Structure and Delivery of Adult Emergency and Crisis Mental Health Services in the Mountain West Region

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ABSTRACT

Objective: The purpose of this qualitative study was to analyze and compare the structure and delivery of mental health services in the Mountain West Region (AZ, CO, ID, MT, NM, NV, UT, WY), with a primary interest in psychiatric emergency services in hospital emergency departments and state/community crisis services and to examine the mechanisms of implementing new policies to improve those services.

Methods: Key informant interviews were conducted to collect pertinent data, governmental and organizational websites and documents were reviewed to supplement and verify the information, literature was searched and draft summaries of the findings were submitted to the state key informants for validation.

Results: The delivery of mental health and emergency/crisis services is very complex and differs state by state or regionally in the public sector, and among individual hospitals and health care systems in the private sector. Major factors driving that variability, besides the relative autonomy of health care facilities, are sources of funding including patients’ insurance, geographical challenges, and local preferences.

Even though states designate, contract, directly employ and/or license community mental health providers and providers of crisis services and as such can mandate minimum service requirements, the operationalization of those prescribed services is usually left up to the individual provider, which results in considerable diversity in mental health care delivery. Some states in the Mountain West Region are developing systematic crisis services to improve access and quality of mental health care.

Conclusions: Future evaluation will be needed to assess the ability of the newly developed systems of crisis services to deliver acute psychiatric/crisis interventions and to prevent self-harm.

Limitations

This qualitative organizational study is based on a primary interview with a key-informant from each state mental health agency, validated and expanded upon through additional interviews with representatives from mental health related organizations/agencies (conducted between March and September 2016) and cross referenced with information from governmental and organizational documents, websites and available literature. Using this approach inevitably introduces the possibility of respondent bias, variability in provided detail and incomplete assessment of the available services and their organization. To eliminate this limitation as much as possible, the state-specific final summaries with questions for clarification from the author and an advisory panel of experts were submitted for a review by the original informants and in the case of SAMHSA Region VIII (CO, UT, MT, and WY), the regional SAMHSA representative. Not all informants provided feedback but there was at least one review per state done by the main informant. The final discussion in Section 3 synthesizes the information from the perspective of the author.

Even though attempts were made to arrange interviews with informants in equivalent positions across the states, this was not always possible, potentially creating some variation in information across states.

Also, though the information for the report was collected from March through August 2016 and verified in September 2016, the fast evolving changes in mental health services may have resulted in some elements not being fully captured.
Table of Contents:

This report is organized into three sections:

The Section 1 examines federal and state legislative, logistical and organizational factors which have a major influence on the delivery of adult mental health services.

The Section 2 describes the organization of adult mental health services in individual states of the Mountain West Region with and subsequently summarizes the findings and compares psychiatric emergency services (PES) among the states.

The Section 3 provides discussion and recommendation for future actions.

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<td>24</td>
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<tr>
<td>Montana</td>
<td>26</td>
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<tr>
<td>New Mexico</td>
<td>29</td>
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<tr>
<td>Nevada</td>
<td>33</td>
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Section 1
**Background:**

It has been commonly recognized that mental health services in the US are not functioning adequately\(^1\), mainly due to fragmentation, underfunding, understaffing and historically discriminatory insurance practices. Psychiatric emergency services (PES), in particular, have been subjected to major critique and to subsequent improvement efforts. PES are delivered primarily by medical emergency departments (EDs) affiliated with private hospitals where it is not unusual for patients with acute psychiatric issues to be exposed to long waiting times due to the need of having a prior medical evaluation. In many instances, there is no immediate access to a mental health provider.

Due to the private status of many hospital facilities, state governmental agencies have limited or no authority over the policies and procedures guiding the delivery of mental health care in the EDs. Nonetheless, states are charged with addressing the high prevalence of mental illness and increasing rates of suicide (Fig 1, Tab.1,2.).

![Figure 1. Trend in the US suicide rates from 2005-2014. Source: http://afsp.org/about-suicide/suicide-statistics/](image)

<table>
<thead>
<tr>
<th>State (Mountain West states shaded)</th>
<th>Crude rate of adult suicide in 2014 per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>USA</td>
<td>16.89</td>
</tr>
<tr>
<td>Montana</td>
<td>30.05</td>
</tr>
<tr>
<td>Alaska</td>
<td>29.08</td>
</tr>
<tr>
<td>New Mexico</td>
<td>27.41</td>
</tr>
<tr>
<td>Nevada</td>
<td>25.78</td>
</tr>
<tr>
<td>Utah</td>
<td>25.7</td>
</tr>
<tr>
<td>Colorado</td>
<td>25.36</td>
</tr>
<tr>
<td>Wyoming</td>
<td>25.12</td>
</tr>
<tr>
<td>Idaho</td>
<td>25.1</td>
</tr>
<tr>
<td>Oregon</td>
<td>24.36</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>24.17</td>
</tr>
<tr>
<td>Arizona</td>
<td>23.62</td>
</tr>
<tr>
<td>West Virginia</td>
<td>23.53</td>
</tr>
<tr>
<td>Vermont</td>
<td>22.97</td>
</tr>
<tr>
<td>North Dakota</td>
<td>22.94</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>22.84</td>
</tr>
</tbody>
</table>

Source: [https://www.cdc.gov/injury/wisqars/fatal_injury_reports.html](https://www.cdc.gov/injury/wisqars/fatal_injury_reports.html)
The Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health (NSDUH) reported that, in 2013, 43.8 million adults in the US suffered from a diagnosable mental illness—of these, 15.7 million experienced a major depressive episode. At the same time, 9.3 million American adults (3.9 percent) reported having serious thoughts of suicide in the past year, 2.7 million (1.1 percent) made suicide plans and 1.3 million (0.6 percent) attempted suicide. There were 42,773 suicides across all age groups in 2014 in the United States—a crude rate of 13.41 per 100,000, which equals 117 suicides each day or approximately one every 12 minutes, making suicide the 10th leading cause of death.

The Mountain West Region is the US Census Region 4, Division 8, which includes Arizona (AZ), Colorado (CO), Idaho (ID), Montana (MT), Nevada (NV), New Mexico (NM), Utah (UT), and Wyoming (WY). In this region, suicide rates are especially high (Tab. 2) and the delivery of psychiatric emergency services (PES) are also frequently compromised by geographic remoteness. Large areas of these states are classified as rural or frontier and therefore commonly underserved. This results in less accessibility to mental health providers and, in some instances, the lack of psychiatric emergency care protocols in rural emergency departments.

The Mountain West includes more than 200 frontier counties with a total population in excess 2.5 million. These counties have a population density of less than 7 persons per square mile. The US Census Bureau qualifies an urban area as “a densely settled core of census tracts and/or census blocks which encompasses at least 2,500 people, at least 1,500 of which reside outside institutional group quarters.” “Rural” describes all population, housing, and territory not included within an urban area. The majority of the Mountain West Region is considered rural (Tab. 3).

### Table 2. 2014, United States, Suicide Injury Death Rates per 100,000, All Races, Both Sexes, Ages 18 to 85+

<table>
<thead>
<tr>
<th>Sex</th>
<th>State</th>
<th>Crude Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>Arizona</td>
<td>36.43</td>
</tr>
<tr>
<td>Females</td>
<td>Arizona</td>
<td>11.18</td>
</tr>
<tr>
<td>All adults</td>
<td>Arizona</td>
<td>23.62</td>
</tr>
<tr>
<td>Males</td>
<td>Colorado</td>
<td>39.61</td>
</tr>
<tr>
<td>Females</td>
<td>Colorado</td>
<td>11.13</td>
</tr>
<tr>
<td>All adults</td>
<td>Colorado</td>
<td>25.36</td>
</tr>
<tr>
<td>Males</td>
<td>Idaho</td>
<td>37.8</td>
</tr>
<tr>
<td>Females</td>
<td>Idaho</td>
<td>12.55</td>
</tr>
<tr>
<td>All adults</td>
<td>Idaho</td>
<td>25.1</td>
</tr>
<tr>
<td>Males</td>
<td>Montana</td>
<td>47.36</td>
</tr>
<tr>
<td>Females</td>
<td>Montana</td>
<td>12.77</td>
</tr>
<tr>
<td>All adults</td>
<td>Montana</td>
<td>30.05</td>
</tr>
<tr>
<td>Males</td>
<td>Nevada</td>
<td>40.36</td>
</tr>
<tr>
<td>Females</td>
<td>Nevada</td>
<td>11.21</td>
</tr>
<tr>
<td>All adults</td>
<td>Nevada</td>
<td>25.78</td>
</tr>
<tr>
<td>Males</td>
<td>New Mexico</td>
<td>43.61</td>
</tr>
<tr>
<td>Females</td>
<td>New Mexico</td>
<td>11.78</td>
</tr>
<tr>
<td>All adults</td>
<td>New Mexico</td>
<td>27.41</td>
</tr>
<tr>
<td>Males</td>
<td>Utah</td>
<td>39.09</td>
</tr>
<tr>
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<td>Utah</td>
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<tr>
<td>All adults</td>
<td>Utah</td>
<td>25.7</td>
</tr>
<tr>
<td>Males</td>
<td>Wyoming</td>
<td>39.17</td>
</tr>
<tr>
<td>Females</td>
<td>Wyoming</td>
<td>10.52</td>
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<tr>
<td>All adults</td>
<td>Wyoming</td>
<td>25.12</td>
</tr>
<tr>
<td>Males</td>
<td>US</td>
<td>26.95</td>
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<tr>
<td>Females</td>
<td>US</td>
<td>7.35</td>
</tr>
<tr>
<td>All adults</td>
<td>US</td>
<td>16.89</td>
</tr>
</tbody>
</table>

Source: https://www.cdc.gov/injury/wisqars/fatal_injury_reports.html
Table 3. Percentage of Rural Area, Population, and Population Density in the states in the Mountain West Region

<table>
<thead>
<tr>
<th>State</th>
<th>Rural Area %</th>
<th>Rural population %</th>
<th>Rural population density per square mile</th>
</tr>
</thead>
<tbody>
<tr>
<td>AZ</td>
<td>98.08</td>
<td>10.19</td>
<td>5.8</td>
</tr>
<tr>
<td>CO</td>
<td>98.53</td>
<td>13.85</td>
<td>6.8</td>
</tr>
<tr>
<td>ID</td>
<td>99.40</td>
<td>29.42</td>
<td>5.6</td>
</tr>
<tr>
<td>MT</td>
<td>99.80</td>
<td>44.41</td>
<td>3.0</td>
</tr>
<tr>
<td>NV</td>
<td>99.30</td>
<td>5.80</td>
<td>1.4</td>
</tr>
<tr>
<td>NM</td>
<td>99.32</td>
<td>22.57</td>
<td>3.9</td>
</tr>
<tr>
<td>UT</td>
<td>98.89</td>
<td>9.42</td>
<td>3.2</td>
</tr>
<tr>
<td>WY</td>
<td>99.80</td>
<td>35.24</td>
<td>2.0</td>
</tr>
</tbody>
</table>

Source: https://www.census.gov/geo/reference/ua/urban-rural-2010.html

The shortage of mental health providers strongly affects the quality of mental health services and PES in particular. In 2010 the US had an estimated 89.3 million Americans living in federally designated Mental Health Professional Shortage Areas (HPSA), compared to 55.3 million living in primary care underserved areas. Mental Health HPSAs are based on a psychiatrist-to-population ratio of 1:30,000 while Primary Care HPSAs use the ratio of 1:3,500. Due to this scarcity, many hospitals, especially in rural areas, contract with outside organizations, like community mental health centers or, if available, rely on crisis services or telehealth to conduct evaluations of ED patients presenting with potential need of acute psychiatric care.

