



ASPE ISSUE BRIEF

HHS OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF BEHAVIORAL HEALTH, DISABILITY, AND AGING POLICY

CRISIS SERVICES AND THE BEHAVIORAL HEALTH WORKFORCE

KEY FINDINGS:

- Crisis services aim to quickly stabilize individuals in less intensive settings using a mix of staff types.
- Crisis services may reduce demand on higher-cost professionals by using staff with less training who perform all functions within their scope of practice. This frees up staff with additional credentials to provide their full scope of practice.
- Funding presents a primary challenge to more widespread adoption of crisis services.
- Strong community partnerships are needed to assist with diversion from less appropriate settings, increase awareness of crisis services, and establish linkages to community services.

Mental health conditions and substance use disorders (SUDs) are among the leading causes of disability in the United States (U.S. Burden of Disease Collaborators 2018). Despite their prevalence, many people who require behavioral health services do not receive care (SAMHSA 2019), due, in part, to behavioral health workforce shortages (Hoge 2009). Provider shortages exist across the behavioral health workforce; however, they are particularly problematic in categories of staff that require higher levels of training or credentials, such as psychiatrists and certain types of licensed professionals. Given that these shortages are projected to continue in coming years (Bureau of Health Workforce 2020), it is critical to identify models of care that more effectively use the behavioral health workforce to increase access and better meet the needs of those experiencing mental health conditions and SUDs.

Crisis service models may present opportunities for more effectively using the behavioral health workforce. Crisis services offer individuals experiencing behavioral health crises stabilization in settings that are less intensive than traditional acute care. These models may align the level of intervention needed by a client to address a crisis with the level of training and credentials of a provider. This allows providers with greater specialized training, who are often more expensive and in shorter supply, to focus on those with more severe symptoms or specialized treatment needs. This brief discusses findings from a targeted environmental scan and case studies of four states examining

the organization of crisis service models, their potential workforce implications, and barriers and facilitators to their more widespread adoption.¹

Crisis Service Model Characteristics

Crisis services provide intervention by trained professionals and paraprofessionals at the point of behavioral health crisis. Consumers access crisis services to seek assistance with a range of medical and nonmedical situations, and to address a variety of behavioral health symptoms. Literature suggests that crisis service systems should include, at minimum, a crisis hotline, mobile response teams, and crisis receiving and stabilization centers (SAMHSA 2020). Most states offer some basic crisis services, although states' systems vary in how services are delivered, who can receive which services, and how the services are funded (SAMHSA 2014). Crisis services also differ in terms of how model components are staffed, and often include an array of licensed and unlicensed providers, and peer support staff. Regardless of organization, crisis services often share a common goal of ensuring people receive the most appropriate level of care. They accomplish this by directing individuals to less intensive services, often diverting individuals from high cost emergency departments, and unnecessary hospitalizations, while also reducing law enforcement involvement.

Workforce Implications of Crisis Services

Crisis service models often rely on a mix of licensed behavioral health professionals, and other staff with lower levels of training and credentials (including unlicensed providers and peer support specialists) who augment the work of licensed staff. Crisis models may have staff perform the full range of functions permitted within their scope of practice, freeing up higher-cost behavioral health professional staff with additional credentials to work up to their full scope of practice and serve clients in need of more specialized care. Peer specialists and unlicensed clinicians often serve on the frontline, where they take the lead to engage people in crisis and coordinate their care, while behavioral health professionals with higher levels of training conduct assessments, provide direct care, and serve in supervisory capacities. However, peer specialists and unlicensed staff who serve in support roles are not a substitute for trained clinical providers when clients require their care. In addition, training and supervision are essential for ensuring that team members deliver safe, high quality client care (SAMHSA 2020). Some examples of the mix of staff used in crisis service components include:

- **Crisis call lines.** States may use staff with less training and credentials than licensed behavioral health professionals to operate their crisis lines, reducing the demand for these more costly professionals. In Colorado, peers and bachelor's-level crisis counselors staff warmlines to address situations that may lead to acute crises, while crisis counselors and licensed clinicians staff hotlines to address acute crises that require more intensive or specialized intervention. In Georgia, unlicensed bachelor's-level and master's-level clinicians, known as care

consultants, handle most of the duties for the state's crisis line, dispatching mobile teams, filling out referral forms, and coordinating care; they conduct warm introductions to licensed clinicians when there are more severe crises.

