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Behavioral Health Crisis Response Strategies: Partnerships, Programs, & Personnel

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Executive Summary

This report provides an overview of state- and local-level programmatic and policy approaches to responding effectively to behavioral health crises. Part I summarizes crisis response system standards. Part II highlights specific partnerships, programs, and personnel strategies that have been developed as part of a comprehensive behavioral health crisis response system. Part III lists state- and national-level legislative approaches to crisis prevention and improvement of behavioral health crisis outcomes.

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Disclaimer

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About MOST Policy Initiative

MOST Policy Initiative is a nonprofit organization that provides nonpartisan information to Missouri's decisionmakers to promote long-term health, sustainability, and economic growth for people and communities by connecting science and policy at the local and state levels.

Conflict of Interest Statement

The author declares no competing interests (financial, commercial, legal, professional, personal, or otherwise) in the publication of this report.

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Part I: Behavioral Health Crisis Care Standards

Introduction

According to the National Alliance on Mental Illness (NAMI), a behavioral health crisis is "any situation in which a person's behavior puts them at risk of hurting themselves or others and/or prevents them from being able to care for themselves or function effectively in the community."[1]

These crises often, but not always, co-occur with conditions such as substance use disorders, depression, or other behavioral health conditions (sometimes undiagnosed). Even in individuals without pre-existing behavioral health diagnoses, several environmental or contextual factors, including home, family, relational, school, and work stressors, can lead to behavioral health crises.

In 2020, the state of Missouri reported 1,125 deaths by suicide and 64,123 mental disorder-related emergency room visits.[2] Additionally, some behavioral health conditions, such as substance abuse, have been exacerbated by the COVID-19 pandemic, creating the potential for worse population-level behavioral health outcomes in the short, medium, and long term.[3]

The Missouri Department of Mental Health (DMH) and Department of Health and Senior Services (DHSS) operate several programs responsible for managing behavioral health crisis reports. These programs are described in detail in Section II of this report. Briefly, DMH provides rapid-response services such as the Access Crisis Intervention hotline, Crisis Intervention Teams, and Community Behavioral Health Liaisons, all of which are equipped to assess crises in real time and provide the resources necessary to resolve crises and prevent follow-up issues. Within DHSS, Adult Protective Services also operates a hotline that responds to behavioral health crises, particularly those involving individuals who require supervision from family or guardians to ensure their well-being.

The Substance Abuse and Mental Health Services Administration (SAMHSA), a branch of the U.S. Department of Health and Human Services, publishes a National Guidelines for Behavioral Health Crisis Care Best Practices guide, which is "intended to help mental health authorities, agency administrators, service providers, state and local leaders think through and develop the structure of crisis systems that meet community needs."[4] The guide serves as an organizing framework for this report.

SAMSHA explicitly lays out the purpose of a crisis care system. Such a system is:

1. An effective strategy for suicide prevention.
2. An approach that better aligns care to the unique needs of the individual.
3. A preferred strategy for the person in distress that offers services focused on resolving mental health and substance use crisis.
4. A key element to reduce psychiatric hospital bed overuse.
5. An essential resource to eliminate psychiatric boarding in emergency departments.
6. A viable solution to the drains on law enforcement resources in the community.
7. Crucial to reducing the fragmentation of mental health care.

The SAMSHA guide also provides several general baseline criteria for adequate behavioral health crisis services. First, it stipulates that crisis services should follow a "no wrong door" approach; in such a system, individuals experiencing a crisis should be able to gain access to assistance through several different contact points, ensuring that they are not denied resources due to interfacing with "inappropriate" elements of the crisis care ecosystem. In other words, crisis services should not operate as stand-alone, independent resources, but rather should be integrated into local community mental health and hospital systems as a coordinated continuum of care.