Hospitals are increasingly utilizing telehealth services to substitute for the physical presence of providers, but their use for emergency psychiatric consults is, so far, rather limited, partially due to complicated insurance reimbursement (Fig. 3) and the providers’ need for individual state licenses. However, even when a mental health provider is readily available, making appropriate ED discharge arrangements for patients in need of acute psychiatric care is another complex matter due to a substantial shortage of psychiatric beds.

Figure 2. Federally Designated Mental Health Professional Shortage Areas (HPSA) by state. Source: https://datawarehouse.hrsa.gov/Tools/MapToolQuick.aspx?mapName=HPSAMH

Figure 3. State Medicaid and Private Payer Telehealth Coverage and Reimbursement Policies. Source: http://www.ncsl.org/research/health/state-coverage-for-telehealth-services.aspx
Many of the state Mental Health Agencies in the Mountain West Region are starting to acknowledge the vast need for improvement of PES and are therefore developing systems for state-funded crisis services.

These efforts by states to improve their PES and mental health services in general are supported (at the discretion of the state) by incentives, resources, and technical assistance from federal agencies involved in mental health care and facilitated by the recent enactment of health care related laws.

SAMHSA offers annual block grants to the states to deliver comprehensive, community-based mental health services. SAMHSA calculates the states’ baseline allotment on the relative shares of the Weighted Population-at-Risk, Cost-of-Services, and Fiscal Capacity Indexes\textsuperscript{11}. SAMHSA also awards Congressionally-approved grant funding. In regards to suicide prevention, there are grants supporting prevention and intervention programs for youth and young adults and tribal youth, the main grant program being Garrett Lee Smith Memorial Act\textsuperscript{12}. SAMHSA also provides extensive technical assistance to states and community agencies; funds the National Lifeline and Veterans Lifeline, the Suicide Prevention Resource Center (SPRC); suicide prevention toolkits; patient and family resources; and special reports/guidance for working with seniors, veterans, and tribal members. While SAMHSA’s funding has principally targeted youth and young adults, future funding initiatives are being planned to address suicide prevention for adults and older adults. (Dr. C. Smith, oral communication, April 2016).

In 2012, SAMHSA created 10 regional offices (Fig. 4.). Their roles are mainly consultative, informing states in their respective regions about the federal SAMHSA strategies and resources, monitoring states’ progress with SAMHSA initiatives, conducting regional surveillance of mental and substance use disorders and initiatives, and facilitating strategic discussions with state, local, and tribal stakeholders. In several instances, SAMHSA Regional Administrators hold periodic meetings with state suicide prevention coordinators. In addition the SAMHSA Regional Offices are co-located, and thus closely collaborate, with other Health and Human Services agencies such as Center for Medicare & Medicaid Services (CMS), the US Surgeon General, US Commission on Civil Rights, Health Resources and Services Administration, and other major federal agencies\textsuperscript{13}.

\textbf{Figure 4.} Map of US Department of Health and Human Services Regions (applies to SAMHSA Regions). Source: http://www.ncmhr.org/resources.htm
Table 4. The Mountain West Region States SAMHSA Regional Office #

<table>
<thead>
<tr>
<th>The Mountain West Region State</th>
<th>SAMHSA Region</th>
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</thead>
<tbody>
<tr>
<td>NM</td>
<td>Region VI</td>
</tr>
<tr>
<td>CO, MT, UT, WY</td>
<td>Region VIII</td>
</tr>
<tr>
<td>AZ, NV</td>
<td>Region IX</td>
</tr>
<tr>
<td>ID</td>
<td>Region X</td>
</tr>
</tbody>
</table>

The states’ plans to address the high prevalence of mental illness and increasing suicide rates have also been facilitated by enactment of The Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008 to ensure parity between insurance benefits for mental and substance use disorders and medical/surgical conditions. Prior to July 1, 2014, when the law became effective, insurance plans often provided highly restrictive benefits for the treatment of mental illness. Since July 2014, health plans purchased through the Health Insurance Marketplace are mandated to include mental and substance use services as essential health benefits and they can’t reject coverage or increase charges based on pre-existing conditions. Also, coverage limits associated with the treatment of mental and substance use services can’t be more restrictive than limits for medical/surgical services. Even though this law intends to provide the needed medical and mental health equity, there are still practice gaps in adherence to the new standard. Some health plans are refusing to cover medical costs for suicide-related injuries referencing their source-of-injury exclusions policies, despite federal law.

As uninsured people are disproportionately affected by mental illness, the Affordable Care Act (ACA) of 2010 represents yet another major law influencing the efforts to improve mental health services. Medicaid is the principal health insurance provider in the US, covering more than 62 million persons and families in 2013. Because states’ Medicaid spending is largely supplemented by federal funds, the ACA mandated that states expand eligibility criteria to guarantee Medicaid insurance coverage for more individuals. In exchange for the adoption of the expansion, the federal government offered to cover 100% of the expenses for newly eligible people for the first three years, decreasing those funds gradually to 90% by 2020 and remaining at that level thereafter. To penalize the non-compliant states, Congress originally gave the HHS Secretary authority to suppress states’ federal matching funds.

Prior to adoption of the ACA, determining Medicaid eligibility was very complicated and generally excluded single men. The ACA simplified the criteria and offered Medicaid coverage to a new group based on a simple criterion of maximum income of 133% of the federal poverty level (FPL), with an additional 5% income allowance establishing 138% of the FPL as the upper limit for the expansion.

However, in 2012 the Supreme Court declared the mandatory Medicaid eligibility expansion unconstitutional and allowed states to opt-out of the expansion without losing their original federal Medicaid funding.

As of now, five out of eight states in the Mountain West Region (AZ, CO, MT, NM, and NV) are expanding their Medicaid program, while Utah, Wyoming, and Idaho decided against expansion (Fig. 5). One of the reasons for states not expanding Medicaid is the prospect of a future reduction in federal...
coverage for the newly eligible group to 90% of the expenses, with states responsible for the extra 10%\(^23\) of the Medicaid cost which some states predict might not be sustainable.

However, studies show that those concerns may not be substantiated. Medicaid-expanding states report saving money since, as a result of more people being insured, the state can decrease expenditures on programs for the uninsured by using federal Medicaid dollars instead of state funds.\(^24\). Insured individuals tend to seek help early\(^25\) in the course of disease. Coupled with the fact that approved preventive services are covered at 100%, this leads to early diagnosis and treatment and consequently to decreased cost of the medical care as well as lesser utilization of the EDs. These savings can be used by states to balance some of the future cost of the expansion\(^26\).

In 2013, it was estimated that through the ACA’s Medicaid expansion and Health Insurance Marketplace “32.1 million Americans will gain access to coverage that includes mental health and/or substance use disorder benefits that comply with federal parity requirements and an additional 30.4 million Americans who currently have some mental health and substance abuse benefits will benefit from the federal parity protections\(^27\)”.

Figure 5. State Medicaid Expansion Decision (January 2016).
Source: https://www.macpac.gov/subtopic/medicaid-expansion/

Figure 6 demonstrates the substantial Medicaid mental health expenditures, which accounted for 27% of the total US $147 billion investment in treatments for mental illness and substance abuse in 2009, and is expected to increase.

Figure 6. Distribution of Mental Health Spending by Payer, with prediction for 2020
Source: http://store.samhsa.gov/shin/content/SMA14-4883/SMA14-4883.pdf
To reduce the cost of health care while increasing its quality, the Center for Medicare & Medicaid Services, or CMS, (another major federal agency involved in funding of mental health services) started, in July 2012, the State Innovation Models (SIM) Initiative. In February 2013, 25 states were awarded SIM grants to develop and test new health care and payment delivery models.

The SIM grant has three categories (Fig. 7):

- Model design: 1-year awards to states to begin work on their innovation plans
- Model pre-testing: 1-year awards to states to continue work on their plans
- Model testing: 3-year awards to states to implement their State Health Innovation Plans

Within the Mountain West Region, only Wyoming is not participating in the initiative, while Colorado and Idaho are leading the endeavor and already testing their models. One of the main SIM agendas involving mental health care in the Mountain West Region is the integration/co-location of primary and behavioral health services. This is intended to increase access to mental health services which should, in the long term, lead to better care for people affected by mental illness and to a reduced burden on the PES through earlier diagnosis and increased availability of treatment.

Figure 7. State SIM Award in Round Two in 2014
Source: https://innovation.cms.gov/initiatives/state-innovations/
Section 2
Even though states organize their mental health services differently, they typically derive them from some common building blocks.

**Common factors in states organization of public mental health services**

**State agencies and payment mechanisms involved in mental health care**

States deliver and oversee adult mental health care through state mental health, Medicaid and, in some states, public health agencies.

