substance use disorder such as MISSION and MISSION-Criminal Justice,[69] supporting individuals shift from homelessness or incarceration to more consistent community treatment, rely upon CTI, trauma-informed principles, and other evidence based practices to implement these transition goals.

First episode psychosis programs, funded in part by SAMHSA's block grant, are another type of program that should be explored by state leaders to address some of the populations who might be accessing crisis lines. It is estimated by the National Institute of Mental Health that about 100,000 adolescents and young adults in the U.S. experience a first episode of psychosis every year,[70] and these individuals can present with prodromal or full symptoms that left untreated all too often result in a downward spiral for the individual and their family. A model of coordinated specialty care (CSC) involving group or individual psychotherapy, family support and education, medications, supported employment/education and case management has been shown to be effective especially if it helps reduce the duration of untreated psychosis.[71]

Access to important and effective medications will also be key for home and community-based supports. Take for example, clozapine, which is the only psychotropic medication FDA-approved for treatment-resistant schizophrenia and reducing suicidality. Despite its evidence and effectiveness, it, is utilized less in the United States than elsewhere in the world.[72] Today, there are many avenues to facilitating prescribing of this evidence-based life-saving medication. The internet-based SMIAdviser.org, funded by a grant from SAMHSA awarded to the American Psychiatric Association, provides technical assistance, frequently asked questions and consultation to promote the prescribing of this and other effective medications for people with serious mental illness.[73] Long-acting injectable medications (LAMs or LAIs) are also important options for persons living with chronic psychotic illnesses with further information about them also at SMIAdvisor.org[74] Barriers to prescribing these medications must be better understood, as maintaining medication at therapeutic levels can be a key mechanism to avoiding crises in the first place.[75]

Access to effective services should also attend to racial and socioeconomic disparities. One illustrative example that should continue to set alarm bells regarding inequitable access to particular evidence-based practices is in access to specific medications for opioid use disorder. Increasing attention to this issue is needed to help ensure that disparities are addressed and eliminated.[76] Recent changes may help in this regard. For example, certain regulatory barriers to Buprenorphine to treat opioid use disorder have been lifted during the COVID-19 pandemic and continue to be lessened to expand access given the growing awareness that the opioid overdose death rates are still alarming.[77,78] Recently, SAMHSA identified that it would maintain its relaxation of regulations, allowing telephonic and video assessments to continue for Buprenorphine induction beyond the Public Health Emergency.[79] Policymakers will want to continue to pursue all avenues for these evidence-based treatments to be as readily available in an equitable fashion as possible across all populations.

As policymakers work to drive greater use of evidence-based practices, the notion of "warm handoffs" could use further examination. Policies and practices to help people move *From Crisis to Care* in their communities will also need to incorporate tighter linkages from one service to another. Since it is well known that transitions in care are fraught with negative outcomes, improving these warm handoffs will continue to be an important part of the community-based service system. In addition to hand-offs and transition points, continuity of care across settings can help further positive outcomes. For example, many advocates are arguing for health reform combined with justice reform with Medicaid services at the cornerstone of the debate for care coordination and community supervision.[80] This area of reentry from criminal legal settings is just one of many examples of where warm handoffs are all too often lacking and negative consequences common. The goal going forward would be to continue to build in supports that reduce these examples and improve outcomes.

From Crisis to Care: Continuity and Linkages

Continuity of Care: Seamless care and treatment that continues despite the setting one is in, where goals and approaches to treatment are not interrupted.

Warm Hand Offs and Tight Linkages: Promote continuity of care by assisting individuals move from one setting to another, preserving information about treatment interventions in place and recovery goals by helping to ensure that providers have the same information across transitions, and that individuals in care are supported to reduce barriers to continuity and help with minimizing stressors in working with new providers.

Legal and Regulatory Realities of Home and Community-Based Services

Although the tenets of *From Crisis to Care* would suggest care must follow the crisis, it is important to recognize that the fabric of care in the community that predates crises may serve to minimize them in the first place. Policymakers must ensure that these services must, whether as part of the community system as a whole or part of the crisis system, keep constant vigilance to the need for full community integration of people with disabilities of all types. Defaulting to hospitals and out-of-home placements for someone in crisis could invoke questions about disability rights. The U.S. Supreme Court decision of *Olmstead v. L.C.,*[81] rested on the Americans with Disabilities Act, requiring that individuals with disabilities have a right to live in the least restrictive and most integrated setting. Since that landmark decision related to state hospital patients, state policymakers and communities have pursued numerous strategies for moving people with serious mental illness, intellectual and developmental disabilities from state hospitals and intermediate care facilities into community settings. The rights of people with substance use disorders have now also spawned attention.[82] In addition, responses to crises are discussed within the framework of least restrictive approaches, in part with this legal framework in mind.

