Building a 21st Century Crisis System

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The goal

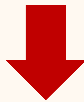
connections

Most communities in America…

911: WHAT'S YOUR EMERGENCY?

"I'm having chest pain."

"I'm suicidal."



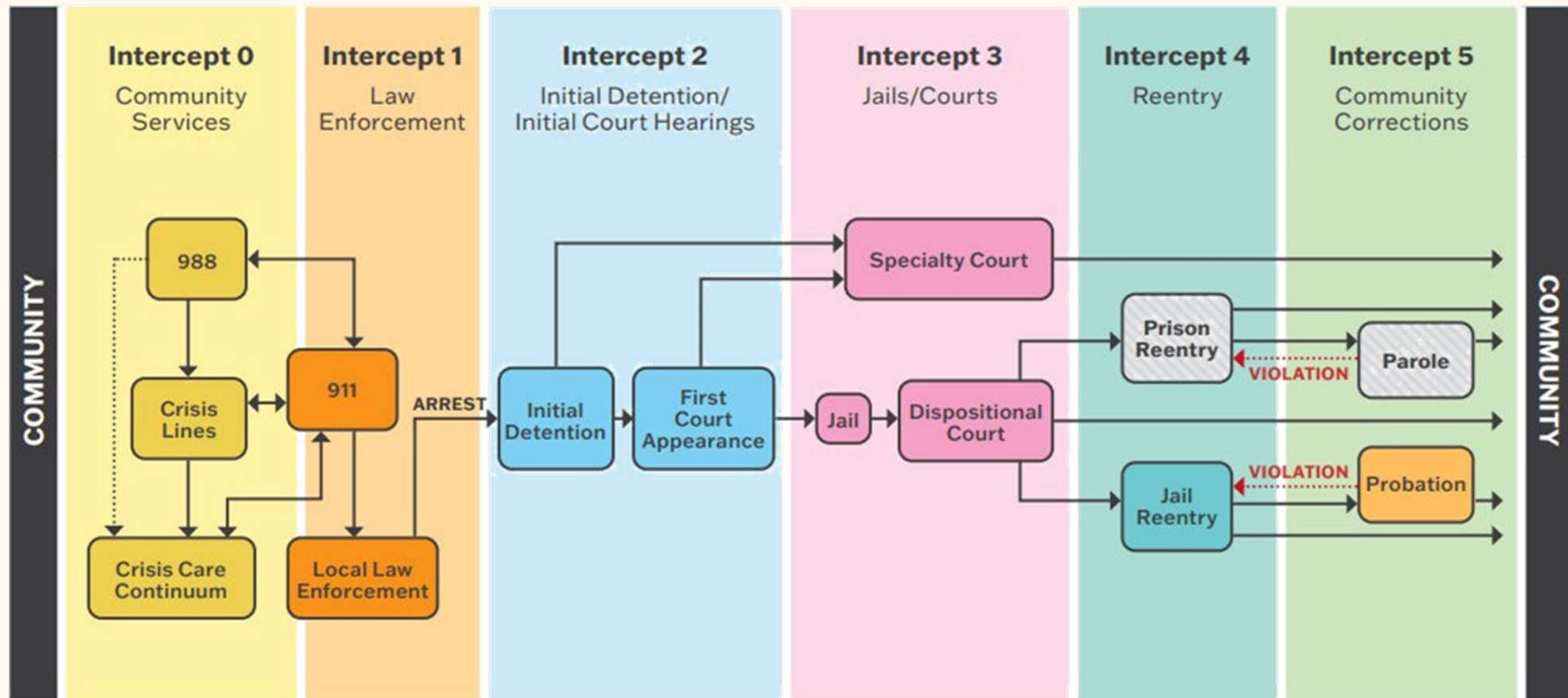
Every system is perfectly designed to get the results it gets.

- **Deadly encounters with police:** One quarter of police shooting deaths involve a person experiencing a behavioral health crisis.
- **Jails are the new asylums:** The prevalence of mental illness in our jails and prisons is 3-4 times that of the general population.
- **ED Boarding:** Over 50% of EDs report they have no psychiatric services available, so patients "board" for hours or days with little or no treatment while awaiting transfer to an outside facility.

Saleh AZ et al.(2018) Deaths of people with mental illness during interactions with law enforcement. *Int J Law Psychiatry* 2018;58:110–6
Steadman HJ et al. Prevalence of serious mental illness among jail inmates. *Psychiatric Services*. 2009;60(6):761-5.
Ellison AG et al. Specialty Psychiatric Services in US EDs and General Hospitals: Results From a Nationwide Survey. *Mayo Clinic Proceedings*. 2022;97(5):862-870

The Sequential Intercept Model

Intercepts 0 and 1 focus on *preventing police interactions & arrest*



Most communities in America…

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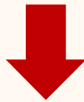
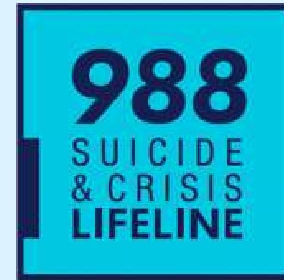
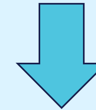


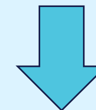
SAMHSA's Vision

"Someone to contact"



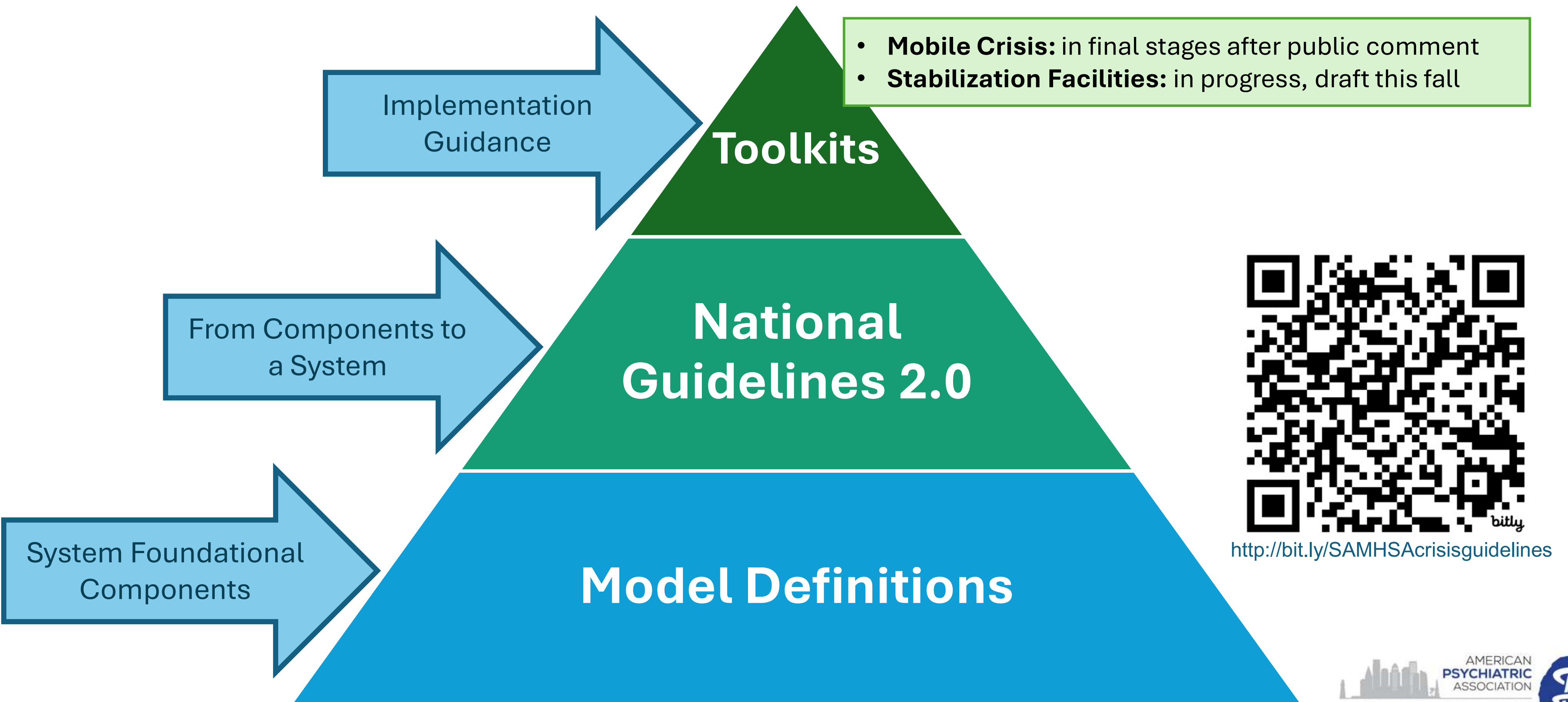


"Someone to respond"
(mobile crisis)

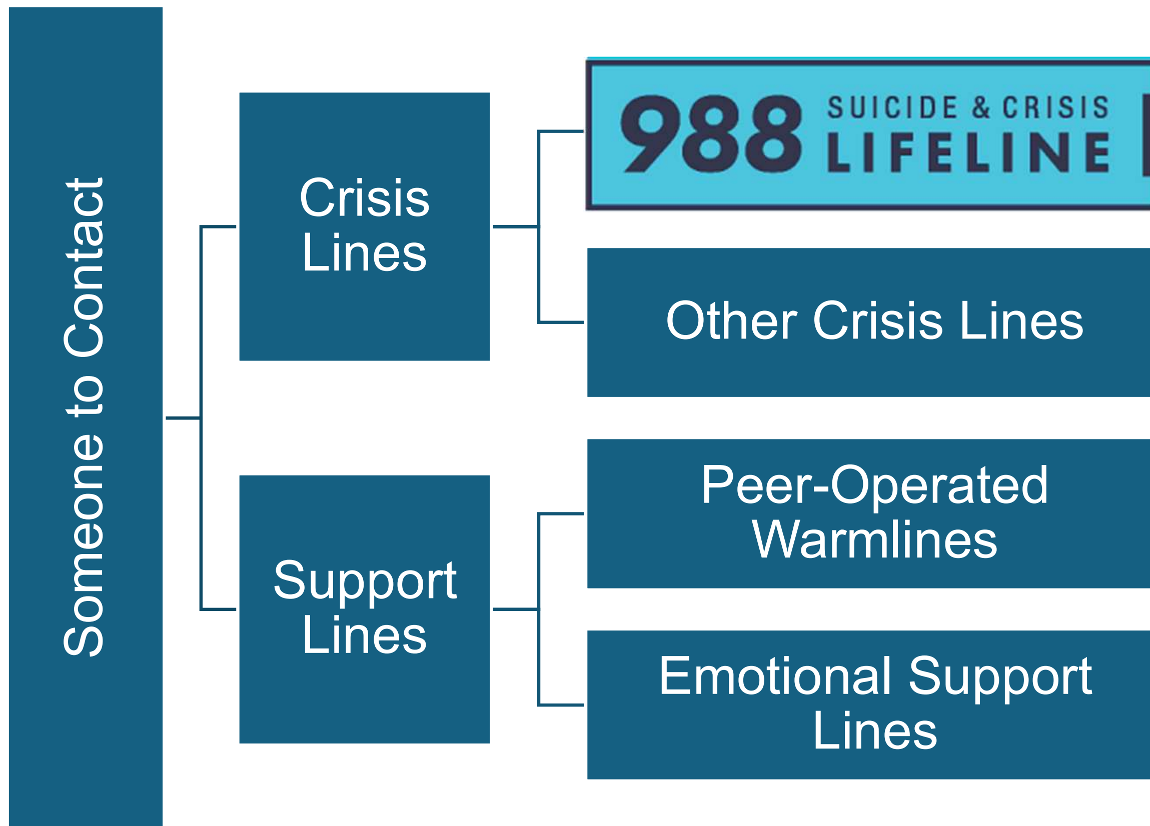


"A safe place for help"
(specialized facilities)

