3 December 2021

To: Oregon Health Authority

From: The Oregon Alliance to Prevent Suicide Executive Committee, on behalf of the Transitions of Care Committee

RE: HB 3090 Emergency Department Release Survey of Hospitals 2021 Legislative Report

Thank you for the opportunity to review the hospital survey results and report developed by OHA on implementation successes and barriers for HB 3090 (2017). After careful review of the report and recommendations, the Transitions of Care Committee within the Oregon Alliance to Prevent Suicide has the following overall feedback, as well as additions or modifications to OHA recommendations:

Overall feedback:

- The committee is very impressed at the 100% participation rate, the overall findings, and the ease in reading the results.
- As was expected when this law was passed, resources seem to be a barrier to implementation of some of the requirements. This barrier could be addressed, resulting in a positive impact, however it is unclear as to where responsibility lies in the system of care. Clarifying responsibilities and accountabilities will help to identify solutions, as well as identifying where specific infrastructure already exists in the system to build on those foundational processes.
- This report is a powerful tool with important data and information that should be leveraged to address the critical behavioral health workforce shortage Oregon faces.

Lack of Hospital Policies Available on Public Facing Websites or Provided to Patients:

- Policy summaries should be provided to patients and lay caregivers in plain language when admitted AND at discharge to ensure patient and lay caregivers understand what is required by law.
- Policy summaries should also be available on hospital websites. The requirement to have the policies made publicly available was intended to create transparency for patients, lay caregivers, and those who may become patients and lay caregivers to know what is required by hospitals and what can be expected. When our group performed a scan of public information on hospital websites, we were only able to locate a handful of hospitals that made their policies publicly available. Improvements in this area will increase accessibility to patients and lay caregivers.

Misinterpretation of Rules by Hospitals:

- As noted in the report, a significant number of respondents misinterpreted that the rules apply to their responsibilities and not that of patients. We would like to add a date for the report's stated recommendations to review OHA and OAHHS guidance, as well as add an outreach effort made to hospitals clarifying what the rules require of them, to take place no later than December 2022.

- We also would like to see added to recommendations that when each hospital's policies are finalized, staff must be trained on the existence of the policies, what they entail, and how to implement them.

Responsibility of Hospitals When Contracting Out Rule Requirements:

- Regular quality improvement assessments should be completed every two years.
- The mental health workgroup *(recommended in next section)* should consider the unique barriers for houseless individuals AND when patients experience substance use disorders (SUD) and co-occurring disorders.

Lack of Understanding on How Companion Bill, HB 3091, Supports Implementation Efforts:

- For hospitals reporting financial resource limitations on their successful implementation, it is critical that HB 3091 (2017) rules are directly aligned with the activities required by HB 3090 (2017), as this was created to address the financial barrier hospitals reported during the legislative process.

Lack of Referral Options for Hospitals to Support Patients in Care Coordination:

- Recommendation 3 should read, "Develop AND enhance community resources in rural communities to support rural hospital execution of care coordination rules." Identify funding sources to ensure this recommendation is feasible.
- Recommendation to align the current explorations for creating Comprehensive Psychiatric Emergency Programs (CPEP) as a strategy to increase hospital capacity to fulfill the requirements of these rules and better meet the needs of patients.

Need to Review Staff Appropriate to Provide Services:

- We support the formation of a workgroup to evaluate if administrative rules should be expanded regarding who can do follow up Caring Contacts. Because "Caring Contacts" is a specific therapeutic intervention, it is important that those who are making these contacts are trained. "Some mental health training" is not specific enough for this section. Examples of topics and areas of focus should be specified.

Regarding the recommended formation of a workgroup, members of the Alliance to Prevent Suicide Transitions of Care Committee would like to be included, as well as having input on additional members, based on continuity of stakeholders who were involved in the writing of the laws and rules.

Thank you for accepting this feedback and our suggestions for additional recommendations to be included in the OHA report and we look forward to any additional follow up engagements on this process.