Medicaid has also had a longstanding goal of maximizing the potential for beneficiaries to receive care through HCBS. These forces have created an impetus for the development of State Plan Amendments and Medicaid Waivers to create opportunities for federal reimbursement across a more complete continuum. In 2014, CMS promulgated a new rule set for HCBS waivers under what has been referred to as the "HCBS Final Rule." CMS set March 17, 2023 as the transition period deadline for full state compliance with the HCBS Final Rule. The shifts in regulations come about as an effort to foster meaningful person-centered planning for beneficiaries and allow states to improve quality of services, including allowing waivers to be more easily administered, and allowing states to combine coverage for multiple target populations under one waiver.[83] At the same time, the Final Rule provides additional protections for individuals, including privacy, dignity, respect and freedom from coercion and restraint

and control of personal resources. The Final Rule also focuses on ensuring that services fully integrate persons served into their community as they choose, with opportunities and access to the community to facilitate relationships with others without disabilities beyond paid staff, and providing individual control over what to eat, who can visit, what services they receive.[84] Though the public health emergency may create exigencies, it is expected that even with staffing shortages, states will still be required to operate policies consistent with the regulations and maximize autonomy and community participation for beneficiaries.[85] At the same time, CMS may authorize corrective action plans (CAPs), which are to be submitted by December 1, 2022, in order to preserve federal reimbursement of HCBS in settings already in existence as of the transition period deadline, if more time is needed for those settings to establish practices that incorporate additional elements consistent with the evolving regulations.

Given current trends, there are increasing opportunities for more in-home and community-based care. The HCBS mandates will allow for waivers to continue that give states flexibility for a robust service delivery system. In a study examining HCBS waivers for services for older adults from 1997 to 2020, there has been overall expansion in the use of 1915(c) and 1115 waivers across the U.S., with a broader range of services offered, especially supports for self-direction and community transitions.[86] The authors point out that efforts to decrease reliance upon nursing homes was seen as even more critical during COVID-19 and will likely continue. Similarly for persons with serious mental illness and youth with SED, opportunities remain ripe for waiver consolidation and simplification at the state level, in order to offer service expansion and decrease reliance upon institutional placements.

Though the areas of promise are many, ongoing challenges for state leaders will include the need to ensure services are compliant with rules that eliminate restrictions and non-integration, which have been part of the community culture and will require systems shifts. It will also be important for these services to be approached with a cultural, diversity and equity lens to maximize their meaningfulness, effectiveness and equitable distribution. These are important steps forward for individuals being served, and strong leadership to pursue these goals will help continue the trajectory toward an improved community-based continuum that can provide the necessary infrastructure to manage and prevent crises.

3. Timely Access to Care

What good is a promising practice if it is not available when it is needed? Today, there are too many examples of individuals waiting to access care. Waitlists for services pepper many areas of the behavioral health continuum. In 2020, the Kaiser Family Foundation identified state-level waiting lists by target population for those accessing Medicaid HCBS waiver services, finding the total waiting lists included more than 665,000 individuals waiting for home and community-based services.[87] This is all the more reason that evolving flexibilities and expanded mental health service capacity for states will be so important. Another concerning example of waits involves “Emergency Department (ED) Boarding,” something that has been studied and described for many years,[88] where individuals determined to need psychiatric hospital level of care wait for days, weeks, and months in EDs “boarding” until a bed becomes available. Washington was sued for ED boarding, with the court ruling that psychiatric boarding was not a legitimate method to avoid overcrowding of evaluation and treatment facilities.[89] In another case decided for plaintiffs, New Hampshire was sued about their ED boarding problem in one case related to the right of individuals to contest their detention within three days of arrival,[90,91] and they are not alone in defending such cases. The crisis of boarding in EDs has continued to make national news, especially for youth who may be particularly impacted.[92]

Many if not most states are also experiencing delays in timely admissions of people into clinical programs and services from jails, particularly those individuals found incompetent to stand trial. A report by Wik, Hollen and Fisher in 2017 highlighted the growing numbers of forensic patients in state hospitals between 1999 and 2016, and how many states were facing unprecedented demands for forensic patients to be served for competency restoration.[93] The reasons for these waits are complex, involving system dynamics with the push and pull of levers from countless stakeholders who have different views of the needs of individuals and the systems that serve them.[94] Advocates have described the wave of litigation against many states related to this issue.[95] State leaders are working hard to shift this balance from all directions, such as Texas, which launched a campaign called, "Eliminate the Wait," and created a related toolkit,[96] which has received positive attention. Every branch of government seems to have taken an interest in this issue, including court leaders who have pursued a national initiative to try to help problem-solve around these logjams.[97] Often these solutions circle back to providing ready access to services that are engaging and effective, to decrease the cycling in and out of care and crisis.