SAMHSA Crisis Guidance Under Development



SAMHSA Definitions: Someone to Contact



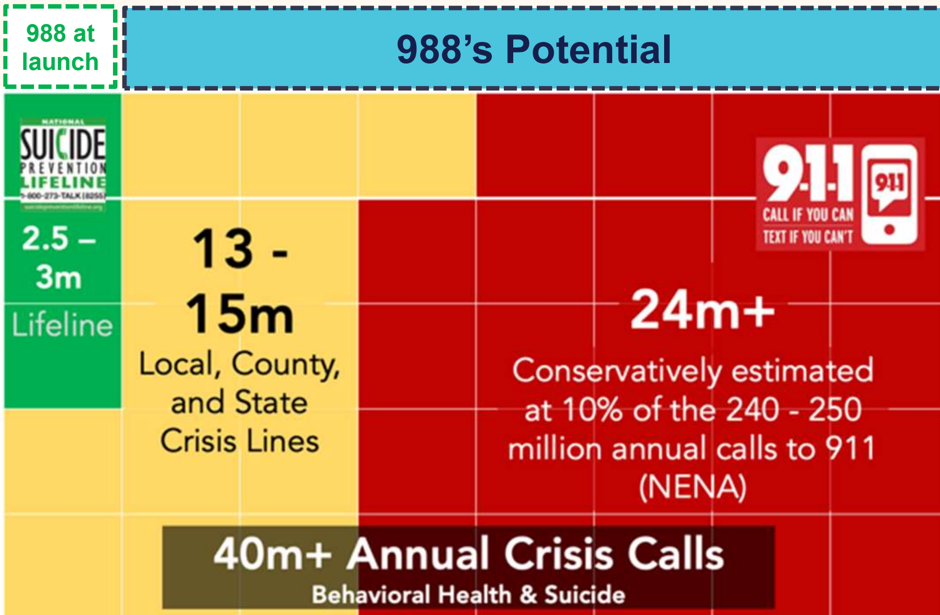
Key Discussions & Decisions

- Crisis Lines v. Support Lines
  - Ability to support/manage crises, stratify, mitigate risk
- Warmlines = Peer
- Emotional support lines provide similar services to warmlines, but are not predicated upon the peer relationship

What happens after the call?

CAPTURING ALL OF THE CRISIS CALLS

New **NENA Standard for 911-988 Interactions** released in 2025
www.nena.org



https://talk.crisisnow.com/wp-content/uploads/2021/04/01-Universe-of-potential-988-calls-2020-10-21.pdf

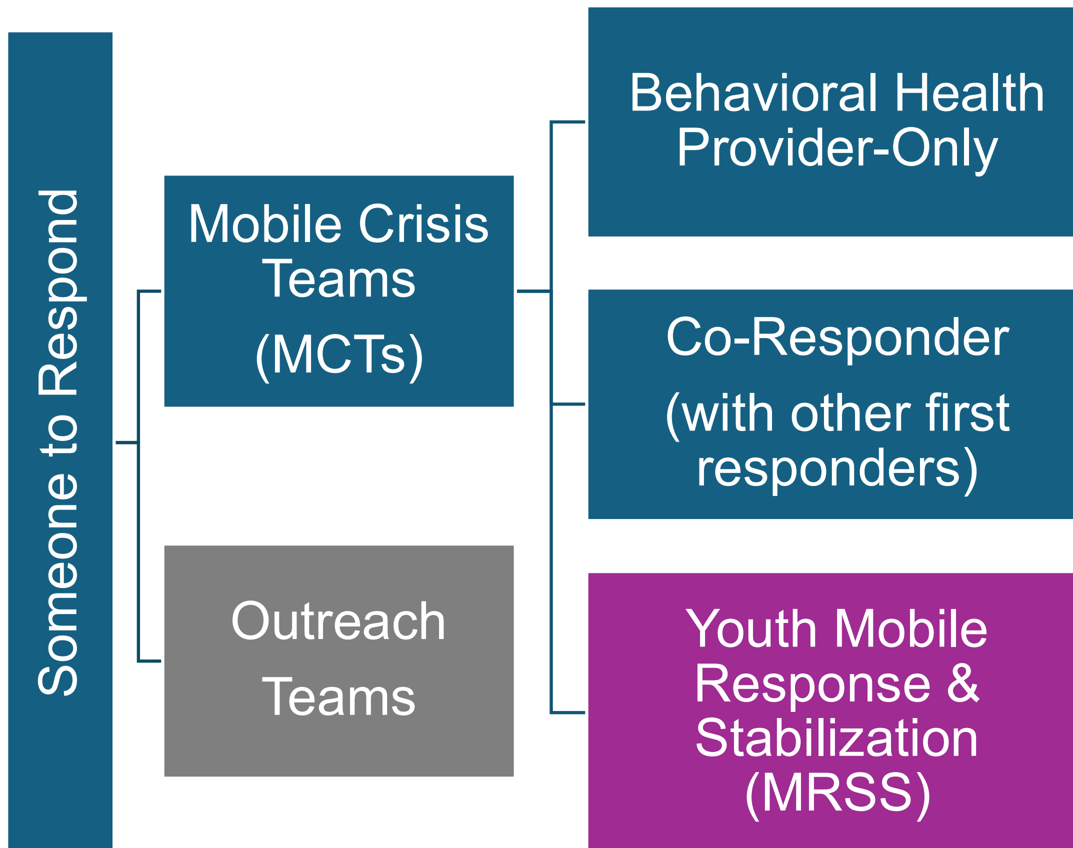
CONNECTING CALLERS TO A "HEALTH FIRST" RESPONSE

The more crisis services a community has, the less need to involve law enforcement.

Pew Survey	
% Indicating they had concerns about using 988 for the following reasons	
Law enforcement would be sent	41%
Would be forced to go to the hospital	40%
The call would not remain private and others might find out	37%
Would end up charged for services that they couldn't pay	36%
988 responders wouldn't be able to handle the issue I contacted them about	34%
Would end up in jail	23%

https://www.pewtrusts.org/en/research-and-analysis/articles/2023/05/23/most-us-adults-remain-unaware-of-988-suicide-and-crisis-lifeline

SAMHSA Definitions: Someone to Respond



Key Discussions & Decisions

- Distinct from "outreach teams" (violence interruption, homeless, veterans, etc.)
- Co-responder teams are MCTs
- Licensed/credentialed clinician engagement in the response (possibly via telehealth)
- Telehealth is an adjunct, but service must be "mobile"
- Rapid, on-demand aspect of the service
- Youth Mobile Response and Stabilization has a component of MCTs with an additional stabilization component

Choosing your mobile crisis model(s)

More research is needed to determine best practices and if/when one model is preferable to another. In the meantime, communities need to adapt to local needs, capabilities, & preferences.

BIG QUESTION: Role of Police

Studies show that clinician-only MCTs:

- Decrease hospitalization
- Decrease ED utilization
- Are cost effective

Outcome studies of police co-responder teams are mixed.

In qualitative studies:
Most people report they prefer clinician only or co-responder teams to police-only responses.

In particular, they value de-escalation and a compassionate and non-criminalizing approach.

When designing crisis systems:

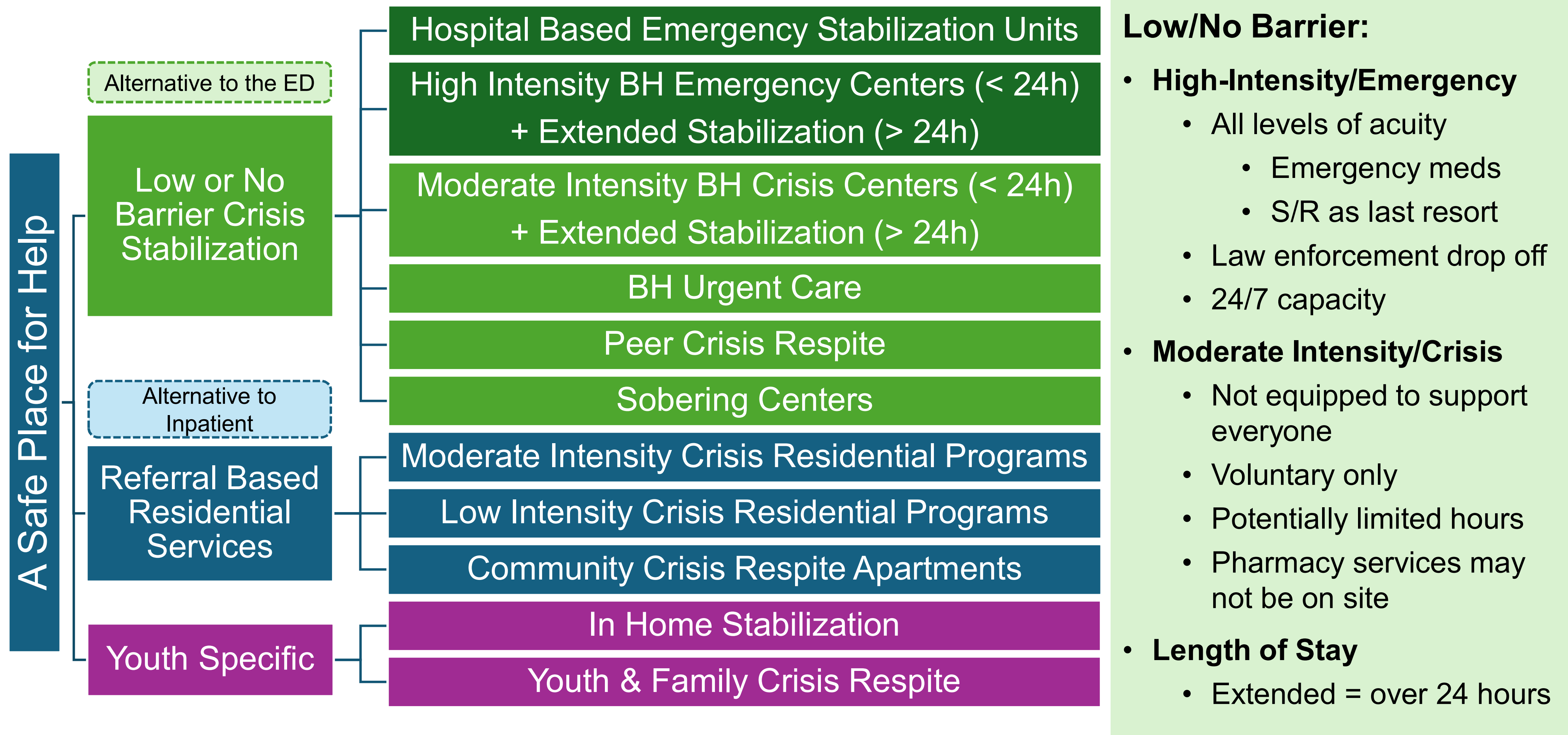
- Acknowledge the distrust of 911, police and healthcare systems in BIPOC communities
- ➢ **Employ a "Health First" approach**
  - **Civilian-led with clinicians and peers**
  - **Involve police only when necessary with clearly defined roles**
- Central role for peers in service delivery and design
- Workforce that reflects the community they serve

https://www.fountainhouse.org/reports/from-harm-to-health

https://www.vera.org/civilian-crisis-response-toolkit

For review see: Balfour ME, Hahn Stephenson A, Delaney-Brumsey A, Winsky J, & Goldman ML. Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. *Psychiatric Services*. 2022 Jun;73(6):658-669. https://doi.org/10.1176/appi.ps.202000721

