ASPE
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OFFICE OF BEHAVIORAL HEALTH, DISABILITY, AND AGING POLICY

Readiness of Our Crisis System for 988: Final Report

Prepared for
the Office of the Assistant Secretary for Planning and Evaluation (ASPE)
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by
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Office of the Assistant Secretary for Planning and Evaluation

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READINESS OF OUR CRISIS SYSTEM FOR 988: FINAL REPORT

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Exhibits

Acronyms

The following acronyms are mentioned in this report.

ASPE	Office of the Assistant Secretary for Planning and Evaluation
BHCC	Behavioral Health Crisis Centers
CBHL	Community Behavioral Health Liaison
CCBHC	Certified Community Behavioral Health Clinic
CCBHO	Certified Community Behavioral Health Organization
CDC	Centers for Disease Control and Prevention
CIT	Crisis Intervention Team
CMS	Centers for Medicare & Medicaid Services
EISS	Early Intervention Support Services
EMS	Emergency Medical Services
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex, Asexual, and More
MHBG	Mental Health Block Grant
N-MHSS	National Mental Health Services Survey
N-SUMHSS	National Substance Use and Mental Health Services Survey
NASMHPD	National Association for State Mental Health Program Directors
NENA	National Emergency Number Association
NHAMCS	National Hospital Ambulatory Medical Care Survey
NSDUH	National Survey on Drug Use and Health
NSPL	National Suicide Prevention Lifeline
SAMHSA	Substance Abuse and Mental Health Services Administration
SME	Subject Matter Expert
URC	Urgent Recovery Center

Executive Summary

The recent designation of the three-digit "988" dialing code is intended to improve public awareness of an immediate means to behavioral health crisis services, resulting in both a diversion of behavioral health calls from 911 as well as increased utilization of call services among the significant proportion of the population in crisis but not currently receiving any care. Call volume is projected to increase from 4 million in 2022 to 9 million in 2024, which will result in substantial impacts on demand for all elements of the crisis response system--**someone to call, someone to respond, a place to go**--in each state. The Office of the Assistant Secretary for Planning and Evaluation (ASPE) contracted with RTI International, in collaboration with NRI, Inc., to answer the following research questions:

1. What existing state-level data sources document the availability and accessibility of behavioral health crisis response services? Per these data, what is the capacity of the current behavioral health crisis system?
2. What are states' plans to improve the availability and accessibility of behavioral health crisis response services in early implementation of 988? Will these actions fill gaps in the current capacity of the system?
3. What data collection efforts could be established or augmented to better understand the availability and accessibility of behavioral health crisis response services?

We used a multi-faceted approach across three project phases. The first phase included an environmental scan and series of subject matter expert (SME) interviews to gather existing information pertaining to state behavioral health crisis systems. The second phase of the project leveraged identified data sources to inventory the availability and accessibility of behavioral health crisis services in and across states and document states' reported plans for improving availability and accessibility of these services. In the third phase, we conducted a series of case studies with five states: Missouri, New Jersey, Oklahoma, Texas, and Washington. Discussions with state representatives were intended to capture a broad understanding of current and planned implementation across each state's crisis service continuum, including perceived barriers and facilitators to improving availability and accessibility to these services.

Current Availability and Accessibility of Behavioral Health Crisis Response Systems

Federal and state data systems speak to the availability and accessibility of behavioral health treatment capacity. However, these data systems have not historically focused on behavioral health *crisis* services. We identified four national data sources from which to extract state-level metrics on availability and accessibility of each element of the crisis continuum: (1) the 2021 Community Mental Health Block Grant (MHBG) applications, (2) the National Suicide Prevention Lifeline (NSPL) website (now referred to as the 988

Suicide & Crisis Lifeline); (3) the 2020 National Mental Health Services Survey (N-MHSS; as of 2021, the National Substance Use and Mental Health Services Survey or N-SUMHSS); and (4) the 2021 Centers for Medicare & Medicaid Services (CMS) State Planning Grants for Qualifying Community-Based Mobile Crisis Intervention Services applications.

MHBG application data showed that states are, in general, furthest along in implementation of **someone to call** services, relative to **someone to respond** and **a place to go** services. Indeed, states typically reported earlier stages of implementation, in comparison, for **a place to go**, suggesting that there is the most room for growth in this area of the crisis services continuum. Case study interviews mirrored these findings; many voiced concerns about having sufficient "downstream" services to meet demand. Simultaneously, most states noted that the introduction of 988 served as a catalyst for positive outcomes, including increased communication and coordination among stakeholders, enhanced services, and revised protocols to ensure alignment with best practices for crisis response.

Using national data sources, we looked for metrics to reflect capacity for each of the core elements. Relative to other elements, there is more standardized data for **someone to call** services (e.g., NSPL data on number and reach of Lifeline call centers). However, there are no systematic national data regarding other relevant metrics, including geographic availability, the number and performance of non-Lifeline call centers, the call center workforce, and engagement of calls in post-crisis behavioral health care. States vary widely in terms of the degree to which they can and do track these pieces of information. Many states offer **someone to respond** services, but not all models satisfy Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Guidelines or the requirements specified in Section 1947(b) of the American Rescue Plan. Similarly, while there are many **places to go**, but inconsistent definitions pose challenges to systematic analysis, and emergency departments remain a common entry point into crisis response services

States' Plans to Improve Availability and Accessibility of Behavioral Health Crisis Response Systems

Moving forward, states will be required to collect data under the terms of MHBG funding, including the use of a uniform data collection tool (to be provided by SAMHSA), and submission of monthly data on key performance metrics (e.g., number of calls, chats, texts received and answered, average speed to answer, abandonment rate, direct/rollover calls to backup centers, and mobile crisis outreach referrals). In funding applications and case study calls, states also reported plans to improve their data collection and reporting systems by tracking encounter data beyond the immediate crisis episode.

Data extraction of MHBG applications included identifying states' proposed/planned activities utilizing 5% set-aside funds specifically allotted for crisis stabilization. In roughly one-third of state applications, the described activities spanned the crisis continuum, either

building on existing efforts in each of the three core elements, or in some cases, adopting a model that better reflected SAMHSA's National Guidelines for Behavioral Health Crisis Care (SAMHSA, 2020). Other states planned to prioritize funds to develop or enhance one specific element of their crisis system; call centers and mobile crisis services were often highlighted in these cases (e.g., expanding staffing at call centers in advance of 988; establishing a new mobile crisis team in a rural area). Crisis facilities were cited alone or in tandem with one or both other core elements in fewer than half of the responses to the 5% set-aside, despite **a place to go** generally being the "least" developed crisis element according to states' self-reported stages of implementation. Across the five states selected for case studies, efforts to recruit and retain a crisis response workforce were paramount.

In general, states' planned activities represent promising steps toward filling the identified gaps in the current capacity of the behavioral health crisis system. Increasing in-state answer rates is a straightforward way to improve availability of **someone to call** services. Efforts to increase linkages between 911 and 988, such as expanding crisis call diversion programs and facilitating warm hand-offs to behavioral health specialists, will also help individuals in crisis receive the most appropriate form of care.

Several planned activities to improve mobile crisis intervention services will fill the outstanding gaps in **someone to respond** services. Specifically, developing mobile crisis units that satisfy the requirements specified in Section 1947(b) of the American Rescue Plan to serve all state residents would address most of the limitations to this element of the crisis services continuum. Incorporating peers and implementing other creative solutions to workforce challenges will help, but sufficient staffing remains an issue. Though in early stages, efforts to develop youth-serving mobile crisis teams and ensure timely deployment of mobile crisis teams to people in rural or other difficult-to-reach areas could have a major impact on the crisis system and lived experiences of people in crisis.

Many states are working to stand up crisis receiving and stabilization centers, respite centers, and other facilities to provide options for **a place to go** other than a hospital emergency department. At the same time, representatives from multiple states selected for the case studies highlighted the need for a "culture shift" to increase diversion and appropriate use of crisis services. Rather than building places to go and expecting people in crisis to come, significant effort is needed to engage stakeholders such as key federal agencies (e.g., SAMHSA, CMS), law enforcement, behavioral health care providers and peers, consumers, and payers. Indeed, case study interviewees identified that part of the challenge is ensuring all stakeholders are aware of the available alternatives to emergency department care but view the implementation of 988 as a catalyst for increasing knowledge about, support for, and utilization of crisis stabilization services. Accordingly, legislative support, community engagement, awareness of available services, and representation of peers within the workforce may be especially helpful strategies for making sustainable improvements to the current gaps in this crisis system element.