This approach also emphasizes that crisis services should be available to "anyone, anywhere, anytime", further highlighting the broad, visible, and responsive nature of an adequate care system. Some examples of common

crisis services that meet these criteria include 911 accepting all calls and dispatching support based on the assessed need of the caller; emergency response personnel being dispatched to wherever the need is in the community; hospital emergency departments serving everyone that comes through their doors from all referral sources. Behavioral health-specific analogs to these services may include crisis lines accepting all calls and dispatching support based on the assessed need of the caller; mobile crisis teams dispatched to wherever the need is in the community (not hospital emergency departments); and crisis receiving and stabilization facilities that serve everyone that comes through their doors from all referral source.[4]

Finally, an adequate crisis care system must be personalized and coordinated. Individual needs and preferences must be assessed to inform interventions and further care. Due to the complexity typical of healthcare delivery services in the U.S., regular communication between crisis service providers, hospitals, law enforcement, community groups, and other partners should be coordinated in a transparent and flexible manner. At the governmental level, interagency collaboration is often necessary, and can take several forms (e.g., personal relationships between departments/agencies/programs, Memoranda of Understanding (MOUs), shared protocols or technological resources).[4]

Figure 1 provides a schematic of crisis care coordination levels. This continuum ranges from "minimal" and "basic" coordination protocols (e.g., interpersonal relationships, protocol sharing, program partnerships) to "close" coordination (e.g., data/technology sharing). At the highest level of coordination is "air traffic control connectivity". In such a scheme, crisis and surrounding services are coordinated in real time, leading to flexible dispatching of crisis-specific resources. In best-case scenarios, such an operational arrangement will incorporate workflow tools such as internal dashboards that track the availability and location of resources such as personnel and outpatient capacity at provider facilities.

← CRISIS SYSTEM COMMUNITY COORDINATION & COLLABORATION CONTINUUM→				
Level 1	*Level 2*	*Level 3*	*Level 4*	*Level 5*
MINIMAL	**BASIC**	**BASIC**	**CLOSE**	**CLOSE**
Agency Relationships	*Shared MOU Protocols*	*Formal Partnerships*	*Data Sharing (Not 24/7 or Real-Time)*	*"ATC Connectivity"*

Figure 1. SAMSHA Crisis Care Coordination Level Designations. Higher levels on this scale indicate crisis service coordination that is more interconnected, flexible, real-time, transparent, and navigable.

Part II of this report will provide a synopsis of selected partnerships, programs, and personnel strategies that are considered "best practices" by researchers, practitioners, and interest groups involved in the provision of behavioral health care.

References:

1. Brister, T. (2018) Navigating a mental health crisis: A NAMI guide for those experiencing a mental health emergency. The National Alliance on Mental Illness. https://www.nami.org/Support-Education/Publications-Reports/Guides/Navigating-a-Mental-Health-Crisis/Navigating-A-Mental-Health-Crisis
2. Missouri Department of Mental Health. (2021) 2021 Status Report on Missouri's Substance Use and Mental Health. https://dmh.mo.gov/sites/dmh/files/media/pdf/2022/01/sr2021-section-e.pdf
3. Mueller, J.M. (2020) COVID-19, Mental Health & Substance Abuse. MOST Policy Initiative Science Note. https://mostpolicyinitiative.org/science-note/covid-19-mental-health-substance-abuse/
4. Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit. https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

Part II: Crisis Care Partnerships, Programs, & Personnel

Partnerships

1. Law enforcement

Law enforcement agencies nationwide have reported increases in police contacts with people with mental illness or experiencing behavioral health crises in recent years. Due to widespread awareness of law enforcement agencies as a generalized crisis response service, pre-existing law enforcement resources, and varying degrees of integration of law enforcement with communities, these agencies have an ongoing role in responding to behavioral health crises (which may in some cases also overlap with criminalized activities).

Research on law enforcement responses to individuals with mental illness finds that police officers often encounter people at risk of harming themselves due to mental illness, consistently spend time attempting to resolve behavioral health crises, respond informally to crises by talking to the individual experiencing crisis, encounter a small subset of "repeat players", and transport individuals to emergency medical facilities.[4,5,6] Police officers may also provide support in potentially dangerous situations or provide "warm hand-offs" to behavioral health crisis personnel.