Signed,

Exec Committee

Friday, November 12, 2021

To: Alliance leadership – Annette Marcus,
Jenn Fraga, Galli Murray, Ryan Price
CC: Jill Baker, Shanda Hochstetler

RE: Alliance Transitions of Care Committee

Dear Annette Marcus, Jenn Fraga, Galli Murray, Ryan Price:

We are writing with a request from the Transitions of Care (TOC) Committee regarding our scope of work and structure. As you know, the focus and scope of work for TOC has centered around safe discharges from hospitals after a behavioral health crisis has occurred by mainly advocating for and monitoring the implementation of HB 3090 / 3091 (2017). With the current trajectory of this work, the committee is feeling that we don't have to have such a heavy presence on HB 3090 / 3091 work and that we can begin to focus on other transitions of care.

We have recruited new members over the last year with specific interest and expertise in a variety of transitions of care, including youth corrections, and their hope is to expand our focus from specifically looking at hospital / emergency department transitions to other areas of transition.

During our October committee meeting, there was a discussion around the possibility that the scope of our work would change from solely looking at transitions of care and expand to the larger scope of healthcare. A variety of concerns were expressed regarding this and the committee said that they would want more information from Alliance leadership about this concept before they would be able to come to a decision.

The committee has started talking about future workplans and areas of focus. We recognize that leadership wants all committees to support YSIPP initiatives and that only a few YSIPP initiatives for FY 21-22 fall under our current committee scope. While ideas and project plans the committee creates would be able to connect to a specific YSIPP Pathway, there are not many specific initiatives that connect directly to this committee as it currently stands. So, in order to better plan for moving forward, the committee would like to request the following from Alliance leadership:

- If there will be an ask from leadership, please make this by Tuesday, December 7th so that we are able to review it as committee leadership and bring this to our regularly scheduled committee meeting Thursday, December 9th to discuss as a committee and vote on how we want to respond.
- That the ask be written and sent to committee chairs, Charlette Lumby and Joseph Stepanenko, and include the following information requested by the committee:
    - Why you think it's important to make the change from overall transitions of care to healthcare.
    - How would this change the current committee mission?
    - What would the specific charge of the Healthcare focus look like?
    - What you hope the goals of this change would be. What do you see us being able to accomplish by making this change?
    - What next steps would be if this committee votes to not change the focus.

Thank you so much for your time and consideration. We appreciate being able to do this work with you and look forward to moving suicide prevention efforts forward.

Sincerely, Charlette Lumby & Joseph Stepanenko, TOC Chairs

Transforming the crisis system for children and families

Mobile Response and Stabilization Services (MRSS)

System of Care Advisory Council 11.2.2021

Chelsea Holcomb, LCSW Child and Family Behavioral Health Director

Youth and Family

- Fail up system
- Not feeling heard
- Wisdom and experience is not trusted
- Emergency Department is the front door
- Emergency Department is not designed to treat children's behavioral health crises, needs are often left unmet
- Families left to prove how bad things are
- Shame and blame throughout the lifespan of the concern/emergency
- Lack of access to support navigating the system
- Lack of access to peer support
- Concerns and emergencies often started in school and when children were very young