Data Collection Improvements

In general, the identification and extraction of information from national data sources yielded a repository of information pertaining to current availability and accessibility of states' behavioral health crisis systems. However, findings also underscore the existing gaps in data collection which preclude a deeper understanding of behavioral health crisis service capacity. First, available metrics may not adequately capture the construct in question. For example, the statistics associated with NSPL (now 988 Suicide & Crisis Lifeline) call centers do not always present a full picture of *all* crisis call lines in a state, as many states have locally based call centers that are not affiliated with NSPL. Second, many metrics on availability and accessibility are inconsistently measured and/or reported across states. MHBG applications typically included additional information regarding current implementation of their crisis response system. However, states differed widely in the extent and type of information that they included to describe each of the core elements, preventing direct comparisons across states. Moreover, data do not necessarily represent the metrics used by the state to capture availability and accessibility of their crisis service system.

Given these limitations, data collection efforts could be established or augmented to better understand the availability and accessibility of behavioral health crisis response services. For example, new questions could be added to existing surveys to better understand national and state-level treatment need and unmet need for crisis services, as well as crisis services provided by public and private behavioral health treatment facilities. A national survey of state behavioral health agencies could be fielded to better understand each states' call center and mobile crisis capacity. More in-depth assessment of existing information, including state regulations to determine how states are defining and regulating crisis providers and services; hospital discharge data to approximate emergency department wait time; electronic data registries and linked data to calculate crisis systems' follow-up capacity; and claims data could be utilized to evaluate use of crisis services.

1. Introduction

A behavioral health crisis system is an important set of services that seeks to help people when they are most in need. In 2020, the National Suicide Prevention Lifeline (NSPL) website (now referred to as the 988 Suicide & Crisis Lifeline) received 3.5 million calls from people experiencing, or who were aware of someone else experiencing, a behavioral health crisis (Vibrant Emotional Health, 2020). In 2017, emergency department visits related to behavioral health disorder diagnoses resulted in service delivery costs of over $5.6 billion (Karaca & Moore, 2020). The United States has established specialized crisis response systems for crime, fires, and medical emergencies. In recent years, federal and state governments have been investing more money and effort into implementing a comprehensive and specialized crisis response system for behavioral health crises.

SAMHSA has recently developed guidelines for establishing a comprehensive crisis response system for behavioral health (SAMHSA, 2020). Per these guidelines, a comprehensive system should include "someone to call," "someone to respond," and "a place to go" to receive services when someone is in crisis. More specifically, SAMHSA recommends establishing regional call centers that are available 24/7 for people experiencing a behavioral health crisis; mobile crisis teams of trained personnel that can meet with people in the community within a timely manner; and crisis receiving and stabilization facilities that are for short-term (under 24 hours) observation and are a home-like, non-hospital environment. Another key element of this recommended system is integration across services, such that there is no wrong door for individuals in crisis to receive the care and support they need. In short, crisis services should be for anyone, anywhere, and anytime.

One significant and recent change to the behavioral health crisis response system in the United States is the designation of the three-digit "988" dialing code to allow anyone to connect with a regional behavioral health crisis response call center at any time. This number became fully operational across all telephone service providers in the United States in July 2022, replacing the current 24/7 NSPL, though the ten-digit NSPL number will remain operational. 988 is intended to improve public awareness of an immediate means to behavioral health crisis services, resulting in both a diversion of behavioral health calls from 911 as well as increased utilization among the significant proportion of the population in crisis but not currently receiving any care. Vibrant Emotional Health, the coordinator of call centers for the NSPL, projects that call volume to 988 will increase from about 4 million in 2022 to almost 6 million in 2023, and 9 million in 2024, with substantial spillover impact on the other elements of the crisis response system in each state.

In anticipation of the immediate and cascading effects of 988, the federal government is investing resources to help support states' implementation of comprehensive behavioral health crisis response systems. The American Rescue Plan (P.L. 117-2) provides an enhanced 85% federal medical assistance percentage for mobile behavioral health crisis

intervention services which can be used by states that cover mobile crisis under Medicaid. In 2021, CMS awarded state planning grants for qualifying community-based mobile crisis intervention services to 20 states to support efforts to develop a state plan amendment, 1115 waiver application, or 1915(a) or 1915(c) waiver request to provide community-based crisis services. In addition, the Consolidated Appropriations Act, 2021, and the Coronavirus Response and Relief Supplement Appropriations Act, 2021 (P.L. 116-260) require that states set aside 5% of their Mental Health Block Grant (MHBG) allocation to support crisis stabilization services. However, most payers, including commercial insurers, Medicare, and TRICARE, do not generally cover mobile crisis services (Shaw, 2020). Furthermore, there are gaps in the coverage of behavioral health crisis stabilization centers (Beronio, 2021).

Given the expansion of crisis systems, it is critical to identify long-term solutions to implement and sustain a comprehensive behavioral health crisis response system in and across states. This report was commissioned by ASPE to identify what states are doing and what additional infrastructure may be needed to create and maintain a comprehensive behavioral health crisis system across the entire United States. Specifically, this report addresses the following research questions:

1. What existing state-level data sources document the availability and accessibility of behavioral health crisis response services? Per these data, what is the capacity of the current behavioral health crisis system?

2. What are states' plans to improve the availability and accessibility of behavioral health crisis response services in early implementation of 988? Will these actions fill gaps in the current capacity of the system?

3. What data collection efforts could be established or augmented to better understand the availability and accessibility of behavioral health crisis response services?

2. Technical Approach

2.1 Environmental Scan and Subject Matter Expert Interviews

The first phase of this project began with an environmental scan and a series of SME interviews, intended to gather information from the grey and white literature and existing data sources pertaining to state behavioral health crisis systems. This phase incorporated a multi-faceted approach to gather information, including:

- Review of key organization websites (e.g., National Association of State Mental Health Program Directors [NASMHPD], National Association of State Alcohol and Drug Abuse Directors, and Crisis Now[1]), general web searches, and review of the relevant literature on PubMed.gov and Google Scholar.
  - General web queries used key words such as "behavioral health" and "crisis" in combination with "mobile crisis," "crisis stabilization," and other relevant terms.
- Semi-structured interviews with key stakeholders at SAMHSA and RI International, an organization that designs and operates behavioral health crisis services and peer delivered care throughout the United States and abroad, with specific questions about existing reports, current studies and analyses, and potential data sources for cataloging crisis systems.

Results of the environmental scan and SME interviews were compiled in an Excel database, including links and additional details to the reports, manuscripts, search results, and datasets. Findings were documented in an Environmental Scan and SME Summary and are synthesized in ***Section 3*** of this report.

2.2 State Data Inventory

The second phase of the project leveraged key data sources identified in the environmental scan and SME interviews to: (1) inventory the availability and accessibility of behavioral health crisis services in and across states; and (2) document states' reported plans for improving availability and accessibility of these services. RTI and ASPE mutually agreed upon suitable data sources from which to extract state-level metrics on availability and accessibility of each element of the crisis continuum.

[1] Crisis Now is led by the NASMHPD, and was developed in partnership with the NSPL, the National Action Alliance for Suicide Prevention, National Council for Behavioral Health, and RI International.

2.2.1 Data Sources and Metrics

Data from each of the four sources described immediately below were extracted for each state in systematic fashion, and the extraction approach was developed in collaboration with ASPE via a State Inventory Approach Memorandum. Once all data were extracted and assessed for quality and completeness, the study team then reviewed and synthesized qualitative data to identify and condense key information within and across states. Results were organized by existing and planned capabilities for each of the three elements of the crisis continuum.

MHBG Applications. SAMHSA provides non-competitive block grants to states for behavioral health services. In their 2021 applications, states were required to provide information on their crisis system, including access to local crisis call centers, availability of mobile crisis units, and the availability and/or utilization of short-term crisis receiving and stabilization centers. States were also asked to indicate proposed/planned activities to utilize the 5% set-aside.