With these realities in mind, if a crisis occurs and an individual needs care, timely access to that effective care will be critical, and policymakers should examine their systems prioritizing not just effective care, but timely access to it. As described by Parks and colleagues,[98] one of the leading models to try to address more urgent access involves the CCBHC effort, which reflects a collaboration between SAMHSA and CMS for both demonstration and expansion sites and the develop of a more flexible funding model to deliver a comprehensive array of behavioral health services to communities and include a requirement for time standards for accessibility. A CCBHC must provide comprehensive mental health and substance use services that ensure timely access to care, provide services that include 24/7 crisis response and MAT for opioid and other substance use disorders.[99] In addition, CCBHCs are required to coordinate with both the criminal-legal stakeholders in their communities and education systems, which means that efforts at jail diversion and law enforcement partnerships, as well as school mental health partnerships, are part of their development. With the prospective payment system and rates set for the population to be serviced, the clinics are able to provide functions that are not revenue generating and might not otherwise be provided because budgets would be too inflexible and tight. Given that Congress has passed the Bipartisan Safe Communities Act[100] that expanded the opportunities for CCBHC expansion across all states and any territory, it is a categorical game-changer to community mental health across many regions in the United States.

Other forces also push for minimizing wait times for behavioral health services and these have included increasing attention to data, such as in Washington where the state made a large investment in a data infrastructure to try to move the needle on the waits for people in jail needing to access therapeutic settings.[101] As another example, behavioral health leaders are working with 911 and learning about Computer Aided Dispatch (CAD), Automatic Call Distribution (ACD) systems, and the roles of the Public Safety Answering Points (PSAPs) to build coordinated networks for rapid response to 911 and 988 calls regarding behavioral health crises. There is also work occurring to develop bed registries that go beyond just knowing where there are openings but are using technology to forward referral information and have receiving facilities work cooperatively to minimize waits for access to residential and inpatient psychiatric services.[102,103] In addition, in *Lending Hands*,[104] Pinals describes the evolving potential for initiating real treatment in a crisis context, which could have a significant impact on being stabilized at home, decreasing demand for some services. Creating more opportunities for in-home care, establishing clear data sets to understand who is waiting for what service and identifying barriers that are creating delays are some of the strategies to address a current imperative to maximize timely access to the most effective services.

4. Engagement Strategies to Foster Retention in Care

According to a report on engagement from the National Alliance on Mental Illness, 70% of people who drop out of mental health care do so after their first or second visit.[105] One meta-analysis noted that although approximately 42% of persons with schizophrenia become non-adherent with prescribed medication, only 13% of patients dropped out of psychosocial treatment.[106] In the Treatment of Early-Onset Schizophrenia Spectrum Disorders (TEOSS) study, young persons aged 8-19 years-old with early onset illness found that aggressive behaviors reported by parents and being African American were associated with a greater likelihood of drop out, even though many had positive responses to medications.[107] The authors noted that these findings point to the need for building additional supports for particular populations, and given disparities across the healthcare system, additional supports undoubtedly need to tackle structural issues that may further disengagement across varying racial and ethnic populations. In a study of outpatient care attrition after psychiatric hospitalization of veterans, 88% of 202 patients had disengaged from care, with attrition associated with male gender, younger age, increased expectations of stigma, less short-term participation in group therapy and poorer medication adherence.[108] Those with fewer prior-year inpatient psychiatric days, more perceived support and less short-term attendance at psychiatric appointments left care earlier than those with more inpatient days.

On the substance use front, the data of dropouts and relapse is also robust. In a study out of Germany examining drop-out of people with Methamphetamine Use Disorder, people who dropped out of treatment after residential treatment services had higher craving scores,[109] while another study showed the association of dropouts with a co-occurring history of injection drug use, even though there had been improvement in psychiatric symptoms during treatment.[110] The cycling of individuals through the justice system, substance use system, mental health services, and houselessness are emblematic of the major challenges with retaining people in meaningful care who may be at various stages of readiness for engagement.

