# New Opportunities to Improve Mental Health Crisis Systems

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National, state, and local actors seem ready to address the long-neglected mental health crisis system in the United States. Elements of an organized system of crisis care are in place in some states, including regional or statewide call centers, mobile crisis teams, and crisis care facilities. These necessary advances are not sufficient to address the urgent problems of increasing suicide rates, the inappropriate use of emergency departments to hold people in psychiatric distress, and the problematic reliance on inadequately trained law enforcement who frequently respond to mental health crises. This article describes the immediate challenges and opportunities that can launch nationwide reform in systems of care for individuals in psychiatric crisis. Five action recommendations describe clear, feasible next steps that can be taken to move these systems forward and meaningfully improve access and quality of care for people in crisis. The recommendations include a central coordinating role for Congress, an increase in federal authorization and appropriation of funds, enactment of a 5% Mental Health Block Grant set-aside, expanded funding for research and evaluation, and the pursuit of additional payment mechanisms by states and counties.

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The National Alliance on Mental Illness defines mental health crisis as a "situation in which a person's behavior puts them at risk of hurting themselves or others and/or prevents them from being able to care for themselves or function effectively" (1). Although finding accessible and effective care is imperative when a health condition is urgent, no organized system for urgent or crisis mental health care exists in the United States. The consequences are profound: distress for people in crisis and their families; overreliance on law enforcement and hospital emergency departments (EDs), which are both poorly suited for and burdened by the problem; high and increasing rates of suicide; costly overuse of scarce psychiatric inpatient care; and rare but tragic acts of violence by and especially upon individuals in psychiatric distress (2). The end results of these maladaptive patterns of care are death, neglect, and high personal and societal costs.

Indeed, concern about these problems is increasing just as potential solutions are being demonstrated. The problems of suicide, the "criminalization" of persons with mental illness, and the consequences of seemingly random violence and of police shootings involving individuals with mental health problems have become widely acknowledged symptoms of a national failure to deal proactively with mental illness. Less widely known are dramatic developments in mental health crisis care in several states and communities, as well as early signs of a possible national willingness to act. Our purpose in this article is to define the immediate challenges and opportunities that can galvanize nationwide reform in psychiatric crisis care and to acknowledge the fiscal and policy constraints on federal leadership in a decentralized and largely state-managed system.

## RECENT DEVELOPMENTS AND POLICY OPPORTUNITIES IN CRISIS CARE

The absence of a national approach to mental health crisis care is partly a consequence of inadequate mental health care in general and is exacerbated by divisions in responsibility between states and the federal government.

### HIGHLIGHTS

- Federal, state, and local mental health authorities are increasingly investing in the crisis care continuum, including call centers, mobile crisis teams, and crisis care facilities.
- Increased federal appropriations to states, including via an additional Mental Health Block Grant set-aside, are urgently needed.
- Other needed components include implementation of a national three-digit crisis hotline and additional research on and evaluation of crisis services.

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Crisis care was required of community mental health centers funded under President Kennedy's 1963 Community Mental Health Act. However, most communities never received funds, and when this program was converted to a block grant in 1981, requirements for crisis care disappeared. Some communities developed adaptive solutions, but the nation until recently had no template for what crisis systems should look like.

This gap was filled by a report issued in 2016 by a task force of the National Action Alliance for Suicide Prevention (3) and subsequently reinforced by a tool kit released in 2020 by the Substance Abuse and Mental Health Services Administration (SAMHSA) (4). The task force surveyed best practices across the country and found that to achieve optimal results, an organized system of crisis care was needed on a state or regional basis. Elements in the system recommended by the task force included regional or statewide call centers, mobile crisis teams, and crisis care facilities.