NSPL website. The NSPL, administered by Vibrant Emotional Health, has a website[2] to provide resources and connect individuals to care. This website also includes key, updated information on crisis call centers, including number of NSPL call centers by state, number of calls received and answered, number of calls and texts answered in-state, and number of calls involving imminent risk and emergency dispatch. These metrics on call centers and call characteristics can inform our understanding of the current availability and accessibility of **someone to call** services.

National Mental Health Services Survey. The N-MHSS was an annual census of all known mental health treatment facilities in the United States. In 2021, N-MHSS was incorporated into the National Substance Use and Mental Health Services Survey (N-SUMHSS). These data are not yet available, however, so we instead focused on the most recent data from the 2020 N-MHSS. A total of 12,595 facilities (out of 15,421 invited facilities; 89% response rate) completed the 2020 survey between March 26, 2020, and January 8, 2021, 12,275 of which were included in the 2020 report. There are two N-MHSS survey items relevant to behavioral health crisis care, intended to capture the number of facilities: (1) with a crisis intervention team (CIT) within the facility; and/or (2) that offer mobile/off-site psychiatric crisis services.

CMS State Planning Grants for Qualifying Community-Based Mobile Crisis Intervention Services Applications. In 2021, CMS awarded planning grants to 20 states through the American Rescue Plan Act of 2021: Section 9813 to support efforts to develop a state plan amendment, 1115 waiver application, or 1915(a) or 1915(c) waiver request to

[2] See https://suicidepreventionlifeline.org/.

provide community-based crisis services. In these applications, states were asked to describe planned activities pertaining to qualifying, community-based mobile crisis intervention services, including proposed goals, measurable objectives, activities, and milestones associated with their use of funds, if awarded. Though not required, most (18 out of 20) of these states also included a brief description of the current access and availability of the mobile crisis services in the state, as well as their perceived gaps and limitations of existing mobile crisis services.

2.3 Case Studies

The third phase of this project centered on case studies of five states: Missouri, New Jersey, Oklahoma, Texas, and Washington. These states were selected through a collaborative process; incorporating input from ASPE and NRI, RTI identified eight states in each major geographic region of the United States that highlight innovations in at least one aspect of the three core elements of crisis systems (i.e., **someone to call**, **someone to respond**, and **a place to go**). NRI conducted initial outreach to key representatives from each of the five states listed above, inviting them to participate in a series of virtual interviews to discuss the current status of their state's crisis service continuum and readiness for 988.

With input from key representatives, a list of up to nine potential interviewees was developed to capture a broad understanding of behavioral health crisis response systems in each state. Across states, this included a mix of leadership overseeing the crisis response system (e.g., behavioral health commissioner, behavioral health associate commissioner), representatives of specific crisis-related programs (e.g., crisis services unit director), and other individuals involved in states' crisis system innovations (e.g., crisis call diversion program supervisor, tribal behavioral health administrator).

Between July 8, 2022, and August 16, 2022, RTI led a series of virtual video calls with 28 total interviewees across all case study states. Discussions were between 30 and 90 minutes long, facilitated by semi-structured interview guides. These guides were tailored according to the interviewee's role to capture a balance of continuum-wide and element-specific information across interviews. Discussions were recorded for note-taking purposes; notes were subsequently shared with interviewees to review for accuracy, if desired. Once all case studies were completed, call notes were reviewed for information relevant to each of the three research questions. These findings are integrated as appropriate in ***Sections 3***, ***4***, and ***5***. It is important to note that findings gleaned from the case studies are offered as illustrative examples only. Given the small number of states included in this task, such information should not be considered representative of all states and territories. Similarly, omission of reference to a specific state when discussing other case study states does *not* mean that the finding does not also apply to the omitted state; rather, examples were

chosen selectively to balance the overall attention given to each of the five states that agreed to participate in the case study interviews.

3. Current Availability and Accessibility of Behavioral Health Crisis Response Systems

In this section, we describe state-level data sources that document the availability and accessibility of behavioral health crisis response services, and what they indicate about the status and capacity of the current behavioral health crisis system. Federal and state data systems collect many data points to track the availability and accessibility of general behavioral health treatment capacity. However, the data systems have not historically had a focus on services aimed at responding to individuals experiencing a behavioral health *crisis.* As described above, we identified four national data sources that assess specific facets of capacity and supplemented this with information from case studies. In what follows, we summarize key findings and limitations in relation to both the full continuum of crisis services and the three core elements individually.

3.1 Stages of Implementation

MHBG applications included states' self-reported stage of implementation, as defined per SAMHSA guidelines[3] (***Exhibit 1***), across each of the core elements of behavioral health crisis services.

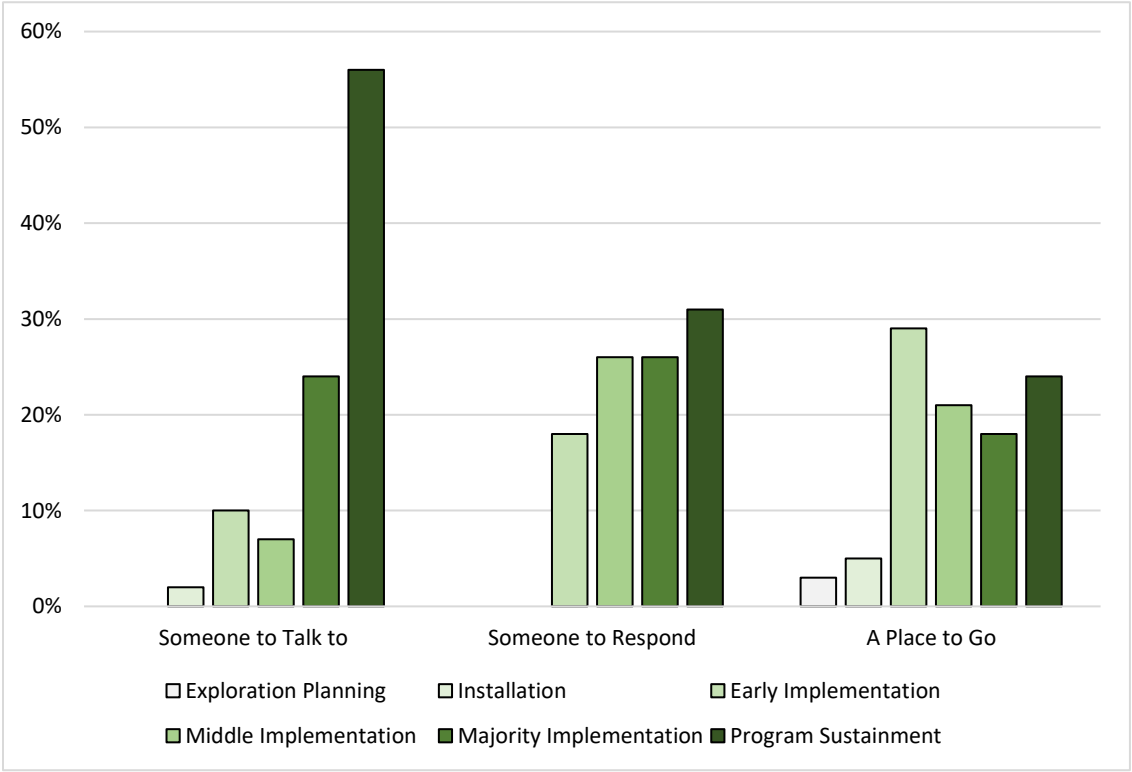
Exhibit 1. SAMHSA Definitions to Guide State-Reported Stages of Implementation of their Crisis Continuum in Their MHBG Applications

Stage	Definition
Exploration Planning	Wherein states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.
Installation	Occurs once the state has proposed a plan and begins making the changes necessary to implement the service based on the SAMHSA guidance. This includes coordination, training and community outreach, and education activities.
Early Implementation	Occurs when the state has the core crisis service implemented in some parts of the state; about 25% or less persons have access to that service.
Middle Implementation	Occurs when the state has the core crisis service implemented such that about half (~50%) of people in the state have access to that service.
Majority Implementation	Occurs when the state has the core crisis service implemented in most parts of the state so that most people (≥75%) have access.
Program Sustainment	Occurs when implementation is statewide and has a clear funding plan.