- **Mobile crisis teams.** States use a variety of staff on mobile crisis teams and may make more efficient use of higher-cost staff by allowing licensed clinicians who may not need to be on scene to provide remote consultation or on-call supervision. For example, in Colorado, a peer specialist and a bachelor's-level clinician may be together on site to address a crisis, with a licensed professional accessible via telehealth. Arizona allows mobile teams to be staffed with various combinations of behavioral health professionals, peer specialists, behavioral health technicians, and paraprofessionals. If a licensed clinician is not onsite at a crisis, a clinician will be available on call. Georgia's mobile crisis teams comprise a licensed clinician and a paraprofessional, such a bachelor's-level clinician. Peer specialists may occasionally be part of a team, although they are more heavily used for follow-up calls to field satisfaction surveys and confirm that individuals were successfully linked to services that they will be able to use, and that their needs were met.
- **Crisis centers.** Crisis centers also use a mix of staff who help provide a recovery-oriented focus, which may enable them to reduce the length of stays, and decrease the demand for higher-cost behavioral health professionals. Staff with less training play key roles in stabilizing, engaging, and educating individuals in crisis and coordinating their care. While the same types of high-level behavioral health professionals (psychiatrists and nurse practitioners) may be needed in both crisis centers and inpatient settings, crisis centers may employ a more robust group of mid-level and lower-level staff performing their full scope of practice, which may allow for more efficient and effective use of more costly professionals' time. Bachelor's-level or master's-level clinicians and peer specialists, who focus on stabilization services and recovery supports, can help people who have experienced a behavioral health crisis return to their homes and communities more quickly, which may enable crisis center staff to serve more individuals with the same staff resources as more intensive settings.

Crisis services strive to quickly stabilize individuals in less intensive settings, using staff with strong engagement and support skills; they may reduce the demand for higher-cost professionals who would otherwise be needed in greater numbers if conditions were to escalate without this strong and timely recovery-oriented focus. By directing individuals to the appropriate level of care and treatment setting, crisis services can reduce the demand for professionals with higher levels of training, who are in shorter supply due to workforce shortages, and provide linkages to other types of behavioral health staff, including peer specialists, to stabilize and support individuals with lower levels of service needs.

Closer Look at Workforce Efficiencies

An Arizona crisis organization representative shared statistics to illustrate potential workforce efficiencies:

- The average length of stay in their subacute unit is two days, so each bed serves 170-180 people a year; a typical inpatient bed serves 52 people per year with an average length of stay of one week.
- Their crisis center often stabilizes people in less than 24 hours, so they do not need to stay in the subacute unit, further reducing the need for bed use.
- Using the Crisis Resource Need Calculator* to estimate community resource needs, the respondent suggested that without crisis care the state would need 2,850 beds; with crisis care the state only needs 820 acute beds, 292 crisis beds, and 343 crisis chairs.
- With their crisis service model, the state needs about half of the bed resources to serve consumers in crisis, necessitating fewer professional-level staff to treat individuals in crisis.
- These efficiencies translate into expanding the reach of behavioral health professionals' limited time to address client needs and the ability to serve more people.

Peer specialists play a critical role in engaging and stabilizing individuals in crisis in this organization. The respondent speculated that licensed clinical social workers--a higher-level provider in greater demand given workforce shortages--would be performing this role in a hospital, whereas peers are in ready supply. Peers, in turn, can work and do "the things that matter to them and [use] their own unique gifts to help others."

* See <http://www.crisisnow.com>.

Barriers and Facilitators to Widespread Adoption of Crisis Service Models

Funding presents a primary challenge to the implementation and expansion of crisis services. Crisis services literature often describes current state funding approaches as "cobbled together," with inconsistent funding streams, and highlights the need to reform funding structures to ensure that crisis services systems can continue to provide comprehensive, robust services and remain financially sustainable. Most states rely heavily on state funding for their crisis system, using Medicaid, block grants, and local and county funds to a lesser extent (National Action Alliance on Suicide Prevention, Crisis Services Task Force 2016). States may also struggle to obtain reimbursement for crisis services from commercial insurers, which limits service availability. For example, in Wisconsin, counties bill commercial insurers, but commercial insurers often deny crisis claims as not medically necessary and counties do not have the resources to challenge denials. For example, in Georgia, crisis centers will not take privately insured individuals unless private facilities are full, because commercial insurers do not reimburse for crisis services.