States are in charge of arranging care for Medicaid and indigent patients. For that purpose, they usually either directly operate or fund community mental health centers. Those centers are designated, contracted and/or licensed by the state which can set minimum service expectations, including screening, outpatient treatment, emergency mental health services, and day treatment programs.

In most cases the community mental health centers are also able to serve and bill privately insured patients. Private insurance accounts cover a fairly large proportion of community mental health centers’ annual revenue.

**Mental health financing**

States finance mental health services through a combination of the following mechanisms:

1. Medicaid – covers the cost of health care for Medicaid patients, and often accounts for more than 50% of state mental health expenditures, paying for most suicide-related, interventions and treatment.

2. State general fund - states need to follow strict, prescribed ways of making annual or biannual applications. State funds are awarded by the executive and legislative branches of state government. States have an option to include or exclude public input.

3. Federal SAMHSA Mental Health Block Grant – states annually apply to SAMHSA for the federal Mental Health Block Grant (as well as the Substance Abuse Block Grant). The grant request is formed and progress is monitored by the state Mental Health/Behavioral Health Planning Councils, which are required by SAMHSA. The Mental Health Block Grant can be used for various purposes: advocacy, state staff salaries, support of governor’s initiatives, mental health care services for the indigent population, etc. In contrast to the state funds, federal funds can be used for undocumented immigrants. Planning sessions are open to public input. The Mental Health Block Grant does not require suicide prevention or intervention services. The use of this fund for those services is at the discretion of the state.

4. SAMHSA discretionary grants – Congress determines the grant’s subject matter and eligibility for applications. An example is a current SAMHSA Certified Community

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*This report did not examine VA, Tribal or Criminal Justice adult mental health services*
Behavioral Health Clinics (CCBHCs) grant which calls for creation and certification of behavioral clinics providing intensive standardized services, including crisis services with 24-hour mobile crisis teams and crisis stabilization units. Within the Mountain West Region Colorado, New Mexico and Nevada each received one-year planning grants in October 2015.

5. Other discretionary grants
6. County/local funds (mandatory in Utah, otherwise at counties discretions)
7. Third-party collections
8. Client collections

Psychiatric emergency services

In regards to the prevention of psychiatric emergencies, each state is involved in suicide prevention. The preventive measures differ by states, regions and counties but each state appoints or contracts with a suicide prevention coordinator. The agency locus varies by state.

Though individual state systems for providing psychiatric emergency services demonstrate some commonalities there also is much variation, as documented in the state-specific sections that follow.
Arizona

The state mental health agency in Arizona, the Division of Behavioral Health Services (DBHS), was dissolved as of July 2016 and became part of the Medicaid agency, the Arizona Health Care Cost Containment System (AHCCCS). Public health is under the umbrella of the Department of Health Services and is responsible for one state psychiatric hospital. The state contracts with Regional Behavioral Health Authorities, who then subcontract with local community providers.

Community Mental Health Centers

AHCCCS contracts with three Regional Behavioral Health Authorities (RBHA) and four Tribal Regional Behavioral Health Authorities and, as such, can mandate new policies and adoption of best practices. The RBHAs consequently contract with local community providers in order to administer integrated, managed care. Arizona does not follow the community mental health centers model. Each RBHA aligns its own strategies with the state strategy, based on the review of the plan from the previous year and analysis of utilization, complaints, grievances and appeals, unmet needs, access to care, and network inventory data.

Crisis services

Central and Northern RBHA

In 2012, the Central and Northern RBHAs, contracted a non-profit organization, the Crisis Response Network, to provide crisis services in corresponding regions of Arizona. Their services are available to everyone regardless of insurance coverage and there are a number of entry points. Even though the organization of the crisis services in the Northern Region is similar to the Central Region, it is not as robust due to a smaller population and service density.

The hotline, which is affiliated with the National Lifeline, is the same for both the Central and Northern Regions. The calls are answered by licensed, master’s level crisis intervention specialists who provide assessment and either deal with the situation via phone or dispatch a mobile team.

The mobile team usually consists of two people, one master’s level clinician and one behavioral health technician, who generally holds a bachelor’s degree with some requisite behavioral health experience and who is not typically licensed. The mobile services team can transport patients to one of the freestanding psychiatric emergency room facilities financed by state behavioral health funds. These facilities accept walk-ins and are also eligible for involuntary processing and have subacute beds for voluntary inpatient admissions.

The crisis services providers can bill private insurance if relevant. In the case of providing care to uninsured patients, screening for Medicaid eligibility is started and, if applicable, patients are assisted in obtaining benefits. If eligibility is not established the state would cover non-compensable care
from general state funds administered through structured crisis benefits.

In case of imminent threat, law enforcement is dispatched. The RBHAs provide training for law enforcement officers to educate them about the possible conditions causing behavioral changes and about the existence of the free-standing psychiatric emergency services. This enables officers to de-escalate instead of escalate the situation and arrange for appropriate disposition of the person in need of mental health care, instead of taking them to jail. The Central RBHA provides 10-12 classes for 250-400 officers per year. In 2014, approximately 19,000 law enforcement contacts were re-directed to the crisis system and, as such, potential incarceration avoided.

Calls to the crisis hotline, which is intended for high acuity issues, can be diverted, if appropriate, to the warm line (a call system for lower acuity issues operated by peers).

The state promotes peer services by contracting Arizona State University to coordinate a Peer Career Advancement Academy which offers advanced training and certification to individuals in recovery from mental illness and/or addiction who can be subsequently employed by the mental health services system.36

Emergency departments

Another entry point to the crisis services is the regular medical ED. The Central Region has 25 different hospitals with emergency departments (EDs), some of which have a psychiatrist on staff but the coverage is limited. To resolve this shortage, EDs contract with a crisis services provider who will, within 2 hours, send an on-call mental health provider. Telehealth is not frequently used for evaluation due to the complexity of reimbursement.

Southern RBHA

To address acute mental and physical health needs in Southern Arizona, the Southern RBHA contracts with NurseWise - a national multilingual nurse triage and telehealth provider. Registered nurses and mental health providers answer crisis calls 24/7 and can dispatch a mobile crisis team where available. They also provide follow-up calls to assure patients' medical stability and referral to additional services.

Suicide prevention

In Arizona, suicide prevention is managed under the Arizona Health Care Cost Containment System (AHCCCS). Since 1999 the Arizona Suicide Prevention Coalition, a grassroots organization, has spearheaded statewide efforts and partnerships. It has representatives from a variety of community sectors, including state agencies, but has always been independent. In 2004, a position for a suicide prevention coordinator was created at the former Arizona Department of Health Services, Division of Behavioral Health Services. This state agency supported statewide suicide prevention efforts despite changes in funding, and was instrumental in securing grant funds to target efforts towards youth, Native American tribes, and universities.

The Central RBHA (Mercy Maricopa Integrated Care) is committed to creating suicide-safer communities and offers a
variety of free trainings for providers and community members, including Mental Health First Aid, safeTALK, and ASIST (Applied Suicide Intervention Skills Training). Trainings like these have helped increase preparedness and have been widely embraced.

**Public health**

The public health agency is involved only in the management of one state psychiatric hospital.

**Arizona Hospital Association**

There appears to be tension between the Arizona Hospital Association and the RBHAs since hospitals tend to routinely initiate a 72-hour hold for psychiatric patients, leading to “congestion” of the psychiatric inpatient services. The involved parties are working to resolve this problem.

**State Innovation Model Initiative**

Arizona received $2,500,000 for the Model Design stage of the SIM.

The SIM Initiative will aid in supporting the state’s effort to create an integrated health care model independent of the coverage source. They employ three main strategies:

- Facilitating integration and decreasing system fragmentation;
- Improving care coordination; and
- Driving payment reform.38
Colorado

The state mental health agency in Colorado is the Office of Behavioral Health (OBH) within the Department of Human Services. The Medicaid agency, Department of Health Care Policy and Financing (HCPF), and the public health agency, the Colorado Department of Public Health and Environment (CDPHE), are each under different umbrellas. OBH directly funds, but doesn’t operate, local community based agencies (17 community health centers and 7 specialty clinics) and crisis services. OBH also operates two state psychiatric hospitals.

Community mental health centers

Community mental health centers (CMHC) are designated by the Office of Behavioral Health (OBH) and the Colorado Department of Public Health and Environment (CDPHE) under the Colorado Revised Statutes 2014 Title 27 Behavioral Health Article 65: Care and Treatment of Persons with Mental Illness. There are 17 CMHCs in Colorado. Each of the centers has similar, yet an individual design of services, reflecting their autonomous standing. Due to serving populations with diverse insurance status, CMHCs usually employ varied reimbursement models. They receive capitated payments for their Medicaid patients, use fee for service payment models for privately insured patients and some Medicaid clients and receive annually determined amounts of money from OBH in monthly installments for care of indigent people. However, the CMHCs are not obligated to see uninsured patients if those monthly funds are insufficient. Each CMHC belongs to and submits all their Medicaid services as encounters to one of the five Behavioral Health Organizations (BHOs) which are the managed care organizations contracted by HCPF (the state Medicaid agency).

Crisis services

Crisis services are contracted by the OBH which sets minimum expected requirements for provided services. Crisis services are divided into four regions based on the 17 CMHCs. An essential part of the system is the central, statewide 24/7 hotline staffed with master’s level clinicians who provide immediate assessment as well as follow up calls the next day. Callers with less acute problems can be diverted to a warm, peer-operated line. The line can be utilized for personal need or for other-than-self consultation, which includes medical providers seeking help for their patients with mental health needs.

Each of the four regional crisis services provides:

- 24-hour walk-in, stabilization centers with a nurse available and mental health specialist on call.
- Stabilization units where patients can be referred for up to five days. There is at least one stabilization center per region, some free standing and some re-designated beds in hospitals. As of now the number of beds is limited, not enough to meet need.
- Respite care, for voluntary stays up to fourteen days in a peer-managed setting initiated by a crisis services clinician.
- Mobile services that can be dispatched by the hotline or by the CMHC to provide in-person evaluation and, if needed, transfer to a stabilization center.\(^{40}\) The mobile services are mostly provided by CMHC staff with master's degrees. They don’t all have to be licensed, but they need to have access to a licensed supervisor.

The system was initiated in 2014 and as such is still in a developing phase and not consistently meeting all of the contractual requirements for delivery of services.

