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Answering the Call

988: A NEW VISION FOR CRISIS RESPONSE

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Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, M.D., BPC's Health Project develops bipartisan policy recommendations that will improve health care quality, lower costs, and enhance coverage and delivery. The project focuses on coverage and access to care, delivery system reform, cost containment, chronic and long-term care, and rural and behavioral health.

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Glossary of Acronyms

ACA	Affordable Care Act
ARP	American Rescue Plan Act of 2021
CCHBC	Certified Community Behavioral Health Clinic
CDC	Centers for Disease Control and Prevention
CIT	Crisis intervention team
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare and Medicaid Services
COE	Centers of Excellence
CSU	Crisis stabilization unit
DOJ	Department of Justice
DOT	Department of Transportation
ED	Emergency department
EMS	Emergency Medical Services
ET3	Emergency Triage, Treat, and Transport
FCC	Federal Communications Commission
FICEMS	Federal Interagency Committee on Emergency Medical Services
FTE	Full-time employee
GAO	Government Accountability Office
HHS	Department of Health and Human Services
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
LRP	Loan repayment program
MCRT	Mobile crisis response teams
NAMI	National Alliance on Mental Illness
NEMESIS	National Emergency Medical Services Information System
NHSC	National Health Service Corps
NHTSA	National Highway Traffic Safety Administration
NSPL	National Suicide Prevention Lifeline
SAMHSA	Substance Abuse and Mental Health Services Administration
SUD	Substance use disorder
USDA	United States Department of Agriculture



Executive Summary

The introduction of 988 in July 2022 represents an unprecedented opportunity to ensure that the growing number of Americans needing mental health services receive the care they require. It also provides an opportunity to ensure that the nation's existing emergency response infrastructure is ready to help direct individuals to the proper care.

Rates of mental illness and suicide in the United States are high and rising and are particularly pronounced among young adults and residents in rural areas.¹ With appropriate coordination, training, and financial support—including utilizing existing resources—the nation's emergency infrastructure can better help more Americans needing behavioral health crisis care. This is especially true for those individuals who are in a suicidal crisis. The new number to the National Suicide Prevention Lifeline, 988, will provide an alternate access point into care and help keep individuals in crisis from needlessly cycling through emergency departments (EDs) and the criminal justice system.²

Congress recently made historic levels of investment in behavioral health care and 988, including a \$77 million increase for the National Suicide Prevention Lifeline. President Biden's fiscal year 2023 budget also proposed investing in behavioral health services, including funding to implement 988 and build out the U.S. crisis system.^{3,4} As such, the recommendations in this report focus on enhancing federal support for the effective and equitable buildout of 988 alongside existing crisis response infrastructure while primarily utilizing existing resources.

This report provides insights into three areas essential to the implementation of 988 and the broader crisis response continuum: interagency collaboration, the behavioral health workforce, and financing.

Collaboration between agencies and with states is critical for ensuring that they help providers deliver behavioral health crisis services equitably and effectively. Because behavioral health crisis systems rely on state-level action, the federal government must both support states and strive to maintain interagency coordination. Up to this point, state and local governments have received only limited federal guidance on how to effectively implement and utilize crisis response services across the continuum of care. The federal government should establish federal standards for a coordinated state and local crisis response beyond the 988 call centers.

A well-trained behavioral health care workforce is equally critical to the success of 988. As such, Congress and the administration should make investments to increase, train, and sustain the behavioral health crisis response workforce to ensure that sites across the continuum are adequately staffed to meet the needs of the communities they serve.

Last, Congress should sustainably finance a nationwide crisis response infrastructure to ensure that all Americans have access to the appropriate resources in their time of need. This report identifies areas of near-term federal support and guidance that would prove valuable; however, the success of 988 will require ongoing efforts evaluating the resources needed to support the behavioral health continuum in the long-term should Congress reduce funding. Additionally, there are areas in which guidance from the Centers for Medicare and Medicaid Services (CMS) would help to make the most of existing resources for coverage of services across the continuum of care.

Over the past year, BPC conducted dozens of interviews with experts and policy leaders—including state Medicaid experts, peer support specialists, hospital administrators, and EMS professionals—to develop recommendations for a comprehensive crisis response system. Although this system stands to benefit all Americans, there are unique considerations that pertain to children and adolescent mental health that fall outside this report’s scope.

Section I: Enhance Federal Support for Crisis Response Implementation and Utilization

Interagency and Interdepartmental Collaboration

- The Substance Abuse and Mental Health Services Administration (SAMHSA) should be included as a member of the Federal Interagency Committee on Emergency Medical Services (FICEMS) to better bring behavioral health expertise into the existing emergency response structure.

- SAMHSA and CMS should issue joint guidance to states to support state-level crisis response systems more effectively.
- The Department of Health and Human Services (HHS) should direct SAMHSA to develop a 988 communications strategy to ensure that the public is both aware of and trusts the services associated with the call number.

Federal-to-State Coordination

- SAMHSA should establish a scorecard to assess performance so that program managers can evaluate the extent to which states are implementing their 988 programs; it also should compare progress between states over time.
- SAMHSA should fill its existing vacancies, and CMS should hire and designate behavioral health capabilities within its staff to support increased technical assistance to states.

Data Infrastructure

- To foster accountability and set proper funding levels, SAMHSA and National Highway Traffic Safety Administration (NHTSA) should coordinate tracking 988 data by leveraging the National Emergency Medical Services Information System (NEMSIS).
- Congress should direct CMS to adopt and scale behavioral health quality metrics to better inform policymakers of progress and challenges, as well as guide efforts to provide stronger behavioral health crisis responses.

Section II: Support and Expand the Crisis Response Workforce

Workforce Availability

- HHS should expand National Health Service Corps (NHSC) program requirements to include crisis care sites that are currently ineligible, and Congress should increase program funding to expand the number of awards to crisis response providers and enlarge the provider pipeline.
- The Health Resources and Services Administration (HRSA) should explore opportunities for innovative state and local provider recruitment partnerships, and Congress should consider ongoing retention incentives for crisis care providers in rural and underserved areas with health professional shortages.
- HHS should provide crisis response service administrators and supervisors with additional technical assistance on how to integrate peer support specialists to help expand the workforce and optimize the use of available providers.

Workforce Diversity and Cultural Responsiveness

- To help behavioral health crisis response systems respond better to the unique cultural needs of the populations they serve, Congress should increase funding for programs that recruit students from underrepresented backgrounds.
- To meet the needs of diverse populations, HHS should expand provider training on culturally responsive crisis care and offer technical assistance to administrators to improve crisis services.

Provider Retention

- To improve the uptake of support services and mitigate burnout, Congress should expand peer support services for crisis care providers and incentivize states to eliminate licensing procedures that can deter providers from seeking behavioral health care services.

Workforce Education and Training

- HHS should develop a National Behavioral Health Crisis Response Curriculum, support its integration into training programs, and expand remote continuing education programs in order to accelerate the dissemination of core competencies and best practices.
- To better equip law enforcement to respond to calls from 988, the Department of Justice (DOJ) should expand crisis intervention team (CIT) programs that train the police and partner law enforcement with behavioral health providers, hospital emergency services, and individuals in crisis.
- Congress should provide funding to the National Highway Traffic Safety Administration to revise the national Emergency Medical Services (EMS) Education Agenda and other EMS training standards to better incorporate and promote behavioral health crisis response.

Section III: Ensure Sustainable Financing and Coverage for the Crisis Response Continuum

Streamline Principal Planning, Funding, and Technical Assistance

- Congress should integrate federal funding streams with appropriations report language to maximize use of existing crisis response resources.
- HHS should provide more technical assistance to states on the use of available federal dollars and state-level crisis continuum funding mechanisms, including how Medicaid and block grant dollars can be braided with existing crisis response resources.

Call Centers

- Congress should authorize sustained appropriations for National Suicide Prevention Lifeline operations to support the implementation and utilization of 988.
- Congress should require SAMHSA to submit a recurring report on the resource needs of 988, as well as resource utilization and outcomes to assess system effectiveness and resource shortfalls.

Mobile Crisis Response Teams

- The Departments of Labor, Health and Human Services, and the Treasury should clarify that the emergency classification of benefits under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) includes mobile crisis services; they also should add mobile crisis response to required coverage.
- To expand the coverage of services provided by the mobile crisis response teams (MCRTs) and crisis stabilization units (CSUs), CMS should consider permanently adding additional behavioral health provider types to the list of Medicare-covered providers.
- CMS should release updated Medicaid guidance related to peer support services to expand their usage.
- CMS should expand data collection and the testing of new payment and service delivery models for EMS providers to supplement more traditional MCRTs.
- CMS should issue guidance to clarify that individuals receiving telemental health care services during an emergency are not subject to the in-person visit requirement.

Crisis Receiving and Stabilization Units

- Congress should support an increase in the number of crisis drop-off and stabilization locations to ensure that individuals with additional needs have adequate support and resources.
- Congress should support an expanded role for certified community behavioral health clinics (CCBHCs), which are already well suited to deliver care as part of the crisis response system.
- CMS should consider a demonstration program for peer respite services to test their effectiveness in reducing the crisis system's reliance on emergency departments (EDs) and CSUs, which have limited availability.



Introduction

The upcoming July 2022 launch of a mental health crisis response number, 988, represents a historic opportunity to ensure that a growing number of Americans in need are steered toward appropriate behavioral health care treatment.⁵ The new number also represents a chance to ensure that the nation’s emergency response infrastructure—including 911, EMS, and law enforcement—are prepared to help guide individuals to appropriate mental health services.

Rates of mental illness and suicide are high and rising. In 2020, nearly 1 in 5 adults reported that they suffered from mental illness; this number spiked to more than 41% in 2021, likely due, in part, to the COVID-19 pandemic.^{6,7,8} And, according to the Centers for Disease Control and Prevention (CDC), more than 47,000 deaths by suicide occurred in 2019, a jump from the just more than 38,000 in 2010.^{9,10} Mental illness and suicide rates are particularly pronounced among young adults and those in rural areas.¹¹ In rural America, these higher suicide rates are compounded by greater challenges residents face in accessing care.¹²

However, with proper coordination, training, and financial support, the nation’s emergency infrastructure can better help more Americans who require behavioral health crisis care—especially those who are in a suicidal crisis.

The new number to the National Suicide Prevention Lifeline, 988, will provide a different entry point into care and keep people in crisis from unnecessarily cycling through emergency departments and the criminal justice system.¹³

Creation of 988

To support the new crisis number for people experiencing mental health emergencies, all telecommunications carriers must provide access to 988 by July 16, 2022, which will direct calls to the National Suicide Prevention Lifeline. The bipartisan National Suicide Hotline Designation Act of 2020 (P.L. 116-172), signed into law on October 17, 2020, by President Donald Trump, codified this requirement. The number will likely improve responses to the 2 million calls the National Suicide Prevention Lifeline already receives each year, save lives in the face of rising suicide rates, and steer thousands of individuals into more appropriate treatment.^{14,15}

Enactment of the National Suicide Hotline Designation Act was a seminal bipartisan achievement. The law, however, did not require states to build out crisis call centers or mobile crisis response networks. In fact, many behavioral health advocates and stakeholders consider mobile crisis response teams (MCRTs) (as part of, or alongside, existing 911 emergency response infrastructure) and short-term crisis receiving/stabilization units (CSUs) to be critical aspects of the crisis response continuum. Without these components in place, individuals in crisis may find it difficult to get effective help. This is especially true in rural areas, where access to providers is even more limited than in cities.¹⁶

Yet despite the increasing need for behavioral health-trained clinicians, few states and localities have an adequate infrastructure in place to treat and stabilize individuals struggling with mental illness.¹⁷

In April 2022, Congress provided notable funding for 988, including a \$77 million increase for the National Suicide Prevention Lifeline and \$10 million for a new Mental Health Crisis Response Partnership program. Furthermore, President Biden's budget for FY2023 seeks to invest \$697 million in behavioral health services, including funding specific to the 988 crisis service buildout.^{18,19}

In addition to ongoing funding, however, the federal government can and should do more to help states build on their existing emergency response systems and behavioral health service infrastructure. For instance, the federal government can utilize 988 as a vehicle to help every state establish minimum standards for their behavioral health crisis response systems; provide more technical assistance to help localities in determining their existing, available, and underutilized resources; and meet the unique behavioral health needs of rural communities.