[3] See https://www.samhsa.gov/sites/default/files/grants/fy22-23-block-grant-application.pdf#page=95.

As shown below (***Exhibit 2***), *of the 41 states that marked their implementation stages, most reported being furthest along in implementing* ***someone to call*** *services* with over half (56.1%) reported program sustainment. This was followed by majority implementation (24.4%), early implementation (9.8%), middle implementation (7.3%), and installation (2.4%). No state reported being in the very first stage of exploration planning. For **someone to respond**, states most commonly indicated program sustainment (30.8%), followed by middle implementation (25.6%) and majority implementation (25.6%), and early implementation (17.9%). No state reported exploration planning or installation as the stage that best approximated their implementation. *States typically reported earlier stages of implementation for* ***a place to go*** *services, suggesting that there is the most room for growth in this element of the crisis services continuum*. The most commonly selected stage was early implementation (28.9%), followed closely by program sustainment (23.7%), middle implementation (21.1%), and majority implementation (18.4%). Of the remaining three states, two indicated that they were in the installation stage and one, exploration planning.

Exhibit 2. State-Reported Levels of Implementation



Source: State SAMHSA Mental Health Planning Grants, 2021.
N=41.

The MHBG application also instructed states to report on a range of suggested measures, including number of local crisis call centers in the state (in or not in the NSPL

network), number of mobile crisis responder teams (independent of or integrated with first responder structures), and number of crisis receiving and stabilization centers. However, states were not required to submit this information and *only a subset of states detailed measures of availability and accessibility for each element of their crisis system.*

In case study interviews we asked states to share information about the current capacity and measurement of each of the three elements of their crisis continuum (i.e., **someone to call**, **someone to respond**, and **a place to go**), the extent to which the three elements were integrated, the actual or perceived impacts of 988, and their plans to revise or enhance their crisis services in the future. All states anticipated that 988 would increase service utilization and many had concerns about having sufficient "downstream" services (e.g., mobile crisis, crisis stabilization) to meet the need. Most states also noted that the introduction of 988 served as a catalyst for positive outcomes, including increasing communication and coordination among stakeholders, enhancing services, and revising protocols to ensure alignment with best practices for crisis response.

3.2 Someone to Call

Geographic availability. The use of 988 to access the NSPL went live on July 16, 2022, in all states and five territories. The NSPL responds 24/7 to calls, chats or texts from anyone who needs support for suicidal, behavioral health crisis. Many states also have other behavioral health crisis health call lines (e.g., 211, 311, 1-800); however, *there is no systematic data on their geographic reach.* Additionally, many individuals experiencing crisis call 911, which is available in all states as an emergency number to call to reach the police, fire department, or emergency medical assistance from any phone. As of February 2021, the United States has 5,748 primary and secondary 911 call centers (also known as Public Safety Answering Points; NENA, n.d.).

Case Study Innovations: 911 Diversion

In partnership with the Houston Police Department, Houston Fire Department, and Houston Emergency Center, Harris County's local mental health authority (the Harris Center) operates a crisis call diversion program, wherein trained tele-counselors are co-located at the 911 call center. A case study interviewee from this local mental health authority explained that outcomes of interest include primary diversion, or instances in which no law enforcement or firefighter response was necessary (i.e., the crisis was resolved via telephone with the tele-counselor), and secondary diversion, or instances in which law enforcement and firefighter time on the scene was significantly reduced because of the tele-counseling during the crisis call.

Number and reach of Behavioral Health Call Centers. The NSPL (now the 988 Suicide & Crisis Lifeline) is made up of more than 200 state and local crisis centers across the country (SAMHSA, 2022). Although many states also have other behavioral health crisis call centers that are not part of the NSPL, *there are no national data about the number and reach of these other non-NSPL call centers*. Some states rely on Medicaid behavioral health plans to operate call centers parallel to the NSPL. Some states have crisis numbers focused on specific populations such

as individuals with gambling disorders and peer-supported warm lines for individual with substance use disorders.

In some cases, the number of non-NSPL call centers exceeds the number of NSPL calls centers within a state. For example, on the MHBG application, one state reported that it had one NSPL-affiliated call center and 33 others that were independently operated. The degree to which these systems are operated separately versus in tandem with one another can vary widely. For example, Missouri case study interviewees shared that the state's implementation of 988 was facilitated by the existence of a robust and experienced network of local behavioral health crisis hotlines. The state's Access Crisis Intervention network will continue to operate both NSPL and non-NSPL hotlines throughout Missouri indefinitely.

There are no national data that capture the capacity of individual providers or provider organizations to provide a person to talk to when individuals are in crisis. For example, some independent behavioral health professionals may offer patients 24-hour telephone access. Similarly, some states require that all community mental health centers operate a 24/7 crisis response/emergency services phone number. Federal regulations require that Certified Community Behavioral Health Centers (CCBHCs) provide crisis services that are accessible 24 hours a day.

Number of behavioral health crisis calls. In 2021, the NSPL received 3.6 million calls, chats, and texts. That number is expected to at least double within the first full year after the transition to 988 (U.S. Department of Health and Human Services, 2022). In the week during which the NSPL transitioned to 988, Vibrant reported that calls, text, and chats increased 45% from the prior week and 66% compared to the same week in 2021 (Vibrant Emotional Health, 2022). The NSPL is continuing to collect information on the number of calls received and answered each month, caller demographics (e.g., age), suicide history of the caller, and number of calls involving imminent risk. An estimated 240 million calls are made to 911 in the United States each year (NENA, n.d.). Some portion of calls to 911, perhaps 1%-10%, are for behavioral health crises (Hepburn, 2021a; Vera Institute of Justice, 2022). However, because there is no standard way that call centers define a behavioral health crisis call, there is significant uncertainty around this estimate.

Prior to the implementation of 988, some states reported in their MHBG application that the number of calls to their state behavioral health crisis call centers were many times greater than the calls to the state NSPL. However*, there are no national data on the number of calls to other (i.e., non-NSPL) state behavioral health crisis hotlines.*

Call center workforce. *We were unable to locate any state-level data sources capturing the number of full-time equivalents working in crisis call centers relative to the number needed*. According to a survey conducted by NRI in the summer of 2022, 14 of 31 responding states reported challenges in hiring enough social workers and peer specialists to staff the call centers. The five states we interviewed each reported workforce issues of

their own, though staffing challenges seemed more likely to affect mobile crisis response teams and crisis stabilization centers than call centers. Multiple states observed that, to fill vacancies, providers at times felt as if they were "poaching" from each other or from other elements of the crisis continuum, as demand for crisis services grew faster than the workforce.

Answer rate, timeliness. The NSPL captures the number of calls and texts that were answered out-of-state as a metric of the capacity of state crisis call centers. Calls that cannot be answered in-state because of a lack of capacity are transferred to the NSPL's national backup centers. Ideally, all calls should be answered by in-state counselors who can more effectively link callers to local treatment, support, and emergency services than out-of-state counselors. The data from October 1, 2021-December 31, 2021, showed that the in-state answer rates varied significantly from 19% in the lowest rate state to 98% in the highest rate state. Across the 50 states, the in-state answer rate was 73%. In case study interviews, states reported recent improvements in their in-state answer rates, in part attributed to increased funding to support 988 during the first year of implementation. Multiple states noted, however, that *in-state answer rates as calculated by Vibrant did not include data from non-NSPL call centers*.

States also collected various measures of timeliness beyond those tracked by Vibrant. For example, Oklahoma call center representatives from Solari, Inc. said that they collect the following metrics: average time to answer a call, percent answered within 18 seconds (3 rings), number of people who hang up before 18 seconds, and length of call by acuity. New Jersey captures data on the time callers spend waiting in the queue and the average duration of the call itself.

Case Study Innovations: Access via Technology

Oklahoma CCBHCs issue iPads to law enforcement agencies, equipped with a function that immediately connects officers to treatment providers at local CCBHCs--day or night-- to determine the appropriate treatment protocol for someone experiencing a behavioral health crisis (Comprehensive Crisis Response).

Case study interviewees reported on efforts to provide every CCBHC client a tablet they could use to reach a treatment team, available 24/7, with a simple touch of a button. Interviewees reported that this innovation resulted in lower appointment no-show rates, greater treatment engagement, and reduced use of crisis services.