Some metropolitan homeless shelters have the ability to bill for care and provide independent crisis services.

The State of Colorado also supports certification of peer specialists. The program recently received national accreditation. The peer specialists provide a myriad of services at the CMHCs and within the crisis services, including being someone to talk to and helping with system navigation. At times they accompany clinicians to crisis calls.

Colorado has, at times, offered Crisis Intervention Training (CIT) for law enforcement, as well as Mental Health First Aid training, and a few forces are using “co-responder” models, where a licensed mental health professional is either embedded in the force or goes out on certain calls with the police.

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**Emergency departments**

OBH and CDPHE designate hospitals to provide 72-hour involuntary holds under the Colorado Revised Statutes 2014 Title 27 Behavioral Health Article 65: Care and Treatment of Persons with Mental Illness. This statute also gives the OBH and CDPHE authority to mandate other rules for care. CDPHE licenses the overall facility while OBH designates the policies and procedures. However, private hospitals are lately refusing this designation and with it associated oversight by the OBH. They argue that they are already entitled to provide emergency psychiatric care based on EMTALA (Emergency Medical Treatment & Labor Act, enacted by Congress in 1986)\(^{41}\).

There are distinct differences in the services available at large urban hospitals compared to smaller and more rural facilities. While the metro hospitals usually have mental health specialists on site or on call, smaller hospitals may not employ mental health providers and instead may partner with CMHCs. Rural hospitals might not have the services of a mental health provider readily available and may need to resort to calling the crisis line which can, if necessary, arrange for transfer to one of the twelve Colorado hospitals with psychiatric beds. Still, large numbers of rural hospitals lack a consistent protocol for psychiatric emergencies and appropriate space and staff for treatment. Because there are no standardized protocols across Colorado, each hospital is likely to have an individualized workflow when addressing the needs of patients presenting with a mental health crisis.

In urban hospitals, privately insured and uninsured patients are seen by an evaluator...
Medicaid patients should be evaluated by assessors from a CMHC (with the exception of the City and County of Denver which has its own team) within one hour from the call. However, due to a variety of issues this may not always happen, in which case the CMHC may ask the hospital evaluator to substitute for them. The evaluation and discharge criteria differ among the hospitals as well as the CMHC. Some urban hospitals have very rigorous assessments and require their evaluators to be licensed mental health providers with Assessing and Managing Suicide Risk training, despite the fact that training in suicide assessment is not a state licensing requirement. Evaluation by assessors from CMHC is believed by some private hospitals to be less robust. The CMHC evaluator also must determine if the Medicaid patient will require longer than 72 hours of hospitalization. If so established, the patient is admitted to the state psychiatric hospital or to a private hospital. Uninsured patients with need for an extended in-patient treatment are admitted to the state psychiatric hospital, however the availability of beds is limited.

Safety

Since hospitals are ultimately legally responsible for the care of their patients, in some cases they provide their own evaluations of Medicaid patients due to CMHCs’ more lenient discharge requirements.

One of the hospital systems in Colorado, HealthONE System, uses psychiatric assessors from HealthONE’s Virtual Network. These Collaborative Digital Online Consultants are a group of on-call clinicians providing psychiatric evaluations via telehealth.

Suicide prevention

The office in charge of suicide prevention in Colorado is the Office of Suicide Prevention under the Colorado Department of Public Health and Environment (CDPHE). To develop statewide suicide prevention priorities that are data-driven and evidence-based and to involve public as well as private sector, the Colorado Legislature also established the Suicide Prevention Commission in 2014.

Public health

CDPHE is in charge of Suicide Prevention and Licensing of Medical Facilities.

Colorado Hospital Association

The Colorado Hospital Association (CHA) represents over 100 hospitals in Colorado. The association recommends and advises hospitals on best practices. However actual adoption and implementation of hospital policies are purposefully left up to individual hospitals. CHA closely collaborates with the Suicide Prevention Commission at the Colorado Department of Public Health and Environment.
State Innovation Model Initiative

Colorado received a $65 million three-year model testing grant award to implement its State Health Innovation Plan to develop mechanisms and systems for providing integrated care. The main strategies of the SIM in Colorado are:

- Providing access to integrated primary care and behavioral health services in coordinated community systems;
- Applying value-based payment principles (based not on fee-for-service but on the value of care delivered);
- Expanding information technology efforts, including telehealth; and
- Finalizing a statewide plan to improve population health.

This plan also calls for mental illness screening at primary care which may, in the long term, cause a decrease in psychiatric emergencies.
Idaho

The State Mental Health Agency (SMHA) in Idaho is the Division of Behavioral Health, which is part of the Department of Health and Welfare. The Divisions of Medicaid and Public Health are under the same umbrella. The Division of Behavioral Health directly operates community-based programs through seven Regional Behavioral Health Centers and two state psychiatric hospitals.

Community Mental Health Centers

The State of Idaho provides state-funded and state-operated community based mental health care services through Regional Behavioral Health Centers (RBHC) located in each of the seven geographical regions of the state. The RBHCs are state provision centers with employees directly salaried by state. The centers provide services for those experiencing a behavioral health crisis, and other services available to eligible Idaho citizens including Assertive Community Treatment, mobile crisis units, co-occurring services and peer support services.

Crisis services

Between 2014 and 2016, legislators in Idaho approved the creation of four behavioral health crisis centers funded from state general funds. Two are already fully operational. Each center is staffed by a psychiatrist and other licensed mental health providers. The centers serve as 23 hour, 59 minute walk-in crisis stabilization units which help to divert people in need of acute mental health care from medical EDs or jail. These facilities, commonly known as “23-hour centers,” provide care in a secure environment for up to 23 hours and 59 minutes in order to stabilize patients, assess for safety and refer to appropriate follow-up care.

The statewide Idaho Suicide Prevention Hotline, affiliated with the National Suicide Prevention Lifeline, has operated since 2012 and is staffed with trained volunteers who answer calls 24/7. The hotline provides referrals to other crisis services. People in need of immediate psychiatric evaluations are advised to contact their regional behavioral health center, and if that is not feasible, to go to the nearest ED. If a patient is in danger to himself/herself or others, law enforcement is dispatched.

While there isn’t one warm line for the state, each region does have one.

The Division of Behavioral Health is certifying Peer Support Specialists.

Also, many of the police departments around the state conduct Crisis Intervention Team training.

Emergency Departments

The capacity of mental health providers is very limited. Emergency department patients with mental health issues are therefore usually boarded at the hospital as they await formal psychiatric evaluation.
Suicide prevention

The Idaho Council on Suicide Prevention is appointed by the Governor under an Executive Order. The Suicide Prevention Action Network (SPAN) is a private entity that is “dedicated all aspects of suicide prevention”49. The SPAN representatives cooperate closely with the Division of Behavioral Health. In 2016 the Idaho Legislature established the Suicide Prevention Program, under the Division of Public Health within the Idaho Department of Health and Welfare. The program is responsible for implementing key elements of the Idaho Suicide Prevention Plan and developing a more comprehensive approach to suicide prevention. To achieve this goal the Suicide Prevention Program adopted twelve strategies and is currently addressing four of them:

1. Establishing the Suicide Prevention Program;
2. Continuing to fund and contracting for the “Sources of Strength” – evidence based education program for youth prevention of suicide, violence, bullying and substance abuse;50
3. Providing ongoing funding for 60% of the Idaho Suicide Prevention Hotline budget; and
4. Creating and implementing a public awareness campaign

Public Health

The Suicide Prevention Program is housed in the Idaho Department of Health and Welfare’s Division of Public Health.

Idaho Hospital Association (IHA)

The Department of Health and Welfare holds regular meetings with Idaho Hospital Association but at present time there is not a collaboration pertaining to any specific, mental health services related issues.

State Innovation Model Initiative

In 2014, Idaho received $40 million to test its model design. Idaho concentrates on creating an integrated health care system, delivering care through Patient-Centered Medical Homes (PCMH) with expanded connectivity via electronic health exchange, and by aligning the funding from public and private payers.51
Montana

The state mental health agency in Montana is the Addictive and Mental Disorders Division (AMDD) of the Department of Public Health and Human Services (DPHHS). Medicaid is under the same umbrella. The state mental health agency directly funds, but does not operate, community-based mental health programs. It does operate one state psychiatric hospital. Non-profit organizations administer community mental health services.

Community Mental Health Centers

Community mental health is funded by Medicaid and private funds and delivered by four providers in four geographic regions with satellite clinics. There are 28 licensed CMHCs out of which five are traditional CMHCs offering a broad array of mental health services. They also provide care for indigent patients who are presumably eligible for Medicaid.

Crisis services

Numerous communities have their own hotlines, which are interlinked with other communities to assure coverage. There are two regional lines of National Lifeline, in Great Falls and Bozeman. They are staffed with trained crisis counselors. In the state’s larger communities (Bozeman, Butte, Helena, Kalispell, Missoula), crisis response teams consisting of licensed master’s level mental health providers and law enforcement officers, can be dispatched. In an area where a mobile team is not available, patients are usually advised to go directly to the nearest ED if needed. When imminent danger is detected, law enforcement officers will be engaged. To assure their most appropriate and informed response, communities are starting Crisis Intervention Team (CIT) trainings.

The involved officers will transport the patient to the ED or to a jail (depending on accessibility) to assure a safe environment and will then arrange for assessment. Reportedly, there had been situations when an ED “refused” to see patients due to “being full.” In that case, if urgent, the patient might be taken to the state psychiatric hospital in Warm Springs, Montana.

Community mental health centers and detention centers are starting to utilize telehealth for crisis assessment.

The state contracts with some hospitals (Billings, Great Falls, Havre, Helena, Kalispell, Missoula), crisis stabilization units (Billings, Bozeman, Butte, Hamilton, Helena, Kalispell, Missoula) and CMHC’s crisis home to provide 72-hour, state-funded care for indigent patients in crisis which is inversely prorated by length of stay. Admission to the crisis stabilization facilities needs to be pre-approved by the AMDD or their utilization review contractor in the case of an uninsured patient. For Medicaid or privately insured
patients, approval is done by the corresponding insurer. The capacity for the inpatient stabilization and treatment is, however, not sufficient. Hospitals are refusing to establish new psychiatric stabilization beds due to inability to provide suitably safe environments or trained staff and because of potential legal issues.