Establishment of the National Suicide Prevention Lifeline

Although concerted federal efforts to understand the root causes of suicide in the United States began in earnest in the 1950s, strategies to prevent deaths by suicide did not truly gain momentum until the mid-1990s, culminating in Surgeon General David Satcher's 2001 report, [*National Strategy for Suicide Prevention: Goals and Objectives for Action*](#).

As part of a national strategy to address increases in the rates of mental illness and suicide, SAMHSA established the National Suicide Prevention Lifeline.

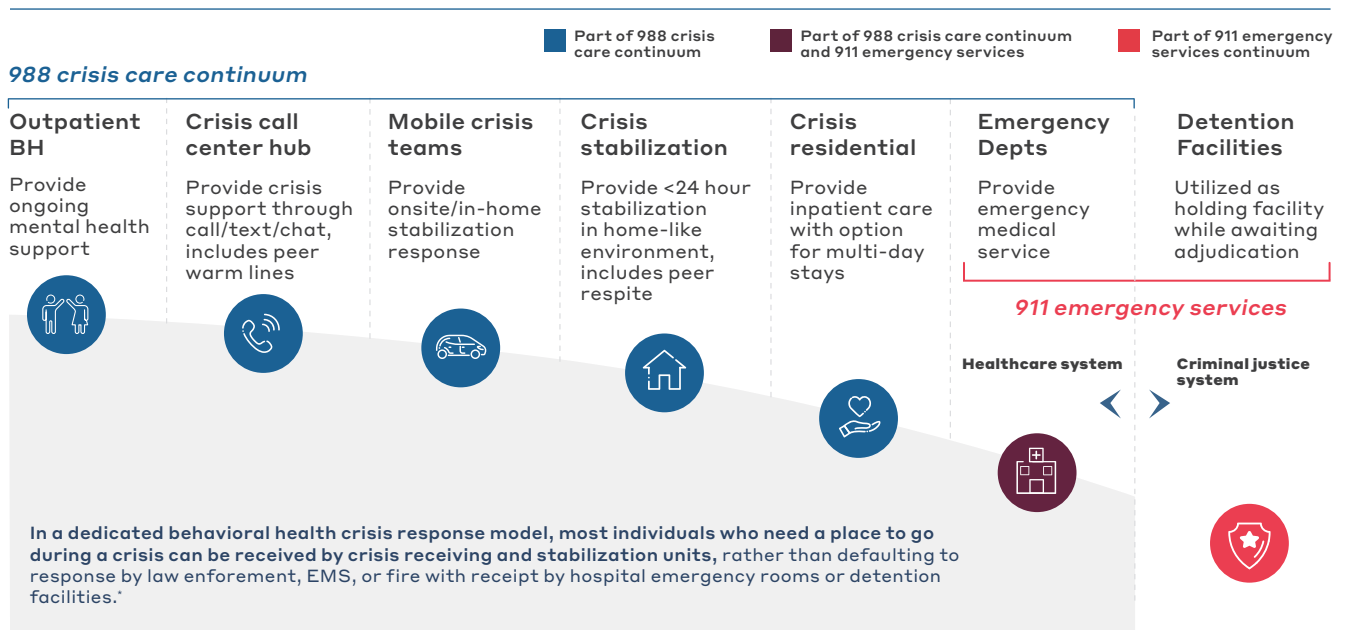
As part of a national strategy to address increases in rates of mental illness and suicide, SAMHSA established the National Suicide Prevention Lifeline. The lifeline went live in 2005 and continues to provide free crisis counseling and emotional support to callers. It is federally funded and operates via a 10-digit number. The lifeline serves as a centralized switchboard that connects more than 2 million calls per year to one of more than 150 crisis centers nationwide or to a national backup center. Individuals who call the lifeline report reduced suicidality (i.e., thoughts or plans of, or attempts at, suicide).²⁰

To make the lifeline more accessible to a growing number of Americans in need, a bipartisan group of lawmakers passed the National Suicide Hotline Improvement Act of 2018. It required the Federal Communications Commission (FCC) to consider the feasibility of designating an easy-to-remember three-digit dialing code for the lifeline. The notion of a three-digit number as an alternative to 911 grew more popular alongside greater awareness of the too-often lethal interactions between law enforcement and individuals with mental illness and the cyclical nature of behavioral health treatment for those experiencing acute mental illness.²¹ As a result, the FCC recommended the adoption of 988 in 2019.²² This recommendation resulted in the passage of the bipartisan National Suicide Hotline Designation Act of 2020, the legislation requiring the formal implementation of 988.

988 as the Front Door to the Behavioral Health Crisis Continuum

The behavioral health crisis continuum comprises several essential services, including 24/7 crisis call centers, MCRTs and short-term crisis stabilization units (CSUs) and similar centers or facilities (see Figure 1). These services meet people where they are and create appropriate alternatives to triaging individuals in EDs or calling law enforcement. SAMHSA expects greater awareness of 988 to double demand on the lifeline.²³ If the lifeline cannot meet the increased demand for assistance, law enforcement, EDs, and the criminal justice system will likely have to fill the void.

Figure 1: Behavioral Health Crisis and Emergency Services Care Continuum ²⁴



Source via Vibrant Emotional Health: Milbank Memorial Fund, "The '988' Opportunity: Improving Our Response to Behavioral Health Crisis," published Nov. 2020. Crisis Now, "Mental Health Care Shouldn't Come in a Police Car," published Dec. 2019.

* For both 988 and 911, a share of calls will be resolved without need for a receiving facility. In some cases, individuals receiving care through a dedicated mental health crisis response model will need receipt by non behavioral health facilities, but this will not be a default response.

The FCC's final rule in 2020 implementing the National Suicide Hotline Improvement Act noted that even a small reduction in suicide mortality could create savings beyond the estimated 988 implementation costs, as well as provide savings to medical care and public safety providers.²⁵ A recent SAMHSA report to Congress stated that 988 "will decrease suicides, reduce arrests and criminal justice involvement for individuals with behavioral health needs, and will facilitate linkages to care that reduce unnecessary ED boarding and hospitalization."²⁶

State and Local Implementation of Crisis Response

Resources deployed to address mental health crises vary greatly by state. A BPC review of nationwide crisis response systems found that most states and many counties have MCRTs and CSUs, which are operated either by state or county departments of health or by private entities. The review, however, found little uniformity in crisis resource availability across counties even within a single state. Additionally, not every state coordinated overall crisis response systems, and few connected services directly to the new 988 number.

Promisingly, many states and localities are seeking to bolster their behavioral health crisis response infrastructure. Supported in a bipartisan fashion by Congress and the Trump and Biden administrations, as well as by prior

administrations, the federal government has already taken steps to prepare for 988 implementation.

Much of this work has been guided by SAMHSA's "[National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit](#)"; by the "[Roadmap To the Ideal Crisis System](#)," produced by the Group for the Advancement of Psychiatry and the National Council for Mental Wellbeing; and by the [Crisis Now](#) model, which was developed by the National Association of State Mental Health Program Directors in concert with the National Action Alliance for Suicide Prevention, the National Suicide Prevention Lifeline, the National Council, and RI International.

Against this backdrop, BPC conducted dozens of interviews with experts and policy leaders, including state Medicaid experts, peer support specialists, hospital administrators, EMS professionals, and others. The goal was to gain additional on-the-ground insights into the behavioral health crisis response landscape and how the federal government can support its development alongside the implementation of 988. BPC also sought to understand the appropriate role of law enforcement, EMS, and other first responders, and how providers across the continuum can be better trained, utilized, and compensated for providing crisis services.



Policy Recommendations

Section I: Enhance Federal Support for Crisis Response Implementation and Utilization

Implementing 988 and improving the entire continuum of care requires a strong federal effort to support states and localities. To ensure states can administer services and understand new sources of federal funding by making better use of data, the system requires:

- Greater interagency and interdepartmental collaboration;
- Better federal-to-state coordination; and
- Optimized data collection.

INTERAGENCY AND INTERDEPARTMENTAL COLLABORATION

To support the new Behavioral Health Crisis Coordinating Office within SAMHSA:

- **Congress should provide SAMHSA and the Federal Interagency Committee on Emergency Medical Services (FICEMS) with the appropriate resources; Congress should also provide clear instructions on how to enhance EMS capabilities for behavioral health crises.**
- **The HHS secretary should direct SAMHSA and CMS to issue joint guidance to states on data sharing, response team structure, and the use of federal funding at the state level.**
- **HHS should direct SAMHSA to further develop a national, equitable communications strategy to educate the public about 988.**

SAMHSA Should Be Included as a Member Agency of FICEMS

To support the implementation of the 988 program, Congress has an opportunity to add SAMHSA as a member to the Federal Interagency Committee on Emergency Medical Services (FICEMS). Created under legislation signed by President George W. Bush in 2005, FICEMS has the statutory purposes of ensuring coordination among federal agencies involved with EMS and 911 services; identifying EMS and 911 needs; recommending new or expanded EMS and communication technologies; identifying ways to streamline the process through which federal agencies support EMS; assisting state, local, and tribal entities in setting priorities; and advising on matters related to implementation or coordinated state EMS programs.^{27,28}

FICEMS members include the Department of Defense; the Department of Homeland Security; the Department of Health and Human Services (specifically the assistant secretary for preparedness and response, Indian Health Service, CDC, HRSA, and CMS); the Department of Transportation; and the Federal Communications Commission. Including SAMHSA as a member would bring behavioral health expertise into the existing emergency response structure by leveraging interagency guidance, programming, coordinated regulatory efforts, and other mechanisms. Moreover, this would enhance EMS teams' ability to respond to behavioral health crises as well as improve behavioral health crisis systems nationally.

As critical first responders, EMS are embedded in the existing emergency infrastructure. EMS would be an asset in responding to behavioral health crises during the transition to 988, thus avoiding the need to establish an entirely new workforce with new processes and procedures. Within FICEMS is a Technical

Working Group composed of interagency staff-level employees who meet monthly to support ongoing activities (e.g., data collection, recommendations for rural areas and helicopter use, etc.). Furthermore, FICEMS releases a strategic plan containing goals for enhancing EMS's capabilities across agencies.²⁹ Including SAMHSA in FICEMS would allow the member agencies to access SAMHSA's expertise so that behavioral health crises become integral to EMS operations, including by changing ambulance crews to contain a behavioral health professional.

SAMHSA could leverage the role of its new Behavioral Health Crisis Coordinating Office and create a role within the office to act as a representative to the FICEMS as part of the office's defined set of responsibilities. The FY2022 omnibus, which was signed into law in March 2022, appropriated \$5 million for the Behavioral Health Crisis Coordinating Office. The office will provide technical assistance and support data analysis and evaluation functions to develop a crisis care system that meets nationwide standards. Part of the Behavioral Health Crisis Coordinating Office's role is to work with other HHS agencies, including CMS, HRSA, and external stakeholders, to "coordinate work related to behavioral health crisis care."³⁰ As such, it is the appropriate office within SAMHSA to liaise with the FICEMS member agencies.