Despite the longstanding knowledge that a “therapeutic alliance” is an important component in psychiatric care, there is still much more to learn about fostering adherence and engagement to reduce attrition and the risk of cycling through complex and disconnected systems. Engagement approaches are a key component of a true care continuum, and lessons from biological and psychosocial research have much to teach. There have been many studies that have looked at engagement itself, especially with complex populations. For example, Angell and colleagues examined strategies to engage prisoners with mental illness upon release, looking at two models such as FACT and CTI (described above). In their qualitative studies they found that practitioner strategies that included tangible assistance as well as specific approaches to interactions and the work with third parties such as family and parole were utilized by program staff as strategies for engagement.[111] Another study of a model of Intensive Case Management for Addiction (ICMA), which combined ACT and CTI methodologies, showed recipients significantly decreased their use of emergency departments for care.[112]

Studies related to enhancing the healthcare experience suggest that respect for a patient’s dignity and humanity, as well as adequate working conditions and resources, facilitate the humanization of care more generally.[113] There have been many strategies that have been used to foster adherence and engagement throughout medicine and mental health care, and even in other venues such as specialty courts and probation services (see Text Box for examples).

Examples of strategies to help foster engagement and reduce attrition from services:

- Follow-up care post-crisis
- Motivational interviewing techniques
- Considering individual attitudes about services in shaping the service delivery models
- Positive reinforcements for participation
- Provide reminders about appointments
- Assisting with skill building such as reliability training, communication with providers, and calendar management
- Facilitating access through transportation
- Assist participants with problem-solving around job responsibilities, childcare, family responsibilities, and pet care for the individual who may need to leave home for appointments or care
- General stress management training
- Offer incentives, welcome messages and positive respectful praise for returning for care

Even with the best of strategies, there will be some individuals with serious mental illness who have difficulty adhering to treatment, challenged by their illness and at times their decision-making capacity. Laws exist to protect those individuals from harm due to impaired judgment and to help them in the event they present a risk of harm to themselves or others. For example, every jurisdiction has laws that allow for temporary holds for evaluation,[114] guardianship,[115] and civil commitment.[116] There are many strategies that can be utilized prior to seeking legal authority to override individual autonomy in delivering mental health services or services for those with complex conditions affecting their well-being, such as maximizing supported decision-making when possible.[117]

Still, these small subset of individuals with serious mental illness for whom retention in care is challenged may need additional approaches. Many jurisdictions are examining their civil commitment laws to make assisted outpatient treatment (AOT) for court-ordered community-based treatment available and more useful.[118] Although a review of these laws is beyond the scope of this paper, it is important to realize that the court order can be helpful for some people, but overuse and over-reliance on a court order as a single solution can be oversold, and will potentially cause unintended negative consequences and at the very least not yield as many desired successes if not applied appropriately. And engagement strategies will still be critical for all.

There are other tools along the “continuum” of strategies that are also potentially important and available in many jurisdictions. Take for example, Psychiatric Advance Directives,[119] which offer an opportunity for an individual to develop their own treatment plan with the understanding that their condition may render them incapable of making decisions in the future. Meaningful dialogue about one’s care well in advance of any crisis can offer opportunities for providers to hear of the individual’s concerns, answer questions about options, and set forth a plan to be able to more rapidly access care needed.

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.

Notwithstanding legal authorities, it is important to realize that perceptions of coercion in treatment can be a component of whether an individual remains engaged in care. Even when court-ordered for treatment, a sense of being coerced may have more to do with whether an individual feels they have been treated fairly and given the appropriate information than it has to do with whether there is actually a court order or not.[120] Other aspects of feeling coerced may have to do with one's own background, such as was seen in a study of veterans engaged in a jail diversion program for individuals with co-occurring mental illness and substance use disorders, who reported fewer measures of perceived coercion, potentially related to backgrounds in their careers of following orders.[121] Researchers in the UK have been examining the impact of coercion on treatment refusal and engagement for years, and initiated work called the CRIMSON (CRisis plan IMpact: Subjective and Objective coercion and eNgagement) protocol.[122] Though one study showed mixed results related to outcomes with the use of joint crisis plans (a statement of the service users' wishes for treatment developed with the clinical and an independent facilitator) on individuals under compulsory treatment per the Mental Health Act, the authors found this may have had more to do with how the plan was implemented.[123] The study's findings raise important questions about how best to train staff on fostering patient voice in development of plans. In another study examining two types of crisis plans—a clinician facilitated crisis plan and a patient advocate crisis plan—it was found that those facilitated by patient advocates had some advantages compared to those developed with clinicians.[124] Regardless, there is much more to learn on this front to help individuals who are struggling with adherence to understand their barriers and perceptions. Research is sorely needed to help improve strategies to maximize their ongoing participation in care.