Receipt of services following the call. The NSPL collects information on number of calls involving imminent risk and emergency dispatch. However, most call centers do not currently collect data on whether callers received behavioral health services as a result of the call. Case study interviews demonstrated different ways in which states track this information following the initial call. For example, Oklahoma has developed client IDs and data systems that allow them to track what happens after someone calls a crisis hotline, including receipt of follow-up services. Crisis centers in Texas reported using the Texas Department of State Health Services Clinical Management for Behavioral Health

Services system, which is used by behavioral health service providers, to track crisis episodes.

3.3 Someone to Respond

The Federal Government does not systematically collect data pertaining to the availability of behavioral health mobile crisis team services. Some data points, described below, suggest *significant gaps in mobile behavioral health crisis team capacity*.

Number and reach of mobile crisis units. Although not required in the application, many of the 20 states selected to receive a CMS Planning Grant for Qualifying Community-Based Mobile Crisis Intervention Services reported on their current availability of mobile crisis services at the time of application. State-reported capacity varied widely, but most (17 out of 20) states reported existence of mobile crisis services--even if these services did not cover all counties in the state, did not serve youth as well as adults, or did not meet program requirements specified in Section 1947(b) of the American Rescue Plan. States with existing mobile crisis services were not asked to report the number of adult or youth units/teams in operation at the time of application.

States also spoke to mobile crisis unit capacity in case study interviews. For example, Washington noted that not all regions with an adult-serving mobile crisis team also had a youth-serving mobile crisis team. Additionally, an interviewee from Texas emphasized that assuming accessibility across all counties, the true need for mobile crisis units is probably lower than public expectation, given that much of the "work" in crisis de-escalation and resolution occurs during the conversation with a crisis call counselor.

Number of facilities offering mobile/off-site psychiatric crisis services. According to data from the 2020 N-MHSS, 21% of responding mental health facilities offered mobile/off-site psychiatric crisis services (***Exhibit 3***). The rate varied by type of facility; for example, 39% of community mental health centers reported offering mobile/off-site psychiatric crisis services as compared to 62% of certified community mental health centers and 16% of outpatient mental health facilities.

Mobile crisis workforce. In response to the 2022 NRI survey, 21 of 31 (68%) responding states reported problems hiring enough social workers and other credentialed behavioral health professionals to staff mobile crisis teams. Across case study states, there was concern about filling staff vacancies within the crisis services system, including on mobile crisis teams. Interviewees from Texas emphasized workforce challenges in rural areas. Washington interviewees also noted workforce staffing shortages, though they cited a focus on increasing the presence of peers to help mitigate challenges. Similarly, Oklahoma noted that the state's robust peer system has helped to insulate them from workforce challenges that other states may be feeling more acutely.

Exhibit 3. Behavioral Health Treatment Facilities that Offer Mobile/Off-Site Psychiatric Crisis Services		
Type of Mental Health Facility	**Total Number of Facilities**	**Percent of Facilities Offering Mobile/Off-Site Psychiatric Crisis Services**
Psychiatric hospitals	668	14%
General hospitals	967	9%
Residential treatment centers for children	592	5%
Residential treatment centers for adults	807	16%
Other types of residential treatment facilities	63	10%
Veteran Affairs medical centers	552	13%
Community mental health centers	2,548	39%
CCBHCs	336	62%
Partial hospital/day treatment facilities	429	10%
Outpatient mental health facilities	4941	16%
Multi-setting mental health facilities	369	21%
Other types of residential treatment facilities	3	100%
Source: 2020 N-MHSS Data.		

3.4 A Place to Go

The behavioral health crisis system is tasked with providing facilities that can meet the needs of individuals in different crisis acuity levels and medical/psychiatric/substance use/psychosocial needs. Yet crisis stabilization can take many forms and have many names, depending on the state and their licensing structure, and can include 24-hour observation units, subacute care units, living rooms, sober centers, crisis residential, urgent care centers, urgent recovery centers (URCs), crisis stabilization centers, respites, emergency departments, sober centers, and crisis diversion centers. Additionally, providers (e.g., community mental health center staff, individual therapists and physicians) have skills and training to stabilize individuals in crisis. Peers with lived experience can also positively contribute to crisis stabilization. *The lack of clarity of what constitutes a crisis stabilization unit and what acuity levels each type can treat makes it challenging to determine whether there is enough capacity to meet the need*.

Emergency department capacity. Historically, the capacity of acute care hospital emergency departments to treat individuals in behavioral health crisis was a key statistic tracked by states. According to the Centers for Disease Control and Prevention (CDC) National Hospital Ambulatory Medical Care Survey (NHAMCS), in 2017-2019, the emergency department visit rate for patients with behavioral health disorders was 52.9 per 1,000 adults (Santo et al., 2021). According to analysis of the Healthcare Cost and Utilization

Project data, in 2018 about 15% of the 143 million emergency department visits were for treatment of a behavioral health disorder (Santo et al., 2021).

Emergency department wait time has been used by some states and researchers as a metric of emergency department capacity to treat behavioral health emergencies. For example, the NHAMCS data showed that between 2005 and 2015, the percentage of children in the emergency department for more than 6 hours increased from 16.4% to 24.6% (Nash et al., 2021). The CDC reported that from 2017-2019, the percentage of emergency department visits lasting 4 hours or longer was higher among visits by adults with behavioral health disorders than visits by adults without behavioral health disorders. These statistics, albeit dated, suggest that there is not enough emergency department capacity to treat individuals experiencing behavioral health crisis, or that alternatives to emergency departments for individuals experiencing behavioral health crisis may not have been employed enough to prevent prolonged emergency department stays.

The NHAMCS provides a national snapshot of emergency department wait time but cannot track emergency department wait times regionally. Some states collect emergency department wait time as part of their emergency department discharge data that they submit to Agency for Healthcare Research and Quality. According to case study interviewees, New Jersey's county-level Systems Review Committees compile and track data on a variety of crisis-related metrics, including the number of individuals waiting in emergency departments for more than 24 hours. Additional quarterly reports from screening centers contain data on admissions, dispositions, number of crisis telephone contacts, recidivism, and medication follow-up contacts. Representatives from Texas also mentioned having an emphasis on reducing waitlists for inpatient beds, as well as an "Eliminate the Wait" campaign (Texas Judicial Commission on Mental Health & Texas Health and Human Services Commission, 2021) focused on reducing wait time for people in county jails to receive inpatient behavioral health services.

Case Study Innovations: Behavioral Health Crisis Centers

Since 2021, Missouri has focused on expanding its BHCC to better serve those in need of services. All BHCC are part of, or partnered with, a CCBHO, which in turn are financed by a CCBHO Medicaid state plan amendment. Some crisis centers are available 24/7 and others are available 12 hours per day. Missouri anticipates that the expansion will offer more options for law enforcement, emergency departments, and circuit courts when responding to individuals and families in crisis.

Number and reach of mental health facilities offering CITs and psychiatric emergency walk-in services. The N-MHSS collected data on whether facilities offered "a crisis intervention team that handles acute mental health issues at this facility and/or off-site." In 2020, 47% of facilities reported offering a CIT. It should be noted that facilities that *only* provided crisis intervention services were excluded from these data. According to the N-MHSS, psychiatric emergency walk-in services were offered by 32% of all mental health

treatment facilities, ranging from 26% of facilities in the Northeast to 42% in the South (SAMHSA, 2021).

Number of beds available in hospitals and residential facilities. The N-MHSS collected information on the number of residential facilities, psychiatric hospitals, and psychiatric units of general hospitals. The 2020 N-MHSS data indicated that there were 85,948 hospital beds and 46,828 residential facilities designated for mental health treatment. Hospitals were using 90% of designated beds, on average, and residential facilities were using 93% of designated beds. According to the N-MHSS, 16% of the 12,275 mental health responding facilities in 2020 reported that they used their electronic health record to update availability of beds. The percentage reported varied widely by state (from 40% of facilities in a state to less than 10%). Each of the states selected for case study interviews prioritized reducing reliance on emergency departments as part of their efforts to enhance their crisis services system. States worked to support networks of non-hospital, crisis stabilization alternatives, such as URCs in Oklahoma, Behavioral Health Crisis Centers (BHCC) in Missouri, and Early Intervention Support Services (EISS) in New Jersey. In Missouri, Department of Mental Health representatives noted that in towns where a BHCC was located, emergency departments observed a reduction in their intake numbers. Likewise, according to representatives from New Jersey, in counties where EISS have been operational, data show they have been effective, warranting expansion statewide. Providing access to alternatives to emergency departments was not, however, sufficient to divert individuals; states also had to support referrals to these other, non-hospital crisis facilities.