In Missouri, these networks are often maintained informally. Many departments utilize Crisis Intervention Team (CIT) training, or trauma-informed care training to better equip officers to respond to behavioral health crises. More than 10,000 law enforcement personnel in the state have been trained on how to approach and assist individuals who are experiencing a crisis due to mental illness, substance use or developmental disability. Currently, CIT Councils cover 100 counties in Missouri. The State CIT Council recently developed the Missouri Model for CIT Training.[7] These types of resources are discussed in further detail in the "Programs" section of Part II, found below.

There has been a recent national trend of moving away from using law enforcement agencies as the first point of contact for those experiencing a behavioral health crisis. Instead, collaborations between police officers and behavioral health professionals have become more widespread. Specific collaborative frameworks are discussed in the "Personnel" section of Part II, found below.[8,9]

2. Legislative Bodies and Executive Branch Agencies

Within the Missouri General Assembly, the House Health & Mental Health Policy Committee and the Senate Health & Pensions Committee are the primary working groups considering legislation regarding behavioral health. In the summer of 2021, the House Subcommittee on Mental Health Policy Research also convened to consider legislative options for the 2022 regular legislative session. As of January, 2022, the Subcommittee on Mental Health Policy Research has not yet issued a report documenting their findings.

These legislative groups are key players in determining the viability and sustainability of behavioral health program and personnel (discussed in the following subsections of this report), as they must provide authorization for state-level actions (in many, but not all, cases) and also play a part in discussions around the appropriations process for any authorized actions.

Within the executive branch, the Department of Mental Health (DMH) is the primary coordinator of state-provided behavioral health resources. In particular, the Division of Behavioral Health operates numerous programs and manages behavioral health-focused personnel. These programs are discussed in Parts II and III of this report, as appropriate.

3. Stakeholder Groups

Several non-governmental interest groups in Missouri or at the national level provide resources to improve behavioral health crisis responses in the state. A sample of these groups is provided below with brief descriptions and links to their websites.

- Missouri Behavioral Health Council: A network of member agencies throughout the state that provides a comprehensive array of psychiatric and substance abuse treatment services and supports as appropriate for children/adolescents, adults and senior adults. The Council also develops programs and promotes best practices that improve behavioral health in Missouri.
- MO CIT Council: The Missouri Crisis Intervention Team (CIT) Council is a network of representatives from each established local council across the state, Community Behavioral Health Liaisons (CBHLs), state agencies and associations, and those with lived experience. The Council works to address any structural barriers at the state level and advocates for policy and legislative changes that may be necessary to support health and wellness. The Council also provides direction and support on the CIT curriculum, training expansion, and implementation of the program.
- National Alliance on Mental Illness Missouri: NAMI Missouri is a nonprofit organization that provides education, support, and advocacy on behalf of people with serious mental illness and their families. NAMI Missouri is the chartered statewide organization of the National Alliance on Mental Illness and has nine affiliate chapters in Missouri.
- The National Center on Criminal Justice and Disability: The Arc's National Center on Criminal Justice and Disability (NCCJD) serves as a bridge between the criminal justice and disability communities. NCCJD pursues and promotes safety, fairness, and justice for people with intellectual/developmental disabilities as victims, witnesses, suspects, defendants, and incarcerated persons.

Programs

1. Crisis Call Services

According to SAMSHA, crisis call services provide "real-time access to a live person every moment of every day for individuals in crisis." Minimum expectations for adequate operation of a regional crisis call service include:

i. Operating every moment of every day (24/7/365)
ii. Staffing with clinicians overseeing clinical triage and other trained team members to respond to all calls received
iii. Answering every call or coordinating overflow coverage with a resource that also meets all of the minimum crisis call center expectations defined in the SAMSHA toolkit
iv. Assessing risk of suicide in a manner that meets NSPL standards and danger to others within each call
v. Coordinating connections to crisis mobile team services in the region
vi. Connecting individuals to facility-based care through warm hand-offs and coordination of transportation as needed