The need for interagency coordination across programs dealing with serious mental illness is not new. A [2014 Government Accountability Office \(GAO\) report](#) recommended that HHS establish a mechanism for facilitating such an office. Until 2009, HHS directed the Federal Executive Steering Committee for Mental Health. The Behavioral Health Coordinating Council, which the Biden administration resurrected, performs some functions that the steering committee previously carried out; however, it is limited to HHS and is not an interagency committee.³¹ The new Behavioral Health Crisis Coordinating Office has the potential to fill the collaborative void noted years ago.³²

The creation of this office follows the establishment of the 988 number and will aim to expand capacity of, and access to, local resources across the crisis care continuum.³³ According to a [December 2021 report](#) from SAMHSA, a \$10 million investment would help support 988 implementation and broader transformation of the crisis system by providing technical assistance to states and crisis centers, strategic planning, performance management and evaluation, and formal partnerships and convenings.³⁴ In its proposed FY2023 congressional justification, SAMHSA noted that the Behavioral Health Crisis Coordinating Office would support standards setting, provide technical assistance, and aid ongoing program evaluation for 988 call centers.³⁵ SAMHSA has an opportunity to expand the scope of the Behavioral Health Crisis Coordinating Office to include interagency and interdepartmental coordination.

SAMHSA and CMS Should Issue Joint Guidance to States

To support the crisis response systems at the state level, CMS and SAMHSA should issue joint guidance to state Medicaid agencies and state departments of health. The guidance would have two aims: It would define the roles of state Medicaid agencies and state departments of health in statewide behavioral health crisis responses, and it would identify opportunities to coordinate federal funding at the state level to ensure that financing is available across the entire continuum of crisis care. Even before the creation of 988, the unmet need for behavioral health services in the United States was significant and further complicated by physical comorbidities and inequities.^{36,37} Thus, CMS and SAMHSA would need to structure their guidance according to the roles state-level entities would assume to address this unmet need. And as part of the guidance, the agencies would also need to consider the input of these state-level entities.

CMS and SAMHSA issued a joint informational [bulletin](#) in January 2015 that contained a description of the benefit package for evidence-based interventions for youth with substance use disorders and their families.³⁸ Although these agencies have not issued a joint informational bulletin for behavioral health crises, they have separately issued guidance.

Generally, CMS guidance has prioritized only pieces of the crisis care continuum: The agency prioritizes expanding crisis stabilization services in institutions for mental disease—which are excluded from using Medicaid financing, potentially creating barriers to care—through the use of Section 1115 waivers. As of late 2021, CMS is working with states to promote access to Medicaid services for mobile crisis intervention services funded by the American Rescue Plan Act of 2021 (ARP).^{39,40,41}

SAMHSA's guidance focuses on the entire continuum, specifically resources for State Mental Health Program Directors and other state-level entities charged with implementing behavioral health crisis care.⁴² These resources simply note opportunities for collaboration with state Medicaid agencies, but do not explicitly include guidance endorsed by CMS. As a result, mental health agencies may build systems and services that are not aligned with the activities that Medicaid funding can support.

The proposed joint guidance would echo the joint informational bulletin from 2015 with input from the state-level entities to note considerations for implementation. It would include opportunities to leverage federal funding for specific elements of the crisis care continuum, as well as evidence-based and best practices in Medicaid benefits packages that states could implement. The guidance would also include a formal process for ensuring equity. In particular, the guidance would give states flexibility over how their Medicaid and SAMHSA funds are spent, with the goal of tailoring interventions targeting rural and frontier populations, children and youth, and communities of color.

HHS Should Direct SAMHSA to Develop a 988 Communications Strategy

To ensure the public is both aware of and trusts the services associated with 988, HHS should direct SAMHSA to further develop its communications strategy. According to a November 2021 [survey](#) by the National Alliance on Mental Illness (NAMI), only 4% of American adults are either somewhat or very familiar with 988, indicating a huge need to educate the public. During his 2022 State of the Union address, President Biden touted 988 as part of his “unity agenda,” noting its bipartisan appeal in Congress and across the country.⁴³ However, for the information to have a wide reach, SAMHSA will need to be more strategic about where and how it shares resources about 988.⁴⁴

SAMHSA released a [fact sheet](#) in early 2022 with information about 988, its replacement of the National Suicide Prevention Lifeline, the timeline of its introduction, funding pathways, and the ways in which the number differs from 911. Although the fact sheet is a positive first step, much more outreach is necessary to improve overall awareness of 988. Communications about 988 should also target specific geographic locations or demographics, and information should be conveyed in appropriate media outlets. Moreover, the fact sheet does not include information about equitable treatment of mental health patients—especially among people of color. Examples of omissions include the way patients will be treated during crises, the quality of behavioral health services they will receive from practitioners, and the outcomes of these encounters. People will call 988 if they believe and trust that they will receive effective and compassionate care and that services will be reliable and timely regardless of where they live.

Further, the strategy should explain how local law enforcement entities are vital elements of behavioral health crisis response and address public perceptions. Every year, millions of mental health crisis calls are made to 911 and local crisis lines. The November 2021 NAMI survey found that while 72% of respondents have a favorable opinion of law enforcement in their own communities, 4 in 5 people believe that mental health professionals should be the primary first responders; about 3 in 5 respondents said they would be afraid that the police might hurt a loved one while responding to a mental health crisis.⁴⁵

Significantly, in rural areas, the 988 response will rely in part on traditional first responders such as law enforcement and EMS, as these communities may experience difficulties obtaining necessary resources (e.g., funding, personnel) for a comprehensive behavioral health crisis system. However, given the survey information, communications strategies are critically needed to clarify how 988 will function locally and nationally, and what the role of law enforcement will be in these cases as opposed to 911 calls.

Despite these needs, SAMHSA did not receive funding in the FY2022 budget for a communications plan. Given the pandemic's impact on mental health the HHS secretary might consider allocating unused resources from the COVID-19 relief packages rather than requesting additional funding from Congress.

FEDERAL-TO-STATE COORDINATION

To better support states' implementation of 988 and behavioral health crisis response systems:

- **SAMHSA should establish a scorecard for states to assess performance-based national standards.**
- **SAMHSA should fill existing vacancies, and CMS should hire and designate behavioral health capabilities within its staff.**

Establish a Scorecard to Assess Performance-Based National Standards

Although SAMHSA is charged with reducing the effects of substance use disorders and mental illness across the United States, its 2020 guidelines for governments, service providers, and others involved in crisis response have not been consistently adopted across the country.⁴⁶ Moreover, crisis services are significantly more fragmented and variable than other health care services, meaning that there is likely to be substantial disparity in the design and implementation of crisis continuums.⁴⁷ To combat this, SAMHSA should encourage states to implement 988 using a standard set of performance-based indicators and to work with CMS to ensure that these standards are aligned with the realities of what Medicaid can finance. This way, program managers can assess the extent to which states are implementing their 988 programs and compare progress among states and over time.

Unified implementation of these core services through specific state standards from SAMHSA would advance the national crisis response system by standardizing service delivery alongside law enforcement and other key stakeholders. Administering services may present challenges given the multidisciplinary nature of behavioral health crisis care (e.g., first responders such as law enforcement and EMS) and the variability in quality of care. The diversity would also make it difficult to compare and assess these services. SAMHSA's National Guidelines specify some of the approaches to address these implementation challenges, and include implementation resources (e.g., a "crisis resource need calculator" to assess system capacity, tips for system implementation for both workforce and technology, and system evaluation tools). Thus, SAMHSA can use its National Guidelines (see Figure 2) as a benchmark, whereby states can establish and work toward meeting a baseline for their crisis response systems.⁴⁸

The design of the crisis response system provides opportunities for state and local leaders to address inequities. Available data have found racial disparities in the way that first responders handle behavioral health

Figure 2: SAMHSA National 988 Guidelines, 2020

Core Services	Description
Regional Crisis Call Center	Regional 24/7 clinically staffed hub/crisis call center that provides crisis intervention capabilities (telephonic, text, and chat). Such a service should meet National Suicide Prevention Lifeline (NSPL) standards for risk assessment and engagement of individuals at imminent risk of suicide and offer air traffic control quality coordination of crisis care in real time.
Crisis Mobile Team Response	Mobile crisis teams available to reach in a timely manner any person in crisis in the service area in his or her home, workplace, or any other community-based location.
Crisis Receiving and Stabilization Units	Crisis stabilization units providing short-term observation (under 24 hours) and crisis stabilization services to all referrals in a home-like, non-hospital environment.

Adapted from Substance Abuse and Mental Health Services Administration, *National Guidelines for Behavioral Health Crisis Care*, 2020. Available at: <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>.

patients.⁴⁹ Similarly, rural and frontier communities face unique workforce and geographic challenges that make it more difficult to deliver high quality crisis services that meet patients’ needs.⁵⁰ Finally, signs indicate that the COVID-19 pandemic has significantly affected the mental health of children and youth. In 2021, the surgeon general issued an advisory depicting the ways in which the pandemic and surrounding events have corresponded with rates of psychological distress, including increases in symptoms of anxiety, depression, and other mental health disorders.⁵¹

With the upcoming official introduction of the 988 program, SAMHSA should scale and adapt its [National Guidelines for Behavioral Health Crisis Care](#) by offering specific standards for states. The National Guidelines focus primarily on the best practices and characteristics that align with each part of the continuum of care.⁵² SAMHSA should build on this by incorporating lessons learned from the implementation process, from scaling the standards, and from state and local best practices.

SAMHSA should also incorporate guiding principles from the National Council’s [Roadmap to the Ideal Crisis System](#) because it advances the

implementation of national standards. Whereas SAMHSA's National Guidelines include ideal best practices, the National Council's Roadmap includes measurable criteria for states to assess implementation progress.⁵³ By incorporating measurable principles in the National Guidelines, states' abilities to deliver services in a reliable and equitable manner would be enhanced. States would be able to track their implementation progress as they work toward introducing the best practices that SAMHSA has identified for behavioral health crisis responses. This would enhance standardization and some implementation instructions and benchmarks that are missing from SAMHSA's National Guidelines.

Further, SAMHSA should incentivize state-level adoption of performance metrics proposed by the National Council for these reasons. The performance indicators (see Appendix A) encompass three distinct areas—accountability and finance, basic array of capacity and services along the crisis continuum, and basic clinical practice—that make up elements of a successful crisis response system. Ultimately, incentives for adopting the scorecard would reward higher performance in areas like engagement and responsiveness and would balance penalties appropriately. They would undergo an annual review process, and would be phased in to allow some time for states to transition their crisis response systems.

SAMHSA should also strengthen its technical assistance capabilities within the Center for Mental Health Services, the SAMHSA entity that houses the Behavioral Health Crisis Coordinating Office. This would enhance its ability to help administer a broad array of technical assistance efforts and enable SAMHSA to give special consideration for addressing health disparities and factors that affect health equity. In particular, SAMHSA could leverage its expertise to introduce various processes to state departments of health in an equitable manner. For example, SAMHSA included a section in a [December 2021 report](#) to Congress on 988 with training guidelines for at-risk youth.⁵⁴ These guidelines include such activities as updating network counselor training materials for serving lesbian, gay, bisexual, transgender, queer+ youth; targeting youth-focused organizations; and organizing webinars to review best practices.

SAMHSA Should Fill Existing Vacancies and CMS Should Hire and Designate Behavioral Health Capabilities Within Its Staff

Approximately 30% of SAMHSA's full-time employee (FTE) positions are currently vacant, meaning that the agency has opportunities to hire and fill these roles to build its training and technical assistance capacity. As such, Congress should direct SAMHSA to fill its staff vacancies to support increased technical assistance and, if necessary, add funding to SAMHSA's staffing budget.

Although these vacancies are for positions across the agency, the creation of SAMHSA's new Behavioral Health Crisis Coordinating Office indicates that there is congressional interest in a central office at SAMHSA that would offer technical assistance, especially on behavioral health crises. The expanded training, technical assistance, along with improved program management capacity would further expertise on behavioral health crises (including various approaches, such as a trauma-informed response, which promote equity) and data system management. This would also enable SAMHSA to better oversee the 988 program in coordination with the states. States would thus be able to provide input on programmatic direction and receive customized guidance from agency leaders.