To address funding barriers, respondents and experts suggested establishing national policy to encourage commercial payer participation, and leveraging Medicaid whenever possible. A crisis services toolkit developed by SAMHSA proposes some strategies to ensure standardized and equitable funding approaches

when multiple payers are involved, including commercial payers (SAMHSA 2020). It proposes standardizing reimbursement mechanisms by using a common set of Healthcare Common Procedure Coding System codes appropriate for crisis services. It also recommends that states or counties set the same rate for all payers, so that they do not need to cover the shortfall when payers reimburse at lower and inadequate rates. In addition, states use Medicaid to reimburse crisis services to various degrees. The amount of Medicaid funding available for crisis services also depends on the proportion of the population covered by Medicaid, which varies state-by-state. For example, in Georgia, comparatively few people using crisis services are Medicaid beneficiaries because the state has not expanded Medicaid. Thus Medicaid reimbursement (a large percentage of which would be paid from federal funds) is limited, leaving the state as the predominant payer for crisis services. It also can be challenging for crisis providers to obtain information to verify Medicaid status, particularly given that some states choose to offer anonymity to those who use their services. Providers may mitigate this challenge somewhat by asking for enough information to identify Medicaid beneficiaries retroactively. For example, crisis systems could consider using lists of Medicaid-enrolled or commercially insured individuals' phone numbers in combination with caller ID technology to aid reimbursement efforts (SAMHSA 2020).

Strategies to provide equitable geographic coverage with limited resources are needed. For example, Wisconsin's smaller counties struggle with more limited resources to provide crisis services; however, flexibility in state requirements for crisis services and economies of scale help to facilitate counties' provision of crisis services. Stabilization services can occur in a variety of settings, rather than being restricted to a crisis center, relieving counties from needing to invest in building infrastructure for separate facilities. Smaller counties may pool their funding and jointly provide some services by, for example, using regional call centers and choosing how much or little to use these centers; some may use their own staff during business hours, whereas others may use the regional call center 24/7. Providing crisis services to rural areas can be challenging due to low volume as well, but there are numerous strategies to overcome this barrier including using telehealth, setting rural reimbursement rates, and establishing crisis service response times that recognize geography while ensuring access (SAMHSA 2020). If infrastructure to support it is available, telehealth may enable workforce efficiencies when used in rural and frontier settings and at times of day when there is lower volume, shortening travel time and allowing more staff time to be dedicated to direct care and/or supervision (SAMHSA 2020). Additionally, a well-functioning crisis system efficiently coordinates resources, such as mobile teams, allowing limited resources to be optimally used and reducing workforce demand (SAMHSA 2020).

Some states have laws requiring partner agencies that often serve as referral sources, such as emergency medical services and law enforcement, to bring individuals in crisis to hospitals only. This prevents partners from referring individuals to the behavioral crisis system. Laws could be changed for successful diversion from emergency departments and inpatient settings to crisis services to occur.

Bidirectional Partnerships in Action

- A law enforcement partner in Arizona appreciated that their county crisis system prioritizes law enforcement calls and sends the next available mobile team when calls come in. They also recounted how a local crisis facility added a staff member to field police calls when law enforcement relayed that they were having difficulty reaching center staff to ask quick questions about individuals with behavioral health conditions.
- An emergency department partner in Georgia noted that they now send the referral information directly to the local crisis center in addition to supplying Georgia Crisis and Access Line with this information. This facilitates a swift and successful referral. They have collaborated with the crisis center to refine referral processes and transfers when an individual requires medical care.