Number of people receiving crisis outpatient and residential services. *Federal data systems also do not track the number of individuals receiving outpatient and residential crisis services as distinct from outpatient and residential health care services in general*. Some of the states that we interviewed reported that they were planning to collect this information for their own purposes. For example, the 2019 Texas Legislative budget board required that the state report on metrics including the number of persons receiving crisis outpatient and crisis residential services and the number of behavioral health consumers served in behavioral health community hospitals per year.

3.5 Limitations

It is important to note that these capacity and access metrics do not capture the outcomes and impact of the services provided. In theory, the more quickly and effectively the behavioral health system can treat individuals, the less the capacity needed. For example, if more people receive sufficient and appropriate intervention during the crisis phone call, there may be less need for dispatch of a mobile crisis team, and even less need for transportation to a crisis stabilization unit. Research indicates that a follow-up call after the initial crisis call can help reduce further crises (Vibrant Emotional Health, 2021). As such, providing more resources for follow-up calls may reduce the level of resources needed

for crisis stabilization. Unfortunately, most state systems are not able to track episodes of care beyond crisis resolution and therefore cannot determine what upstream actions reduce the need for downstream services.

4. States' Plans to Improve Availability and Accessibility of Behavioral Health Crisis Response Systems

Next, we describe states' plans to improve the availability and accessibility of their behavioral health crisis response services in wake of the recent implementation of 988. We also address whether these planned activities will fill the identified gaps in the current capacity of the behavioral health crisis system. Data sources for this section include the MHBG applications, the CMS Planning Grants for Qualifying Community-Based Mobile Crisis Intervention Services applications, and case study interviews.

4.1 Plans to Improve Data Collection Processes

Moving forward, states will be required to collect data under the terms of MHBG funding, including a uniform data collection tool (to be provided by SAMHSA), and submission of monthly data on key performance metrics (e.g., number of calls, chats, texts received and answered, average speed to answer, abandonment rate, direct/rollover calls to backup centers, and mobile crisis outreach referrals). Plans are currently being made for the 988 Suicide & Crisis Lifeline administrator to implement a unified data collection platform to support more standardized data collection. Additionally, 988 state and territory grantees will be providing data on infrastructure and capacity development. In funding applications and case study calls, states also reported plans to improve their data collection and reporting systems by tracking encounter data beyond the immediate crisis episode. Indeed, case study interviewees from all five states described intentions or plans to develop hospital and residential bed registries to track the availability of beds and to help find an open bed for individuals in crisis (Hepburn, 2021b).

A case study interviewee from one Texas local mental health authority stated that although encounter and outcome data from an initial crisis call through follow-up outpatient care was likely available, they had not been able to begin to analyze these data because staff effort was entirely directed toward immediate system needs. Washington passed legislation in 2021 (H.B. 1477) that requires the state to develop a behavioral health integrated client referral system capable of providing system coordination information to crisis call center hubs and other entities involved in behavioral health care. The system must enable a means to track the outcome of the 988 call such as services dispatched and whether the caller was able to transition to appropriate post-crisis follow-up care.

Missouri is in the process of implementing a centralized data system, known as MOConnect, that will act as a tool for tracking call, text, and chat data, dispatching mobile crisis units statewide, referring callers to resources and, potentially, for tracking individuals' movements through the crisis system and their outcomes. The state is also developing a

protocol and plans to use the MOConnect system to facilitate follow-up with individuals who receive mobile crisis or crisis stabilization services. Case study interviewees from New Jersey reported that, while the state continues to collect monthly and quarterly reports from providers on a variety of metrics, they are transitioning to a web-based application for data collection. The state has funding for and is exploring the idea of hiring a vendor to develop a system to consolidate data collection from all elements of the crisis response continuum. This consolidated system will facilitate more effective referrals throughout the entire behavioral health system and may include a public-facing portal. Oklahoma is developing a data dashboard to provide multiple metrics in real time to providers, including call status and mobile crisis team location and dispatch.

4.2 Plans to Improve the Overall Crisis Services Continuum

Data extraction of MHBG applications included identifying states' proposed/planned activities utilizing the 5% set-aside funds. In roughly one-third of state applications, the described activities spanned the crisis continuum, either building on existing efforts in each of the three core elements, or in some cases, adopting model that better reflected SAMHSA's (2020) National Guidelines for Behavioral Health Crisis Care. Other states planned to prioritize funds to develop or enhance one specific element of their crisis system; call centers and mobile crisis services were often highlighted in these cases (e.g., expanding staffing at call centers in advance of 988; establishing a new mobile crisis team in a rural area). Crisis facilities were cited alone or in tandem with one or both other core elements in fewer than half of the responses to the 5% set-aside, despite **a place to go** generally being the "least" developed crisis element according to states' self-reported stages of implementation. In some instances, states identified additional crisis system-related goals or priorities in the larger context of their application (e.g., obtaining additional funding streams to support crisis service implementation, adding 24/7 texting services to the crisis line).

Across the five states selected for case studies, efforts to recruit and retain a crisis response workforce were paramount. Texas interviewees, for example, cited the tension between building out their crisis services continuum with finite staff. They expressed appreciation for the balance between provider caseload and patient waitlists, and suggested strategies for retaining skilled providers (e.g., incentivizing retention by offering quicker loan forgiveness if a provider commits to working in the system a predetermined number of years). To help address workforce needs, several states were exploring potential changes to education and credentialing requirements for behavioral health professionals. Washington State interviewees noted that incorporating peers with lived experience was helpful, but not sufficient, toward addressing workforce shortages. New Jersey similarly considered peers to be an integral part of the entire crisis services continuum, both as employees and as consultants with an important perspective of how the system will serve its consumers.

4.3 Someone to Call

In the case studies, states with low in-state answer rates said that they were focused on improving the rates or had already taken steps to improve them. Sometimes, these efforts were call center-specific, in that many call centers had satisfactory in-state call answer rates, but one or a few other call centers had lower rates that resulted in an overall state average below the desired level. States also described ongoing efforts to evaluate how to integrate 988 centers with other call centers to facilitate maximum access to crisis tele-counseling. For example, case study interviewees from Missouri planned to provide system-wide training for all call centers, affiliated with 988 or not. States are also working to expand their 988 text and chat capabilities; in Missouri, representatives noted during the case study interviews that their goal was to activate text and chat by September 2022. Case study interviewees also discussed plans to better integrate **someone to call** services with additional care. Representatives from Oklahoma described plans to allow for call centers to link callers to services and immediately schedule appointments with local treatment providers. Case study interviewees in Washington State also noted that a memorandum of understanding with Vibrant to establish a 988 dial pad option for the Native and Strong Lifeline, to serve American Indian and Alaska Native callers, was imminent.

Another area for planned improvements is how to make **someone to call** services salient and matched to the lived experiences of certain populations, such as LGBTQIA+ callers, American Indian and Alaska Native callers, and callers with co-occurring mental health and substance use disorders. Washington State case study interviewees, for example, noted the importance of ensuring that American Indian and Alaska Native callers could speak with a tele-counselor who understood their culture, even if the caller and tele-counselor were not members of the same tribe. Such culturally appropriate **someone to call** service is possible through the Native and Strong Lifeline, designed specifically to serve American Indian and Alaska Natives (similar to how the NSPL's Veterans Crisis Line serves Veterans and Service members and the NSPL's Spanish Language Line serves Spanish speakers).[4] Interviewees noted it was also important to ensure that the Native and Strong Lifeline was staffed with tele-counselors from all four regions of the state, given the regional cultural differences and relevant cultural resources of which only regional tele-counselors might be aware. Case study interviewees from New Jersey described "REACH NJ," which serves state residents seeking substance use disorder services, and a peer recovery hotline, which may not be folded into 988. That said, New Jersey interviewees stated a goal to have all 988-affiliated call centers also be part of the New Jersey Division of Mental Health and Addiction Services to facilitate coordination of services.