Given the well-recognized disparities and structural inequities that impact individuals and families dealing with behavioral health challenges, engagement must also be done in the context of cultural humility.[125] Federal and local policymakers have been more intentionally building in diversity, equity, and inclusion infrastructure into their staffing and leadership for governance to pay closer attention to correct the inequities that exist. The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care should be utilized as one frame of reference to see how one's system is fairing with regard to improving overall quality of services *From Crisis to Care*.[126] The SAMHSA crisis services guidelines make clear that crisis services must serve everyone, and Matthews and Edwards[127] describe the diversity of populations that crisis services must be equipped to help, and this is no less true for the care system and complete continuum attached to the crisis response.

The NAMI Engagement report highlights outdated policies and practices, including overcrowded hospitals, large caseloads, time constraints imposed by payers, lack of training and lack of coordination across systems as challenges and barriers to true engagement.[128] Moreover, they identify the responses of coercion, shackles, locked units, deficits-based as opposed to strengths-based approaches, challenges working across diverse cultures, lack of respect, and an inability to convey a sense of hope for recovery and goal attainment as creating mistrust and roadblocks. To overcome these obstacles, they recommend adopting 12 principles (see Text box) and described a "culture of engagement." This premise is one that is key to the *Crisis to Care* continuum. Policymakers would do well to consider how

the creation of such a culture of engagement is fairing at every step and across systems and make every effort to foster and nurture a realization of this laudable goal.

Summary of NAMIs 12 Principles for Advancing a Culture of Engagement[129]

1. Make engagement a priority at every level of the mental health system
2. Communicate hope
3. Share information and decision-making
4. Treat people with respect and dignity
5. Use a strengths-based approach to assessment and services
6. Shape services around life goals and interests
7. Take risks and be adaptable to meet individuals where they are
8. Provide opportunities to include families and close supports
9. Recognize the role of community, culture, faith, sexual orientation and gender identity, age, language, and economic status in recovery
10. Provide robust, meaningful peer and family involvement in system design, clinical care and provider training
11. Add peer support services as an essential element of mental health care
12. Promote collaboration across systems and providers

5. Strategies for Routinizing and Developing Effective Technology

The use of technology in behavioral health care, such as electronic medical records, health information exchanges and virtual appointments is not new. Technology is clearly a mainstay of crisis services with the crisis hub, text lines and a call center infrastructure that routes callers behind the scenes through a network of technologically connected interfaces and GPS tracking capabilities. Moving *From Crisis to Care* is already easier and will continue to be more rapid and accurate as bed and program registries and appointment apps help facilitate efficiency and connections for making referrals easier. The use of technology to examine big data across systems could identify areas in mental health services where growth and development are needed, as several countries have done where they can cull from large datasets to identify important trends and develop new programs and services.[130]

The necessity for additional technological advancement and availability in multiple ways became crystalized right at the outset of the COVID-19 pandemic. Suddenly, public behavioral health leaders were faced with the need to continue to provide seamless essential services, maximize communications across a workforce that was working from home, and train staff to work with new virtual platforms and standards with little notice. The federal government has assisted with the infrastructure and loosened regulations needed to make treatment through technological means workable during the public health emergency (PHE). In doing so, many have wondered which of the shifts would remain after the pandemic-related emergency period. To that end, SAMHSA recently announced authorization for audio-only assessments for opioid treatment programs to use telehealth evaluations for buprenorphine induction even when the PHE ends.[131]

With the adaptation to technology more in the mainstream, it will be important to continue to improve upon its delivery and ensure that increasingly better mental health outcomes are front and center. Promising findings from implementation of telemedicine for mental conditions, for example, include findings of positive feasibility and resultant improvement in symptoms and quality of life for a broad range of individuals in care through telehealth.[132] Findings related to the benefits of technology have only grown. For example, *Open Minds* reported on telehealth as an effective modality in reducing symptoms of obsessive compulsive disorder and other related symptoms and in helping consumers with I/DD.[133,134] To further its utilization and proper delivery, SAMHSA produced a resource guide on telehealth for the treatment of serious mental illness and substance use disorders, issued in 2021.[135] In that guide they focus on ways in which treatment of these serious conditions can be assisted through telehealth.