SAMHSA Definitions: A Safe Place for Help

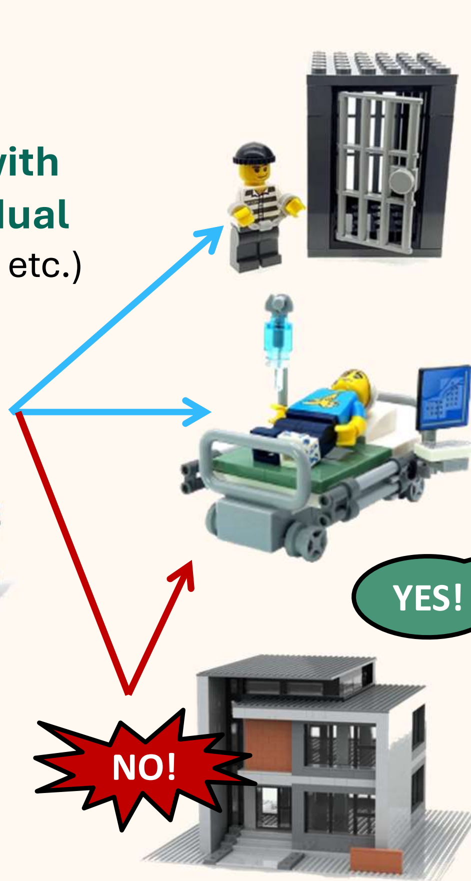


“No Wrong Door” aligns with Emergency Dept Culture

- Accept drop-offs from first-responders
- “You get who you get” vs choosing whether to accept or deny referrals
- Adapt to surges in volume or acuity
- Follows EMTALA principles
  - No one is turned away at the door
  - All comers are accepted and assessed
  - If they need a different level of care, the facility stabilizes and arranges transfer

The need for crisis facilities that can serve highly acute and involuntary individuals

First-responder with high acuity individual
(agitated, involuntary, etc.)



Arrest & Jail

- Incarcerated instead of needed treatment
- High cost / high recidivism / criminal record

Emergency Department

- Little to no treatment in a stressful environment
- Less than half have psychiatric services available
- Hours or days boarding waiting for transfer to an inpatient psychiatric hospital
- More likely to be arrested for assaulting staff or restrained

High Intensity Emergency Behavioral Health Centers Hospital Based BH Emergency Stabilization Units

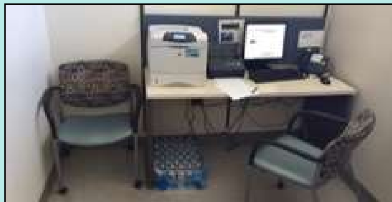
- Specialized treatment with a therapeutic milieu/space designed for this population
- Specialized staff including psychiatrists, social workers, peers (without security guards)
- Most can be stabilized and discharged to community
- Research shows 60% can be converted to voluntary and remain stable in the community

For review see: Balfour ME and Carson CA. Crisis Receiving and Stabilization Facilities: Designing Systems for High-Acuity Populations. *Psychiatric Clinics of North America*. 2024 Sep;47(3):511-30. https://doi.org/10.1016/j.psc.2024.04.022

Quick & Easy Access for 1st Responders (police, EMS, mobile crisis)
so that we're the preferred alternative to jail or the emergency room

Officers don't like:
- Waiting
- Being turned away
- Taking their guns off
- Parading people through the front lobby

Dedicated 1st responder entrance with secure sally port & workspace
Crisis Response Center - Tucson AZ



- Be easier to use than jail.
- Drop off time less than 10 min
- No prior ED "medical clearance"
- Never turn police away.
- Take everyone:
  - No such thing as "too agitated" or violent
  - Can be highly intoxicated
  - Involuntary or voluntary
  - Without using security guards

CIT Recommendations for Emergency Mental Health Receiving Facilities

1. Single Source of Entry
2. On Demand Access 24/7
3. **No Clinical Barriers to Care**
4. **Minimal Police Turnaround Time**
5. Wide Range of Disposition Options
6. Community Collaboration

High Intensity BH Emergency Center (23-hour obs)
Emergency BH treatment in a safe & therapeutic environment

The open design facilitates:

- **Safety**: Continuous observation
- **Therapeutic milieu**: Open area for therapeutic interactions with others
- **Flexibility**: Can accommodate surges in volume

Treatment starts with the assumption that the crisis can be resolved via:

- **Interdisciplinary Teamwork**
  - 24/7 psychiatric provider coverage (MD, NP, PAs)
  - Peers, nurses, techs, case managers
- **Early Intervention**
  - Door to doc time <90 min
  - Meds, detox/MAT
  - Peer support & groups
- **Proactive discharge planning**
  - Coordination with clinics, community resources & family supports

"Least Restrictive Care" means most people are

- discharged to community-based care
- converted to voluntary status

High Intensity BH Extended Stabilization: Continued stabilization in a seamless episode of care

- For individuals who need continued stabilization beyond 24 hours
- Bed-based unit similar to inpatient but with an emphasis on peer support and linkage to community supports
- Seamless episode of care: admitted from 23-hour obs, avoiding the inefficiencies of transfer to a second facility

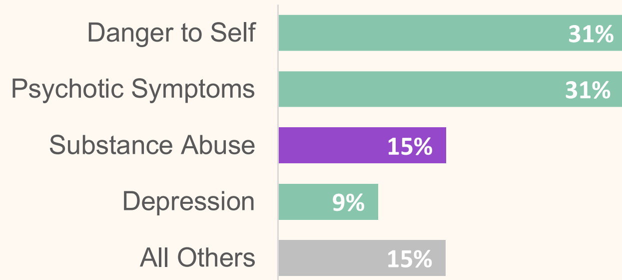
Many would have short stays on a traditional inpatient unit, for example:

- Individuals who are noticeably improving after 24 hours but are not yet stable for discharge
- Individuals who need more time to metabolize substances contributing to their psychiatric presentation

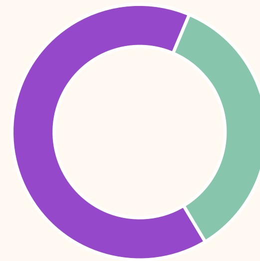
Crisis facilities should address both MH & SUD needs

15% of CRC adults present with **SUD as the primary concern,**

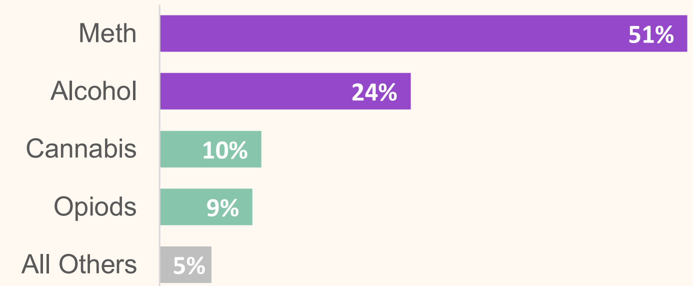
but…



65% have a **SUD diagnosis or positive toxicology results.**



Meth & alcohol account for **three quarters of SUD diagnoses.**

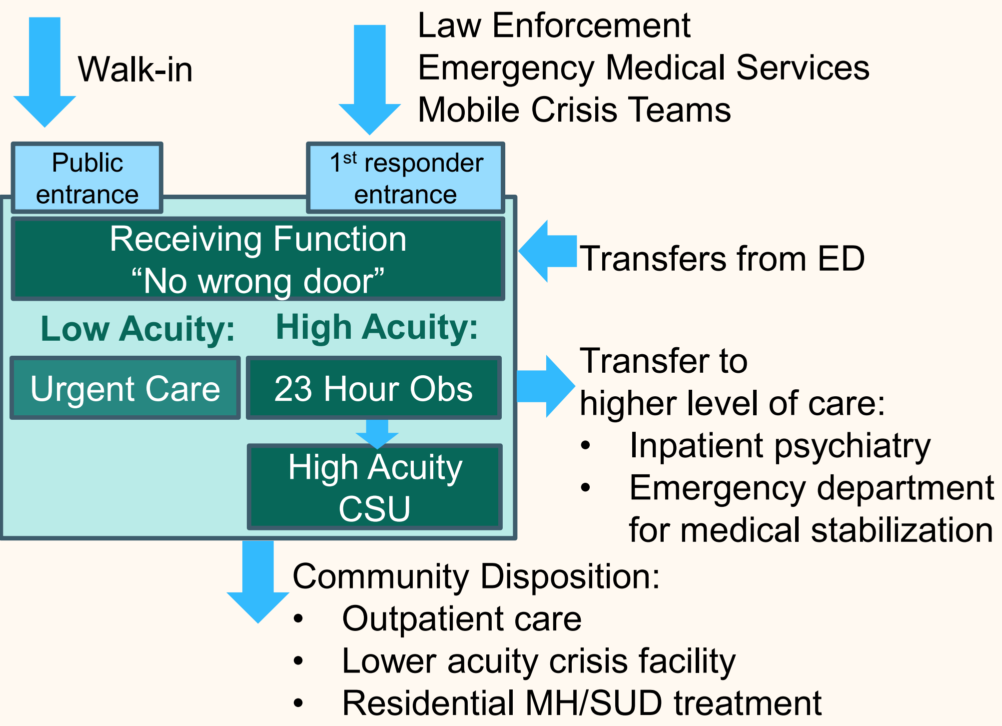


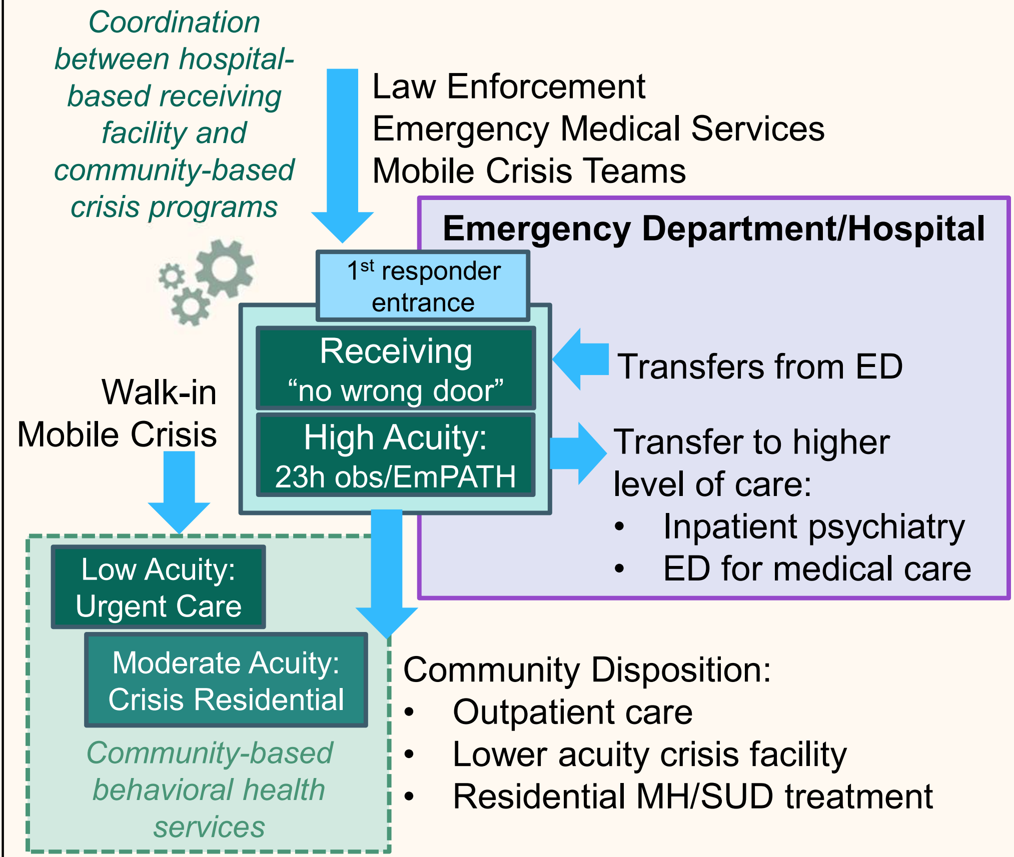
Crisis observation units provide

- Medically supervised detox
- Initiation of MAT
- SUD counseling & peer support
- Harm Reduction (e.g., Naloxone kits distributed at discharge)

Youth and SUDs

- **28%** of CRC youth obs patients have a SUD diagnosis or positive toxicology result.
- The most common diagnoses are **Cannabis** (66%) followed by **Alcohol** (12%) and **Opiates** (11%).