[4] See https://doh.wa.gov/newsroom/988-suicide-and-crisis-lifeline-launches.

Finally, states are considering ways to increase the access and availability of **someone to call** services by leveraging innovative technologies. Interviewees from Washington State commented that their state is prepared to begin conversations about possibly incorporating geolocation into call centers, but that they have not yet done so due to lack of guidance from the Federal Government. Missouri is also discussing the implications of geolocation, including the potential technology needed to support it. At the same time, an interviewee from Texas noted that national discussions about geolocation should be more specific, as geolocation could be used to both identify the caller's location to route the call to the appropriate call center or else to dispatch a mobile crisis team or law enforcement officer to the caller's location (even if this is against the caller's wishes).

4.4 Someone to Respond

In their applications for the CMS Planning Grants for Qualifying Community-Based Mobile Crisis Intervention Services, states described planned uses of funds to explore, develop, or improve relevant and potentially impactful aspects of their mobile crisis intervention services, such as integrating innovative technologies (e.g., telehealth, geolocation) or enhancing provider skills in delivering mobile crisis intervention services appropriate to people from all backgrounds and identities (e.g., LGBTQIA+ populations). All applications identified a long-term aim to develop a mobile crisis response system that met the requirements specified in Section 1947(b) of the American Rescue Plan. Less commonly described in the applications were plans to explore, develop, or improve performance dashboards or bed registries, or to enhance provider skills in working with tribal or military veteran populations. Taken together, the CMS planning grant applications underscored states' perceived need and merit of building up their technological capabilities and addressing behavioral health equity.

Representatives from case study states elaborated on their plans for mobile crisis services during the interviews. New Jersey interviewees shared that dispatch will mostly be handled by 988 call centers, who will have access to a newly developed decision tree to help them route calls to the appropriate resource. When mobile crisis response is needed, individuals will engage with a mobile crisis team comprised of a peer and a behavioral health professional. Texas interviewees noted they were considering developing specialty youth-serving mobile crisis teams, building on their success developing specialized mobile crisis teams serving individuals with opioid use disorder. They also discussed barriers around reimbursement for mobile crisis services provided to residents with private insurance, and are considering ways to better collect insurance information while still prioritizing timely, high-quality service delivery to the individual in crisis. Washington State case study interviewees raised the issue of safely transporting individuals in crisis to care facilities, noting that transportation in an ambulance or police car can be traumatizing or stigmatizing to the individual in crisis. They are currently working to identify solutions so

that mobile crisis teams and designated crisis responders can safely transport individuals to higher levels of care if mobile crisis intervention services are not sufficient to resolve the crisis. Missouri designated funding in 2021 to dramatically expand its Community Behavioral Health Liaisons (CBHLs) network. CBHLs, employed by Certified Community Behavioral Health Organizations (CCBHOs) and substance use disorder agencies statewide, are dedicated to law enforcement and the court system and are available to connect individuals in crisis to resources and provide case management.

As states continue to build out and enhance their crisis services continuum, some of those we interviewed were working with providers to rethink how mobile crisis services were being delivered. In Missouri and New Jersey, where new, statewide mobile crisis response systems are being stood up, state agencies are taking steps, such as developing and delivering training for teams, to ensure mobile crisis teams respond to individuals in the community where crises are occurring. For both states, an important objective of their new mobile crisis systems is to eliminate the need for individuals who are in crisis to travel to meet crisis teams at another location, like a hospital-based screening center. Both states emphasized consistency and safety as important considerations in mobile crisis planning. In Oklahoma, where there was resistance among some providers to treating crises in the community, case study interviewees described how they are resetting expectations around mobile crisis response. Using a recently released request for proposals that specified requirements for mobile crisis providers and providing training on what mobile response should look like, they aim to facilitate a "mindset change" to ensure a consistent, community-based mobile crisis response.

Case Study Innovations: Early Intervention

New Jersey's EISS are similar to psychiatric urgent care, available 7 days a week. EISS is currently active in 11 counties, with recently contracted providers in various stages of implementation in the state's remaining 10 counties. EISS programs are intended for people who are in crisis but do not need inpatient care. Anyone can access the service, regardless of insurance. The programs are a community-based approach to connect individuals to integrated care and to divert behavioral health crises from the emergency room. The expansion of this program represents a significant addition to the state's **a place to go** services and continues the state's movement toward providing more non-hospital alternatives for people seeking behavioral health care.

States also described working on better coordinating 988 and 911. In interviews, four of the five states discussed their efforts to coordinate 988 and 911 and the impact the introduction of 988 may have on 911. Texas is one state where there are well-documented efforts to coordinate 988 and 911. The Harris County local mental health authority (the Harris Center) partnered with the Houston Police Department, Houston Fire Department, and Houston Emergency Center to co-locate trained tele-counselors in 911 call centers. Despite the successes of the program (i.e., millions of dollars saved), case study interviewees noted that not all stakeholders in Harris County are aware of the crisis call

diversion program or fully appreciated the program's value add to the county. Accordingly, efforts are underway to increase awareness and accurate knowledge of this program to increase its utilization and impact. In Missouri and New Jersey, representatives from the states' behavioral health divisions are working closely with partners within the 911 dispatch system to develop protocols for warm hand-offs. In Oklahoma, officials have considered different options for integrating the two services, including embedding staff trained on mobile response processes within 911 and coordinating the transfer of calls from 911 agencies throughout the state to 988 as needed. Despite lacking tools to resolve crises such as suicidality or anxiety, Oklahoma interviewees noted that, historically, 911 dispatched firefighters, police, or emergency medical technicians (EMTs) to 90% of behavioral health crisis calls. The Oklahoma Department of Mental Health and Substance Abuse Services has contracted with a vendor (Solari Crisis and Human Services), to address multiple aspects of their crisis services system. One such activity is to implement a decision tree to help 911 dispatch the appropriate resources by asking the caller, "Are you looking for law enforcement or would you prefer to talk to a behavioral health counselor?" In Solari's experience, people elect to talk to a counselor in most instances.

4.5 A Place to Go

Case study interviews yielded additional information about short-term plans to improve the accessibility and availability of **a place to go** crisis services. Oklahoma's plans for crisis expansion builds off its CCBHCs. Oklahoma has a Medicaid state plan amendment which turned all its community mental health centers into CCBHCs. The amendment allows Oklahoma to reimburse CCBHCs using a per person prospective payment system that is based on historic costs. This allows Oklahoma the flexibility to finance crisis capacity by increasing the CCBHC base rate. Oklahoma requires that community mental health centers have crisis services available 24/7/365 and delivered within 1 hour from the time the services are requested. They must also make available either directly, or through an agreement, facility-based crisis stabilization, URC, and outpatient substance withdrawal management (Oklahoma Department of Mental Health and Substance Abuse, 2020).

New Jersey recently conducted analysis of data from multiple sources and determined that there was a significant need for additional crisis receiving and stabilization services to complement the more than 20 diversion-focused, community programs funded by the state. In addition to the EISS program, New Jersey is planning to introduce integrated crisis receiving and stabilization centers that will leverage funds from various sources including the MHBG. The plan for implementing these centers closely follows the SAMHSA National Guidelines and Best Practice Toolkit.

Case study interviewees from Washington State also described goals related to expanding **a place to go** services. For example, they are considering adding a 23-hour crisis stabilization facility in Eastern Washington to increase service access for residents

living in rural areas. There are also ongoing efforts to expand crisis care teams to include peers with lived experiences. Other plans in Washington include developing a behavioral health aide training program (in coordination with Oregon and Idaho) to develop a workforce of providers already versed in a tribe's culture, working to facilitate tribally operated behavioral health inpatient facilities, and doing what they can to support tribes building up their own behavioral health crisis systems within their reservations.