Mobile options such as text messaging for crisis support and strategies that help with progress monitoring provide a "new frontier" for mental health support and data collection according to the National Institute of Mental Health (NIMH).[136] Another area of growth is in the development of mental health apps. The NIMH website on this topic describes several types of apps, such as those for self-management, those that purport to improve thinking skills, those that help with more general skills training, illness management and supported care, symptom tracking and data collection.[137] They also note that clinicians and engineers are forging relationships (see partnerships section below), finding that technological interventions must be well-liked and engaging, and must rely upon the engineers' skills for ease of use and the clinician's skills for effective interventions.[138]

In 2017, an NIMH initiated National Advisory Mental Health Council Workgroup on Opportunities and Challenges of Developing Information Technologies on Behavioral and Social Science Research released a report that focused on technologies to advance assessments, research on and delivery of preventive and therapeutic interactions, and technologies to improve reach, efficiency and quality of mental health services.[139] In a 2022 NASMHPD paper by Phillippi and Thomas, several types of technological advances in behavioral health are reviewed, including efforts to expand self-directed care options.[140] Virtual reality (VR) is being explored to expand tools for people with behavioral health needs across the globe.[141] Artificial Intelligence (AI) is yet another area of growing interest in the mental health space. For example, The Trevor Project, a suicide prevention and crisis intervention organization for LGBTQ young persons, launched a partnership with Google.org to develop an AI-based Crisis Contract Simulator, a unique counselor training tool powered by AI. By simulating digital conversations with LGBTQ youths in crisis, counselors are trained to deliver services by experiencing a realistic conversation.[142] Other areas of growth include the use of AI to help improve the mental health of the workforce more generally.[143] At the same time, experts are predicting that a large proportion of the workforce could be shifted to computerized labor through the developments in AI, which creates anxiety about job loss and can further impact worker mental health.[144]

Beyond Beds

Recommendation #8: Technology

Create and expand programs that incentivize and reward the use of technology to advance care delivery, promote appropriate information sharing, and maximize continuity of care. Policymakers should require as a condition of such incentives that outcome data be utilized to help identify the most effective technologies, and they should actively incorporate proven technologies and computer modeling in public policy and practice.

Although the promises for telehealth service delivery and expanded use of technology are broad and exciting, there are caveats to consider. Even with the potential for reaching anyone at any time day or night, there is the important need to look at how these technologies are regulated, whether there is appropriate privacy, and whether the services espoused as effective have the backing of research to support claims made by developers. There is also a need to examine the goodness of fit of the patient population for specific virtual services (e.g., certain older adults or children/families may benefit from some types of technology in behavioral health services but not others).[145] Ethical, clinical and legal challenges still arise in the telehealth space (some of them similar to in-person issues) and over time will continue to need to be addressed as new information becomes available.[146] Disparities in access to the internet and to technology devices and programs must also be addressed given the potential for inequities that have already been seen.[147] Rural communities for example may not have the same broadband access and thus less access to these growing supports. Even with these caveats, the role of technology will likely only grow going forward, and thus, policymakers would do well to advocate for advances that work and stay abreast of its growth as a key element in the *Crisis to Care* considerations.

6. Old, New, and Improved Partnerships

Although the idea of collaborations across systems is not new, the COVID-19 pandemic and some of the political unrest that catapulted the country to consider alternatives to police response to behavioral health emergencies has shown new avenues for partnerships that can be improved, and mechanisms to think more broadly about those partnerships. Examples of newly evolving partnerships are abundant.

Take for example, the more in-depth work between SBHAs and public health officials, both to reduce the impact of COVID-19 on the total population of people served in the behavioral health system, but also in working to uplift society's mental well-being. CCP grants were issued throughout the United States to foster improved disaster behavioral health responses.[148] These forces leveraged new partnerships between state and local leaders.