Best practices for operation of a crisis call service include:

i. Incorporating "Caller ID" functionality
ii. Implementing GPS-enabled technology in collaboration with partner crisis mobile teams to more efficiently dispatch care to those in need
iii. Utilizing real-time regional bed registry technology to support efficient connection to needed resources
iv. Scheduling outpatient follow-up appointments in a manner synonymous with a warm handoff to support connection to ongoing care following a crisis episode.
v. Offering text and chat options to better engage entire communities in care

In Missouri, the Department of Mental Health (DMH) operates the Access Crisis Intervention (ACI) hotline to field crisis calls. ACI provides free access to services for both youth and adults experiencing a behavioral health crisis. All calls to ACI are strictly confidential, and hotlines are staffed 24/7 by behavioral health professionals.

Assistance may include follow-up phone contact, referrals to resources in the community, next day behavioral health appointments, or a mobile response. Mobile is defined as either going to the location of the crisis, or to another secure community location.

ACI data are tracked quarterly using this form to inform program performance.

2. Crisis Call Dispatcher Diversion Training

In addition to dedicated crisis call lines, 911 or other emergency dispatchers may be trained to handle behavioral health crisis calls. Such training is expected to instruct dispatchers on how to:

i. Practice active engagement with callers and make efforts to establish rapport to enhance the caller's collaboration in securing their own safety
ii. Use the least invasive intervention and consider involuntary emergency interventions as a last resort, except for in circumstances as described below
iii. Initiate life-saving services for attempts in progress (in accordance with guidelines that do not require the individual's consent to initiate medically necessary rescue services)
iv. Initiate active rescue to secure the immediate safety of the individual at risk if the caller remains unwilling and/or unable to take action to prevent their suicide and remains at imminent risk
v. Practice active engagement with persons calling on behalf of someone else ("third-party callers") towards determining the least invasive, most collaborative actions to best ensure the safety of the person at risk
vi. Maintain caller ID or other method of identifying the caller's location that is readily accessible to staff

The City of St. Louis is currently partnering with Behavioral Health Response (BHR) to train 911 dispatchers to divert calls to behavioral health professionals at BHR rather than law enforcement personnel. This program is being rolled out simultaneously with a co-responder program that will partner behavioral health professionals with law enforcement.[10]

3. Intellectual/Developmental Disability-Specific Trainings

Due to the frequent co-occurrence of intellectual/developmental disabilities (I/DD) with behavioral health crises, I/DD-specific trainings and services have been developed to instruct professionals how to best serve this population.[11] According to the Arc's National Center on Criminal Justice and Disability, "Pathways to Justice is a model for law enforcement, victim services professionals, and legal professionals developed by the National Center on Criminal Justice and Disability. It was designed to create and support Disability Response Teams (DRTs) to better serve people with I/DD who come in contact with the criminal justice system, whether they are crime victims/survivors, suspects, witnesses, defendants, incarcerated, or some combination. DRTs can include a range of community members, including law enforcement, victim service providers, attorneys, self-advocates, parent advocates, and disability advocates. The training is designed as a kickoff event for longer-term cross-system collaborations to identify barriers to justice for people with I/DD and develop practical site-specific solutions."[12]

In addition, Crisis Intervention Team (CIT) training (discussed in more detail below) usually does not specialize in these areas. The Vera Institute for Justice notes that "(a)n examination of the frequency of CIT responses to people living with I/DD and the nature of these events would help determine whether CIT programs benefit this population. Research might highlight the need for additional CIT training content, I/DD-specific training, and the need to engage additional community partners in model development or implementation to better serve people living with I/DD who may come in contact with police during a behavioral health crisis."[11]

4. Crisis Response Resource Access Standards

To ensure uniform adherence to best practices, regulatory action may be taken to enshrine crisis response requirements in state code. For example, the State of Iowa administrative code lays out minimum crisis

response statewide standards, stipulating that:

i. Crisis services shall be available 24 hours per day, 7 days per week, 365 days per year for individuals experiencing mental health and disability-related emergencies. A region may make arrangements with one or more other regions to meet the required access standards.
ii. An individual who has been determined to need CSCBS shall receive face-to-face contact from the CSCBS provider within 120 minutes from the time of referral.
iii. An individual in need of mobile response services shall have face-to-face contact with mobile crisis staff within 60 minutes of dispatch.
iv. An adult who has been determined to need 23 -hour observation and holding shall receive 23-hour observation and holding within 120 minutes of referral. The service shall be located within 120 miles from the residence of the individual.