4.6 Limitations

There are several limitations to the reviewed information on states' plans that should be considered. First, states' plans to improve the availability and accessibility of their crisis services are inconsistently reported, especially across the MHBG and CMS planning grant applications. Given the nature of these applications, states could approach their description of plans in any number of ways. For example, although the CMS planning grant application instructions required that all states "provide a work plan describing [their] goals, measurable objectives, activities, and milestones under the planning grant," there were no parameters related to the required number of proposed goals, objectives, activities, or milestones; required level of detail describing each of these four required elements; minimum or maximum length of text describing each of these elements, so long as the overall application page limits were observed; or presentation format (e.g., table versus narrative text). Moreover, absence of described plans is not sufficient to identify the gaps in a state's crisis services system. For example, it is possible that some states did not describe certain uses of CMS planning grant funds because those elements already existed in the system or because the state had secured alternative funding to support those improvements to the system. For the purposes of CMS planning grant and MHBG applications, states typically focused on identifying the discrete use of funds within each core element of the crisis services continuum--or spoke to them collectively--offering a useful but incomplete picture of where each state was headed. Finally, developments within

Case Study Innovations: Tribal Behavioral Health

The Washington Indian Behavioral Health HUB ("the HUB") was developed in partnership with the Washington State Health Care Authority, Washington State Department of Health, Tribal Centric Behavioral Health Advisory Board, and American Indian Health Commission. The HUB performs numerous functions, including helping individuals in crisis identify open treatment beds, coordinating care after individuals have been discharged from a facility (e.g., emergency department, psychiatric hospital), and connecting individuals to post-crisis outpatient care in the community with culturally competent providers.

Case study interviewees reported plans to "re-launch" the HUB in the context of 988, including offering both tribal and non-tribal behavioral health resources to an even wider audience, training non-tribal providers in culturally competent care, and following up to ensure that individuals received the services they needed and had a positive experience with both the HUB staff and any non-tribal providers the HUB referred them to.

the United States behavioral health crisis system are quickly unfolding, and states' progress toward improving the availability and accessibility of their crisis services continuum is likely to continue at a rapid pace.

4.7 Planned Activities in Relation to Identified Gaps in the Current System

These limitations notwithstanding, states' planned activities represent promising steps toward filling the identified gaps in the current capacity of the behavioral health crisis system. Increasing in-state answer rates is a straightforward way to improve availability of **someone to call** services. Improving linkages between 911 and 988, such as expanding crisis call diversion programs and facilitating warm hand-offs to behavioral health specialists, will also help individuals in crisis receive the most appropriate form of care. However, with no national data about the performance of non-988 call centers, it is unclear how states' ongoing and planned efforts to improve their systems will affect the entire **someone to call** element of the United States' crisis services continuum.

Several planned activities to improve mobile crisis intervention services will fill the outstanding gaps in **someone to respond** services. Specifically, developing mobile crisis units that satisfy the requirements specified in Section 1947(b) of the American Rescue Plan to serve all state residents would address most of the limitations to this element of the crisis services continuum. Incorporating peers and implementing other creative solutions to workforce challenges will help, but sufficient staffing remains an issue. Though in early stages, efforts to develop youth-serving mobile crisis teams and ensure timely deployment of mobile crisis teams to people in rural or other difficult-to-reach areas could have a major impact on the crisis system and lived experiences of people in crisis.

Many states are working to stand up crisis receiving and stabilization centers, respite centers, and other facilities to provide options for **a place to go** other than a hospital emergency department. At the same time, representatives from multiple states selected for the case studies highlighted the need for a "culture shift" to increase diversion and appropriate use of crisis services. Rather than building places to go and expecting people in crisis to come, significant effort is needed to engage stakeholders such as key federal agencies (e.g., SAMHSA, CMS), law enforcement, behavioral health care providers and peers, consumers, and payers. Indeed, case study interviewees identified that part of the challenge is ensuring all stakeholders are aware of the available alternatives to emergency department care but view the implementation of 988 as a catalyst for increasing knowledge about, support for, and utilization of crisis stabilization services. Accordingly, legislative support, community engagement, awareness of available services, and representation of peers within the workforce may be especially helpful strategies for making sustainable improvements to the current gaps in this crisis system element.

5. DATA COLLECTION IMPROVEMENTS

In general, national data sources yield a repository of information pertaining to current availability and accessibility of states' behavioral health crisis systems. However, these findings also underscore existing gaps in data collection which preclude a deeper understanding of behavioral health crisis service capacity nationwide. First, available metrics may not adequately capture the construct in question. For example, the statistics associated with NSPL call centers do not always present a full picture of *all* crisis call lines in a state, as many states have locally based call centers that are not affiliated with NSPL. Second, many metrics on availability and accessibility are inconsistently measured and/or reported across states. MHBG applications typically included additional information regarding current implementation of their crisis response system. However, states differed widely in the extent and type of information that they included to describe each of the core elements, preventing direct comparisons across states. Moreover, these data do not necessarily represent the metrics typically used by the state to capture availability and accessibility.

In this section, we discuss data collection efforts that could be established or augmented to better understand availability and accessibility of behavioral health crisis response services.

Understanding Population-Level Need, Unmet Need, and Services Received for a Behavioral Health Crisis Using the SAMHSA National Survey of Drug Use and Health (NSDUH). SAMHSA could leverage the NSDUH to determine national and state-level treatment need and unmet need for crisis services, as it does for behavioral health disorder treatment, in general. For example, for those who report experiencing a behavioral health crisis in the past year, the survey could ask follow-up questions such as, "did you have someone to talk to at the time of your crisis? If so, who was it, how long did it take to reach them, did they follow-up with you, did they connect you with treatment, and did you feel that they were helpful?"

Determining Providers' Ability to Treat Individuals in Crisis Using the SAMHSA N-SUMHSS. N-SUMHSS is a survey of all behavioral health treatment facilities, sponsored by SAMHSA. The N-SUMHSS is intended to provide information about the number and characteristics of public and private substance use and mental health treatment facilities nationwide. SAMHSA could add questions to the N-SUMHSS that ask about facilities' ability their ability to treat clients who are experiencing a behavioral health crisis, such as the availability of providers 24/7 to speak with people in crisis and the ability to see walk-in patients 24/7. SAMHSA could add questions to the N-SUMHSS to query inpatient and residential facilities about their average occupancy rate, how often they are full and unable to accommodate new admissions, and whether they are able to quickly find patients in crisis an alternative inpatient placement when they are full. In addition, our

understanding is that the N-SUMHSS excludes facilities that only provide crisis intervention services. SAMHSA could consider expanding the sampling frame to add these services.

Assessing Call Center and Mobile Crisis Capacity Through State Behavioral Health Agency Surveys. The Federal Government could conduct a survey of state behavioral health agencies to develop a better understanding of each state's crisis system capacity. Questions could include: (1) the number of non-NSPL call centers and their call volume; and (2) the number of behavioral health mobile crisis teams and the number of individuals in crisis treated by those teams.

Reviewing State Regulations to Determine How States are Defining and Regulating Crisis Providers and Services. The new energy around crisis services has states establishing regulations to define new types of crisis facilities and refining regulations as to how existing centers, such as CCHBCs, respond to crises. States are also reconsidering education, training, and other licensure/certification requirements to increase the provider workforce able to serve individuals in crisis. It would be useful to understand this regulatory landscape in more detail.

Tracking Emergency Department Times Using Hospital Discharge Data. Most states collect discharge data from their hospital emergency departments. In many states, this data indicates the time of arrival and discharge from the emergency department. This data could be leveraged more systematically across time, regions, and states to identify lack of emergency department capacity and/or effective use of alternatives to emergency departments, as well as to determine whether crisis diversion programs are having an impact.

Calculating Crisis Systems' Follow-Up Capacity by Analyzing Electronic Data Registries and Linked Data. States that have data registries and have linked data across the crisis continuum (e.g., call centers, mobile crisis response, and crisis stabilization centers) could track the extent to which individuals are being followed up with after a crisis, the extent to which they received needed services, and the outcomes of their crisis. Lack of follow-up could indicate gaps in capacity. Lack of follow-up may also be indicative of a lack of timely information-sharing. For example, the overall bed capacity of a region may be adequate, but because providers cannot "see that capacity," they may not know which specific facility has an open bed at any one time.

Evaluating Use of Crisis Services Using Insurance Claims Data. To the extent that providers are billing for crisis services using a crisis-specific billing code, use of crisis services can be tracked in claims data. Examples of crisis billing codes include: H0030 *Behavioral Health Hotline Service*, H2011 *Crisis Intervention Service per 15 minutes*, S9484 *Crisis Intervention Mental Health Service Per Hour*.

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