There is only one walk-in, 23-hour stabilization crisis center, which is located in Billings.

Montana has a virtual drop-in center/warm line which is not affiliated with any crisis line and is operated by peers who are supervised by licensed clinicians. They respond to warm line calls (40% of which are from out of state) and text messages and keep in touch with clients via chat room, podcasts, and blogs.

There are also four in-person drop-in centers funded by a SAMHSA Mental Health Block Grant affiliated with the CMHCs. They cater mainly to the homeless population during the day and provide an array of services including education, teaching daily living skills, therapeutic sessions, and recreational activities.

Presently, Montana does not certify peer specialists or fund peer services. Legislation for Medicaid reimbursement for peer support services has been proposed.

Montana’s Peer Network, a statewide non-profit recovery organization, currently leads the effort for peer training and expansion of peer support services.\(^5^3\)

### Emergency departments

The evaluators in the hospitals are usually licensed master’s level social workers who have a right to initiate 72-hour involuntary hold. However, risk assessment is usually started by nurses.

Five hospitals in Montana provide inpatient psychiatric treatment (Billings, Great Falls, Helena, Kalispell, and Missoula).

### Suicide prevention

The state’s Suicide Prevention Office is located under the Montana Department of Public Health and Human Services. The state suicide prevention coordinator is positioned in the DPHHS directors’ office in order to circumvent otherwise complex interdepartmental access.

### Public health

The state public health agency is accountable for suicide prevention.

### Montana Hospital Association

The Montana Hospital Association (MHA) supports efforts of the Suicide Prevention Office as well as of the CMHCs. They advocated jointly for Medicaid expansion in Montana. The MHA also promotes development of new, hospital affiliated, mental health outpatient services.
State Innovation Model Initiative

Montana received the SIM model design award. The initiative will primarily address:

- Behavioral and physical health integration, including substance use/chemical dependency and mental health (Medicaid health homes; community health teams, Telehealth); and
- Disparities and social determinants of health;
- Health information exchange (HIE) and telehealth54
New Mexico

The state mental health agency in New Mexico is the Behavioral Health Services Division under the Department of Human Services. Medicaid is under the same umbrella, and public health is in a separate agency. The Behavioral Health Services Division directly funds, but does not operate, community-based programs. State psychiatric hospitals are operated by the Department of Health and not by the state mental health agency.

Community Mental Health Centers

The mental health and behavioral system in New Mexico continues to be challenged by ongoing controversy. In 2013, the Governor’s office raised accusations of Medicaid fraud by 15 Community Mental Health Centers (CMHCs). All funds to CMHCs were withheld and five provider companies from Arizona were contracted instead. Three of these companies have since terminated their services.

By 2016, the New Mexico Attorney General made a final decision that the allegation of fraud by any of the accused 15 providers cannot be substantiated. Those provider organizations are now subject to a Fair Hearing by the Department of Human Services to determine if there had been erroneous billing. Each of them has the right to appeal any findings and some have elected to do so with Federal District Court.

When the three AZ providers ceased operations in NM in 2015 and 2016, existing NM providers assumed the active cases and services in the respective service areas. Many, but not all, of these existing NM providers were Federally Qualified Health Centers.

Unrelated to the above mentioned audits, Centennial Care, NM’s Medicaid Managed Care Plan, was implemented in January 2014 and included the carving-in of behavioral health. The state contracted with four statewide managed care organizations to provide integrated primary and behavioral health care.

In fiscal year 2016 New Mexico received the one-year Certified Community Behavioral Health Clinics (CCBHC) Planning Grant from SAMHSA. The new plan calls for the CCBHC to provide “intensive, person-centered, multidisciplinary, evidence-based screening, assessment, diagnostics, treatment, prevention, and wellness services, including 24/7 crisis responses and peer support services.”55 However, as of now, the system is still in its development phase and as such, still has serious insufficiencies. The full range of psychiatric emergency services, namely mobile services and crisis stabilization units, are not yet available. Their availability is, however, not required for the planning phase of the grant. Those services are intended to be developed during the following two-year...
demonstration phase of this grant (SAMHSA's final selections for this grant award will be announced no later than December 31, 2016).

Legislation was passed in 2015 to establish crisis triage centers. This major initiative will create regional crisis centers which will operate 24/7 and also provide adult and adolescent detoxification services. Current work concentrates on creating licensing standards and Medicaid reimbursement mechanisms.

### Crisis services

At the present time, crisis services in New Mexico are not well integrated. The vision of the Behavioral Health Services Division, however, is to create one, unified system. The Division developed a plan during the SAMHSA CCBHC grant planning phase and will apply for two-year demonstration pilot funding.

As of now, the Behavioral Health Services Division contracts with a statewide Crisis and Access Line (NMCAL), which is a centralized, single telephone number hotline answered by professional counselors 24/7. Some behavioral health agencies, centers and health systems still operate their own hotlines, some of which contract with the Crisis and Access Line to answer their after-hours calls. The Behavioral Health Services Division encourages these providers to support the use of the central hotline and repurpose their hotline resources. ProtoCall Services (parent company of NMCAL) uploads information about calls into a secure database for the specific agencies the NMCAL is contracted with to answer on behalf of their agency, to support coordination of care.

The Crisis and Access Line provides three levels of service. Level one service includes de-escalation and discussion of a safety plan for an otherwise safe individual and accounts for about 58% of the calls. Meanwhile 40% of the calls fall into a level two care category in which the caller is not believed to be in immediate danger to him/herself or others but may require a follow-up call, which is delivered 24 hours after the original call was placed. The remaining 2% of callers require level three care, which involves a response from law enforcement due to the possibility of imminent danger to self or others. The law enforcement officers assess the caller and transport him/her to the nearest ED. This is, however, seen as a least preferred alternative due to public mistrust in law enforcement. In 2014, a mentally ill homeless man was killed by police, which led to the Albuquerque police department being investigated by the Department of Justice, resulting in public protests. The Crisis and Access Line is currently implementing the 911 dispatch protocols with various jurisdictions.

Mobile Crisis Teams are a Medicaid reimbursable service but to date, the teams operating in Santa Fe and Las Cruces are supported by county funds. Bernalillo County is anticipated to seek Medicaid reimbursement. As of now those teams can't be dispatched by the state hotline.

The Department of Human Services, BHSD, Office of Peer Recovery and Engagement certifies non-crisis peer counselors who answer the calls from less acutely ill individuals and who provide their services only during business hours. Even though the line is separate from the hotline, there is close cooperation between them with active cross-referring when appropriate.
Each of the Medicaid Managed Care Organizations employs Certified Peer Support Workers. They are also, with state support, serving in Psychosocial Rehabilitation programs, Supportive Housing, and in peer operated Wellness Centers. Certified Peer Support Workers are also required positions for Certified Community Behavioral Health Clinics. Community providers also employ Certified Peer Support Workers as part of their workforce, not related to the provider's ability to have that service reimbursed by Medicaid.

**Emergency departments**

Emergency departments (EDs) in NM have minimal behavioral health capacity. The University of New Mexico at Albuquerque created one free-standing psychiatric emergency room. As of now there is no contract between this ED and the state hotline.

New Mexico is planning to implement Emergency Department Information Exchange (EDIE) a program which notifies EDs about recent ED visits by the patient upon patient’s ED registration and has a capability to share patient care coordination information.\(^58\)

**Suicide prevention**

There is no official office of suicide prevention in NM. The youth suicide prevention program in New Mexico is a part of the Office of School and Adolescent Health under the public health agency, which is part of the Department of Health. The office serves all populations but concentrates mainly on youth. The Behavioral Health Services Division also receives money from SAMHSA for suicide prevention managed by the Suicide Prevention Program. Currently the program concentrates on training primary care providers on suicide screening protocols.\(^59\) New Mexico also formed a Suicide Prevention Coalition, which provides suicide prevention related education, support and advocacy.\(^60\)

**Public health**

The Public Health Division of the New Mexico Department of Health administers the youth suicide prevention programs through the Office of School and Adolescent Health.

**New Mexico Hospital Association**

The NM Hospital Association is collaborating with the Behavioral Health Services Division and the mental health managed care organizations on the reduction of unnecessary ED visits.

**State Innovation Model Initiative**

New Mexico has been awarded approximately $2 million for a SIM Initiative Model Design. The New Mexico Department of Health is planning to address five main objectives:

- Alignment and integration of public health and primary care;
- Reducing costs and slowing the rate of health care inflation;
- Increasing the number of New Mexicans who have health insurance;
– Building the healthcare workforce and supporting infrastructure; and
– Expanding the use and integration of health information technology.\textsuperscript{61}
The state mental health agency in Nevada is the Nevada Division of Public and Behavioral Health (NDPBH), which is located in the Department of Health and Human Services. Medicaid is under the same umbrella, as is public health. SMHA funds and directly operates community-based programs (22 community mental health clinics). The state mental health agency operates two adult state psychiatric hospitals and one forensic psychiatric hospital.

Community Mental Health Centers

The Nevada Division of Public and Behavioral Health – has three regional divisions:

1. Northern Nevada Adult Mental Health Services (Reno)
2. Southern Nevada Adult Mental Health Services (Clark County)
3. Rural Clinics (rest of the state)

By design the mental health services provided in the different regions should be standardized but in reality they are more autonomous. The public Behavioral Health Clinics are operated directly by the Nevada Department of Public and Behavioral Health which employs individual providers to work at the clinics and who are salaried through state general funds. They offer their services primarily to Medicaid, Medicare, and uninsured patients. In rural areas, due to the absence of private providers, they are also set up to provide fee-for-service care for patients with private insurance. The centers’ mental health and behavioral services are generally available Monday through Friday from 8 am to 5 pm. The presence of after-hours services depends on location. Urban areas may have a private 24/7 crisis center but patients mostly utilize traditional EDs, the hotline, or 911.

In October 2015 Nevada received a one-year Certified Community Behavioral Health Clinics (CCBHC) planning grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). In October 2016 Nevada will apply for the subsequent two-year Demonstration Program.