The task force recommended that the regional or statewide call centers should be part of the National Suicide Prevention Lifeline (NSPL) and serve as hubs for coordinating crisis care, using technology, which is now ubiquitous, to link people in crisis with services and to monitor access and quality by using real-time tracking of service capacities. The mobile crisis teams that were recommended by the task force often include a licensed therapist and a nonclinician (e.g., psychiatric technician or peer specialist) and are dispatched centrally by the regional call center. Mobile crisis teams have been able to resolve as much as 72% of the mental health crises to which they respond without resorting to hospitalization or arrest (5). In addition, the crisis care facilities offer an array of services and supports: immediate counseling, peer support, or medication treatment; community-based rapid assessment and stabilization (as in a psychiatric ED but usually in a stand-alone facility with a hospital affiliation) and short-term care (e.g., 23-hour observation); "no wrong door" arrangements with local law enforcement agencies so that officers can quickly transfer people in need into a therapeutic setting; and linkages to crisis residential and respite facilities that provide 3- to 7-day residential support for individuals who need close support but not a hospital level of care.

Although some components of crisis care are available in most states, the most significant innovations are often not present. These include a 24/7 coordinating hub, which is necessary for the system to function efficiently and accountably, and crisis facilities, especially those that provide high-urgency brief assessment and stabilization and that operate in partnership with trained police teams to provide easy access to treatment and diversion from the criminal justice system. It is even rarer to have all elements of the modern crisis system in place. Arizona is the only state with all of these capabilities implemented statewide, and Georgia comes close. However, there is great interest in many states in the Crisis Now approach (crisisnow.com), and a number of states, with the support of the National Association of State Mental Health Program Directors, are moving in this direction. Given the complexity of the multiple systems and agencies that often intersect and, at times, quarrel in the midst of a crisis intervention, these efforts require extensive collaboration and clear lines of accountability among stakeholder groups. Furthermore, these systems must prioritize recovery-oriented services and actively seek input from people with lived experience of mental health crises.

Given divided federal-state responsibilities in mental health and the absence—until recently—of strong national leadership on crisis care, implementing comprehensive crisis systems is primarily a state responsibility. However, catalytic federal leadership and modest funding are needed to accelerate solutions and to ensure some consistency in approaches (Box 1). Fortunately, national leadership on these issues is emerging.

## NATIONAL LEADERSHIP OPPORTUNITIES TO IMPROVE CRISIS CARE

With an adequate focus on building "a 911 system for the brain," the goal of creating an organized system of crisis care can be realized. National leaders are well positioned to support the advancement of crisis systems that are better coordinated, financed, and evaluated than ever before.

### Recommendation 1. Congress Must Play a Central Coordinating Role

> Congress should help advance the new mission of mental health crisis lines, playing a central coordinating role in the crisis care continuum. Specifically, as Congress moves to support the landmark Federal Communications Commission (FCC) action to implement a nationwide 3-digit number (988) for the NSPL, it should authorize and appropriate sufficient funds to enable the development of a crisis coordination system also accessed by dialing 988. This system should not just answer calls but build the capacity to coordinate the delivery of crisis care locally, including through real-time dispatch and monitoring of mobile crisis teams, crisis facilities, and inpatient care.

The most important actions to improve mental health crisis care will capitalize on a remarkable new development. There has been increased recognition of the rising tide of suicide, the effectiveness of the NSPL in responding to suicidal callers, and the role that a national crisis line plays in addressing mental health and suicidal crises (6, 7). In response, the FCC has recently approved designation of a nationwide three-digit phone number (988) to be assigned for

suicide prevention and crisis response (8). Expanding the mission of the NSPL from suicide prevention to mental health crises is a foundational step toward establishing a national crisis care infrastructure. Many other steps, including complex telecommunications arrangements, are needed to implement the 988 number, and additional federal financial support will be required to stabilize the network of over 170 local and state-based call centers that are now part of the NSPL. These centers are already connected by a single national phone number (800–273-TALK) and an infrastructure managed by the nonprofit Vibrant Behavioral Health.

Currently, federal funds support the national infrastructure but do not substantially support the centers themselves. Federal funds should be directed to both—to the new mental health crisis response agenda and to the suicide prevention mission of the NSPL. Taking advantage of this opportunity to standardize and expand the national mental health crisis infrastructure is essential.

### Recommendation 2. Increase Federal Authorization and Appropriation of Funds

> Federal authorization and appropriation of funds must be increased to promote the expansion of crisis services in all states. Funds should include grant programs aimed at developing mobile crisis services and crisis facility services.