In addition, CMS should build behavioral health capacity by hiring staff with this subject matter expertise. Currently, CMS does not have a dedicated senior behavioral health expert, limiting its ability to provide technical assistance to state Medicaid agencies. Behavioral health technical assistance to states would enhance states' abilities to appropriately expand coverage within their Medicaid programs by identifying additional services that could be covered and tracked and to determine clinical effectiveness for behavioral health crisis services across the continuum of care.

DATA INFRASTRUCTURE

To optimize data collection for behavioral health crisis response:

- **SAMHSA and NHTSA should coordinate tracking 988 data by leveraging the National Emergency Medical Services Information System (NEMSIS).**
- **Congress should direct CMS to adopt and scale behavioral health quality metrics for each component of the crisis response continuum.**

Coordinate with NHTSA to Leverage the NEMSIS for 988 Data Management

Within the National Council's Roadmap, data sharing is one of the core building blocks of the crisis response system, fostering accountability and financing.⁵⁵ As such, SAMHSA should coordinate with NHTSA to use the National EMS Database known as NEMSIS—a data set managed by NHTSA at the Department of Transportation (DOT) and used for EMS data—as the data management system for the mobile crisis response portion of the 988 program.⁵⁶

The data used for other emergency response systems are more conducive to surveillance. In particular, NEMSIS collects information from incidents involving EMS activations for emergency care and transport in response

to a 911 call for assistance. It is a valuable surveillance tool because it can be updated on a national level weekly and in as little as seven minutes in those states using the latest version of the data standard.

Because NEMSIS is so well suited for surveillance activities, it would aid SAMHSA in supplementing its other program data to have a population-level benchmark. In its report to Congress, SAMHSA noted that the data currently being collected for the National Suicide Prevention Lifeline are primarily process measures (e.g., calls, chats, and texts initiated). Using NEMSIS will give SAMHSA access to metrics such as the “dispatch reason” with options for several types of crises (e.g., overdose), protocols used, and others.

Although NEMSIS has a well-defined list of metrics it collects from states, new metrics can be added; for example, during the COVID-19 pandemic, NEMSIS was modified to include metrics to assist with the national surveillance efforts to track the coronavirus.⁵⁷ SAMHSA would be able to directly access this data set in coordination with NHTSA, enabling them to track the 988 data alongside other EMS metrics.

Even with NEMSIS, SAMHSA must keep several considerations in mind if it is to further understand the impact of the 988 program. First, while NEMSIS offers valuable insights into behavioral health crises at the population level, SAMHSA would need to work with NHTSA to establish a process for noting which of the EMS responders received calls through 988 as opposed to 911, and vice versa for 988-appropriate calls that come through 911. Second, it could match 911 call data with ambulance data to account for individuals who experienced a behavioral health crisis but either refused transport or were stabilized at the scene. Finally, SAMHSA would need to coordinate with both NHTSA and CMS to track and further support behavioral health crisis patients who are transported by ambulance to emergency departments and/or CSUs while complying with the Health Insurance Portability and Accountability Act (HIPAA), especially when integrating the data from NHTSA and CMS claims. Because these are all within the federal government’s domain, these datasets should be de-identified. They do not, however, require data use agreements to be incorporated.

Direct CMS to Adopt and Scale Behavioral Health Quality Metrics

The National Council’s Roadmap emphasizes the need for defining quality metrics to measure performance to ensure transparency and quality.⁵⁸ As behavioral health crisis response efforts grow, CMS should adopt and scale quality metrics for each part of the behavioral health crisis response continuum. A scorecard to measure state-level performance (see Appendix A) would enable the federal government to compare states’ crisis response systems. These metrics—including for structural, process, and outcome

quality—would help assess and compare quality of services across the entire continuum of crisis care.

Notably, behavioral health is not well represented in existing quality metrics, and when it is included, the measures are not optimal for behavioral health crises.⁵⁹ One data source is CMS's Core Set of Adult Health Care Quality Measures for Medicaid, which provides an alternative set of health service delivery metrics.⁶⁰ The Core Set includes 12 behavioral health measures that could assess quality of care for behavioral health crises (e.g., follow-up after an ED visit for mental illness) that could be updated to include metrics that enhance understanding of crisis care. Establishing better behavioral health metrics and more frequent reporting would inform policymakers about progress and challenges, as well as guide behavioral health crisis response efforts. Still, given the unique nature of crisis services, it is important to consider other potential data inputs.

The three parts of the crisis response continuum—call centers, MCRTs, CSUs, and similar facilities—would need to operate together to assess improvements in patient outcomes across the behavioral health crisis system. The Core Set is a primary vehicle for Medicaid to report quality and performance information to CMS, but supplemental crisis-specific performance metrics would make comparability across services and settings possible. There should be timely reporting across the continuum with metrics that correspond with the services administered to people experiencing behavioral health crises. Examples of such metrics include:⁶¹

- Percent of individuals who have a welcoming, hopeful experience.
- Percent of individuals who receive “no force first” (person-centered) engagement.
- Setting-specific:
 - Percent of crisis calls that are resolved without having the patient processed through the criminal justice system.
 - Percent of MCRT encounters resolved in the field.
 - Percent of individuals discharged safely to non-hospital settings.
- Percent of individuals who receive crisis follow-up care within 48 hours.
- Percent of patients with one or more person they know (e.g., family member) and who are engaged collaboratively in the crisis intervention process.

Establishing better behavioral health metrics and more frequent reporting would inform policymakers about progress and challenges.

- Percent of crisis encounters resolved successfully within two hours.
 - Percent of calls that meet patient needs telephonically without having to dispatch MCRTs.
 - Percent of MCRT encounters that resort to 911 activation.
 - Percent of MCRT encounters that meet patient needs without having to transport to an emergency department or other facility.
- Percent of CSU encounters that are discharged to community settings without having to be admitted to inpatient psychiatric units or ED.

To date, crisis response metrics are difficult to track. If 988 expands to encompass other behavioral health crises beyond the National Suicide Prevention Lifeline, ongoing infrastructure upgrades will be necessary to expand access and provide a consistent user experience. Medicaid funding can support these upgrades, particularly for the call centers as they anticipate higher call volumes. Although Medicaid can pay for call centers, including the data infrastructure, only a handful of states do. CMS and SAMHSA would need to coordinate on quality metrics and require that they be collected and accurately reported for states to receive their crisis funding.

System upgrades may involve more efficient routing technologies and data collection to track response times, as well as more consistent demographic data collection to identify population needs and any disproportionality in service delivery and outcomes.⁶² One potential option for capturing these metrics is that DOT could track them using NEMSIS down to the state and “crew” levels for each EMS team. Still, 911 data in general (not just EMS data) are collected and managed at the state level. In general, data collection can be standardized using advanced technology systems (e.g., Computer Aided Dispatch, a software vendor that stores data from various 911 systems), although the systems are limited in rural areas.⁶³



Section II: Support and Expand the Crisis Response Workforce

Successful implementation of crisis intervention services across the United States requires both an adequate supply of the behavioral health workforce and better preparation. This includes bolstering:

- **The availability of the crisis care workforce;**
- **Workforce diversity and cultural responsiveness;**
- **Provider retention; and**
- **Education and training for crisis care providers.**

Despite ongoing efforts to enlarge the health care workforce, significant shortages of behavioral health care providers persist alongside inadequate distribution of providers and inequitable demographic representation. These challenges limit the staffing of call centers, mobile response units, and stabilization centers, and create disparities in access to services and culturally responsive care.

To realize the full potential of the crisis intervention continuum, Congress should support and expand efforts to increase the pipeline of behavioral health providers, improve provider retention, optimize the effectiveness of the available workforce, and train providers to meet patients where they are. Congress and the administration can bolster the workforce by increasing funding for programs that incentivize entrance into behavioral health crisis intervention professions; piloting innovative strategies to grow, diversify, and strengthen the crisis response workforce; and improving education, training, and support for crisis care providers.

WORKFORCE AVAILABILITY

To grow the number of available behavioral health crisis intervention providers and improve the distribution of the workforce:

- **HHS should expand National Health Service Corps (NHSC) program requirements to include crisis care sites that are currently ineligible and Congress should increase program funding to raise the number of awards to crisis response providers.**
- **HRSA should explore opportunities for innovative state and local provider recruitment partnerships, and Congress should consider ongoing retention incentives for crisis care providers in areas with health professional shortages.**
- **HHS should provide crisis response service administrators and supervisors with additional technical assistance on integrating peers.**

Expand NHSC Sites and Increase Program Funding

The availability of the behavioral health workforce is a critical limiting factor in expanding crisis services. 988 will serve as a crucial point of entry for those with urgent behavioral health needs and, with increased access to an easier-to-remember number, demand for services is expected to rise in the near term.⁶⁴ Although crisis care staffing varies based on programmatic and community needs, most programs utilize a multidisciplinary team of behavioral health professionals and paraprofessionals. Therefore, the behavioral health workforce must be expanded across disciplines to ensure adequate staffing and universal access to the full crisis care continuum. However, using [data](#) from the County Health Rankings & Roadmaps program at the University of Wisconsin, Mental Health America [reports](#) that, while the rate of mental health providers has improved in nearly every state in the past year, the need for care significantly surpassed the growth of the workforce.⁶⁵

To expand the pipeline of behavioral health crisis response providers, such as psychiatrists and mental health nurse practitioners, Congress should increase

funding for programs that incentivize entrance into the field, such as HRSA’s NHSC, which provides loan repayment and scholarship awards in exchange for a period of service in a health professional shortage area (HPSA). Additional support for these programs is especially critical in rural areas, as the Health Resources and Services Administration [reports](#) that approximately 60% of HPSAs are considered rural, but only 36% of NHSC clinicians serve in rural areas.⁶⁶

The types of sites eligible to become NHSC Provider Locations have diversified over the past few years, but a variety of behavioral health crisis employers still do not qualify their providers for NHSC awards. Expanding eligibility to include those working across the crisis response continuum—such as those staffing crisis care centers that are not part of currently eligible facilities—would help incentivize entrance into these professions, grow the behavioral health crisis care workforce, and improve staffing availability.

Despite recent increases in the number of NHSC providers who are actively fulfilling their service obligations, funding shortfalls continue to limit the number of NHSC awards and therefore the number of eligible sites that can utilize NHSC providers. As of December 2021, more than 1,500 open NHSC positions could not be filled due to funding limitations.⁶⁷ In FY2021, funding from the ARP provided a one-time \$800 million appropriation to increase the number of scholarship and loan repayment program (LRP) awards the NHSC can make; this appropriation included funding for nearly 1,200 scholarship awards and \$100 million for states’ LRP awards. However, the increase is only temporary, and additional permanent funding is needed to sustain and grow the behavioral health care workforce over the long term.

Explore Innovative Recruitment Partnerships with State and Local Institutions and Additional Provider Retention Incentives

A significant increase in the number of providers in rural and underserved areas is needed to ensure that all Americans have access to the crisis care system regardless of where they live. Federal scholarship programs and LRPs aid in the recruitment and redistribution of behavioral health providers during their required service, but do not necessarily lead to permanent relocation. Expanding initiatives that partner with states and local entities could improve the likelihood of providers remaining by recruiting from, and placing participants in, areas of service where they have existing ties.

To do so, HRSA should consider the viability of establishing recruitment programs, similar to NHSC scholarship awards, that are administered through local institutions, such as community colleges and universities in underserved areas, and require participants to complete their service at a local partner site (e.g., Certified Community Behavioral Health Clinics (CCBHCs) or Critical

Access Hospitals). These programs should be considered for their potential to generate interest in the behavioral health field at the local level and to create a clear pathway for providers to train and serve in their own communities, rather than bringing in outside providers.