Crisis services

Nevada Department of Health and Human Services administers Nevada 2-1-1 under Nevada Revised Statute (NRS) 232.359. 211 Nevada is statewide directory assistance for Health and Human Services in Nevada. The line can connect people in crisis with the Crisis Call Center (described below), dispatch 911, or refer callers to appropriate services but does not have dedicated mobile services. In some urban areas, police can arrange for a social worker to accompany them to the crisis scene if the call appears to be related to a mental health issue. However, this service is not widely available.

The state employees and other community partners are involved in providing Crisis Intervention Team (CIT) training for law enforcement officers. There are established CIT training programs in Las Vegas, Reno, and Carson City and within the last year or two
those practices have been spreading out to some of the rural counties as well.

The Crisis Call Center, an independent not-for-profit agency is a long established crisis line located in Reno. It started many years ago as an outreach suicide prevention program of University of Nevada\(^{64}\). The center, which is affiliated with the National Lifeline, is staffed with trained volunteers and provides 24/7 services. It is funded from federal and state grants and receives private funding as well.

There are no state-funded warm lines.

Both, Northern Nevada Adult Mental Health Services (Reno) and Southern Nevada Adult Mental Health Services (Clark County), run “drop in centers” that are peer facilitated. They include peer support groups as well as activities (e.g., exercise, social activities, etc.)

Medicaid allows for peer-to-peer services to be reimbursable and the state is working to create a broader peer-to-peer program.

**Emergency departments**

In urban areas, hospitals are generally capable of utilizing their own behavioral health staff. In rural areas psychiatric assessments are done mostly by the provider on call or, if not available, during business hours by a provider from the public mental health center who would come directly to the ED or evaluate the patient via telehealth. If a patient presents with a psychiatric emergency after hours and the ED does not have a mental health provider on staff or on call or psychiatric bed available, the patient needs to wait in the ED until services can be provided, which can possibly be all weekend. However, this is becoming less of an issue.

Two public psychiatric hospitals (Reno, Las Vegas) and about five private hospitals are licensed for psychiatric beds. If a patient presents in an area where a psychiatric hospital is not available, the patient is transferred to one of those hospitals.

**Suicide prevention**

The Office of Suicide Prevention is a part of the Nevada Department of Health and Human Services. In 2005, a statewide Nevada Coalition for Suicide Prevention was formed. The Coalition brings together public as well as private representatives\(^{65}\) and is involved, among other things, in training Nevadans to intervene with persons at risk of suicide\(^{66}\).

**Public health**

Public health in Nevada is a part of the Nevada Division of Public and Behavioral Health.

These associations collaborate with Nevada Division of Public and Behavioral Health, especially on telehealth. Recent Nevada laws require coverage of telehealth services by Medicaid and private insurance to be the same as for services provided in person\(^{67}\).
State Innovation Model Initiative

Nevada has been granted the SIM model design award of $2 million and is planning to:

- Redesign the state’s health care delivery system to contain health care costs while increasing health care value;
- Establish reliable and consistent access to primary and behavioral health care services;
- Improve quality and health outcomes for all Nevadans; and
- Foster greater Health Information Technology (HIT) and health data infrastructure adoption, exchange and utilization.
Utah

The state mental health agency in Utah is the Division of Substance Abuse and Mental Health (DSAMH) under the Department of Human Services. The Medicaid agency and the public health agencies are separate but both under the Department of Health. The state mental health agency funds county mental health authorities that, in turn, fund local provider agencies or directly provide mental health services. There are 15 community mental health providers that deliver or contract for behavioral health services. The state mental health agency operates one state psychiatric hospital.

Community Mental Health Centers

Each county in Utah is represented by a local mental health authority. The local authority is governed by the county commissioner. Some counties have joined together to provide services for their residents. There are 29 counties, and 15 local authorities. Under UCA §17-43-301, the public mental health system provides an array of services that assure an effective continuum of care. While local mental health authorities must provide mandated services, they also are at liberty to supplement with additional services based on county needs.

The local mental health authorities, in most cases, work with a single provider group to deliver all the mandated care. Only Salt Lake County contracts with a managed care organization which, in turn, contracts with many providers. The Division of Substance Abuse and Mental Health conducts yearly monitoring of services and creates an annual report which is distributed to the services as well as to the county health commissioners who can make alterations to their contracts with the provider if changes are needed.

The Division of Substance Abuse and Mental Health yearly revises its division directives in which they make recommendations for local mental health authorities. The local mental health authorities then need to make a plan for how to accomplish suggested modifications. The Division of Substance Abuse and Mental Health monitors progress toward those goals and, if improvement is not achieved, the agency will use stronger language to encourage change. If that does not bring required alterations, Division of Substance Abuse and Mental Health addresses the county commissioner directly. The changes are generally not mandated but rather accomplished based on the partnership principle.

Crisis services

Crisis services in Utah are not unified and they differ widely based on urban versus rural location. The state partially funds the University of Utah Neuropsychiatric Institute Hotline which is affiliated with National Lifeline for their statewide work. Besides that, each local mental health authority provides separate crisis hotlines. Most of those operate on an active rescue model, which means that staff take all action necessary to ensure the safety of a caller,
including initiating emergency response if needed\textsuperscript{70}. The line is, in urban areas, staffed 24/7 with clinicians. In rural regions, mental health providers on call might be dispatched or may provide telehealth services. If the evaluation reveals a need for immediate intervention, Crisis Intervention Team officers, who are volunteers from uniformed patrol divisions, are dispatched. These officers maintain their responsibilities as patrol officers, but become primary responding units to situations involving a person experiencing a mental health crisis. They arrange for proper disposition of the person in crisis.

In the urban areas, the crisis services also offer:

- a warm line staffed with peers;
- a receiving center for 23-hour care;
- walk-in centers; and
- a wellness and recovery center which can provide care up to two weeks.

Crisis services are part of the mandated services a local authority needs to provide. The services are funded by a variety of mechanisms including some state funds, federal funds, and county funds.

The Division of Substance Abuse and Mental Health offers Certified Peer Support Specialist Training Certification. This training, provided by Utah State University and others, is partially funded by federal grants. Other peer certification programs are offered through the University of Utah School of Social Work and through community mental health providers.\textsuperscript{71}

There are many different peer services offered throughout the state. All local mental health authorities employ certified peer specialists for different roles (mobile outreach teams, treatment providers, support groups, and general peer support activities). Family resource facilitators provide peer support to parents and families.

**Suicide prevention**

The Utah Suicide Prevention Coalition is the main prevention body in the state of Utah and is open to any organization, agency or individuals involved and interested in prevention of suicide. The coalition’s meetings, which happen six times a year, are open to the public. The Division of Substance Abuse and Mental Health started, hosts, and co-leads the coalition. The DSAMH promotes in-person training in reducing access to lethal means as a suicide prevention measure. Legislation was passed in 2014 to provide cable gun locks to hospital administrators to distribute to anyone in need (30,000 were distributed since the program started 2015). Also, since 2015, behavioral health providers need to obtain 2 hours of CME approved for suicide prevention and intervention every two years for their license to be issued or renewed.

**Emergency departments**

In Utah, emergency department (ED) mental health related protocols are inconsistent and depend heavily on location and available staff. Usually, patients in the ED are first triaged by the nurse who, if needed, will call crisis evaluators. These evaluators are typically social workers or other providers available via telehealth. However, rural hospitals
struggle to have mental health providers on site.

If a Medicaid patient who is under care of the local authority is hospitalized, the hospital is required to coordinate with the local mental health authority.

Public health

Public health in Utah is not required to handle mental health, however its Injury Prevention Division cooperates with The Division of Substance Abuse and Mental Health. They recently hired a dedicated staff for suicide prevention. They also co-lead the Utah Suicide Prevention Coalition and cooperate in braiding funding for some state initiatives and in implementing state suicide prevention plan.

Utah Hospital Association

The Utah Hospital Association provides lobbying and advice to its 62 hospital members. They established a 15-member Behavior Health Committee originally to help address inadequate mental health services staffing. Over time, the Committee lost its focus and there are current efforts of reviving the group, with scheduled quarterly meetings addressing issues of mental illness related violence occurring in the ED.

State Innovation Model Initiative

Utah has been working on the model design and the following are the key priorities:

- To adapt to and perform well in a value-based purchasing environment;
- To facilitate end-of-life preferences for Utah citizens so they receive care with dignity, respect and efficiency;
- To increase access to primary care and behavioral health; and
- To create community-clinical linkages and healthful environments.72
Wyoming

The state mental health agency in Wyoming is the Behavioral Health Division (BHD) of the Wyoming Department of Health. Medicaid and public health are under the same umbrella. The Behavioral Health Division directly funds, but does not operate, community-based programs provided by 18 Community Mental Health and Substance Abuse Centers. The Behavioral Health Division operates one state psychiatric hospital plus the Wyoming Life Resource Center (WLRC).

Community Mental Health Centers

There are currently 18 Community Mental Health and Substance Abuse Center contracted by the Behavioral Health Division providing care for 23 Wyoming counties. Those private, non-profit centers deliver services to all patients regardless of their insurance status. The services are funded from federal, state, city, and county funds, United Way, client fees and insurance. Medicaid patients’ charges are billed directly to Medicaid. Indigent patients’ care is covered from a grant provided by the Behavioral Health Division.

Crisis services

Each individual Community Mental Health and Substance Abuse Center has its own after-hours crisis line staffed with licensed mental health providers. These providers also cover emergency department evaluations. Three Community Mental Health and Substance Abuse Centers have a crisis stabilization unit. There are no state-funded mobile services. Wyoming also has a crisis hotline based in Casper. The Wyoming Behavioral Institute and the WORLAND Victims of Violence Center each have a statewide Crisis Line but neither is funded through the Behavioral Health Division or officially affiliated with National Lifeline. There is no state-funded warm line. As of July 1, 2016, all state-funded peer services were discontinued due to budget cuts but some centers continue their peer specialists' services.

There are crisis stabilization centers in Cheyenne, Rock Springs and Worland which can provide 72-hour crisis care but they are not state funded under the Wyoming Statute Title 25 “When a person is detained under W.S. 25-10-109, the county in which the person resided shall be liable for costs of treatment for the first seventy-two (72) hours of detention.”

Emergency departments

Hospital emergency departments (EDs) are generally not staffed with mental health providers. The only exception is Cheyenne. Rather, the ED would call the Community Mental Health and Substance Abuse Center to conduct a psychiatric assessment.
Suicide prevention

In July 2012, the Wyoming Department of Health established the Prevention Management Organization of Wyoming to serve as a statewide, coordinated prevention system, with local program staff dedicating a portion of their time to suicide prevention.