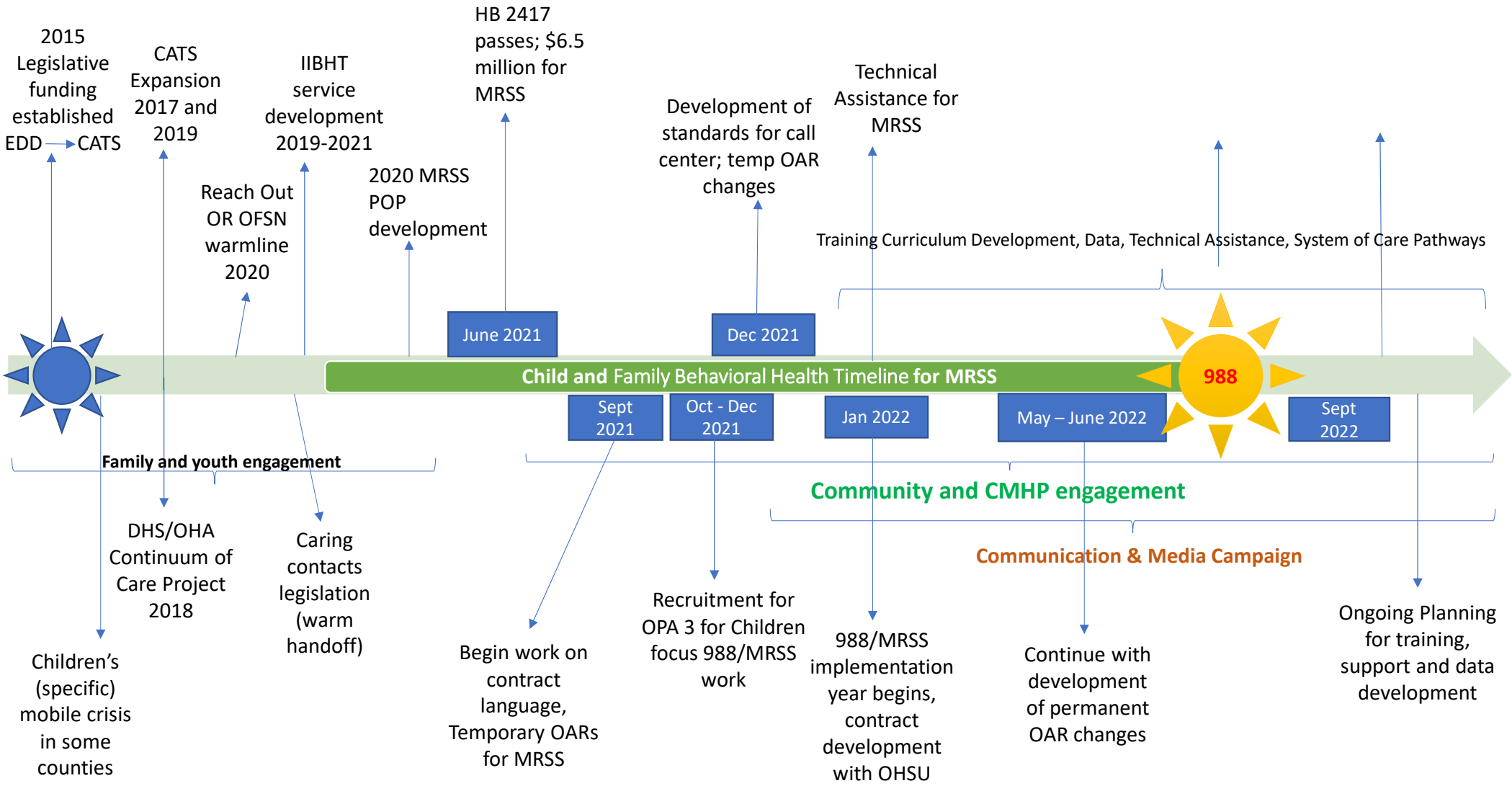
Timeline of policy option package (POP)