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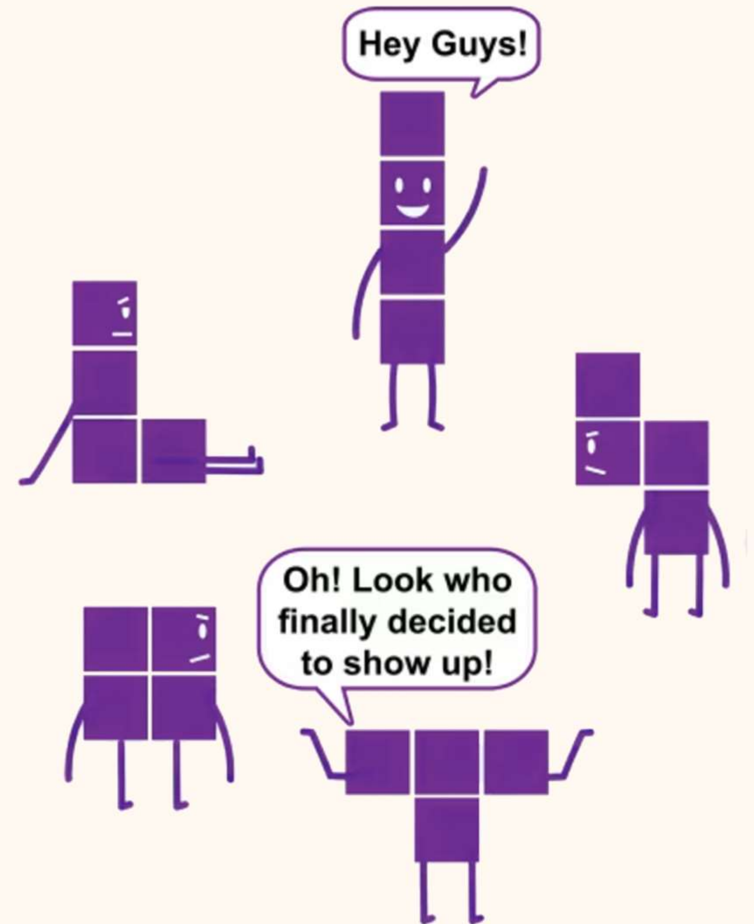
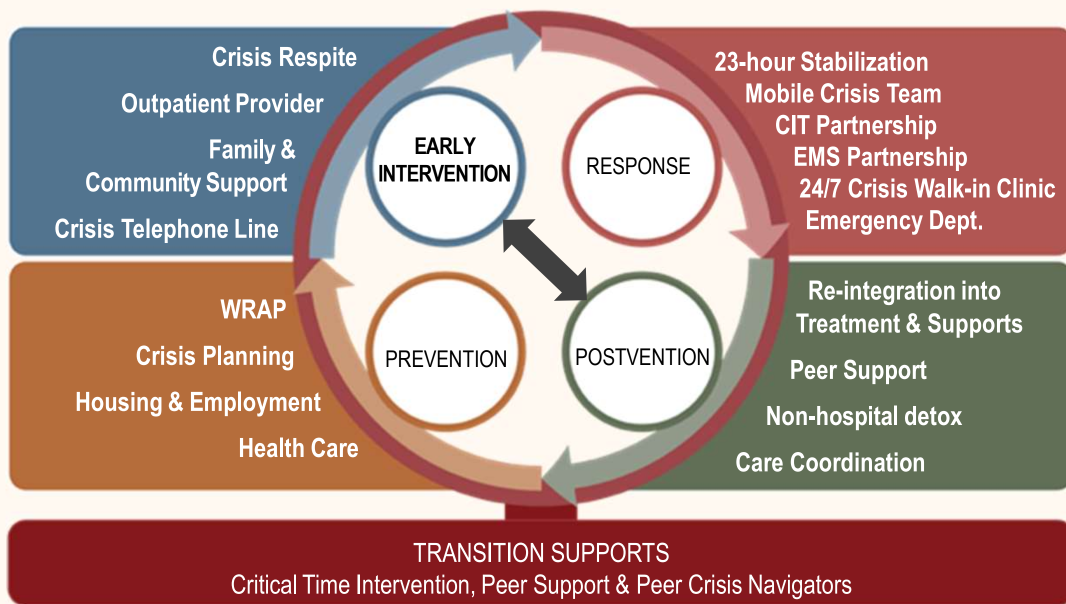
Putting the pieces together...



Contact us about sharing or duplicating these slides.

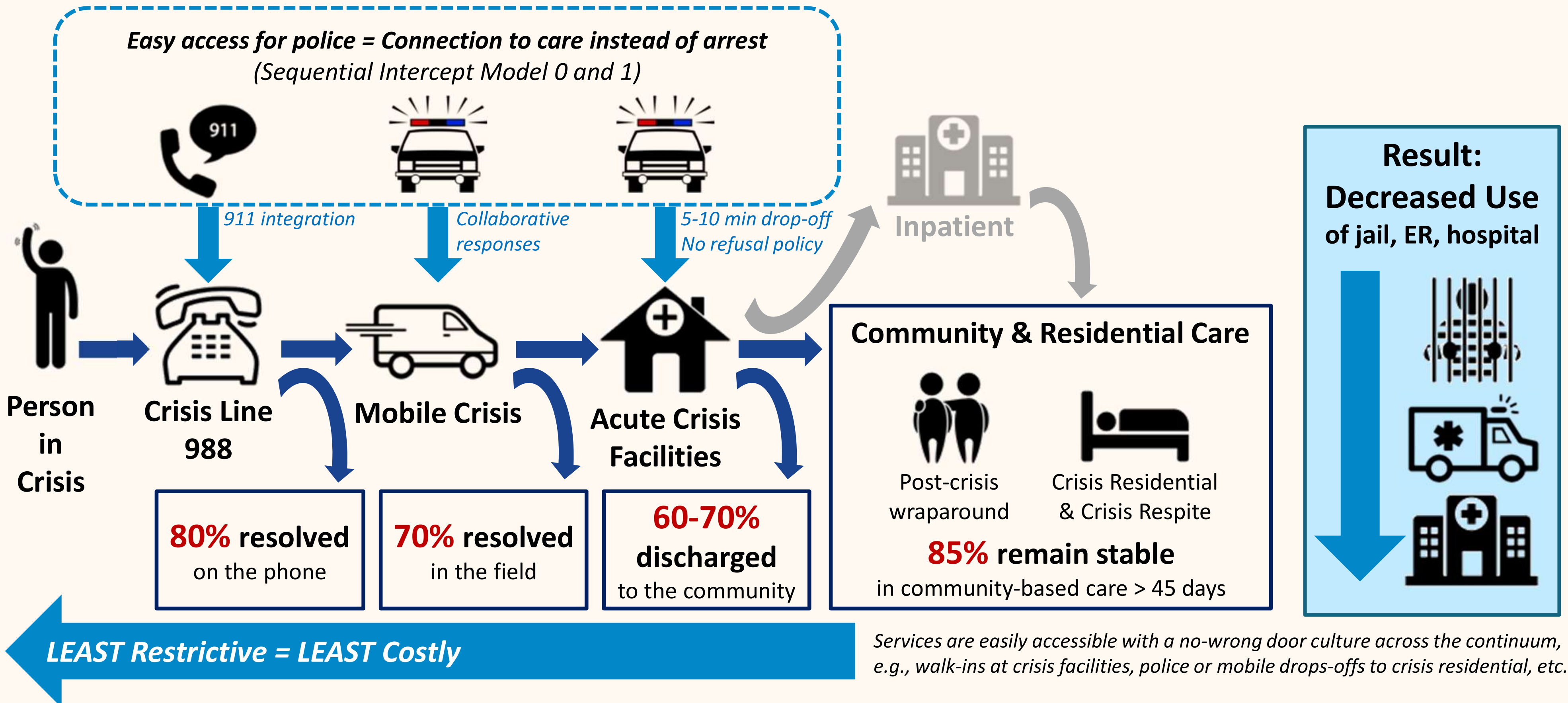
Key Feature: Systems Thinking

A crisis system is
more than a collection of services.



Adapted from: Richard McKeon (Chief, Suicide Prevention Branch, SAMHSA). Supercharge Crisis Services, National Council for Behavioral Health Annual Conference, 2015.

A Coordinated Crisis System: Aligned towards common goal of care in the least-restrictive (and least-costly) setting