These partnerships could also help increase the number of providers in specific locations with critical needs, as well as raise participation in rural HPSAs. Although rural areas disproportionately make up HPSAs, the majority of NHSC participants serve in urban HPSAs, and there is evidence that additional incentives are needed to fill gaps in rural areas. Additionally, these programs could expand opportunities for rural students to enter behavioral health professions through early recruitment and by providing additional financial support for education.

To improve retention of behavioral health providers in shortage areas, Congress should also consider establishing long-term incentives beyond limited-duration programs such as LRPs. BPC's previous report, [The Impact of COVID-19 on the Rural Health Care Landscape](#), articulated several policy options for Congress and the administration to leverage the tax system to improve retention of practitioners in rural areas. Examples included a federal tax credit for rural providers and the exemption of Indian Health Service loan repayment funds from federal income tax, as is already done for other federal LRPs.

Provide Technical Assistance on Integrating Peers

Peer support specialists—trained individuals with lived experience who can assist others in their treatment and recovery—play a vital role in many crisis intervention service models. Peer specialists can counsel crisis center callers, mobilize in teams to meet callers in-person, and support patients over the course of their treatment within stabilization units. In addition to the valuable services they provide, peers on behavioral health crisis care teams can help expand the available workforce and optimize the use of available providers by allowing those with more specialized training to increase the clinical time they spend on patients with more acute needs.

Although SAMHSA offers some training [resources](#) on the utilization of peer specialists in behavioral health and substance use disorder (SUD) services, more support is needed to accelerate the uptake of peer services across the crisis care continuum. HHS should provide additional technical assistance on growing the role of peers in various crisis care settings and conduct outreach to engage crisis care administrators in this effort. CMS should also provide technical assistance to state Medicaid agencies on the authorities and pathways to expand the use of peers in crisis care settings. Lack of understanding of the role of peers, effective supervision of peers, and obtaining reimbursement for peer services can hinder implementation efforts, since coverage varies significantly based on a program's sources of payment and care

delivery models utilized. Technical assistance can help administrators identify sustainable financing models for utilizing peers and incorporating them in clinical workflows. This assistance can also help clinics receive reimbursement for the appropriate use of peer services and help clinical supervisors attain the skills they need to support peers in the workplace to maintain their own recovery.

WORKFORCE DIVERSITY AND CULTURAL RESPONSIVENESS

To improve the diversity of the behavioral health crisis intervention workforce:

- **Congress should increase funding for recruitment programs for behavioral health professions that target students from underrepresented backgrounds during high school and college.**
- **HHS should expand provider training on culturally responsive crisis care and offer technical assistance to crisis service administrators to improve services for diverse populations.**

Increase Funding for Programs That Recruit Students From Underrepresented Backgrounds

To fulfill the vision of 988 and effectively serve people in need, providers across the crisis care continuum must understand, and be prepared to respond to, the unique cultural needs of the populations they serve. However, lack of diversity and cross-cultural understanding continue to be a challenge for the behavioral health care workforce.

To improve workplace diversity, efforts to recruit students from underrepresented backgrounds must begin early to ensure students are on a pathway to enter behavioral health professions. These initiatives should include early education on behavioral health to increase awareness of the field and reduce stigma; career counseling to assist students in navigating behavioral health career pathways; and mentoring opportunities to support students throughout their training. Across a variety of professions, the cost of health care education is a significant deterrent to potential students, especially those from relatively lower income backgrounds. These efforts should therefore be paired with increased financial aid for students in need.

To accelerate efforts, Congress should increase funding for programs that recruit students from diverse backgrounds, including from rural areas, and support these students during behavioral health care education and training. These programs include HRSA's Health Careers Opportunity Program, which [aims](#) to "assist individuals from economically and educationally disadvantaged backgrounds with entering and graduating from an allied health or health

professions program,” and SAMHSA’s Minority Fellowship Program, which [aims](#) to “improve behavioral health care outcomes for racial and ethnic populations by growing the number of racial and ethnic minorities in the nation’s behavioral health workforce.”^{68,69} In addition to increasing funding for these programs, allocations should specifically provide for an increased number of awards to behavioral health care professions that support the crisis care continuum.

Expand Provider Training on Culturally Responsive Crisis Care

To fully realize the bold vision of 988, it is critical that crisis response services effectively engage those seeking help and foster trust in the system. To do so, crisis care providers must be able to understand, recognize, and adapt to the unique needs of diverse individuals. However, differences in provider training and a lack of diversity in the behavioral health crisis workforce can create disparities in the availability of culturally responsive care.

Additional training and technical assistance can help bridge this gap and ensure more-equitable access to crisis services. These supports should be provided to both individual providers—such as educational resources on caring for specific populations—and to crisis call centers, mobile response teams, and stabilization centers, with technical assistance helping address the needs of communities in their coverage area, such as assistance with development of workflows to overcome language barriers between patients and providers.

To ensure all crisis care providers have the skills and understanding needed to provide culturally responsive care, Congress should increase funding for programs that develop cultural competency training resources for providers, such as HRSA’s [Centers of Excellence](#) (COE), with a specific focus on improving responsiveness across the crisis care continuum. COE grantees recruit underrepresented minority students and faculty into health profession education programs and provide training on minority health issues and social determinants of health. HHS should also consider other opportunities to expand technical assistance to crisis care site administrators. The goal is to improve services for specific populations with access barriers and to improve the recruitment of providers who have specialized skills or abilities required to meet the needs of their community.

PROVIDER RETENTION

To support the well-being of the crisis care continuum workforce and improve retention of providers, Congress should:

- **Expand peer support services for crisis care providers and incentivize states to eliminate licensing procedures that can deter providers from seeking behavioral health care services.**

Expand Peer Support Services for Crisis Care Providers and Eliminate Penalties for Seeking Behavioral Health Care

Stress and burnout are significant factors in workforce attrition, and the acute nature of crisis care can place additional emotional demands on crisis care providers. Expanding supports for crisis care providers would help them better maintain their own well-being, mitigate burnout, bolster the workforce, and help ensure that crisis services are widely available. Peer support services and peer mentoring can be powerful tools in mitigating workplace stress, enhancing providers' ability to navigate challenging cases, and improving retention. Congress should provide funding to HHS to expand the availability of these services in crisis care workplaces and reduce barriers to providers seeking care.

The United States has begun increasing investments in provider well-being in response to the effects of COVID-19 on the health care workforce. The ARP provided \$103 million to fund programs aimed at promoting provider wellness, reducing burnout, and improving retention of health care workers to help address current staffing challenges. In addition, in February 2022, Congress passed the Dr. Lorna Breen Health Care Provider Protection Act. The act requires HHS to distribute grants to hospitals, medical professional associations, and other health care entities to promote mental health and resiliency among health care providers; to conduct a campaign to encourage health care providers to seek support and treatment for mental and behavioral health concerns; and to disseminate best practices to improve mental well-being among providers. The act also provides up to \$135 million in funding over three years for these activities. A bipartisan coalition in the Senate, led by Chuck Grassley (R-IA), also recently introduced a bill, the Fighting Post-Traumatic Stress Disorder Act of 2022 ([S. 4007](#)), to establish mental health programs for first responders and help police, fire, emergency medical, and 911 personnel cope with the stresses of responding to crisis situations.

Along with these initiatives, Congress should consider expanding access to peer support services for crisis care workers, such as funding the direct administration of peer support through virtual networks or counseling centers, or incentivizing the expansion of peer support services through crisis care employers. SAMHSA should also consider adding to best practice guidelines to promote the effective supervision of crisis care providers and a sustainable workplace environment, such as issuing guidelines on the development of standards for peer support services in the workplace, or recommendations on how to balance hours of face-to-face time with patients and administrative time.

In addition to the challenges around accessing emotional support, providers may be deterred from seeking help when licensing processes require them to disclose behavioral health conditions or the utilization of related services. These requirements reinforce stigma, create fear of penalties, and disincentivize

providers from accessing care due to the risk of licensure rejection. For example, a 2017 [study](#) found that nearly 40% of physicians reported they would be reluctant to seek treatment for a mental health condition because of concerns about effects on their medical licensure.⁷⁰ In addition to the pressures these processes put on providers, a 2018 [study](#) examining the impact of medical licensure on mental health in all 50 states and the District of Columbia found that the majority of these licensing bodies ask questions that are unlikely to comply with standards set in the Americans with Disabilities Act (ADA).⁷¹

Legal action by the Department of Justice (DOJ) under the ADA could spur reform, but Congress should incentivize states to eliminate barriers to providers seeking treatment by, for example, revising licensure questionnaires to require disclosure only when providers' condition affects their ability to provide appropriate care to patients or to fulfill their required duties.

WORKFORCE EDUCATION AND TRAINING

To improve education on behavioral health crises and culturally responsive care for crisis response providers and adjacent personnel:

- **HHS should develop a National Behavioral Health Crisis Response Curriculum, support its integration into training programs, and expand continuing education programs conducted remotely.**
- **DOJ should expand crisis intervention team (CIT) programs that train and partner law enforcement with behavioral health providers, hospital emergency services, and individuals in crisis when necessary.**
- **Congress should provide funding to NHTSA to revise the national EMS Education Agenda and other EMS training standards to better incorporate behavioral health crisis response.**

Develop a National Behavioral Health Crisis Response Curriculum and Expand Remote Continuing Education Opportunities

As the crisis care system is developed and growing awareness yields increasing demand for services, additional efforts will be needed to ensure that behavioral health providers and adjacent personnel have the skills and understanding necessary to work effectively with individuals in crisis and to assist them in accessing care. To help accelerate the dissemination of core competencies and best practices, HHS and other agencies of authority should provide continuing education opportunities to the existing workforce and support the integration of crisis response into training programs for new providers.

Through SAMHSA and HRSA, HHS should develop a centralized curriculum and training program using lessons learned from similar initiatives. For example, the National HIV Curriculum is an AIDS Education and Training Center Program funded by HRSA, led by the University of Washington, and offered free to the public as a comprehensive self-directed online learning platform. The curriculum “provides ongoing, up-to-date information needed to meet the core competency knowledge for HIV prevention, screening, diagnosis, and ongoing treatment and care to healthcare providers in the United States.” It offers accredited continuing education opportunities to several types of providers.⁷² HHS could develop a similar program to provide learning resources directly to crisis care providers and to educational institutions adapting their curriculum to incorporate crisis response.

To help the currently available workforce better respond to individuals in need of crisis services, HRSA should also expand tele-mentoring and peer learning communities focused on crisis care through existing initiatives, such as [Project ECHO](#), which brings providers together virtually for case-based peer learning and expert-led seminars on an array of topics.

Remote learning opportunities are especially critical for those engaged in crisis response. The seminars enable the rapid dissemination of knowledge and best practices in areas that lack specialized expertise—such as rural areas with shortages of behavioral health specialists—and allow participants to access training wherever and whenever needed while continuing to serve their community. Remote education also offers flexibility to create learning opportunities of varying length and intensity, and provides access to training on a wider variety of topics than traditional in-person education offers, such as courses on culturally responsive crisis care for specific populations. In addition, efforts to increase knowledge of behavioral health crises and the crisis care continuum among the public would help reduce stigma, build trust in the system, and increase awareness of the availability of crisis care points of entry.

Expand CIT Programs

While universal access to the full crisis care continuum is ideal, EMS and law enforcement will continue to be called upon to respond to behavioral health crises in locations where dedicated mental health crisis mobile response or stabilization services are not feasible or accessible. Training these first responders to respond appropriately to calls from 988 and divert individuals in crisis into the most appropriate care setting is critical.

As such, DOJ should expand crisis intervention team (CIT) programs that train law enforcement to identify and respond to behavioral health crisis calls and work in partnership with behavioral health providers, hospital emergency services, and individuals in crisis. The department should also expand eligibility to include EMS in those partnerships. DOJ should also work with CIT

training programs to enhance curriculum and re-envision successful outcomes, shifting crisis response best practices to divert individuals from arrest and emergency departments toward crisis-specific care whenever possible.