Partnerships are critical for ensuring diversion from less appropriate settings, raising community awareness of crisis services, and operating as part of a continuum of services for people with behavioral health conditions. Strong partnerships between the crisis system, law enforcement, emergency departments, first responders, jails, the broader behavioral health system, health plans, schools, and judges may facilitate more widespread adoption. For example:

- Speaking with partners about crisis system principles can help to gain buy-in and increase referrals and successful diversion from less appropriate settings, and can lead to more efficient and recovery-focused interactions, even outside the direct crisis service system. In Arizona, regional behavioral health authorities have worked with police departments in their geographic service areas to provide training, so that police respond to individuals in crisis in an appropriate manner, and send “more of a recovery message rather than a punitive message.”
- An important step in raising community awareness of crisis services is to increase awareness among partners to serve as referral sources and crisis service ambassadors. For example, in Georgia, cards with the state crisis line’s information are distributed to law enforcement, schools, and emergency departments. Mobile teams distribute cards at community agency meetings. Workgroups or collaboratives can also be helpful for strengthening partnerships, seeking community input, and/or improving the crisis system.
- Successful partnerships are bidirectional. For example, law enforcement can offer supports to crisis systems, such as serving as referral sources and helping to make sure mobile crisis teams are safe when a situation is especially dangerous. In return, crisis organizations can help ensure that law enforcement’s interactions with the crisis system are easy and quick.
- Partnerships enable crisis services to operate as part of an integrated continuum of behavioral health care (SAMHSA 2020). Not only should crisis services liaise with hospitals and EDs, they also should be tightly connected with outpatient services to serve as part of an integrated continuum of care. Through care coordination and follow-up calls, crisis services facilitate recovery, in part, by linking individuals in crisis with ongoing supports.

Summary

Crisis service models rely on a mix of behavioral health professionals and staff with lower levels of training to provide crisis service components. The recovery-oriented and timely nature of crisis services, achieved by using a robust, mixed team of staff with strong engagement skills, may allow for faster stabilization. This reduces the number of higher-level behavioral health professionals that would otherwise be needed if an individual's symptoms were to escalate and require more intensive services. Crisis services may also allow for the provision of care in more appropriate settings and divert people experiencing crises away from higher-cost settings. Barriers and facilitators to more widespread implementation of crisis services include funding; use of telehealth and alternative settings in rural areas; and partnerships to assist with diversion, awareness, and linkages to community services. Although this study begins to build a framework for understanding how crisis service models can extend the workforce and improve access to behavioral health services, additional research is needed to confirm and build on these findings and identify policy solutions to encourage more widespread adoption.

Endnotes

1. The study included interviews with representatives from state agencies, crisis service organizations, and community partners such as emergency departments and law enforcement in Arizona, Colorado, Georgia, and Wisconsin.

References

- Bureau of Health Workforce. "Behavioral Health Workforce Projections, 2017-2030." Washington, DC: Health Resources and Services Administration, Bureau of Health Workforce, 2020. Available at <https://bhw.hrsa.gov/health-workforce-analysis/research/projections/behavioral-health-workforce-projections>. Accessed August 4, 2020.
- Hoge, M.A., J.A. Morris, G.W. Stuart, L.Y. Huey, S. Bergeson, M.T. Flaherty, O. Morgan, et al. "A National Action Plan for Workforce Development in Behavioral Health." *Psychiatric Services*, vol. 60, no. 7, July 2009, pp. 883-887. doi: 10.1176/ps.2009.60.7.883.
- National Action Alliance for Suicide Prevention, Crisis Services Task Force. "Crisis Now: Transforming Services is Within our Reach." Washington, DC: Education Development Center, Inc., 2016. Available at <https://theactionalliance.org/resource/crisis-now-transforming-services-within-our-reach>. Accessed August 4, 2020.
- Substance Abuse and Mental Health Services Administration (SAMHSA). "National Guidelines for Behavioral Health Crisis Care--Best Practice Toolkit." Rockville, MD: SAMHSA, Center for Mental Health Services, 2020. Available at <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>.
- Substance Abuse and Mental Health Services Administration (SAMHSA). "Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health." Rockville, MD: SAMHSA, Center for Behavioral Health Statistics and Quality, 2019. Available at <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf>.
- Substance Abuse and Mental Health Services Administration (SAMHSA). "Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies." Rockville, MD: SAMHSA, 2014. Available at <https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4848.pdf>.
- U.S. Burden of Disease Collaborators. "The State of US Health, 1990-2016: Burden of Diseases, Injuries, and Risk Factors Among US States." *Journal of the American Medical Association*, vol. 319, no. 14, April 2018, pp. 1444-1472. doi: 10.1001/jama.2018.0158.

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