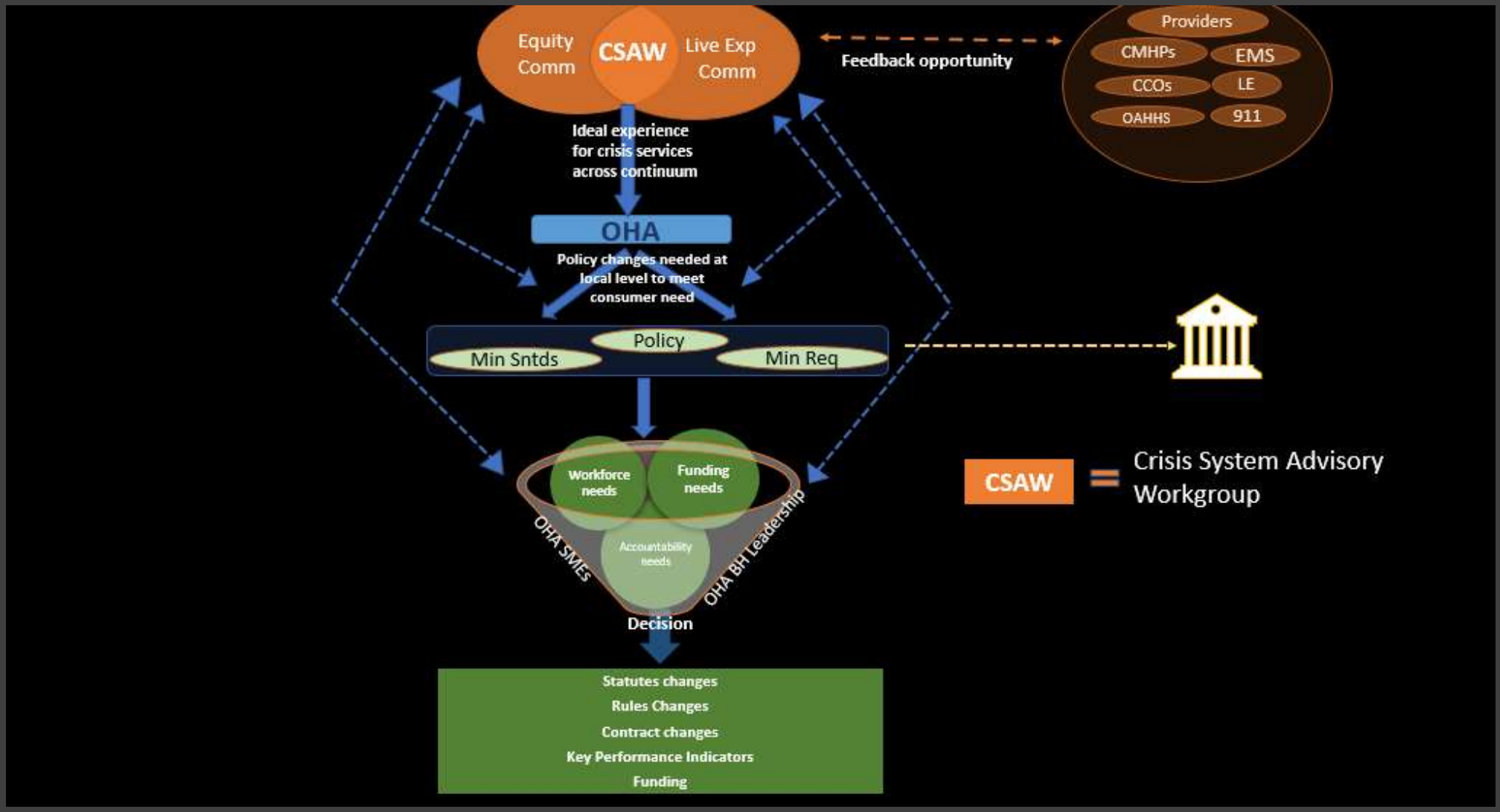
Fall/Winter 2019

Policy Option Package (POP) Development

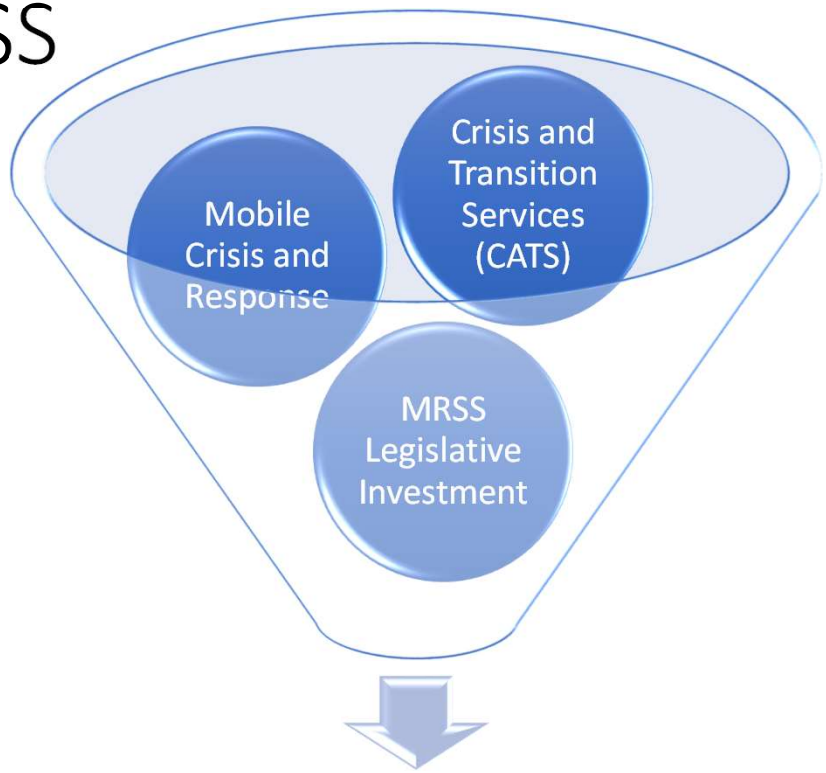
2020 OHA POP refinement, community engagement and presentations