With the 988 transition, states are pursuing laws to help implement and fund 988. To do that, leaders in behavioral health are establishing relationships with 911 and its related "Public Safety Answering Points" or PSAPs, to ensure coordination of crisis care for those who need it and continue to foster responses that do not default to police unless there is a critical need to do so. In NASMHPD's 2022 *Lending Hands*, the issues of old, new and improved partnerships between behavioral health, law enforcement, and emergency medical services is explored with specific areas of potential growth for effective crisis response to get the various responders more coordinated and the right, least restrictive and most therapeutic response to people in need.[149] With the drive for 988 and Crisis Now to have answering hubs and call centers interconnected with networks, partnerships with engineers are a whole new area of focus.[150] Beyond

New and Strengthened Partnerships Seen in Recent Years:

- Public health and behavioral health staff
- Crisis responders including emergency medical services, behavioral health services, and law enforcement as well as behavioral health leaders working with 911 and PSAPs
- Engineers and technology experts and behavioral health
- Children's behavioral health services, schools, child welfare and juvenile justice
- Persons with lived experience and policymakers
- IDD and behavioral health policymakers and providers
- Courts and behavioral health leaders

building new platforms and the connectivity behind the scenes, there are numerous examples of communities breaking new ground to build out legislation and programs as part of forging new and strengthening established partnerships.

State examples of these activities are everywhere. Take Knoxville, Tennessee, for example, where 988 is seen as a means of complementing a co-responder program that was established between police and behavioral health specialists.[151] Legislators in Massachusetts proposed "an Act to better coordinate suicide prevention services, behavioral health crisis care and emergency services through 988 implementation."[152] In the District of Columbia, a coalition of hospitals and health centers explored the needs of people in the District, and issued a white paper examining the crisis system's challenges and opportunities to increase health and reduce harm by properly leveraging partnerships between behavioral health, law enforcement, and 911.[153] This close examination of the system informed growth in activities that leverage meaningful partnerships necessary for proper crisis services across diverse communities in the city. And on a broad scale, as described in NASMHPD's 2022 paper on CCBHCs and other Urgent care models,[154] CCBHCs actively require agreements with various partners such as local law enforcement to enhance jail diversion.

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.

Another area of expanded partnerships has evolved through the recognition of mental health needs for youth and for parents of young children.[155] For older youth, crossover collaboration between behavioral health, education and child welfare systems is also booming. More than 20 years ago Weist, Lowie, Flaherty and Pruitt wrote about the importance of augmenting roles played by mental health and public health systems in improving school-based mental health services while minimizing "turfism and negative attitudes."[156] Today, these collaborations are much more established, yet with the tragic incidents involving school shootings and the mental health toll of the pandemic, there are more reasons than ever to foster and prioritize these collaborations with creative opportunities for their expansion.

NASMHPD and the National Association of State Directors of Developmental Disabilities Services (NASDDDS)[157] are working together on a number of initiatives to address complex populations. Together with The National Association for the Dually Diagnosed (NADD) and NASMHPD, NASDDDS is growing participation in its Capacity Building Institute for Individuals with I/DD and Mental Health Support Needs (CBI).[158] This center aims to help states better serve those individuals with dual diagnoses by facilitating and improving skill sets of participants. As HCBS waivers become more available to those with dual diagnoses and systems begin to build their capacity, these collaborations will continue to expand. Non-governmental partners with states have launched initiatives to help providers navigate some of the complex waters of these collaborations, such as one out of Alaska, the Alaska Healthcare Providers Toolkit, which emerged in 2015 as a joint project of University of Alaska Anchorage (UAA) Center for Human Development Leadership Education in Neurodevelopmental and related Disabilities (LEND) and the WITH Foundation.[159]

Partnerships across branches of government are also growing. The National Judicial Task Force to Examine State Courts' Response to Mental Illness launched in March 2020 by the Conference of Justices and the Conference of State Court Administrators and facilitated by the National Center for State Courts is an important example of partnerships between judicial and executive branch representatives.[160] This initiative has produced reports and tackled issues related to criminal justice, civil and probate courts,

juvenile justice, child welfare and family, leadership and collaboration and education, with ongoing work being done in these domains. Reports will continue to be produced from this body of diverse leaders, and collaborative meetings with SAMHSA on a regional level have already begun to inspire work to implement many of the Task Force recommendations. On a local level, the Miami-Dade County's Eleventh Judicial Circuit of Florida has been diligently growing its Criminal Mental Health Project under the Direction of The Honorable Steve Leifman and in partnership with the local behavioral health system and with support from the legislature and getting national attention for its work.[161]

Partners with the advocacy community, persons with lived-experience and their families, tribal leaders, veterans' administration and services and faith-based organizations to name a few are underway throughout the community to help improve the lives of so many individuals who daily struggle with behavioral health conditions. The movement of building non-traditional partners across the country as recommended in *Beyond Beds* has been impressive.[162] Though examples abound, SMIAdviser.org is one to not as a resource that has been built with voices from a broad range of stakeholders.[163] With federal attention on improving mental health as part of President Biden's Unity agenda, there will be growing work across federal agencies that examine how to implement the President's strategy.[164] This work marks an important time to build a stronger system from *Crisis to Care*, with partners both traditional and non-traditional ready to serve and stand up for improvements for better mental health outcomes.