The MO DMH Access Crisis Intervention (ACI) program has similar, but less thorough, rules in place (9 CSR 30-4.195).

5. **Data Collection and Sharing**

To move up SAMSHA's "Crisis System Community Coordination & Collaboration Continuum" (Figure 1), states may also consider improving data collection and sharing protocols. Documenting behavioral crisis event data such as time, location, type of event, type of response, and event resolution can provide a tool for improvement of services, as well as a basis for program accountability.

Ultimately, real-time data-sharing is required to achieve "Air Traffic Control"-level coordination (SAMSHA's highest-level designation) between crisis response elements.[13] For example**,** when people with serious mental illnesses or intellectual/developmental disabilities give consent in advance, agencies can use real-time "flagging systems" to alert responders to an individual's specific needs during an encounter, potentially tailoring the response to the situation more appropriately.

Personnel

1. Crisis Intervention Trained Teams

Data suggest that ~10% of all police contacts with the public involve persons with serious mental illnesses. Law enforcement surveys suggest that officers often do not feel adequately trained to effectively respond to behavioral health crises, that such events are very time-consuming, and that behavioral health providers are not very responsive to attempts to coordinate.[14] Officers also perceive these calls as unpredictable and dangerous, which may lead them to escalate the situation rather than resolve it through de-escalation.

To better prepare law enforcement for these encounters, Crisis Intervention Team (CIT) training has become widespread nationally and in Missouri. This instruction includes 40 hours of specialized training for officers provided by behavioral health clinicians, consumer/family advocates, legal experts, and experienced CIT officers. Training includes information on signs and symptoms of mental illnesses, mental health treatment resources, co-occurring disorders, legal issues, and de-escalation techniques. CIT curricula may also include content on intellectual/developmental disabilities, age-specific issues, and trauma-informed care.[14] Following the initial training, officers may also meet for debriefing meetings and in-service trainings to discuss tactical issues, relay different experiences and scenarios they have encountered, and participate in advanced training.

After training, the CIT officer leads a police-based crisis intervention team of non-CIT-trained officers. The CIT officer may utilize de-escalation and resolution techniques and provide referral services, access ACI crisis services, or transport the individual to a partnered hospital emergency room or crisis stabilization center.

CIT-trained officers are more likely than their non-CIT peers to report "verbal engagement" as the highest level of force used. CIT-trained officers are also more likely to resolve calls with referral or transport to mental health services and less likely to resolve calls with arrest than officers without CIT training. CIT implementation results in significant increases in the number of identified mental health calls, more transports to the emergency department for mental health-related reasons, and an increase in the proportion of transports that are voluntary.[11]

The Missouri Crisis Intervention Team (MO CIT) Council hosts trainings for Missouri law enforcement and corrections officers. Trainings are offered several times each year, and local CIT councils cover the majority of counties in the state.

2. Co-Responder Teams

Clinicians can accompany or respond at the request of officers in the field, providing on-site assessment and referral services. Co-responder clinicians may also follow up with each individual to ensure resources have been provided.

Interviews with police and co-responder team members indicate that they agree that the program has improved response outcomes and reduced the time police spend on calls. Calls handled by co-responder teams are significantly more likely to be resolved without psychiatric hospitalization of (55% vs. 28%) and costs are 23% lower than calls handled by police alone. Surveys of officers and consumers suggested relatively high levels of satisfaction as well. The most common outcomes from co-responder team visits are: referral to an agency other than law enforcement (58.6%) and recommended clearance/resolution (20.7%).[11]