2021 Legislative Investment (partial biennium funding) $6.5 Million


2015 Legislative funding established EDD → CATS
CATS Expansion 2017 and 2019
IIBHT service development 2019-2021
HB 2417 passes; $6.5 million for MRSS
Development of standards for call center; temp OAR changes
Technical Assistance for MRSS
Training Curriculum Development, Data, Technical Assistance, System of Care Pathways
Reach Out OR OFSN warmline 2020
2020 MRSS POP development
June 2021
Dec 2021
Child and Family Behavioral Health Timeline for MRSS
988
Sept 2021
Oct - Dec 2021
Jan 2022
May – June 2022
Sept 2022
Family and youth engagement
Community and CMHP engagement
Communication & Media Campaign
DHS/OHA Continuum of Care Project 2018
Caring contacts legislation (warm handoff)
Children's (specific) mobile crisis in some counties
Begin work on contract language, Temporary OARs for MRSS
Recruitment for OPA 3 for Children focus 988/MRSS work
988/MRSS implementation year begins, contract development with OHSU
Continue with development of permanent OAR changes
Ongoing Planning for training, support and data development


Equity Comm
CSAW
Live Exp Comm
Feedback opportunity
Providers
CMHPs
EMS
CCOs
LE
OAHHS
911
Ideal experience for crisis services across continuum
OHA
Policy changes needed at local level to meet consumer need
Policy
Min Sntds
Min Req
Workforce needs
Funding needs
Accountability needs
OHA SMEs
OHA BH Leadership
Decision
Statutes changes
Rules Changes
Contract changes
Key Performance Indicators
Funding
CSAW = Crisis System Advisory Workgroup