7. Sustainable and Expandable Services

Funding of crisis services are critical to ensure that they are effective and available. The American Rescue Plan provided an additional $1.5 billion in Mental Health Block Grant dollars to states to be spent over the next several years, which SAMHSA has encouraged states to use to develop partnerships among critical stakeholders to the crisis services continuum.[165] Announcements of expanded funding in various areas, such as HHS announcing nearly $35M to strengthen supports for children and young adults and suicide prevention are always welcome.[166] But what will behavioral health service needs look like over time? With the infusion of dollars related to the pandemic slated as temporary, there will need to be careful attention to long-term funding. Before the pandemic, it was anticipated that spending on mental health and substance use treatment would double between 2003 and 2014.[167] Yet, behavioral health has a long history of being inadequately funded. This cannot be an option, especially given recent data reported in the *Lancet* showing a critical increase in disability adjusted life years related to depression and anxiety for people in the workplace as a result of the impact of the COVID-19 pandemic. Findings like this support an urgency to strengthen mental health systems in most countries.[168] It is anticipated that the demand for mental health services will grow, and the 988-call line is due to be in high demand. To help shift people *From Crisis to Care*, the behavioral health care continuum will need to grow accordingly, or there will be more demand than supply resulting in greater waits for services.

In the President's strategy to address our national mental health crisis, many aspects of needed improvement are noted (See Text Box),[169] which speak to issues addressed throughout this paper. With this commitment at the highest level of government to include not just expansion of behavioral health services but focused attention on assisting individuals with substance use disorders and helping to integrate primary care and behavioral health, there will undoubtedly be funding strategies to support this work. Moreover, efforts to address parity and make it meaningful can only assist in ensuring access to proper care for people with behavioral health conditions. And, as part of the infrastructure, innovations like the Healthy People Initiative[170] that sets forth planning for the future and envisioning

what it would take to create healthy people by 2030, there is promise ahead that systems are growing in the same direction and advocates will have the tools needed to inspire funding to meet the goals set forth by the President.

Summary of President Biden's Strategy to Address Our National Mental Health Crisis

1. *Strengthen system capacity*
    a. Investing in programs to bring providers into behavioral health
    b. Pilot new approaches to train a diverse group of paraprofessionals
    c. Build a national certification program for peer specialists
    d. Promote the mental well-being of our frontline health workforce
    e. Launch the "988" crisis response line and strengthen community-based crisis response
    f. Expand the availability of evidence-based community mental health services
    g. Invest in research on new practice models
2. *Connect Americans to Care*
    a. Expand and strengthen parity
    b. Integrate mental health and substance use treatment into primary care settings
    c. Improve veterans access to same-day mental health care
    d. Expand access to tele- and virtual mental health care options
    e. Expand access to mental health support in schools and colleges and universities
    f. Embed and co-locate mental health and substance use providers into community -based settings
    g. Increase behavioral health navigation resources
3. *Support Americans by Creating Healthy Environments*
    a. Strengthen children's privacy and ban targeted advertising for children online
    b. Institute stronger online protections for young people, including prioritizing safety by design standards and practices for online platforms, products, and services
    c. Stop discriminatory algorithmic decision-making that limits opportunities for young Americans
    d. Invest in research on social media's mental harms
    e. Expand early childhood and school-based intervention services and supports
    f. Set students up for success
    g. Increase mental health resources for justice-involved populations
    h. Train social and human services professionals in basic mental health skills

Conclusions

The transition to 988 has been described by Balfour as a "*carpe diem* moment" for behavioral health crisis services.[171] It is true that these are unprecedented times, and the political winds and societal needs are coalescing to shape a promising future for behavioral health services within the crisis care continuum. With this moment comes the imperative to continue to connect the dots in the psychiatric continuum of care, thinking beyond crisis to the accessible care that will be required both to avoid crises in the first place and to deliver timely care in the moment that it is most needed. This paper set forth seven key elements that are considered crucial to make this work successful. In building out services beyond 988 and *From Crisis to Care*, behavioral health leaders have shifted far from the days where the

single solution to the mental health system fragmentation was more state hospital beds. Now, levers of all sorts are pushing for a safety-net infrastructure that is well-funded, sustainable and expandable to meet the growing demands not just for people in the public behavioral health system, but for all individuals who serve them, their families, and the public as a whole.

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