The Prevention Management Organization of Wyoming has an office in each of the 23 counties. Individual offices have a suicide prevention specialist who, based on a county's needs, resources and population, facilitates implementation of evidence-based suicide prevention programs. Up to seven county offices are supervised by prevention directors who conduct weekly update meetings.

The Prevention Management Organization implemented an evidence-based program, Kognito, which offers training simulations to recognize when someone is in a state of psychological distress and to learn how to conduct a dialog with the affected person in order to link them to appropriate services and successfully trained hundreds of medical professionals in hospitals and primary care offices across the state.

Public health

The Prevention and Health Promotion Unit of the Public Health Division supports programs that provide outreach, education and funding for prevention.

State Innovation Model Initiative

Wyoming is not participating in SIM.

The Wyoming Hospital Association cooperates with the Prevention Management Organization of Wyoming to introduce trainings for emergency department providers. The training includes: Kognito’s At Risk in the ED, Assessing and Managing Suicide Risk, and Applied Suicide Intervention Skills Training. Starting in October they will also provide a Zero Suicide workshop and in May 2017 the Zero Suicide Academy.
Summary of State-funded Crisis Services

Many of the state mental health agencies in the Mountain West Region are starting to acknowledge the enormous need for improvement of psychiatric emergency services and therefore, are developing or contracting for state-funded provision of crisis services. In most states in the region, however, this effort has not yet reached its full potential. As of now, crisis services represent a broad spectrum from well-functioning services in Arizona’s central region to sporadic crisis care in rural Nevada. Some states, like Colorado, are developing crisis services state-wide, while others like Arizona have taken a regional approach.

In many instances poor and inadequate advertisement of crisis response systems also diminishes their possible reach. Community members as well as health professionals might not be aware of the available crisis services. As a result, patients in need of urgent mental health care still primarily utilize the traditional emergency departments where provision of care by mental health professionals is highly varied.

Crisis hotlines are one element of a functional crisis system. Some states rely on numerous individual hotlines, while others have developed an integrated statewide system. Even though crisis hotlines are available in all states, their abilities to respond to emergencies are quite variable depending on the qualifications of the call center employees and on the availability of supporting services. In some states the lines are staffed with licensed mental health providers who can professionally assess the caller and dispatch a mobile response team if necessary. Some have rudimentary capacity; for example, a layperson answering the call and dispatching 911 if needed. Due to this fact, some of the states in this region still heavily rely on law enforcement for psychiatric crisis response.

When law enforcement is managing psychiatric emergency services, typically they evaluate the situation and if required either transfer the patient to the nearest emergency department, crisis stabilization unit or, if not feasible, to the next safest environment, a jail.

The participation of law enforcement in mental health care is not without criticism. Some professionals see involvement of law enforcement as a last resort due to the “criminalization of mental illness” and the possibility of inappropriate placement of the patient. Others support law enforcement’s contributions in addressing psychiatric crises due to their ability to respond immediately. Arizona and Utah consistently provide mental health crisis response training for officers to gain an understanding of mental illness and its presentation as well as the capability to deescalate the situation and take appropriate action.

State crisis lines might be affiliated with the National Lifeline, which was launched by SAMHSA and the Mental Health Association of New York City in 2005. In order to become a part of the network, centers must conform to prescribed standards, including accreditation by an external body and written policies or guidelines addressing referral, training and suicide risk assessment but they are not required to be networked into additional crisis services (e.g., mobile team, walk-in center, etc.).
In 2007, Centers for Medicare & Medicaid Services recognized peer specialists as an important addition of the mental health services spectrum and began to reimburse for their services. All states in the region with the exception of Montana can bill Medicaid for peer services and all states certify peer specialists or have begun developing a certification process.\(^79\)

In 2014, SAMHSA published a case report, “Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies”\(^80\). The report identified the following as core crisis services: 24/7 crisis hotlines, warm lines, 23-hour crisis stabilization/observation beds, short term crisis residential services and crisis stabilization, mobile crisis services, peer crisis services, and psychiatric advance directive statements. The following table shows the presence or absence of those core services (except psychiatric advance directive statements) in the states of the Mountain West Region.

<table>
<thead>
<tr>
<th>State</th>
<th>Systematic, integrated crisis services</th>
<th>Statewide crisis hotline</th>
<th>At least one hotline affiliated with National Lifeline</th>
<th>Hotline staffed with licensed mental health providers</th>
<th>Warm line</th>
<th>23-hour crisis stabilization units</th>
<th>Designated crisis stabilization units</th>
<th>Short term crisis residential services</th>
<th>Mobile crisis services</th>
<th>Medicaid billable peer crisis services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Colorado</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Idaho</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Montana</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>P</td>
<td>Y</td>
<td>P</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Nevada</td>
<td>Y</td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>New Mexico</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Utah</td>
<td>Y</td>
<td>Y</td>
<td>P</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>P</td>
<td>Y</td>
</tr>
<tr>
<td>Wyoming</td>
<td>Y</td>
<td>Y</td>
<td></td>
<td></td>
<td></td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>
Each state is also directly or indirectly involved in suicide prevention. The preventive measures differ by states, regions and counties. The following table (Table 6), created using the National Association of State Mental Health Program Directors Research Institute data and updated based on the key informant interviews, shows selected psychiatric emergency and suicide-related preventive efforts supported by respective state mental health agencies.

Those suicide prevention tactics are, however, not commonly seen as a part of the crisis system continuum. Rather, they are separate undertakings.

### Table 6. Suicide prevention initiatives supported by corresponding State Mental Health Agencies in 2015.

<table>
<thead>
<tr>
<th></th>
<th>SMHA supported suicide prevention in form of....</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Suicide prevention/crisis hotline</td>
</tr>
<tr>
<td>Arizona</td>
<td>Y</td>
</tr>
<tr>
<td>Colorado</td>
<td>Y</td>
</tr>
<tr>
<td>Idaho</td>
<td>Y</td>
</tr>
<tr>
<td>Montana</td>
<td>Y</td>
</tr>
<tr>
<td>Nevada</td>
<td>Y</td>
</tr>
<tr>
<td>New Mexico</td>
<td>Y</td>
</tr>
<tr>
<td>Utah</td>
<td>Y</td>
</tr>
<tr>
<td>Wyoming</td>
<td>Y</td>
</tr>
</tbody>
</table>

Source: [http://www.nri-incdata.org/Profiles.cfm?State=CO&Year=15&Keyword=](http://www.nri-incdata.org/Profiles.cfm?State=CO&Year=15&Keyword=)
The states in the Mountain West Region are at various stages of development of their crisis services systems and their approaches differ. Most of them are planning or already integrating the core crisis services. However, two aspects not commonly identified as a part of the crisis services system, are: systematic prevention and early intervention. As such, the systems still heavily stress the reactive versus proactive, public health, approach.

Table 7 points out some of the specific, noteworthy features of the individual states’ crisis systems.

<table>
<thead>
<tr>
<th>State</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona</td>
<td>Well integrated services; intensive training for law enforcement officers</td>
</tr>
<tr>
<td>Colorado</td>
<td>State-wide system; main state-wide, integrated hotline</td>
</tr>
<tr>
<td>Idaho</td>
<td>Up to 23 hour/59 minute patient stabilization in 24/7 walk-in crisis units</td>
</tr>
<tr>
<td>Montana</td>
<td>Virtual drop-in center</td>
</tr>
<tr>
<td>Nevada</td>
<td>Crisis responding officer can be accompanied by licensed social worker; telehealth services considered for reimbursement purposes same as in-person services</td>
</tr>
<tr>
<td>New Mexico</td>
<td>ProtoCall Services (parent company of NM Crisis and Access Line) uploads the encounters on the secure databases for the specific agencies the NMCAL is contracted with to answer on behalf of their agency</td>
</tr>
<tr>
<td>Utah</td>
<td>Training in suicide prevention and intervention is a requirement for behavioral health provider recertification</td>
</tr>
<tr>
<td>Wyoming</td>
<td>State-wide coordinated prevention system</td>
</tr>
</tbody>
</table>
Section 3
Discussion

As the states in the Mountain West Region are developing state-funded crisis services to amend the gaps and inadequacies in the traditional psychiatric emergency services, they could benefit from exploring the systems which are already in place and which report positive impact on the quality of the crisis response. The statewide or regional systematic approach to address psychiatric crises, which has been adopted by some states, in this region by Colorado and Arizona, seems to provide the best continuum of crisis care. However some aspects of psychiatric emergency services are still not widely recognized in the region. The diagram below, adopted from the North Carolina Crisis Solutions Coalition presentation from 2014, adeptly visually describes a model crisis services continuum (Fig. 8) which takes into account services available not only for crisis response and stabilization but also incorporates prevention and early intervention. As such, it not only conforms to the earlier referenced core crisis services but also addresses prevention of future crises.

Therefore, as states in the region move forward with their efforts to advance crisis services, they should stress the need for prevention and early intervention as part of the crisis services system. Prevention and care should be integrated within the entire mental health and crisis system.

However even the presented model of a crisis services continuum omits one crucial aspect. The preventive strategies should take into account not only secondary and tertiary prevention but also include plans related to primary prevention, as summarized in the WHO’s *Prevention of Mental Disorders - Effective Interventions and Policy Options* report. By addressing social, environmental and economic as well as individual and family-related determinants of mental health we can attempt to decrease the prevalence of mental illness in general and consequently diminish the number of psychiatric crises.

To create such a comprehensive and well-functioning system some common, major barriers will first need to be minimized.

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Fig. 8 Example of Crisis Services Continuum
Major barriers in development of crisis services continuum

Fig. 9. Major factors negatively influencing the provision of psychiatric emergency services (PES)

**Fragmentation**

The health care system recognizably suffers from separation of physical and mental health services, especially in primary care settings. The fragmentation and poor coordination of care leads to both limited accessibility and duplication of services.

Many states in the Mountain West Region are trying to remedy this division by developing plans for integration or co-location of primary and mental health/behavior care, or for otherwise increased accessibility of mental health services. The SIM grant provides an opportunity to implement these much needed changes.