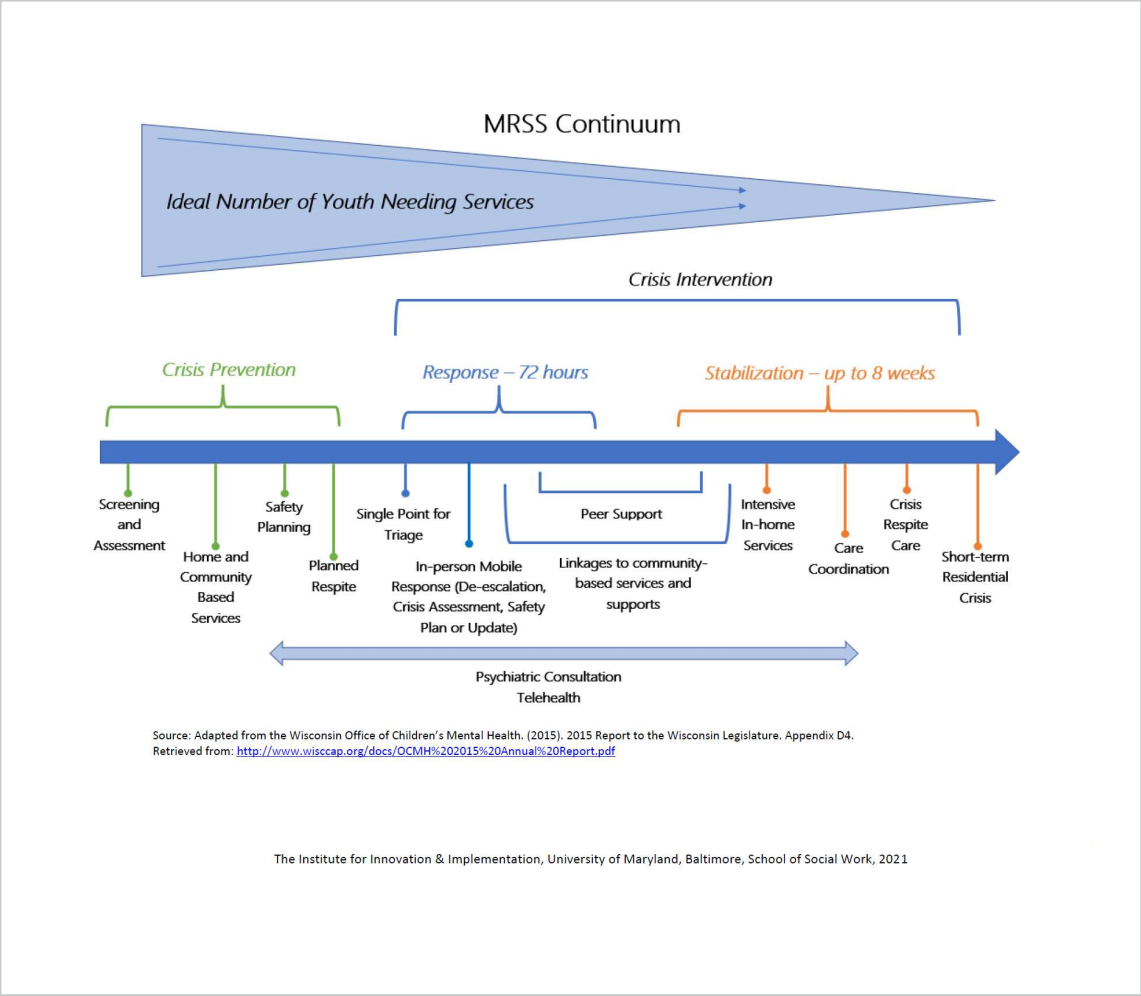
Now → MRSS

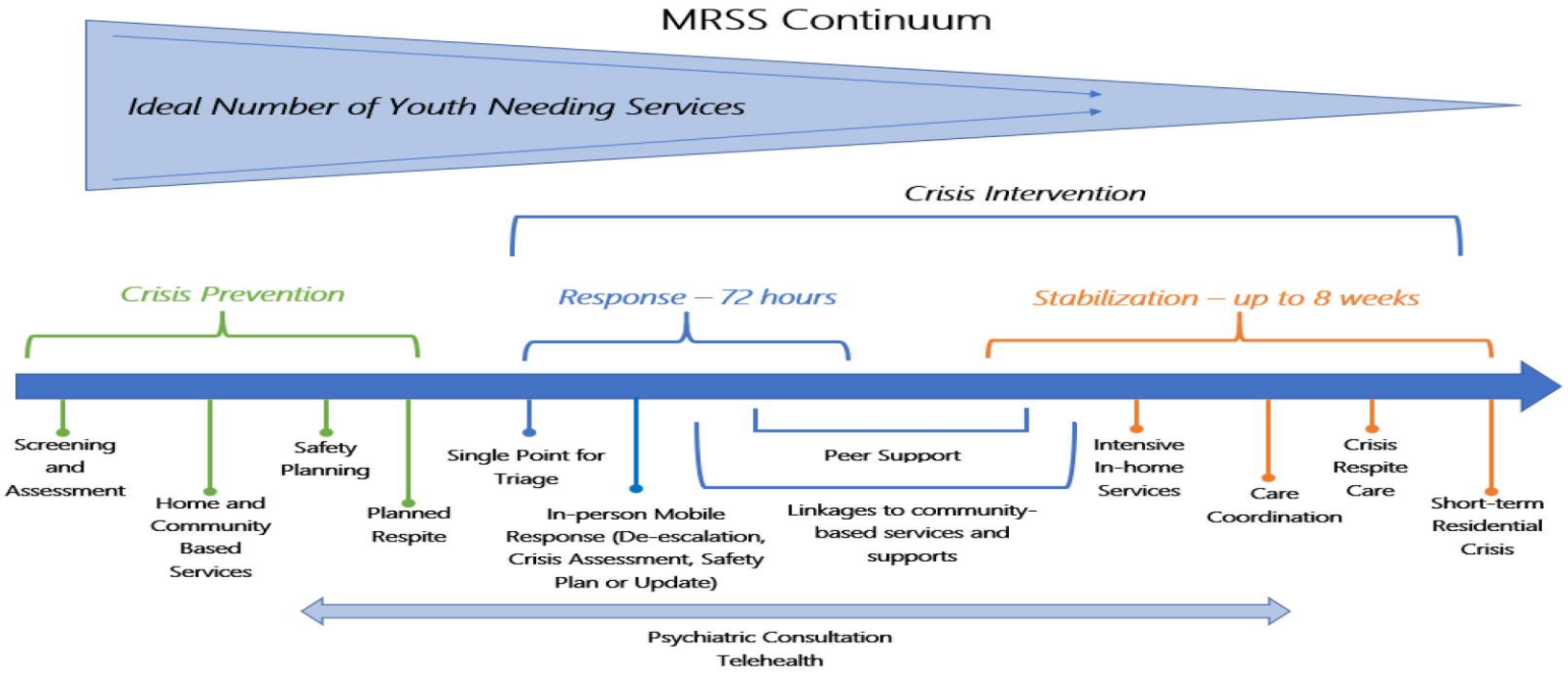


Mobile Response and Stabilization Services (MRSS)

MRSS overview for discussion

- Define MRSS: The mobile response and stabilization services (MRSS) are designed to deliver mobile behavioral health therapeutic response to support youth, young adults and their parents and/or caregivers, as well as youth at risk for involvement in other child serving systems specifically, Child Welfare, and Juvenile Justice. MRSS is a rapid response and integrated service based on the needs of the youth, young adult and/or their family/caregiver. Stabilization services exist on a continuum with the mobile response.





Source: Adapted from the Wisconsin Office of Children's Mental Health. (2015). 2015 Report to the Wisconsin Legislature. Appendix D4. Retrieved from: http://www.wisccap.org/docs/OCMH%202015%20Annual%20Report.pdf

MRSS overview for discussion

- Family and youth define what the need is; team goes to them, services provided in natural environments, not offices.
- Requires screenings and mental health assessment
- Allows for telehealth in areas without timely access
- Use of Crisis Assessment Tool (abbreviated CANS specific for crisis) also considering HOPE scale (youth/adults)
- Family and Youth Crisis and Safety Planning using MRSS team input
- Incorporates Care Coordination and system navigation

MRSS overview for discussion

- Uses centralized referral system (911 transitioning to 988)
- *Creates a mobile response team consisting of QMHP, other team members include a QMHA and a Peer Support Specialist. For a response, a minimum of 2 people, one of whom is qualified and credentialed to conduct a behavioral/mental health assessment and one of whom is a peer support specialist.*