To create a crisis care system, call centers must move beyond the core functions of a suicide hotline. Enabled by innovative technologies, call centers are well positioned to form the backbone of a national infrastructure that finally enables reliable access to adequate mental health crisis services across the United States. An increase in federal funding can support much-needed activities, such as providing technical assistance to local and state mental health authorities, supporting 988-receiving NSPL call centers as they augment their roles in suicide prevention to include crisis care coordination, expanding and training the call center workforce, and collecting metrics aimed at ensuring meaningful expansion of access to crisis care across localities.

Developing this national crisis call and dispatch network is a crucial first step, but other actions are required to create the capacity for crisis care. The task of advancing crisis systems must take place at the state and local levels, but national leadership and modest funding support are required. Section 9007 of the 21st Century Cures Act authorized a national discretionary grant program for "states to develop, maintain, or enhance a database of beds at inpatient psychiatric facilities, crisis stabilization units, and residential community mental health and residential substance use disorder treatment facilities, for adults with a serious mental illness, children with a serious emotional disturbance, or individuals with a substance use disorder." Although the Cures Act authorized $12.5 million annually over 5 years to be overseen by SAMHSA, this provision was not adequate in purpose or scope to drive the improvements in crisis care that are now understood to be necessary, and funding was never appropriated. Nevertheless, this was an important first step, confirming congressional awareness of the problem and an intention to address it.

**BOX 1. Recommended actions to improve U.S. mental health crisis systems**

1. Hold Congress accountable for playing a central coordinating role in the crisis care continuum, starting with implementation of 988 as a three-digit number for the National Suicide Prevention Lifeline.
2. Increase federal authorization and appropriation of funds for expansion of crisis services in all states.
3. Enact a 2021 federal budget that includes a 5% set-aside in the Mental Health Block Grant, with a proportional increase in funding.
4. Expand funding for research and evaluation of mental health crisis services.
5. Urge states and counties to pursue additional payment mechanisms and develop value-based payment models for behavioral health crisis services that have parity with other crisis services.

### Recommendation 3. Enact a 5% MHBG Set-Aside

> The 2021 federal budget should include a 5% Mental Health Block Grant (MHBG) set-aside, totaling $35 million. The program should focus on state implementation of modern crisis care services and be guided by SAMHSA to expand upon the 21st Century Cures Act authorization described above.

A recent example of federal leadership on mental health suggests a focused path to improving crisis care services nationwide. Following the Sandy Hook school shooting in 2012, Congress expanded the MHBG—a federal grant program that allocates funds to all U.S. states and territories—specifically to facilitate development of services for young people in the early stages of psychotic illness (e.g., schizophrenia). This targeted federal investment in modestly expanding services in all states for individuals experiencing a first episode of psychosis, paired with a widely disseminated technical assistance program, has galvanized a remarkably successful national effort to engage young people in individualized care by using the evidence-based coordinated specialty care model.

Initial steps to apply this approach to crisis care have been noted by advocates and applied to crisis care. In both 2019 and 2020, the House budget proposal included a similar 5% set-aside, with $35 million to be added to the MHBG to help states expand crisis care services. But the proposal has not yet been included in an enacted budget. Remarkably, the President's 2021 budget followed the House's example and included an MHBG set-aside for crisis services. A broad coalition of mental health groups are advocating strongly for both houses of Congress to incorporate these provisions in future appropriations.

### Recommendation 4. Expand Funding for Research and Evaluation

> Funding for research and evaluation of mental health crisis services should be expanded. These efforts should be aimed

at moving toward consensus on best practices across settings to inform clinical practice as well as accountability and accreditation mechanisms.

As crisis services continue to develop, steps must be taken to strengthen the data and evidence about which approaches are most effective. Although broad consensus exists about the need to improve crisis care and about the essential elements of strong systems, there is considerable heterogeneity among crisis services currently being offered and a lack of definitive data on which workflows and service modalities are most effective. The evidence base is strong regarding the effectiveness of suicide prevention crisis calls (6, 7), which is reflected in the NSPL standards and American Association of Suicidology accreditation. Mobile crisis teams and crisis facilities have been studied, but there is not yet consensus on best practices in these unique clinical settings. The National Institute of Mental Health has acknowledged the need for research into the efficacy and implementation of high-functioning crisis programs across a range of contexts (e.g., urban versus rural) (9). Clinical protocols defining preferred types of interventions and expectations for follow-up care should be standardized, including when nonlicensed professionals are providing direct services. Additional efforts must be made to conduct evaluations of existing programs operating in real-world settings, where a wide range of clinical presentations, psychosocial factors, cultural considerations and health disparities regularly influence the types of care that are provided. Development of quality measures for crisis care is also needed to improve accountability (e.g., by regional health authorities and payers) and facilitate accreditation.