Provide Funding to NHTSA to Update EMS Training on Crisis Response

Congress should provide funding to NHTSA, which oversees EMS within the DOT, to revise the national EMS Education Agenda and other guiding standards to incorporate and implement crisis response training across EMS professions. Support for these efforts will help ensure that, regardless of location or the availability of crisis care infrastructure, especially in underserved rural areas, first responders will have the skills needed to provide an effective response to behavioral health crises and aid individuals in accessing more specialized services.



Section III: Ensure Sustainable Financing and Coverage for the Crisis Response Continuum

The effectiveness of response across the continuums of health crisis care requires that all aspects of the continuum be adequately funded. This includes:

- Streamlining principal funding and technical assistance for the entire continuum of care;
- Adequately funding the National Suicide Prevention Lifeline and associated call centers;
- Supporting infrastructure and care coverage for MCRTs; and
- Ensuring availability of CSUs and similar facilities.

As outlined earlier in the report, the continuum of crisis care consists of three primary components: 24/7 crisis call centers, MCRTs, and short-term CSUs and similar centers or facilities. While outside of this report's scope, it is important to note that effective crisis response systems can also include peer-run warmlines, crisis case management, and other components.

Available data suggest that 80% of contacts to crisis call centers can be resolved over the phone.⁷³ Of the remaining calls, 70% can be resolved during an interaction with an MCRT.⁷⁴ Yet despite the effectiveness of the crisis response continuum, states still need additional federal support to develop crisis systems capable of delivering adequate levels of care to Americans in need. This includes support on how to make the best use of existing federal resources.

Congress has just delivered historic levels of investment into behavioral health care and 988, including a \$77 million increase for the National Suicide Prevention Lifeline. President Biden's FY2023 budget also recommended notable investments into behavioral health services, including funding specific to 988 implementation and buildout of the crisis system. As such, the recommendations in this section focus on enhanced federal support for the effective and equitable build out of 988 alongside existing crisis response infrastructure utilizing primarily existing resources.

BPC recommends a suite of options to address crisis continuum planning and implementation funding, as well as options specific to the financing needs of call centers, MCRTs, and CSUs.

STREAMLINED PRINCIPAL FUNDING, PLANNING, AND TECHNICAL ASSISTANCE

To address the overarching financing, planning, and implementation needs of an adequate behavioral health crisis response continuum:

- **Congress should integrate federal funding streams with appropriations report language to maximize the use of existing resources.**
- **HHS should provide more technical assistance to states on the use of available federal dollars and state-level crisis continuum funding mechanisms, including how Medicaid and block grant dollars can be braided with existing resources.**

Integrate Existing Federal Funding Streams

Congress should integrate or “braid” existing federal funding streams by including House and Senate Appropriations Committee report language that requires similar programs from agencies to formally collaborate. This would allow programs with comparable objectives related to crisis response to work together to maximize their resources.

As Sens. John Cornyn (R-TX) and Michael Bennet (D-CO) noted in their 2021 paper, [*A Bold Vision for America's Mental Well-being*](#), despite substantial federal spending on mental and behavioral health services, “a unified strategy is not apparent for how these federal programs, agencies, and departments are to expend funds, nor is there a clear goal of how they collectively advance our nation's mental health.”

BPC reviewed discretionary fiscal year 2022 funding streams to identify which programs could be leveraged for behavioral health crisis response. In addition to ensuring that various funding streams in agencies within SAMHSA work together, funding streams outside the agency should also coordinate with one another. This could include funding streams that directly affect law enforcement operations, such as those that prioritize CIT, through DOJ funding.

Figure 3, below, illustrates a non-exhaustive list of programs with areas of overlap that could be better coordinated to maximize existing monetary resources. Braiding could be accomplished by adding Appropriations Committee report language that directs these agency programs to formally collaborate, with the aim of reducing duplication, and allowing agencies to further utilize their respective areas of expertise. It is also important to note that the effect of this funding could be amplified by using mandatory Medicaid dollars.

Figure 3: Behavioral Health Crisis Response Funding Continuum Opportunities, FY2022

Component	Programs	Combined Resources
Overall Continuum Funding	<ul style="list-style-type: none"> • SAMHSA Community Mental Health Block Grant • SAMHSA Behavioral Health Crisis Coordinating Office • SAMHSA Mental Health Awareness Training • SAMHSA National Strategy for Suicide Prevention • SAMHSA Tribal Behavioral Health Grants • SAMHSA American Indian and Alaska Native Suicide Prevention • SAMHSA Criminal and Juvenile Justice Programs 	\$1,011,570,000
Call Centers	<ul style="list-style-type: none"> • SAMHSA National Suicide Prevention Lifeline (NSPL) 	\$106,421,000
Mobile Crisis Response Teams	<ul style="list-style-type: none"> • SAMHSA Mental Health Crisis Response Partnership Pilot Program • DOJ State and Local Law Enforcement Assistance and Community Oriented Policing Services 	\$301,000,000
Crisis Stabilization	<ul style="list-style-type: none"> • SAMHSA Primary and Behavioral Health Care Integration • SAMHSA CCBHCs Expansion Grants • SAMHSA Assisted Outpatient Treatment • USDA Community Facilities Programs 	\$632,751,714

Increase Technical Assistance to States

SAMHSA, CMS, and CDC should use existing resources to provide technical assistance to states on how to identify and build out their own funding mechanisms to finance their crisis continuums of care. Technical assistance would facilitate states' working closely with federal partners to determine the financing mechanisms that could best support each state's unique policy environment and existing crisis continuum services. Options to be explored with states could include:

- How states can make use of the CCBHC model, which is reimbursed by state Medicaid programs.
- Guidance on the use of the enhanced Medicaid federal medical assistance percentage (FMAP) for mobile crisis services, created as part of the ARP.
- How to structure and make the best use of funds generated from 988 fees levied on telecommunications providers.

The National Suicide Hotline Designation Act of 2020—the legislation that codified the creation of the 988 number—permits states to impose and collect fees on telecommunications providers for 988-related services. Specifically, the legislation allows states to impose and collect a fee that is held in a designated account to be spent in support of 988 services. As of this writing, only four states have imposed such fees: Colorado, Nevada, Virginia, and Washington.⁷⁵ Colorado's legislation levies a surcharge with funds diverted to a nonprofit to operate 988 and crisis care services.⁷⁶ Several other states are considering 988-related legislation that would use general fund money, rather than telecommunication fees. HHS's technical assistance could be used to guide states on how to utilize collection of these fees to fill resource gaps.

Because many aspects of the behavioral health crisis response are within states' jurisdictions, Figure 4 notes more specifically how SAMHSA, CMS, and CDC could each support state technical assistance.

Figure 4: Federal Agency Roles in State Technical Assistance

Agency	Description
SAMHSA	SAMHSA, whose mission is to reduce the impact of substance use disorder and mental illness, would be able to provide expertise in behavioral health and information on funding for programs such as CCBHCs, which are integral to the crisis system.
CMS	With a direct link to state Medicaid agencies, CMS could help states acquire the authorities they need to finance and set guidelines for standardizing how Medicaid funding is leveraged to finance their crisis response systems. This help could include guidance on the enhanced Medicaid FMAP for community-based mobile crisis intervention services. Because CMS also collects and tracks claims data, state Medicaid agencies and health systems would be able to systematically assess outcomes and costs, as well as identify trends. And CMS would be able to help states improve their ability to assess and enhance clinical quality and services.
CDC	CDC would be able to assist states in optimizing and standardizing their surveillance capabilities. Epidemiologists at the CDC could use their data or help states—including state Medicaid agencies and state EMS offices—leverage and improve their own data collection and analysis processes. This could guide state departments of health and policymakers as well. The CDC would also be able to use its Communities of Practice model to offer support to states seeking to bolster their community networks, especially for each level of the crisis continuum of care.

CALL CENTERS

Estimates indicate that, once 988 goes live, the number of behavioral health crisis calls may more than double.⁷⁷ Congress should take the following steps to ensure that states and call centers can meet this increased demand:

- **Congress should authorize sustained appropriations for National Suicide Prevention Lifeline operations.**
- **Congress should require SAMHSA to submit a recurring report on the resource needs of 988, as well as on resource utilization and outcomes.**

Sustain Funding for the National Suicide Prevention Lifeline

Congressionally appropriated dollars to SAMHSA fund the lifeline, and a federal vendor, Vibrant Emotional Health, administers it. In FY2022, Congress appropriated \$101.6 million for the lifeline—a fourfold increase over FY2021 levels. Before FY2022, funding for the lifeline increased from \$12 million in FY2019 to \$24 million in FY2021. In fact, the lifeline currently remains authorized at just more than \$7 million. Lifeline funding supports the coordination of a network of more than 170 crisis call centers around the United States and will be expected to absorb the increased volume of 988 calls.

According to SAMHSA, “As of December 2020, the lifeline only had sufficient capacity to address approximately 85% of calls, 56% of texts, and 30% of chats.”⁷⁸ This means that current funding falls short of connecting those who seek help from a trained counselor by calling the lifeline. With implementation of 988, SAMHSA anticipates the contact volume—including calls, texts, and chats—to increase from a projected 3.3 million in FY2022 to approximately 7.6 million by FY2023.⁷⁹ Further, call centers operate independently of one another, and their day-to-day operations are funded largely by state and local dollars, supplemented by donations and volunteer time to local call centers.

As such, Congress should continue to evaluate the utilization and resource needs of the lifeline to determine an appropriate amount of ongoing funding for the program. The FY2022 funding for the lifeline was a rare cash infusion designed to meet the costs associated with increased demand as well as needs associated with an expansion of the 988 infrastructure.⁸⁰ Short of relying on annual appropriations legislation, Congress could also consider options for a sustainable funding source for lifeline operations.

Require a Recurring 988 Report to Congress

To address potential gaps in 988 and crisis continuum funding, as well as to assess the changes in resource needs over time, Congress should require SAMHSA to submit periodically a report to Congress. This report should outline the resource utilization and outcomes of the previous year along with anticipated resource needs in the coming years. SAMHSA should do so with the unique needs of both rural and urban areas in mind.

The purpose of this report will be to ensure that federal policymakers are well equipped to make appropriations decisions for the upcoming fiscal years; as such, it should include information on how much resource needs change from year to year. The report should also reflect changes in demographics and rates of mental illness across the country.

At a minimum, the report should detail 988 utilization as well as, to the best of SAMHSA’s ability, data on use of services across the continuum of care, including MCRTs and CSUs. These data could contain, for example, details

on the usage of services across the continuum of care after a call to 988 and details on the number of calls diverted from 911. The report should detail how well existing federal resources met the needs of Americans across the continuum and where these resources still fall short. The report should attempt to measure the overall effectiveness of the 988 number and associated crisis response infrastructure in reducing the burden on emergency departments and criminal justice systems. This should also include updated information on the effectiveness of 988 in reducing caller distress and suicidality.

Finally, SAMHSA should be required to consider in its report where opportunities exist for cross-agency collaboration, such as with DOJ and the U.S. Department of Agriculture (USDA), to make the best use of existing resources without duplication of effort. With DOJ, this partnership might include areas where collaborative response training can occur; with USDA, this might include areas where department resources can be utilized to fund crisis response and stabilization infrastructure in rural areas.