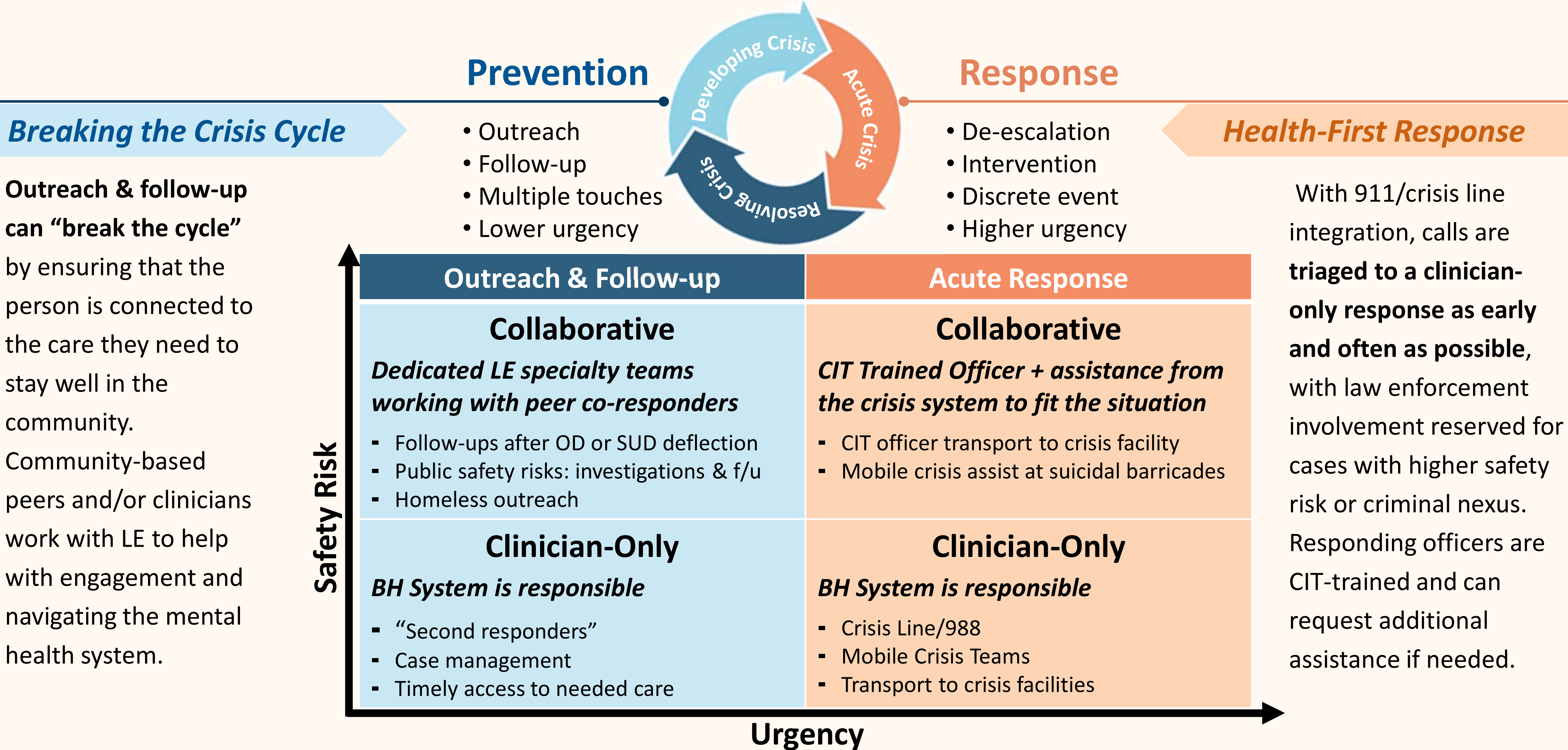


Services are easily accessible with a no-wrong door culture across the continuum, e.g., walk-ins at crisis facilities, police or mobile drops-offs to crisis residential, etc.

Data courtesy Arizona Complete Health for the southern Arizona region

Balfour ME, Hahn Stephenson A, Delaney-Brumsey A, Winsky J, & Goldman ML. Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. *Psychiatric Services*. 2022 Jun;73(6):658-669. https://doi.org/10.1176/appi.ps.202000721

Tucson's Police-MH Collaborative Response Model



CONNECTIONS

Building a “high resolution” crisis system

A coordinated crisis system with multiple levels of care aligned towards common values

The concept of an **Accountable Entity** was introduced in the ***Roadmap to the Ideal Crisis System*** report and is an essential element of a **Behavioral Health Coordinated System of Crisis Care (BHCSCC)** in the **new SAMHSA guidelines**.

CrisisRoadmap.com

Community support
Crisis system support to families, police and first-responders, schools, etc.

CLINICAL PRACTICES

Clinical best practices
Engagement, assessment, safety, clinical interventions, evidence-supported treatment, peer support, coordination and continuity of care

SERVICE CONTINUUM

Array of services and capacities
Service components, levels of care, staffing and volume capacities, special population capacities

ACCOUNTABILITY AND FINANCE

System oversight and governance
Structure, financing, eligibility, quality metrics, customer satisfaction, performance incentives, flow and throughput, data sharing, utilization management, collaboration

Essential functions of Accountable Entities

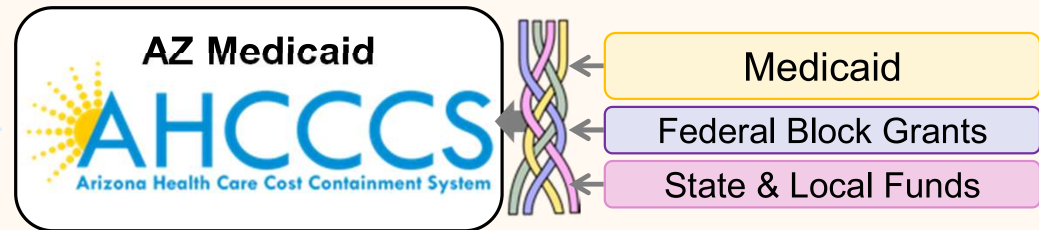
- Authority & Accountability
- Community assessment and planning
- Coordination and integration
- System flow, continuity & throughput
- Financing
- Regulations
- Data, Evaluation & Quality Improvement

22

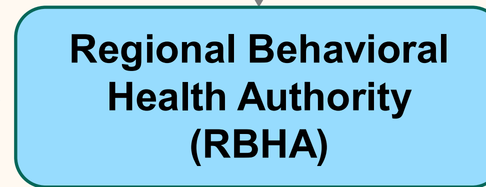
Arizona Crisis System Financing & Governance Structure

creates the foundation for an organized, coordinated, and sustainable system

Braided funding maximizes the impact of multiple funding streams, creating a sustainable system **that can serve anyone regardless of payer.**

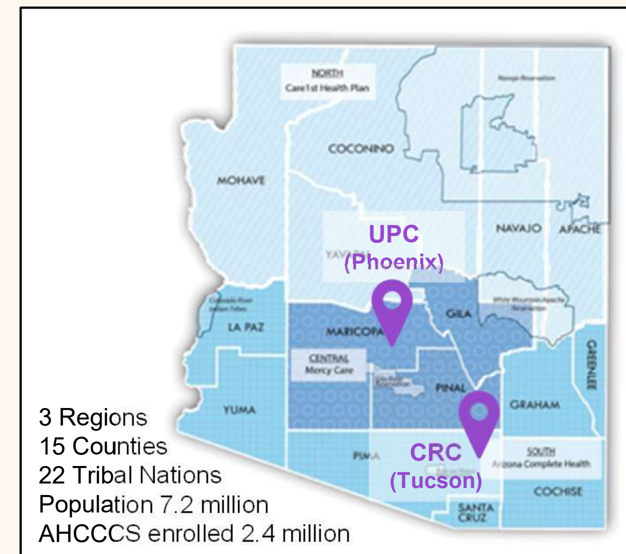


A single **"accountable entity"** creates the structure for strategic planning & oversight.

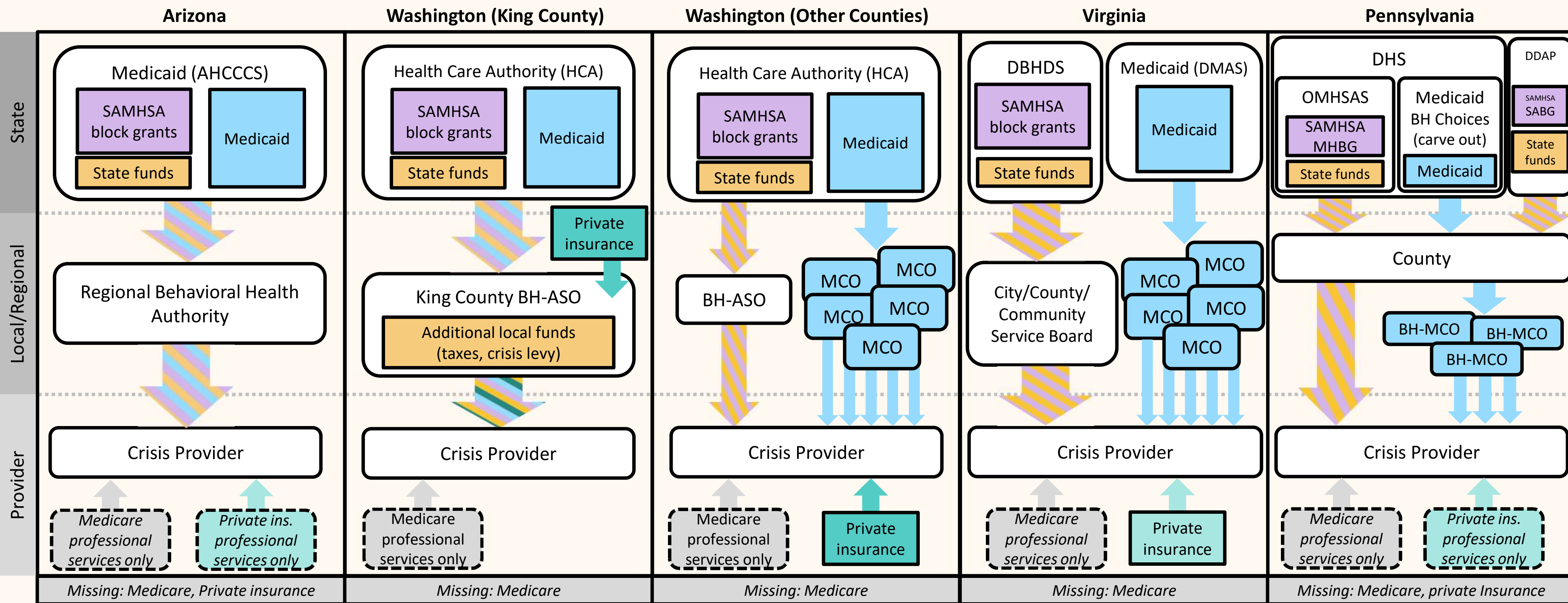


Contracted services are aligned towards common goals that are both clinically desirable & fiscally responsible:

DECREASE use of ER, Hospital, Jail
INCREASE community stabilization



Crisis Funding Models by State



Key Points:

- **Funding from multiple sources is needed to serve everyone.**
- **Braided funding by an "accountable entity" supports centralized planning and oversight.**

Certified Community Behavioral Health Clinics (CCBHCs)

CCBHCs are specially designated clinics that provide a comprehensive range of MH and SUD care with a reimbursement model based on the actual cost of care, which allows financing to grow and organize crisis systems.

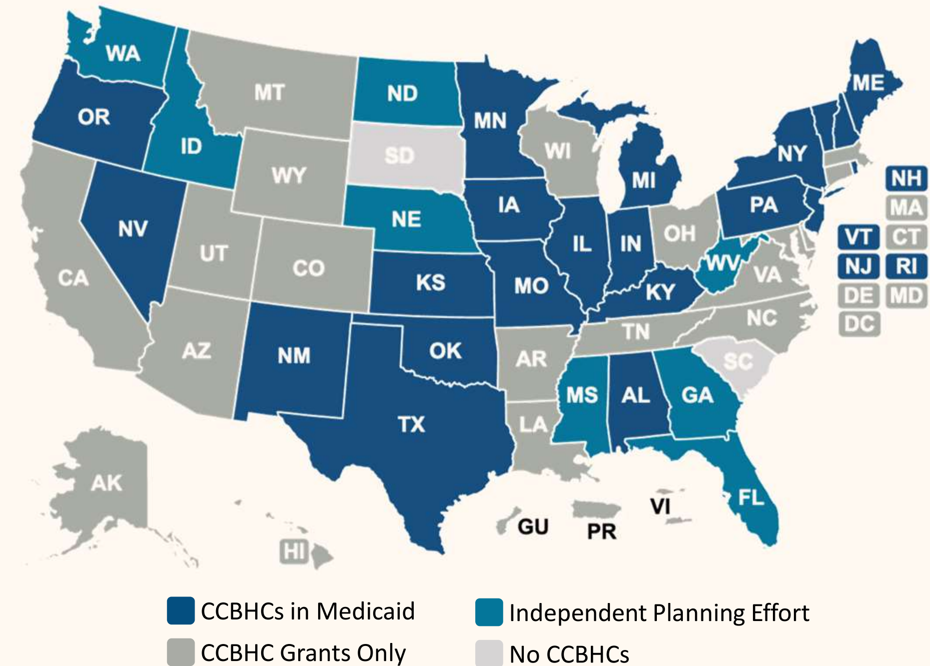
- **Ensure access** to integrated, evidence-based substance use disorder and mental health services, including 24/7 crisis response and medication-assisted treatment (MAT).
- **Meet stringent criteria** regarding timeline of access, quality reporting, staffing and coordination with social services, criminal justice and education systems.
- **Receive flexible funding** to support the real costs of expanding services to fully meet the need for care in their communities.