There are models for this type of response in Springfield, Missouri (Virtual-Mobile Crisis Intervention) and St. Louis. MO DMH also has 31 Community Behavioral Health Liaisons (CBHLs), with budgeting for 50 more in FY 2022. CBHLs, who are based at community mental health centers, work with local law enforcement and court personnel to connect people experiencing behavioral health crises to available treatments and community services. CBHLs have referred over 70,000 Missourians in crisis for services and provided more than 900 trainings on behavioral health topics for over 13,600 law enforcement officers. These trainings are provided at no cost to law enforcement and are Peace Officer Standards and Training (POST) certified.[7]

3. Mobile Crisis Teams

Mobile crisis teams consist of two or more individuals who offer community-based intervention to individuals in need wherever they are (including at home, work, or anywhere else in the community). A proposed benefit of the MCT model is that it is connected to the community mental health system, which may help in making linkages to care. Ideally, the mobile approach could even provide short-term case management until referral to other services.

SAMSHA indicates that the minimum expectations for operation of a mobile crisis team include:

i. Including a licensed and/or credentialed clinician capable to assessing the needs of individuals within the region of operation
ii. Responding where the person is (home, work, park, etc.) and not restricting services to select locations within the region or particular days/times
iii. Connecting individuals to facility-based care as needed through warm hand-offs and coordinating transportation when and only if situations warrant transition to other locations

Additionally, best practices for mobile crisis teams include:

i. Incorporating peers within the mobile crisis team
ii. Responding without law enforcement accompaniment unless special circumstances warrant inclusion in order to support true justice system diversion

iii. Implementing real-time GPS technology in partnership with the region's crisis call center hub to support efficient connection to needed resources and tracking of engagement
iv. Scheduling outpatient follow-up appointments in a manner synonymous with a warm handoff in order to support connection to ongoing care

Callers who receive a mobile crisis team response are 17% more likely to receive community-based mental health services within 90 days of the crisis event than those who receive a police response.[11] However, research highlights some limitations of mobile crisis team's abilities to address psychiatric emergencies. These include limited capacity (e.g., one team, may serve an entire geographic area) and availability (e.g., only on duty during certain hours or on certain days), long wait times, and the need to call law enforcement for assistance in certain situations.[11]

The Missouri Department of Mental Health currently dispatches MCTs through the Access Crisis Intervention (ACI) program.

4. Case Management Services

Law enforcement agencies, in partnership with mental health providers or other emergency service agencies, are developing strategies to better meet the needs of "high utilizers" (people who have repeated contacts with crisis response teams). These teams provide outreach and follow-up to keep people connected to care and reduce the number of contacts with police and emergency response systems. Strategies include short-term follow-up and referrals or longer-term case management in partnership with community organizations. Currently no research available on the outcomes associated with these services, but pilot program results from Houston, TX report a 70% decrease in contacts with high utilizers in the 6 months after implementation.[11]

MO DMH currently provides case management services for individuals with developmental disabilities.

5. Crisis Stabilization Centers

Crisis stabilization centers provide "no-wrong-door" access to behavioral health care by operating similarly to hospital emergency department that accepts all walk-ins and emergency responder drop-offs. Crisis stabilization services may include walk-in services, telephone services, short-term residential treatment, 23-hour crisis stabilization units, the "living room model", and psychiatric hospitalization.

SAMSHA indicates the following minimum expectations for operating a crisis stabilization center:

i. Accept all referrals
ii. Do not require medical clearance prior to admission but rather assessment and support for medical stability while in the program
iii. Design services to address mental health and substance use crisis issues
iv. Employ the capacity to assess physical health needs and deliver care for most minor physical health challenges with an identified pathway in order to transfer the individual to more medically staffed services if needed
v. Be staffed at all times (24/7/365) with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community; including psychiatrists or psychiatric nurse practitioners (telehealth may be used), nurses, licensed and/or credentialed clinicians capable of completing assessments in the region, and peers with lived experience similar to the experience of the population served.
vi. Offer walk-in and first responder drop-off options
vii. Be structured in a manner that offers capacity to accept all referrals at least 90% of the time with a no rejection policy for first responders
viii. Screen for suicide risk and complete comprehensive suicide risk assessments and planning when clinically indicated

ix. Screen for violence risk and complete more comprehensive violence risk assessments and planning when clinically indicated.