## STATE LEADERSHIP OPPORTUNITIES TO IMPROVE CRISIS CARE

Although the focus of this article is primarily on federal actions to improve crisis care—which we believe is appropriate, given growing recognition of the need for change and national momentum—crisis systems are usually financed and operated at the state or county level. Therefore, state action is also required.

### Recommendation 5. States and Counties Should Pursue Additional Payment Mechanisms

States and counties should pursue additional payment mechanisms for mental health crisis services. Medicaid agencies in particular should conduct cost analyses to examine the potential savings of increasing reimbursement rates for crisis services to incentivize care in less acute and costly settings, including as a part of value-based payment models. The goal of financing arrangements should be to ensure parity in access to behavioral health crisis services and to other health care emergency services.

Initial state and local efforts could be facilitated by expanded MHBG funding to be used essentially as a down payment on much-needed long-term investments. Often the leadership for crisis programs is within mental health agencies, and as with other mental health services, state Medicaid programs are major payers for crisis care—yet there is tremendous variability. Some state Medicaid programs, such as the Arizona Health Care Cost Containment System, have developed robust financing models for crisis call centers, mobile teams, and crisis facilities that have resulted in millions of dollars of savings for the overall system by diverting individuals from expensive hospitalizations, lengthy ED stays, and inappropriate jail and prison terms (10, 11). However, some states do not even provide Medicaid coverage of discrete services, such as mobile crisis teams or care in crisis facilities.

Financing options differ for the various elements of crisis systems. Crisis call centers have been financed primarily by state mental health authorities and, less frequently, Medicaid agencies. Mobile crisis teams have been financed via mental health grants and reimbursed on a per-visit basis by Medicaid. Crisis facility construction has been achieved through state and local mental health construction grants and from state and local bond funds, and care in crisis facilities has been reimbursed by Medicaid. Finally, payment for mobile crisis and crisis facility services from commercial health insurance has been provided in some states.

## CONCLUSIONS

National, state, and local actors seem ready to address the long-neglected mental health crisis system in the United States. Clear, reasonable actions can be taken to move these systems forward and meaningfully improve access and quality of care for individuals in crisis. The steps taken thus far have been necessary, although not sufficient, to address the urgent problems of suicide and to create alternatives to the reliance on law enforcement as the mental health crisis system (with the resultant criminalization of mental illness) and the use of EDs to hold people in psychiatric distress. The window of opportunity for advancing mental health crisis services seems to have opened wide. Now is the time to act.

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## *Psychiatric Services* Announces New Column: Racism & Mental Health Equity

*Psychiatric Services* welcomes Michael Mensah, M.D., M.P.H., and Lucy Ogbu-Nwobodo, M.D., M.S., as contributing editors, joining Ruth S. Shim, M.D., M.P.H., to review submissions for a new column, Racism & Mental Health Equity.

This column examines the intricate ways that structural racism is embedded in psychiatry and investigates strategies to mitigate the impact of structural racism on mental health service delivery. Contributions to the column will explore antiracism and antioppression frameworks of practice and organizational change in relation to service delivery. Submissions that consider how the intersections of race, ethnicity, class, gender, gender identities, and sexual orientation shape mental health experiences and access to psychiatric services are welcomed. Authors are encouraged to present innovative strategies and solutions to transform and dismantle structures of racism across different dimensions of mental health, including (but not limited to) clinical services, education, training, research, and advocacy.

Submissions (via mc.manuscriptcentral.com/appi-ps) are limited to 2,400 total words, inclusive of a 100-word abstract, two or three one-sentence Highlights, and up to 10 references.