MEDICAL DIRECTOR INSTITUTE

Released Sept 2024

The Role of Certified Community Behavioral Health Clinics in Crisis Services and Systems

CCBHCs Today



Full Array of Crisis Best Practices

(criteria 2.c.2, 2.c.3, 2.c.6, 4.C)

CCBHCS' ROLE IN THE IDEAL CRISIS SYSTEM

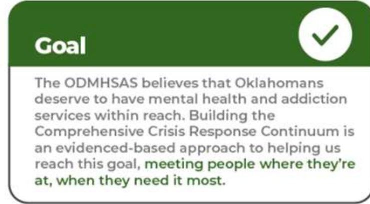
Someone to talk to	*Someone to respond*	*A safe place for help*
Provides or coordinates with **988** Suicide & Crisis Lifeline.	Operates or partners with behavioral health mobile crisis teams providing **24/7 services** anywhere the crisis is experienced.	Provides or partners with crisis receiving and stabilization services like **urgent care** and **walk-in services**.

Crisis prevention

- Works with people postcrisis to create a crisis plan to prevent and de-escalate future crises.
- Provides postcrisis follow-up care to support people with managing their condition(s) and preventing future crises.

- Air traffic control, crisis coordination and care coordination requirements
- Welcoming trauma-informed care
- Recovery-oriented peer support
- Triage
- Assessment
- Crisis response: Intervention and prevention
- Suicide and overdose prevention and medication
- Post-crisis follow-up

OKLAHOMA's
Comprehensive Crisis Response



1 One Call Away **Helpline**

988

It all starts with **an easy to remember helpline number (988)** staffed by mental health professionals to answer calls around the clock of those experiencing a mental health crisis. Approximately 80% of crisis calls can be resolved at this touchpoint.

2 When Necessary **Mobile Crisis Team**

When needed, the 988 call center will dispatch statewide mobile crisis teams to the situation for further assessment and intervention. Approximately **70% of crisis situations can be resolved at this touchpoint.**

Reducing the need for law enforcement intervention and costly hospitalizations.

3 Follow Up **Appointments**

Every level of the continuum will be equipped with the ability to make same day or next day appointments at every Community Mental Health, Community Behavioral Health, and Comprehensive Community Addiction Recovery Centers across Oklahoma.

4 Integrated **Technology**

Every law enforcement officer across the state will be equipped with **24/7 access to a licensed behavioral health practitioner** to assist with assessment, evaluation, and connection to treatment.

5 Getting There **Transportation**

Reducing the need for law enforcement to transport long distances.

Some people need more in-depth care. If this is the case, transportation will be provided to help Oklahomans in need safely arrive at an Urgent Care and Crisis Center.

6 Nearby Care **Facilities**

Minimizing law enforcement travel for assessment and treatment.

The continuum will add 50% more urgent care and crisis centers across the state – **diverting 90% of those needing inpatient psychiatric hospital care.**

OKLAHOMA Mental Health & Substance Abuse

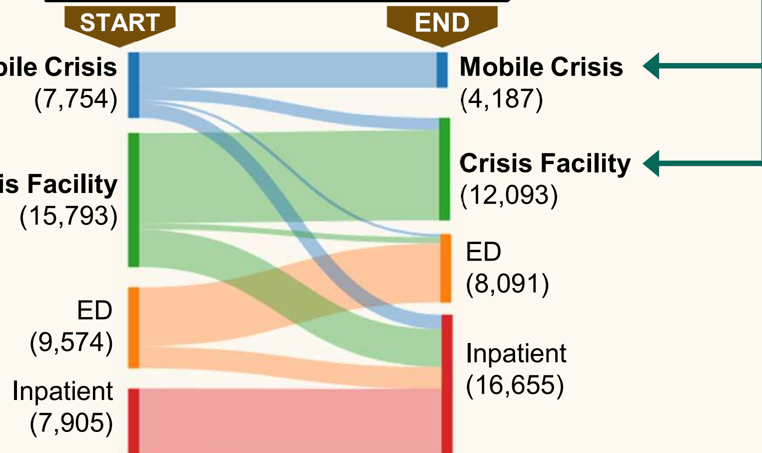
Your Jedi mind tricks don’t work on me, only data

Research Study: Patient Flow and Reutilization of Crisis Services Within 30 Days in a Comprehensive Crisis System

Crisis Episode Flow

57.4% of the crisis episodes **began** with a mobile crisis team or crisis facility rather than the emergency department (ED) or inpatient.

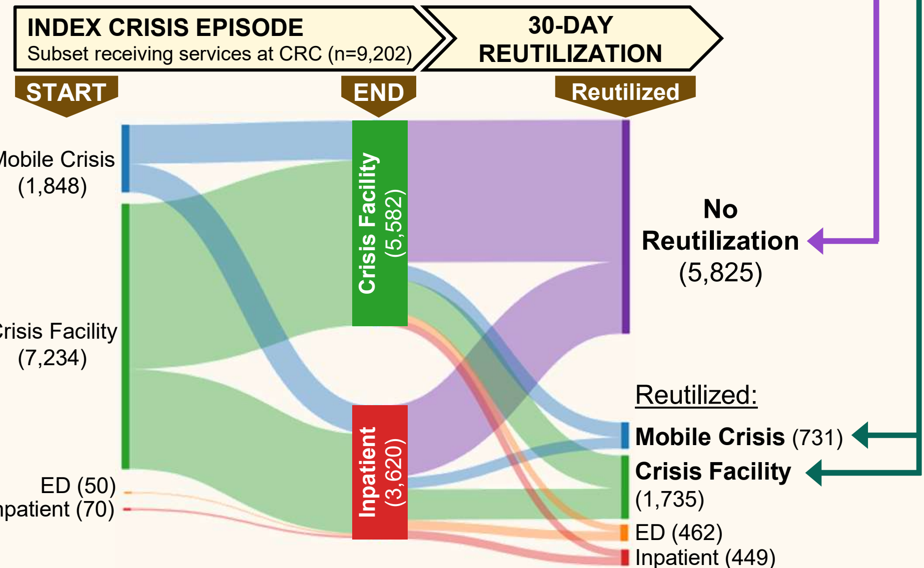
Of those, 69.1% **remained** in the crisis system (ending in mobile crisis or crisis facility).



Reutilization within 30 days

63.3% did not reutilize any services.

Of those that did, 73.0% occurred in a crisis setting (mobile crisis team or crisis facility) rather than the emergency department (ED) or inpatient.



AHCCCS claims analyzed by the ASU Center for Health Information and Research

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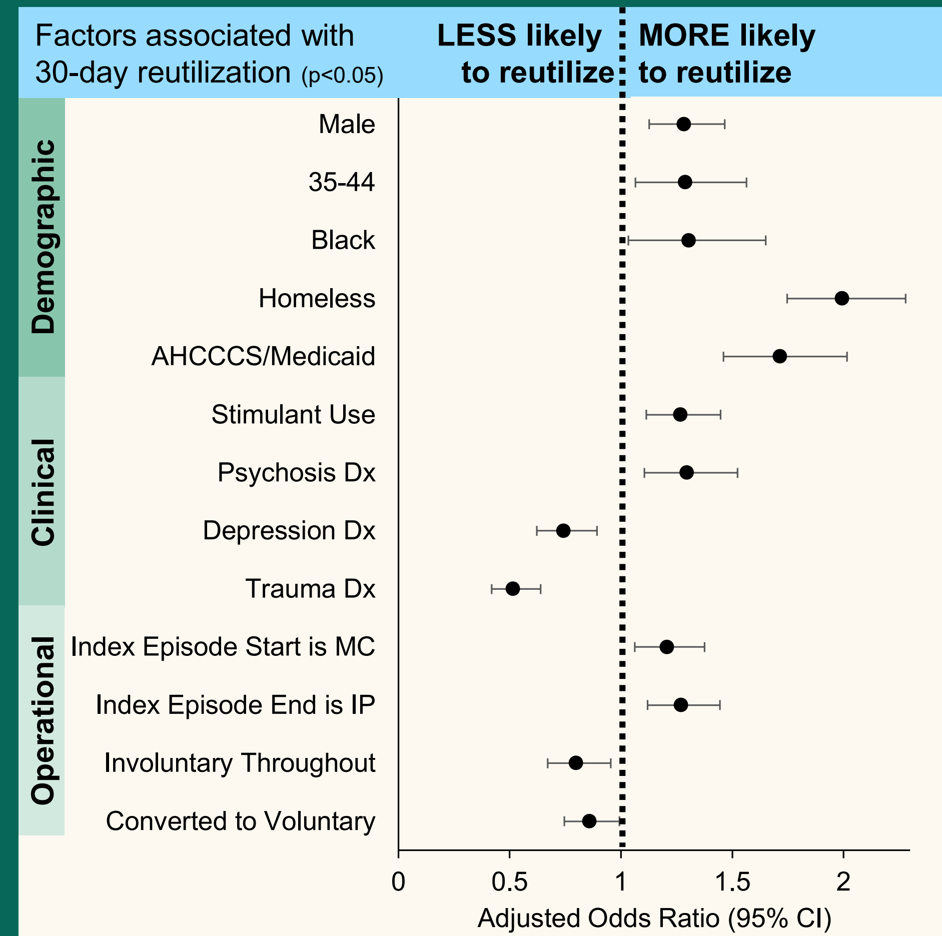
Tomovic M, Balfour ME, Cho T, Prathap N, Harootunian G, Mehreen R, Ostrovsky A, Goldman ML. (2024) Patient Flow and Reutilization of Crisis Services Within 30 Days in a Comprehensive Crisis System. *Psychiatric Services.* Online ahead of print 2024 Feb 27. https://doi.org/10.1176/appi.ps.20230232

Research Study: Patient Flow and Reutilization of Crisis Services Within 30 Days in a Comprehensive Crisis System

- To identify factors associated with reutilization, we merged Medicaid claims with Connections EHR data for the 9,202 episodes that included a Crisis Response Center (CRC) visit.
- We also examined the trajectory of individuals who received care at the CRC under an involuntary commitment due to danger to self or others.
  - Most (59.3%) of the visits that began with an involuntary legal status were **converted to voluntary status** at the time of discharge.
  - This group, as well as those who remained involuntary throughout their visit, had **decreased odds of 30-day reutilization** compared to the voluntary population.