MOBILE CRISIS RESPONSE TEAMS

*Only 20% of callers to 988 are expected to require an elevated, in-person response.⁸¹
To ensure that such a response is available in an equitable manner across the nation:*

- **The Departments of Labor, HHS, and the Treasury should clarify that the emergency classification of benefits under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) includes mobile crisis services and add mobile crisis response to required coverage.**
- **To expand coverage of services provided by the MCRTs and CSUs, CMS should consider permanently adding additional behavioral health provider types to the list of Medicare-covered providers.**
- **CMS should update Medicaid guidance related to peer support services.**
- **CMS should expand data collection and testing of new payment and service delivery models for EMS providers.**
- **CMS should issue guidance to clarify that individuals receiving telemental health care services during an emergency are not subject to the in-person visit requirement.**

Strengthen Coverage of Crisis Response Services

Congress passed the [Mental Health Parity and Addiction Equity Act of 2008 \(MHPAEA\)](#) to require most types of health plans to cover treatment for mental health and substance use disorders (MH/SUD) no more restrictively than treatment for physical health conditions, if the plans cover any MH/SUD

services. The Affordable Care Act (ACA) requires individual and small-group plans to cover MH/SUD services and triggers the MHPAEA nondiscrimination requirements.

The MHPAEA prohibits Medicaid managed care plans, most group health plans, and individual health plans from imposing less favorable benefit limitations on mental health or substance use disorder than on medical/surgical benefits. The act was amended by the ACA to apply to plans providing individual health insurance coverage.

The MHPAEA does not apply to Medicare or traditional fee-for-service Medicaid. BPC's Behavioral Health Integration Task Force released recommendations in March 2021, [Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration](#), that supported expanding coverage parity to Medicare and all Medicaid beneficiaries and strengthening the enforcement of parity law.

Although plan coverage of behavioral health services has come a long way, private insurance rarely covers mobile crisis services, despite these services being a key element of an effective behavioral health crisis continuum.

For more equitable insurance coverage of mobile crisis services, the Departments of Labor, Health and Human Services, and Treasury should clarify—either through guidance or, if necessary, through updated regulations—that behavioral health crisis response services should be placed in the MHPAEA's emergency classification of benefits. This would help ensure that treatment limitations placed on crisis services are analogous to emergency services (e.g., EMS, ambulance transport, and emergency department care) for physical health.

Since mobile crisis services are relatively nascent and coverage gaps remain throughout the United States, BPC also suggests that CMS evaluate provider readiness to deliver mobile crisis services nationally, assess effects on network adequacy requirements (e.g., time and distance standards, provider-enrollee ratios, etc.), and assess the need for any time-limited exemptions for health plans to comply with any new requirements or enforcement approaches.

The bipartisan Behavioral Health Crisis Services Expansion Act introduced in the 117th Congress ([S. 1902](#), [H.R. 5611](#)) includes adding behavioral health crisis services to essential health benefits and Medicare.

Consider Permanently Adding Additional Behavioral Health Provider Types in Medicare

Building a steady pipeline of psychiatrists, psychologists, clinical social workers, behavioral-health-trained paramedics, call center staff, and other mental health specialists to support the crisis response continuum will take time. That is why more immediate action can and should be taken to make

better use of existing professionals who can bolster and support the work of licensed behavioral health professionals along the crisis continuum. Drawing on existing providers is especially important in the face of current national workforce shortages, which are even more pronounced in rural and frontier communities.

CMS should evaluate the appropriateness and effectiveness of including additional provider types under Medicare, such as peer support specialists and marriage and family therapists. Additional provider types should be assessed in terms of both cost and potential to improve outcomes. Based on these findings, the secretary of HHS should make the determination for which providers should be reimbursed.

BPC's Rural Health Task Force recommended adding marriage and family therapists, as well as licensed mental health counselors, to the list of Medicare-covered providers, in its report, [Confronting Rural America's Health Care Crisis](#).

Update Medicaid Guidance Related to Peer Support Services

Certified peer support specialists are state-certified individuals with their own lived experiences of mental health challenges. According to SAMHSA, "Peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process."⁸² As such, peer support specialists can assist those in need with their own treatment and recovery and are well-positioned to play a role in crisis response.

Although CMS previously issued guidance to encourage states to cover peer support services under Medicaid, not all states currently allow for Medicaid reimbursement of peer support specialists for mental health purposes, and this guidance has not been updated since 2007.⁸³ This is unfortunate, as states do have the option to offer peer support service coverage under Medicaid via Section 1905(a)(13) and 1915(b) and (c) waiver authorities.

In light of 988 implementation, CMS should issue updated guidance on Medicaid coverage of peer support specialists. This updated guidance should consider changes and growth in the peer support field, all viable options for states to offer peer support service coverage based on their available resources, as well as the delivery of peer support specialist services along the entire crisis response continuum.

Expand Data Collection and Testing of New Payment and Service Delivery Models for EMS Providers

Currently, EMS providers are typically not reimbursed for their services unless they deliver a patient to an emergency department. This, by

design, disincentivizes EMS providers from delivering patients with behavioral health issues to treatment providers, such as CCBHCs or CSUs, that may be better suited to address their needs.

To promote “access to the most appropriate emergency services at the right time and place,” the Center for Medicare and Medicaid Innovation (CMMI) created the voluntary, five-year Emergency Triage, Treat and Transport (ET3) Model demonstration program. The program began in 2021 with a one-year ramp-up in light of the COVID-19 public health emergency.

The ET3 Model allows ambulance service providers to transport patients to predetermined alternative destination partners, such as community mental health centers, and currently has 184 participants with varying operational structures designed around the unique needs of each community. The program also includes a “treatment in place” option, which allows a qualified health care partner to provide care at the scene via telehealth. The purpose of the model is to “provide greater flexibility to ambulance care teams to address emergency health care needs of Medicare Fee-for-Service beneficiaries following a 911 call” and “aims to improve quality and lower costs by reducing avoidable transports to the ED and unnecessary hospitalizations following those transports.”⁸⁴

As previously stated, the onset of 988 is expected to generate at least a doubling of calls to the National Suicide Prevention Lifeline. As a result, more individuals will ultimately need the support of a MCRT. To reduce the burden on MCRTs in areas that lack adequate resources, CMS should consider expanding the ET3 Model and allowing more participants to take part, at least until it is determined that an adequate number of MCRTs are available to meet local needs. As part of this expansion, however, CMS should continue rigorous data collection, evaluation, and dissemination of information on the effectiveness of the ET3 Model. These data should include information on patient outcomes, as well as on savings to hospital and carceral systems, where possible.

Issue Guidance on Telemental Health Services in the Context of an Emergency

In December 2020, Congress passed legislation that imposed in-person visit requirements on telemental health coverage under Medicare (Consolidated Appropriations Act of 2021). CMS finalized the 2022 Physician Fee Schedule rule on in-person visit requirements, outlining numerous exceptions, for Medicare coverage of telemental health services. The rule is set to go into effect five months after the federal public health emergency ends.

Medicare will cover a telehealth service while the patient is at home if the provider conducts an in-person visit at least six months before the initial telehealth service; the telehealth service is for the purposes of diagnosis, evaluation, or treatment of a mental health disorder (other than for treatment

of a diagnosed substance use disorder or co-occurring mental health disorder); and the provider conducts at least one in-person service every 12 months of each follow-up telehealth service.

CMS outlines several exceptions to the in-person requirement, including if the patient is located at a qualifying originating site in an eligible geographic area (e.g., a practitioner office in a rural HPSA), if SUD is diagnosed, or the patient has co-occurring mental health disorders. (The SUPPORT Act already made the patient’s home an eligible originating site for such services.) The in-person visit requirement will not apply for a 12-month period if the patient and practitioner agree that the benefits of an in-person, non-telehealth service outweigh the risks and burdens associated with an in-person visit, and if the basis for that decision is documented in the patient’s medical record.

CMS should issue guidance to clarify that individuals receiving telemental health care services in the context of an emergency are not subject to the in-person visit requirement. For example, an individual receiving crisis care through the tablet of a first responder should not be subject to the in-person visit requirement. Additionally, the provider (e.g., a psychiatrist) delivering care virtually in that situation should be eligible to receive reimbursement from Medicare.

CRISIS STABILIZATION

Of individuals who require interaction with a MCRT, about 30% need additional support from the crisis system in the form of crisis stabilization.⁸⁵ To meet this need:

- **Congress should support an increase in the number of crisis drop-off and stabilization locations.**
- **Congress should support an expanded role for CCBHCs.**
- **CMS should consider a demonstration program for peer respite services.**

Increase the Number of Crisis Drop-Off and Stabilization Locations

In addition to existing workforce shortages, the crisis intervention system also suffers from a dearth of places for individuals to go should they require services beyond intervention by a MCRT. This includes places designed around the “living room” model for individuals to rest and be connected to additional behavioral health services, such as peer respites, as well as federally supported health centers that focus on integrating care for patients.⁸⁶

This shortage of safe and supportive places to go during a crisis leads to a heavy reliance on emergency rooms and, sometimes, jails for urgent mental health

needs. In these settings, patients tend to receive short-term or no care before being discharged, often back to the same unsupported circumstances that led to the emergency room visit or law enforcement encounter in the first place.

Although some emergency room visits are short, others can result in individuals waiting extended periods for an inpatient bed. Some individuals could be diverted from hospital care if other services were available, such as services from social workers, peer support or specialists, or licensed therapists in a crisis stabilization or peer respite program. These are just the types of services offered through HRSA's Health Center Program centers, which saw a 100% increase from 2014 to 2019—to 2.9 million people—in the number of individuals who received behavioral health care services.⁸⁷

Congress should consider financially supporting the creation of more crisis drop-off and short-term stabilization locations, either through direct initial grant funding dollars via HRSA's Health Center Program or through the authorization of a CMMI model that would offer additional payments to these types of facilities. Congress might also consider encouraging HRSA to utilize funding for Rural Hospital Flexibility Grants and related rural grant funding to give rural health centers the means to expand their capacity to treat individuals experiencing a mental health crisis in non-acute units. HRSA could utilize grant funding to create these units as stand-alone and new infrastructure, or as part of existing infrastructure at HRSA-designated health centers (Community Health Centers and Rural Health Clinics, for example) and EDs.

Emergency Psychiatric Assessment, Treatment & Healing (emPATH) units are one such model that Congress might consider supporting via initial grant dollars or a CMMI demonstration payment model. These psychiatric emergency room units are often designed as large, open, central rooms that promote socialization with other individuals and clinical staff.⁸⁸

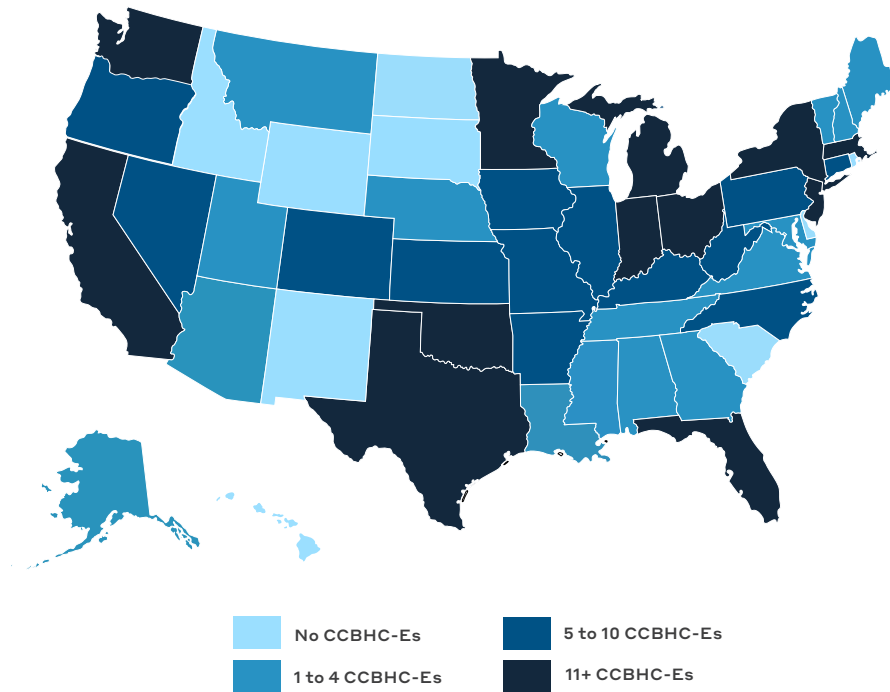
Such locations should be available for use by both MCRTs and EMS and law enforcement responders to transport individuals in need of behavioral health crisis care.