Additionally, SAMSHA indicates that best practices for operation of a crisis stabilization center include:

i. Functioning as a 24 hour or less crisis receiving and stabilization facility
ii. Offering a dedicated first responder drop-off area
iii. Incorporating some form of intensive support beds into a partner program (could be within the services' own program or within another provider) to support flow for individuals who need additional support
iv. Including beds within the real-time regional bed registry system operated by the crisis call center hub to support efficient connection to needed resources
v. Coordinating connection to ongoing care

Crisis stabilization centers are effective at providing suicide prevention services, addressing behavioral health treatment, diverting individuals from entering a higher level of care and addressing the distress experienced by individuals in a behavioral health crisis. Studies also show that the cost of crisis stabilization centers is significantly less than psychiatric inpatient units, and satisfaction among clients is greater.[11,15]

The Missouri 2021-22 budget provides funds to establish six new crisis stabilization centers and maintain/expand operations in KC, Springfield, and Joplin.

References:

5. Reuland, M., Schwarzfeld, M., Draper, L. (2009) Law Enforcement Responses to People with Mental Illnesses: A Guide to Research-Informed Policy and Practice. Council of State Governments Justice Center. https://csgjusticecenter.org/wp-content/uploads/2020/02/le-research.pdf
6. Geller, J.L., Fisher, W.H., McDermeit, M. (1995) A national survey of mobile crisis services and their evaluation. *Psychiatr. Serv.,* 46(9):893-7.
7. Missouri Department of Mental Health. (2021) Legislator Briefing. https://dmh.mo.gov/media/pdf/2021-legislator-briefing
8. National Conference of State Legislatures. (2020) Police-Mental Health Collaboration. https://www.ncsl.org/research/civil-and-criminal-justice/mental-health-needs-of-criminal-justice.aspx
9. Beck, J., Reuland, M., Pope, L. (2020) Behavioral Health Crisis Alternatives: Shifting from Police to Community Responses. Vera Institute of Justice. https://www.vera.org/behavioral-health-crisis-alternatives
10. Behavioral Health Response. (2021) Inspiring Hope and Saving Lives: 2021 Annual Report. https://bhrstl.org/docs/BHRAnnualReport.pdf
11. Watson, A.C., Compton, M.T., Pope, L.G. (2019) Crisis Response Services for People with Mental Illnesses or Intellectual and Developmental Disabilities: A Review of the Literature on Police-based and Other First Response Models. Vera Institute of Justice. https://www.vera.org/downloads/publications/crisis-response-services-for-people-with-mental-illnesses-or-intellectual-and-developmental-disabilities.pdf
12. The Arc's Center on Criminal Justice and Disability (2021) Pathways to Justice. https://thearc.org/our-initiatives/criminal-justice/pathway-justice/
13. National Council for Behavioral Health. (2021) Roadmap to the Ideal Crisis System: Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response. https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031121_GAP_Crisis-Report_Final.pdf?daf=375ateTbd56
14. Watson, A.C., Fulambarker, A.J. (2012) The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners. *Best Pract. Ment. Health*, 8(2):71.
15. Saxon, V., Mukherjee, D., Thomas, D. (2018) Behavioral Health Crisis Stabilization Centers: A New Normal. *J. Mental Health & Clin. Psychology*, 2(3): 23-26.

Part III: State & National Legislative Trends

Legislative Proposals in Missouri and Other States

In the 2021 regular session, the Missouri House and Senate considered numerous pieces of legislation related to behavioral health. These proposals, and their outcomes, are listed in the table below.