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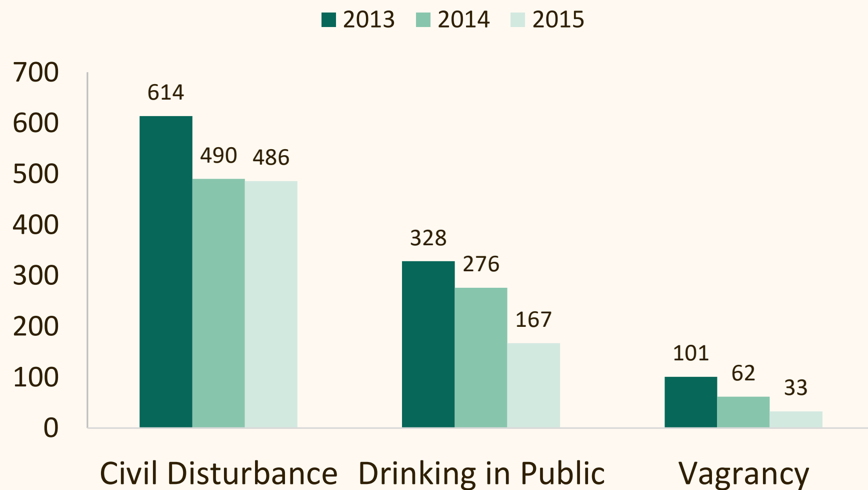
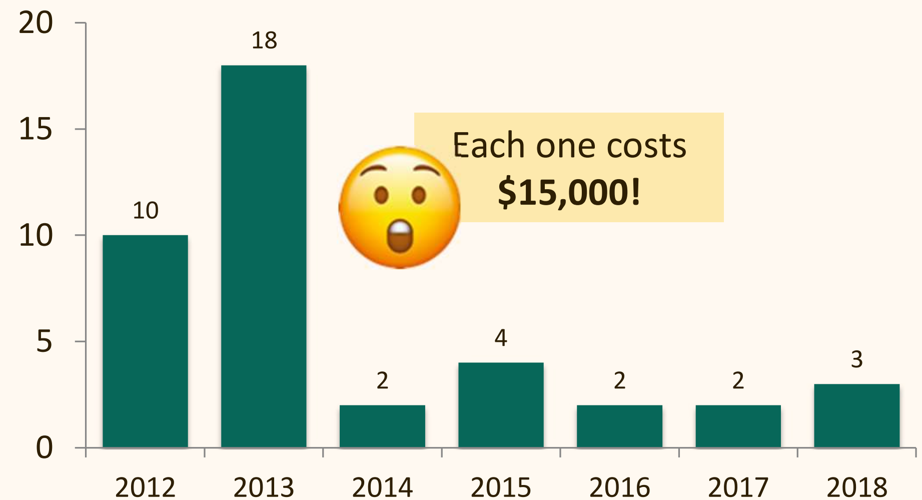
Less Justice Involvement

Fewer calls for low-level crimes that tend to land our people in jail.



Culture change in how law enforcement responds to mental health crisis.



connections

Balfour ME, Winsky JM and Isely JM; The Tucson Mental Health Investigative Support Team (MHIST) Model: A prevention focused approach to crisis and public safety. Psychiatric Services. 2017;68(2):211-212; https://dx.doi.org/10.1176/appi.ps.68203

Quality Measurement in Crisis Services

MEDICAL DIRECTOR INSTITUTE

Crisis Services Committee

A companion to the *Roadmap to the Ideal Crisis System* report

Quality Measurement in CRISIS SERVICES

I. Introduction

Mental health crisis systems are becoming increasingly sophisticated and multi
as emergency department boarding, unnecessary law enforcement involvemen
and inadequate and inequitable access to mental health care services. Crisis sy
to care for individuals experiencing mental health challenges to alleviate distre
these systems evolve, it is necessary to use performance metrics that can adva

All systems are essentially an aggregation of linked processes working in conc
intended outcomes. However, they are prone to error (human and otherwise
make up a mental health crisis care continuum. Measuring processes and ou
these systems are adhering to their intended function and goals and to deter

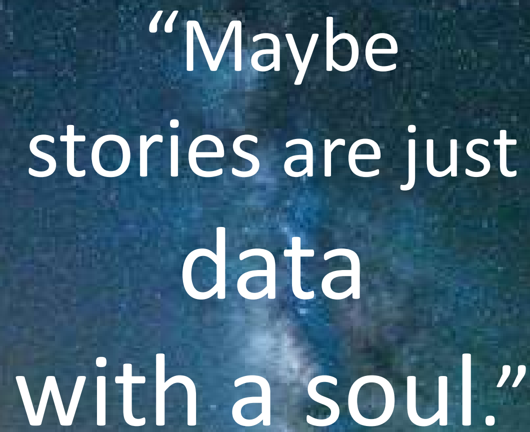
As crisis systems mature across the US, there are increasing demands for m

- Reporting mandates tied to funding and accreditation.
- Demonstrating success and value (or the lack thereof).
- Identifying weaknesses to inform continuous quality improvement (
- Maintaining a focus on the needs of service recipients based on thei

For optimal performance, crisis systems should employ a "balanced sco
that tracks system performance across a combination of different types
developing a set of metrics.

Download the Report

bit.ly/MDICrisisMeasures



Systems Approach:
How can crisis data help improve the whole behavioral health system?

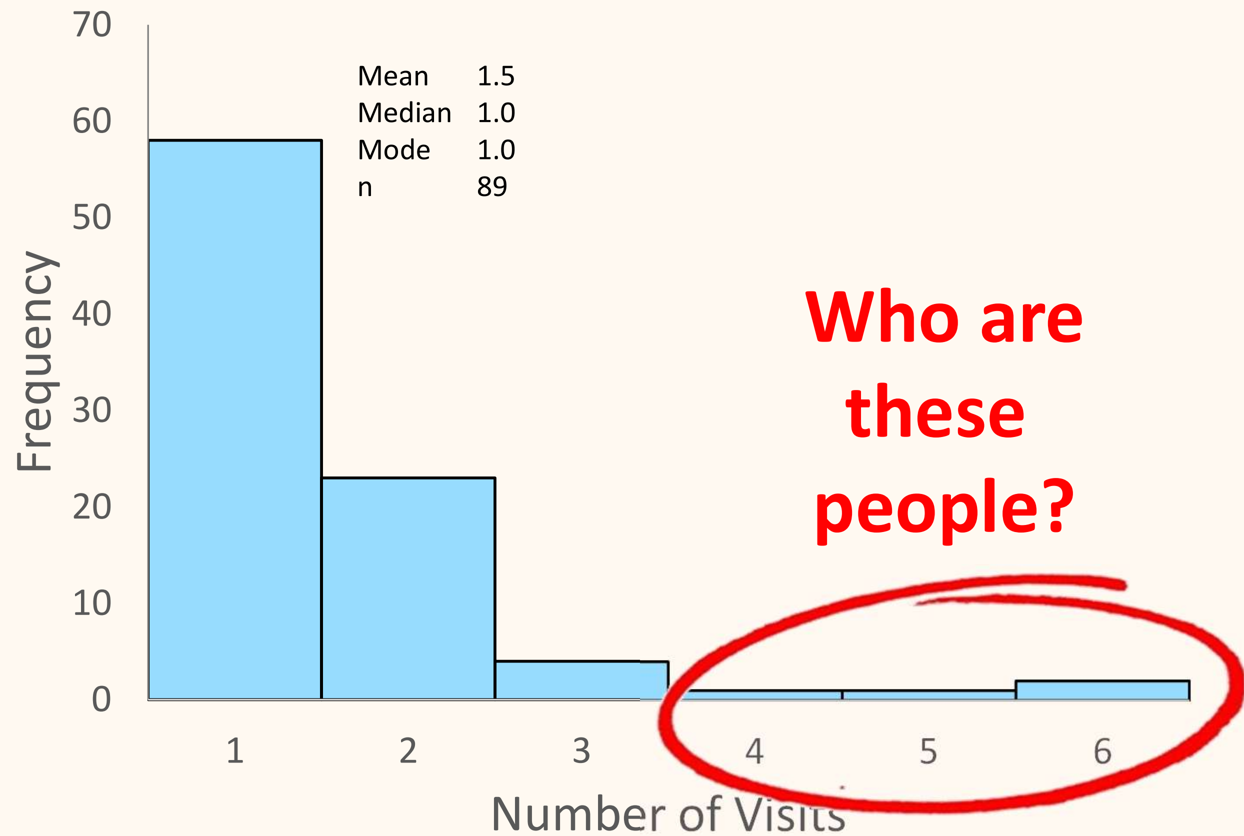
Every crisis visit is a **story** about how someone couldn't get their needs met in the community.

If we **turn the stories into data**, it can reveal trends about things that need improving in the overall behavioral health system.

Using Data to Solve Complex Problems

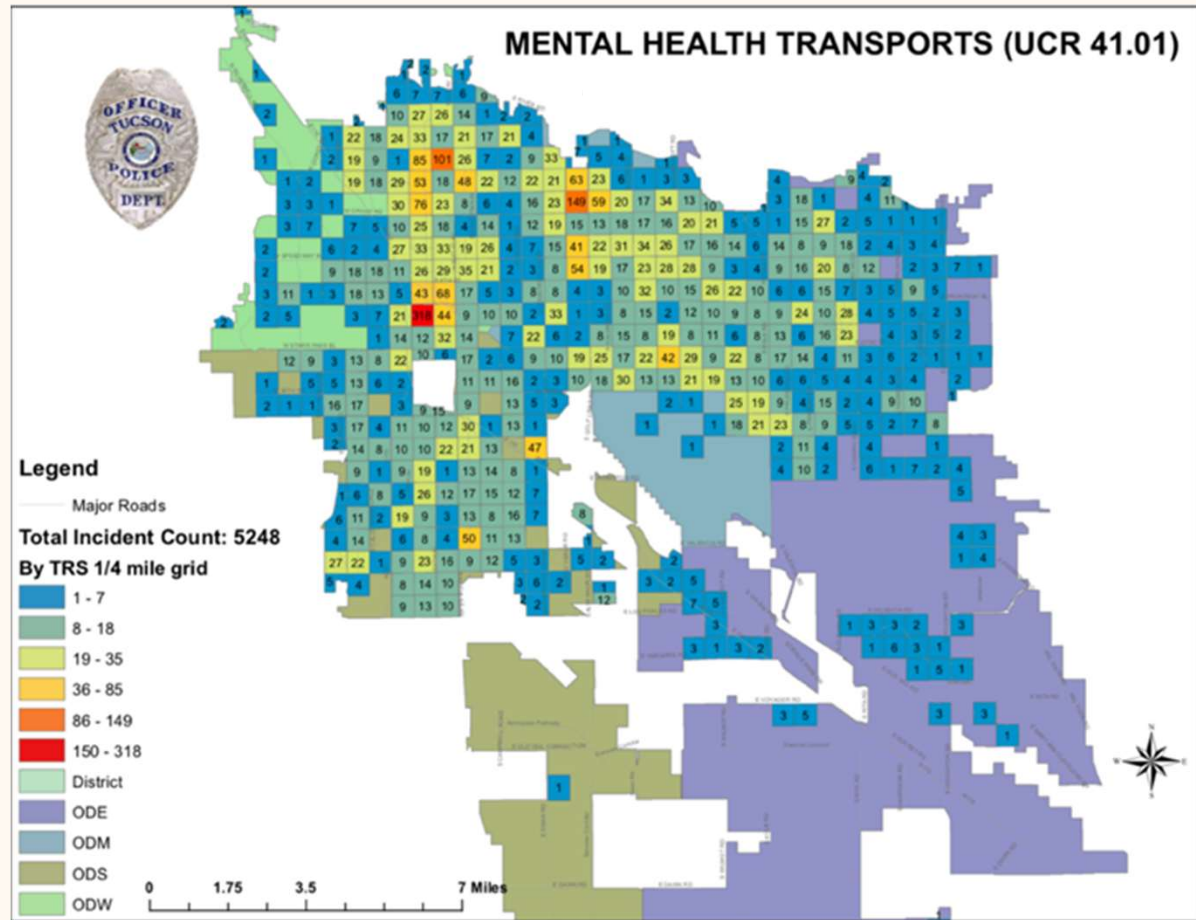
Example:
Repeat revocations to the CRC

for individuals on COT (outpatient civil commitment)



Where are these individuals coming from?