Support an Expanded Role for CCBHCs

As part of the Protecting Access to Medicare Act of 2014, Congress designed the CCBHC demonstration program. States that operate as part of this demonstration “receive enhanced federal funding for CCBHC services provided to Medicaid beneficiaries.”⁸⁹ Further, in FY2022, SAMHSA received \$250 million in funding for the CCBHC program.

Certified community behavioral health clinics are designed and required to deliver a range of behavioral health services, either directly or in coordination with Designated Collaborating Organizations. These services include crisis services (including crisis call lines, MCRTs, and CSUs); psychiatric

rehabilitation services; peer, family support, and counseling services; and treatment planning, among others. All CCBHCs either operate a crisis line or can refer individuals in crisis to other community crisis lines, and more than 90% are “engaged in one or more innovative practices in crisis response,” according to the National Council.⁹⁰



Currently, there are over 400 CCBHCs operating across the country, as either CCBHC-E grantees or clinics participating in their states’ Medicaid demonstration.
 Source: Substance Abuse and Mental Health Services Administration

Figure 5: Current Number of CCBHC Expansion Grant Sites Per State⁹¹

These requirements make CCBHCs well positioned to become an even more integral part of the crisis response infrastructure in the states and localities in which they currently operate. They also offer a promising option for states and localities without CCBHCs that wish to expand crisis and behavioral health care options.

Congress can increase the number of community behavioral health clinics in operation by expanding the demonstration program and authorizing funding for additional grants to CCBHCs. More specifically, Congress could focus on awarding CCBHC grants to states that are not part of the demonstration program.

Legislation currently in Congress—the Excellence in Mental Health Addiction Treatment Act of 2021 ([S. 2069](#), [H.R. 4323](#))—would, if passed, expand the

CCBHC demonstration program by awarding planning grants to states that do not operate CCBHCs.

Consider a Demonstration Program for Peer Respite Services

Peer respites for individuals experiencing mental health crises are a homelike, “voluntary, short-term, overnight program that provides community-based, non-clinical crisis support” and are often staffed by individuals with their own history of mental illness.⁹² Stays at peer respite are less expensive than hospitalization and result in 70% less likelihood of a crisis patient utilizing inpatient or emergency services.^{93,94} Data also indicate that respite program patients have lower Medicaid expenditures in the months following usage.⁹⁵

State and local government general funds largely finance peer respites. As of 2021, however, only 12 states operated peer respites, with 41 peer respites in total operating across the country.⁹⁶

To build upon the value and early success shown by peer respites—sometimes known as “hospital diversion programs”—CMS should consider creating a demonstration program to test the value of a new payment system for peer respites.⁹⁷ Such a demonstration would allow CMS to determine how to financially support and operationalize a peer respite with the support of Medicare dollars.

In coordination with the limited number of peer respites already operating, Congress or CMS should also ensure that any demonstration program adequately measures patient outcomes to understand the effectiveness of peer respite programs. These measures might include patient experience, emergency room readmission rates, and long-term outcomes such as employment, housing, and social connections.⁹⁸



Conclusion

The implementation of 988 presents a rare opportunity for our country to build a universal entry point into behavioral health care treatment services for Americans in need.

It also represents an opportunity for existing emergency infrastructure—including 911, EMS, and law enforcement—to play a greater role in diverting patients to behavioral health services by coordinating with 988 infrastructure and systems. With the backing of Congress and the administration, the federal government can support every state in achieving minimum standards for its behavioral health crisis response systems, as well as meet the unique needs of rural and frontier communities.

With the right coordination, training, and financial support, all these systems can and should work in tandem to ensure that Americans receive timely and effective services in their time of need.

Appendix

Performance Indicators for a Crisis Response Scorecard (as proposed by the National Council for Mental Wellbeing)

Section	Indicator
Accountability and Finance	The accountable entity is identified and established.
	Behavioral health crisis system coordinator has been identified.
	<p>The community behavioral health crisis system is collaborative.</p> <ul style="list-style-type: none"> • The behavioral health crisis system coordinator has been identified. • Data are collected and there is analytic capacity. • The crisis coordinator oversees, delineates, and continually improves the policies, procedures, protocols, and services that govern the system. • The accountable entity and crisis coordinator hold a regular crisis coordination meeting at least monthly for each geographic area. • The structure of the crisis coordination meetings has procedures for individual case review and root cause analysis to respond effectively. • The quality improvement collaborative is data-driven. • Collaborators share protected health information (PHI) safely.
	All services are accountable for system values.
	Multiple payers contribute to financing services and capacity in the crisis care continuum.
	The accountable entity coordinates financing.
	<p>Financing is adequate for supporting the population's needs.</p> <ul style="list-style-type: none"> • The accountable entity is able to support a global budget for the ideal crisis continuum. • There is a shared contribution of resources (e.g., electronic health record or ambulance district). • There is a director or delegated governmental financing authority. • Financing supports system capacity, not just utilization. • Reimbursement rates are adequate. • There are incentive payments. • There are payment mechanisms for full continuum of crisis services. • The budget is designed with the expectation that utilization for each component is over maximum capacity no more than 5% of the time.

Section	Indicator
Accountability and Finance	<ul style="list-style-type: none"> • There are payment mechanisms for all populations, including those with comorbidities. • There are financing mechanisms for appropriate safety net services.
	Everyone is eligible, regardless of insurance.
	The crisis continuum meets standards for capacity and geographic access for the population.
	<p>Quality metrics are established and being measured for each service and the crisis continuum as a whole.</p> <ul style="list-style-type: none"> • Structure measures • Process measures • Outcome measures
	Data are being collected and used collaboratively for customer-oriented continuous improvement.
	Providers within the crisis response system have contracts that include incentives for performance in line with values and metrics.
	The system metrics include attention to how clients flow through the continuum timely/successfully.
	The crisis system has data and the capability to keep track of client progress through the continuum.
	The satisfaction of primary customers (clients/families) and secondary customers (first responders/referents) is being measured and showing improvement.
	Care determination and utilization management criteria are at a consistent level throughout the system.
	All of the services in the crisis system function as safety-net support partners for behavioral health system programs.
	<p>The standards for the crisis systems define how they work collaboratively with other community systems (e.g., criminal justice, housing, intellectual and developmental disabilities (I/DD), child protection).</p> <ul style="list-style-type: none"> • There is a welcoming response to community requests. • There are customer service protocols for staff. • Community partners receive instructions on how to ask for help. • The administrator is on-call to facilitate a crisis response if necessary.

Section	Indicator
	<ul style="list-style-type: none"> • Customer complaints receive responses. • Community partners receive support and consultations proactively. • There is continuous improvement.
Crisis Continuum: Basic Array of Capacity and Services	The services throughout the continuum are safe, welcoming, and value-based.
	The crisis services address the continuum of crisis experience from precrisis to post-crisis.
	The spaces and security practices where services are administered are safe, warm, welcoming, and therapeutic.
	Patients' social support networks are partners/customers.
	First responders are priority customers.
	The service continuum responds to patients of all ages.
	There is enough capacity for people with co-occurring needs, including: mental health/substance use disorder (MH/SUD), behavioral health/intellectual and developmental disabilities (BH/IDD), behavioral health/physical health (BH/PH), domestic violence (DV), homeless, criminal justice (CJ).
	There is cultural/linguistic/immigrant capacity.
	The continuum of services is described operationally.
	Capacity for seamless flow and continuity of care.
	There is client information-sharing through the continuum.
	Clients are kept track of through the continuum.
	There is outreach and engagement with family members/collateral.
	There is outreach/consultation with community providers
	Telehealth is being utilized effectively throughout the continuum.
	The crisis hub has secure access and urgent care center(s).
	There is a crisis call/text/chat center (911/non-911).
	There are crisis-trained first responders being deployed.
	There are available, low barrier medical screening/triage.
	Mobile crisis services are for all ages (deployed to homes, schools, etc.).
	There is 23-hour observation in stabilization centers.
	Residential crisis services have both high and low medical capacity.
	There is access to peer respite/living rooms.
There are capacities for detox and sobering support in stabilization centers.	
There are psychiatrically capable emergency room services.	
There is psychiatric inpatient capacity for all ages in both general units and specialized units.	
There is continuity of crisis intervention in homes and offices.	
There is both emergency and non-emergency transport.	

Section	Indicator
	<p>There are adequately staffed multidisciplinary teams in all settings.</p> <p>There is clinical, nursing, and medical leadership.</p> <p>There is access to specialty consultation.</p> <p>Peer support is available throughout the continuum.</p>
Basic Clinical Practice	<p>There is a crisis system framework for practice improvement and competency development that uses hiring and orientation standards, supervised practice-based training, positive language, trauma-informed principles and care that is culturally appropriate, and intentional tracking of race/primary language/housing status.</p>
	<p>Providers practice the following universal competencies: they are welcoming, hopeful, safe, trauma-informed, and culturally affirming.</p>
	<p>Providers are engaging families and other natural supports.</p>
	<p>Providers are competent in sharing information.</p>
	<p>Providers use crisis plans and advance directives.</p>
	<p>There are basic core competencies for call center staff and first responders.</p> <ul style="list-style-type: none"> • All first responders know how to triage a behavioral health emergency situation with the assumption that behavioral health crisis responders will be brought in unless there is indication of a medical emergency or an immediate risk of violence. • All first responders have guidelines for safe and non-stigmatizing transport of individuals who need to be moved to a behavioral health crisis center or other behavioral health facility. • All first responders, in addition to 911 call dispatchers, receive basic or introductory training in CIT Core Elements and MHFA for Public Safety.
	<p>There are basic core competencies for behavioral health crisis staff.</p> <ul style="list-style-type: none"> • There are training and competency development plans. • There are assessments in the crisis setting must be thorough enough to inform decision-making and focused enough to work within a fast-paced setting in which only limited information may be available.
<p>Providers leverage a “no force first” approach, which aims to maximize trust and minimize restraint.</p> <ul style="list-style-type: none"> • There is a comprehensive crisis continuum consisting of programs capable of safely managing a continuum of acuity, including programs capable of serving the highest acuity individuals. • The accountable entity has a quality assurance/performance improvement plan that includes oversight of use of seclusion and restraint. 	

Section	Indicator
Basic Clinical Practice	There is suicide risk screening and intervention.
	There is violence risk screening/threat assessment.
	Providers use medical triage and screening.
	Substance use disorder triage and screening.
	Providers apply civil commitment (in both inpatient and output settings).
	<p>There are basic core competencies for call center staff and first responders.</p> <ul style="list-style-type: none"> • Multidisciplinary crisis teamwork, including the role of peers. • Non-medical crisis intervention. • Crisis psychopharmacology. • Co-occurring substance use disorder and incorporate medication-assisted treatment startup. • Co-occurring mental illness. • Youth/families/guardians. • Older adults and caregivers. • Cognitive disabilities.
	There are workflows within the crisis continuum.
	There is a post-crisis continuity, critical time intervention.
	There is pre-/post-crisis planning with community providers.
	There is coordination of care with community systems.

Adapted from: Group for the Advancement of Psychiatry, *Roadmap to the Ideal Crisis System: Essential Elements, Best Practices, and Measurable Standards for Behavioral Health Crisis Response*, March 2021, Washington, DC: National Council for Mental Wellbeing. Available at: <https://www.thenationalcouncil.org/roadmap-to-the-ideal-crisis-system/>.

Note: Scoring is indicated using a 1-to-5 scale whereby 1 is “just getting started” and 5 is “nearly completed or completed.”

Endnotes

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