The fragmentation also affects the crisis response. Many states still depend on numerous hotlines and individual, not well connected services.

**Limited collaboration**

Limited collaboration is yet another obstacle in mental health service improvement initiatives. Even though states may have distinct needs, it seems that there are some common elements which could be resolved regionally as opposed to relying only on the individual states. High suicide rates in the Mountain West Region are a priority for all states in the region. However, even though there are periodic meetings facilitated by the regional SAMHSA office between the suicide prevention coordinators (namely in Region VIII), close interstate cooperation between
the representatives of state agencies involved in mental health care is minimal. In some states, this is the case even within state agencies. This lack of partnership and exchange of information among entities trying to solve very similar problems contributes to lack of efficiency and effectiveness in approaches across and within states. Also, the division of responsibilities for the mental health care system between different agencies results, at times, in an inadequate understanding of the whole system by people working for the system. This again leads to missed opportunities for collaboration and improvement initiatives. One of the prime examples is the lack of broader awareness of the SIM, which was implemented with the goal to improve medical and behavioral/mental health care. Yet, many people involved in the organization and delivery of the care have very limited, if any, understanding of the SIM initiative.

**Funding**

Funding is considered to be a substantial barrier for mental health services. Insufficient funding, unsustainability of programs due to expiring grants, complex financing mechanisms, low Medicaid reimbursement rates and convoluted billing all complicate the delivery of efficient mental health services.

There are also extremely limited funds for data collection resulting often in undependable data on the epidemiology of mental health concerns, accessibility and quality of care. These data limitations reduce the capacity to plan and fund services.

**Shortage of providers and psychiatric beds**

One problem which is undeniably affecting all the states and especially their rural and frontier areas is insufficient staffing. Rural emergency departments usually rely on external help, using mental health evaluators from community health centers, crisis services or telehealth services to assess clients’ needs. Some rural hospitals lack a clear protocol for dealing with psychiatric emergencies.

The use of telehealth could potentially solve some of the provider shortage issues, however, the complications associated with reimbursement seems to be one of the major roadblocks at the present time. Another logistical concern standing in the way of greater use of telehealth across states is the requirement for licensure in the states in which the telehealth is provided, as explained in more detail below.

Still, even with the availability of telehealth evaluation, the admission to inpatient services, if necessary, remains problematic as hospitals without designated psychiatric beds are not equipped to guarantee the safety of patients with acute psychiatric conditions. Admitting such a patient could create a hazardous situation with potential legal consequences for the hospital.

The shortage of psychiatric beds is influenced also by the Centers for Medicare & Medicaid Services Institute for Mental Disease exclusion in section 1905(a)(B) of the Social Security Act, which prohibits federal Medicaid reimbursement for adults 21-64 years of age admitted to a primarily mental health facility with more than 16 beds. Under the Emergency Medical Treatment and Labor Act (EMTALA), hospitals that have the
ability to stabilize psychiatric patients must accept all patients who are a danger to themselves or others. Institute for Mental Disease limits the size and thus number of facilities in a state that can provide in-patient psychiatric care, thus impacting access and creating a great strain on state-funded psychiatric hospitals.

**Licensure and training/education**

Due to the insufficient number of mental health providers, licensing requirements may be more lenient. Likewise, rigorous education in psychiatric assessment and suicide prevention and intervention may not be required for registration or licensure. Utah, for example, is remedying these substandard practices by introducing mandatory education modules for recertification. However, legislative changes calling for extra courses are usually received with resistance from the mental health providers' community. At the same time, some hospitals (mostly urban) have more strict requirements for their mental health providers than the state licensing agency mandates. For example, some demand comprehensive training in assessing and managing suicide risk.

Some states are also expanding authorities of the mid-level mental health providers. For example Utah Bill HB 143 “Allows for a license in advanced practice registered nursing in the psychiatric mental health specialty” and “removes a provision that requires the applicant to complete clinical practice requirements before licensure”.

To facilitate the evolution of the outreach services “the Interstate Medical Licensure Compact (Fig. 10) offers a new, voluntary expedited pathway to licensure for qualified physicians who wish to practice in multiple states, increasing access to health care for patients in underserved or rural areas and allowing them to more easily connect with medical experts through the use of telemedicine technologies.”

Some states are devising new, innovative practices, mainly for supporting services, like Peer Academies funded by the state. These are designed to cultivate a new workforce among individuals with personal experience and genuine empathy. Another example of a state-contracted initiative is the Arizona LOSS (Local Outreach to Suicide Survivors) team where survivors of suicide support new survivors.

**Geographic access**

The ability of people from the rural or frontier areas within the region to access psychiatric emergency services, or mental health services in general, is also largely influenced by geographic remoteness.
Some of the small communities might have a local mental health provider, or peer support services but the lack of anonymity and the still present stigma of mental illness might prevent people in need from seeking help.

### Data collection

One additional issue, not directly influencing psychiatric emergency services and mental health services but leading to a problematic interpretation of available data is the inconsistency in data collection. State agencies as well as other data collecting entities often divide states or regions very differently which complicates comparisons. Even on the national level, for example, the districts for census data and regional divisions designated by the Department of Health and Human Services vary. County level data might be used but their comparability could be questionable as well due to factors related to different background and qualification of individuals providing the entries; inconsistencies in defining data categories etc. In order to yield as much information as possible from the data provided, standardization of the data collection and creation of a data exchange platform would be useful.

### Future directions

As states in the Mountain West Region are progressively developing crisis services to improve psychiatric emergency services, it would be beneficial to create a crisis services continuum framework that incorporates standardized data collection and evaluation plans. This will enable better assessment of the capability of those systems to deliver acute psychiatric/crisis interventions so as to prevent self-harm.

The consistent evaluation of the existing services could inform future systematic design of crisis services by states where those services are not yet broadly available or not effectively interconnected. As such, states may be able to establish the best strategies and eliminate possible unnecessary, redundant and inefficient use of resources.

### Recommendations for moving forward

- When designing the framework, involved parties need to not only deal with necessity for more therapeutic services but also adopt preventive strategies, including primary prevention, to eventually decrease the number of psychiatric emergencies.

Screening by primary care physicians for depression and other mental health related conditions and establishing a referral system should become a standard of practice, especially under the Affordable Care Act and its 100% reimbursement for the recommendations of the US
Preventive Services Task Force. Care should include crisis services, peer services as well as telehealth services for patients with problematic access or reluctance to seek help due to a perceived stigma. Contact information for all those support and treatment options should be provided to patients. As diagnosis and/or treatment of mental illness might be challenging for primary care physicians, developing a consultation partnership with mental health providers is imperative as well, particularly where services are not yet well integrated.

- Existence of multiple hotlines and therefore crisis-related phone numbers likely make it hard for a person in crisis to know the best place to reach out for help. It is important to unify the systems and create a state-wide hotline, possibly affiliated with the National Lifeline, to adhere to high standards and use a unified crisis phone number. This has the promise of creating an integrated response system to more effectively streamline resources for individuals in crisis. This arrangement can also free some of the funding used for local hotlines to be utilized for other needed services.

- Some states have state-wide crisis lines but their reach is limited as they cannot dispatch mobile teams, even if such teams are available in the state. This situation calls for better integration of already existing core crisis services.

- Peer specialists have been established to be a critical addition of the mental health services system. Based on recent evidence, their role potentially could be increased. In August, 2016 *Lancet* published a randomized, controlled study examining the performance of junior mental health workers who did not have professional mental health degrees. The workers were trained to provide self-help interventions based on "behavioral activation" (identifying and avoiding depression triggers and identifying and increasing contact with positive situations). The results showed their performance in treating depression was not inferior to Cognitive Behavior Therapy delivered by psychotherapists. It was also less costly88. In light of this study, training selected peer specialists in behavioral activation could enhance the services provided by peers and address some of the provider shortages. Some states in the Mountain West Region already partner with local universities to deliver state funded peer specialist trainings.

- As law enforcement officers have the ability to rapidly respond and are often involved in a management of persons in psychiatric crisis it seems only logical to provide proper mental health crisis training to them and to involve them in the crisis network. This way, people in need of acute psychiatric care can be diverted from the detention system and provided appropriate therapeutic care. The
Crisis Intervention Team (CIT) training is available and employed by most of the states in the Mountain West Region already, to varying degrees.

- There is also a need for enhanced training in suicide prevention, risk assessment and intervention for behavioral health and health care providers. And, there is a need for education for the public to enhance awareness and capabilities in responding to crises. Many states are considering or already implementing the ZERO Suicide initiative which calls, among other recommendations, for appropriate training, skills, and organizational support for suicide prevention.

- To address many obstacles to accessible mental health care including physical shortage of providers, geographical remoteness, and perceived stigma, telehealth should be included as a viable alternative to the in-person evaluation and care when appropriate and reimbursed by Medicaid and insurance companies as such.

- Methods for efficient and secure exchange of medical records among providers also are vital elements of addressing psychiatric crises, assuring continuity of care, and eliminating duplication of services.

- A well-functioning network of partnerships between involved stakeholders and thoughtful integration of their undertakings is necessary for a truly integrated crisis system.

The theoretical framework including all the aspects of the crisis services continuum could be used by future researchers and planners to more efficiently identify the missing parts of the crisis continuum and to devise policies guiding their development. This would help create more effective crisis and mental health services.
Reflections of the author

We seem to be in a vicious circle, needing more programs and professionals to address the increasing demand for mental health services, while really needing to focus on prevention so as to reduce the need.

Maybe we should promote consolidation instead of fragmentation. If the programs out there are similar, why not bring them together to build on what’s already developed to create the best and most comprehensive strategies including all levels of prevention?

Once I saw a cartoon defining prevention. You can either build more rails to prevent people from falling off the cliffs or put more ambulances under them. While both are important, we should try to build more rails.

As the photo below illustrates, it is all too easy to just pass by and ignore people in crisis. We, as a society, need to find the best ways to not just “walk by.”

“The Desperate Man” by French painter Gustave Courbet. Photograph: FRANK RUMPENHORST/AFP/Getty Images
References:


27 Office of the Assistant Secretary for Planning and Evaluation. Affordable Care Act Expands Mental Health And Substance Use Disorder Benefits And Federal Parity Protections For 62 Million Americans.