Can we target interventions to prevent the need for involuntary law enforcement transports?

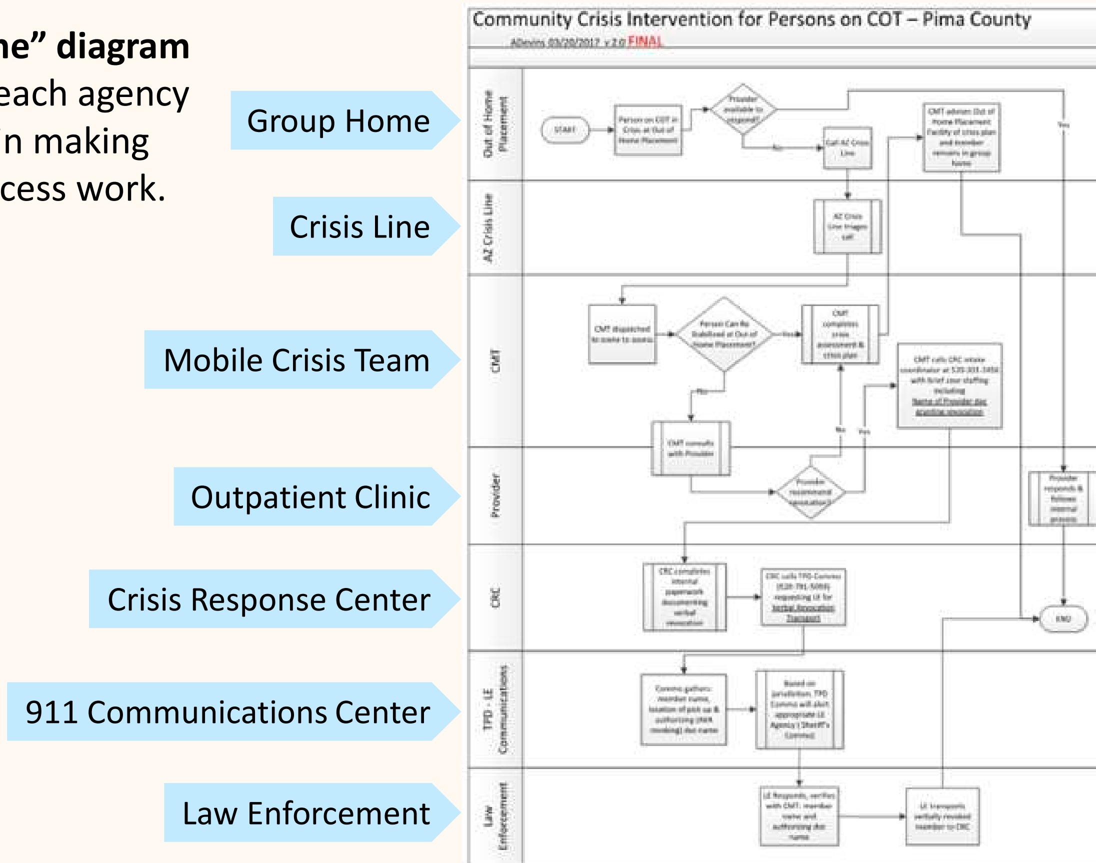


Courtesy Sgt. Jason Winsky, Tucson Police Dept.

“The Group Home Guy”

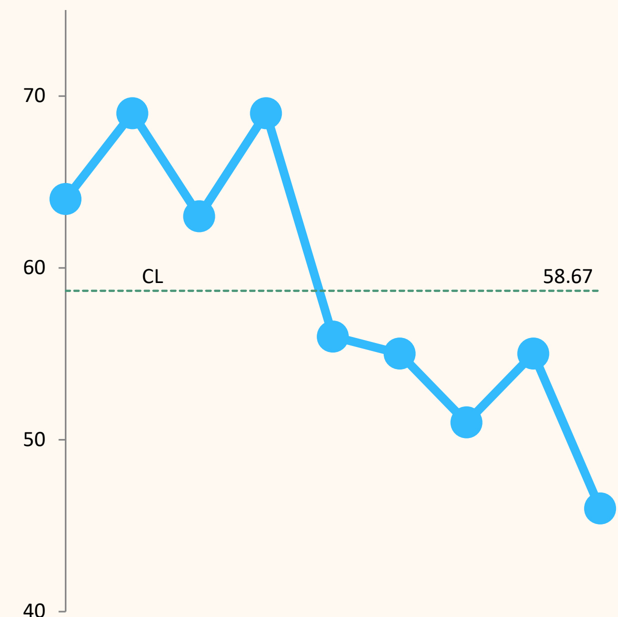
Multiagency QI Process to reduce repeat civil commitment orders

A “Swim Lane” diagram shows how each agency plays a role in making the new process work.

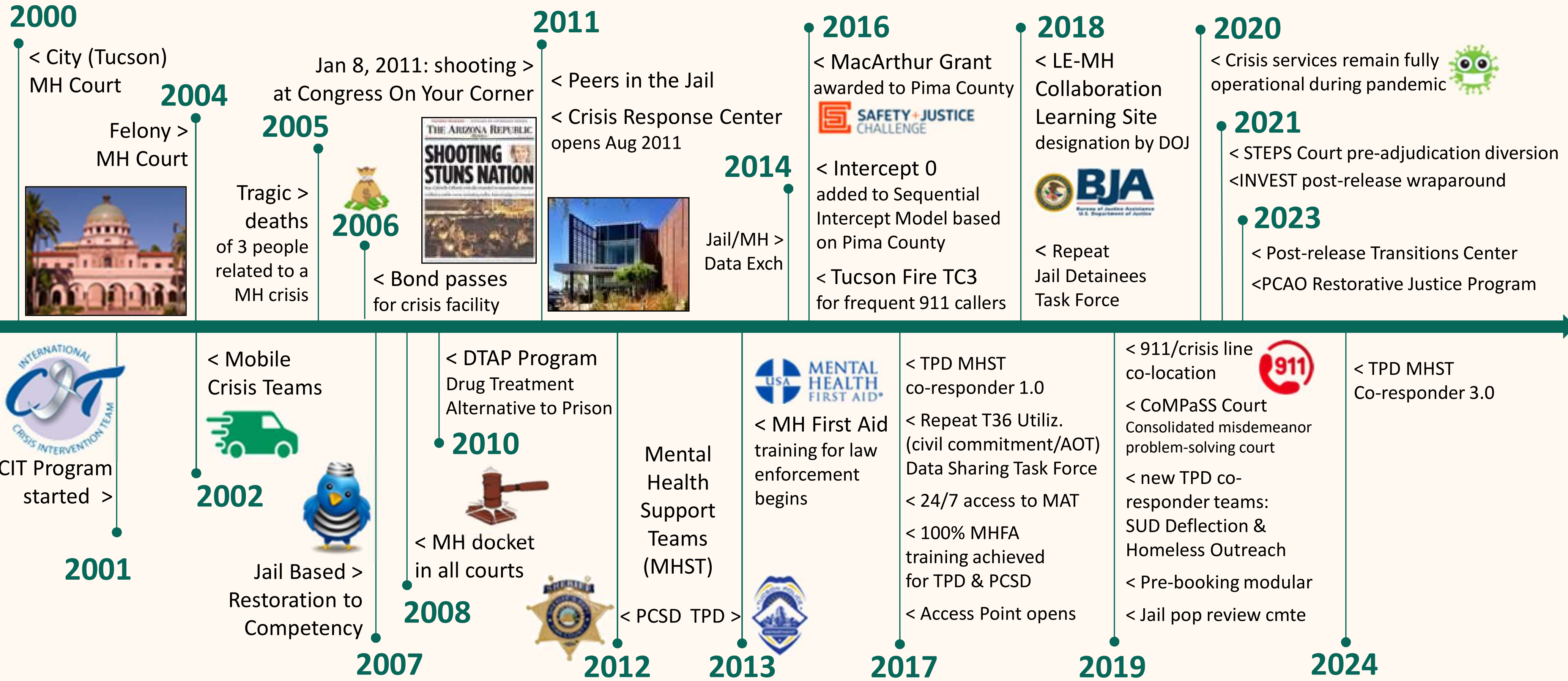


Courtesy of Amy Devins, Arizona Complete Health

Decrease in CRC COT Revocations Per Month



Pima County's Roadmap:
It took a LONG time and LOTS of collaboration to get where we are today.



CONNECTIONS

Disparities in the Response to Emergencies

Medical vs. Behavioral Health

Call for Help

Medical	Behavioral Health
911 has been in place for decades and has evolved into a system that is viewed as an essential service with dedicated funding.	988 was established in 2022. Infrastructure is still developing. Financing mechanisms are variable across states.

Emergency Response

Medical	Behavioral Health
Trained healthcare personnel (EMTs, paramedics) are available 24/7 and respond within minutes. Emergency medical services are reimbursed by Medicare, Medicaid, and private insurance.	Law enforcement is often the default 1st responder, resulting in death and over-incarceration. Mobile crisis exists in some communities, but availability and practice vary widely. Funded mostly by local and SAMHSA funds, and (in some states) Medicaid. Not reimbursed by Medicare or private insurance.

Emergency Transport

Medical	Behavioral Health
Ambulances transport patients to the appropriate emergency department (ED) and/or trauma center based on their needs. Transport is reimbursed by Medicare, Medicaid, and private insurance.	Ambulances are not reimbursed (or at a much lower rate) for transport to a behavioral health crisis facility, contributing to unnecessary ED utilization. Involuntary patients must often be transported by law enforcement.

Emergency Care Facilities

Medical	Behavioral Health
Patients arrive at a facility equipped to meet their needs. Trauma classification system facilitates clear understanding of the capabilities of different facilities. ED visits are reimbursed by Medicare, Medicaid, and private insurance.	BH patients “board” for hours in EDs, without treatment, awaiting transfer to a psychiatric hospital. Most could be stabilized in specialized crisis facilities, but lack of standard classification/licensure and reimbursement creates barriers to implementation. Reimbursed by Medicaid & SAMHSA funds but not Medicare or private insurance.

Step-Down / Alternatives to Hospitalization

Medical	Behavioral Health
A variety of community-based step-down options exist (skilled-nursing facilities, home-health, etc.) and are reimbursed by Medicare, Medicaid, and private insurance.	Community-based crisis services (crisis residential, peer respite) exist but lack of standard classification and reimbursement creates barriers to implementation. Reimbursed by Medicaid & SAMHSA funds but not Medicare or private insurance.

Action Needed

Support the 988 Suicide & Crisis Lifeline
Continue to strengthen the new 988 Suicide & Crisis lifeline so that it can become an essential and sustainable service like 911.

Reimbursement for Mobile Crisis Services

- Make permanent the state option to provide Medicaid reimbursement for mobile crisis
- Provide Medicare payment for mobile crisis services
- Require all federally regulated health plans to cover mobile crisis services

Equitable Transportation Reimbursement

- Provide parity reimbursement for transport to BH crisis facilities
- Encourage states to examine involuntary commitment statutes to allow non-police transportation

Reimbursement for Crisis Stabilization

- Create standards and definitions for crisis stabilization services as a foundational step towards developing licensing and reimbursement regs
- Include 23-hour observation and crisis stabilization provided at Medicare certified hospitals (including psychiatric and pediatric hospitals) as well as free-standing community-based programs
- Provide Medicare coverage of behavioral emergencies and reimbursement of the full continuum of crisis services
- Require all federally regulated health plans to cover behavioral emergencies and reimbursement of the full continuum of crisis services

Connections Health Solutions

Questions?

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