Bill	Description	Status
SB 80/HB 889	Mental health parity	Passed (as provisions of HB 604)
SB 173	Removes restrictions to access for any individual antipsychotic medication for MO HealthNet participants	Passed (as provisions of HB 432)
SB 521	Requires that those detained or incarcerated in jails or prisons are assessed for substance abuse disorders, and that medication-assisted treatment services, including buprenorphine and naltrexone, are available	Passed (as provisions of SBs 53 & 60)
SB 551	Establishes the "Critical Incident Stress Management Program" within the Department of Public Safety	Passed (as provisions of SBs 26, 53, & 60)
SB 122	Individuals accused of committing an offense who have been committed to the Director of DMH for lack of mental fitness accused shall remain in custody until the Department determines it is appropriate that they be placed in the community	Referred to committee
HB 170	Creates the crime of encouraging a suicide attempt	Referred to committee
HB 270	Creates a grant program for behavior crisis care centers	Referred to committee
HB 304	Enacts requirements relating to suicide prevention education and information	Referred to committee
HB 422	Establishes provisions relating to civil actions for abuse, bullying, or neglect of certain persons with disabilities	Referred to committee
HB 537	Requires the Department of Social Services to apply for a wavier from the Centers for Medicare and Medicaid Services in order to give MO HealthNet coverage for mental health services provided in residential programs in psychiatric facilities.	Referred to committee
HB 751	Requires step therapy protocols to be designed around peer-	Hearing conducted

	reviewed research or some other process that includes feedback from multidisciplinary experts.	
HB 978	Modifies the powers and duties of a guardian of an incapacitated person	Passed out of committee
HB 1011	Provides funding for public schools to hire a school nurse and a mental health professional	Referred to committee
HB 1244	Allows a physician or pharmacist to alert a prescriber of a potential increased risk of suicidal ideation or behavior associated with a drug, to counsel patients on how to recognize symptoms, and to provide the patient the number for the national Suicide Prevention Lifeline.	Referred to committee

Table 2. Legislative proposals relating to behavioral health in the 2021 Missouri General Assembly.

Beyond these proposals and actions, the Department of Mental Health identifies several other areas of need with regards to behavioral health, including workforce training, recruitment, and retention; opioid overdoses; health services payment reform; state inpatient facility waitlists, staffing, and capacity; and services for uninsured individuals.[7]

Outside of Missouri, several states have considered legislation proposing the creation of a children's behavioral health system; allowing children to receive psychotherapy services without parental consent; requiring health insurance plans to provide coverage of specialty care for first episode psychosis treatment; requiring health education courses to include mental health information; and requiring behavioral health intervention training for educators and school staff; modifying insurance and behavioral health service compensation requirements; mandating de-escalation training for law enforcement and corrections officers; reducing barriers to entry for behavioral health professionals; considering expansion of mental health courts; prohibiting discredited medical practices; examining involuntary outpatient commitment requirements; and establishing peer support certifications.[17] For a comprehensive overview of these and other policy proposals, see NAMI's 2019 report on trends in state mental health policy.

National Legislative Approaches

Nationwide, several other behavioral health-related legislative proposals have been considered in recent years. In 2020, the U.S. Congress passed the National Suicide Designation Act to establish a nationwide three-digit behavioral health crisis hotline; starting in 2022 users can call 988 to access behavioral health resources. Currently, calls made to the lifeline will be answered by the nearest available call center (this may be located in an adjacent state) or the national response center headquartered in New York City. States may, but are not required, to establish a surcharge fee to support these call centers and other response programs.[16]

Other Congressional proposals include bills to establish and extend programs to coordinate and support services for infants, children, youth, and families who have experienced, or may experience, trauma; support for school-based mental health services, including screening, treatment, and outreach programs; requiring private health insurance plans that offer both medical and mental health coverage to prepare a comparative analysis of nonquantitative treatment limitations; and establishing a loan repayment program for mental health professionals who work in designated workforce shortage areas.

References:

16. Severance-Medaris, C. (2021) Legislatures Prepare for New National Suicide Prevention Lifeline. National Conference of State Legislatures. https://www.ncsl.org/research/health/legislatures-prepare-for-new-national-suicide-prevention-lifeline-magazine2021.aspx
17. NAMI. (2019) Trends in State Mental Health Policy. https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/NAMI-State-Legislation-Report-Trends-in-State-Mental-Health-Policy-(2019)/NAMI-2019-State-Legislation-Report-FINAL.pdf