- Primary goals is diversion from hospitalization, residential treatment, child welfare involvement, placement or school disruption, houselessness and incarceration through clinically appropriate community-based supports and services.
- Staff must be specifically trained and experienced in working with children, youth and young adults and their families.
- Training includes appropriate crisis response, cultural responsiveness, trauma informed approaches, de-escalation and safety techniques appropriate in crisis situations including suicide risk;

MRSS overview for discussion

- Use of police and EMS response is limited to situations where there is a need that is out of scope for MRSS teams (legal, safety, medical)
- For young adults, follow-up in appropriate system (child or adult) will be based on the need/desire identified by the young adult and the clinical assessment of MRSS team
- OARs will be updated to support these changes.
- Stabilization Services available up to 8 weeks

Local Children's System of Care commitment and involvement for MRSS is required for teams to be successful.

Want to continue to engage?

- Community Conversation on MRSS: Dec. 7th Register in advance for this meeting: https://www.zoomgov.com/meeting/register/vJIsd-ihrjwoH2pwb0wrpyuFNO0tWCjDjD8
- Sign up for our Newsletter for information and future events here.
- Email our Team: kids.team@dhsoha.state.or.us
- Website for Child and Family Behavioral Health

First Edition: Oct. 1

Consensus Approach and Recommendations for the Creation of a Comprehensive Crisis Response System

Crisis Hotline

Consensus Approach and Recommendations for the Creation of a Comprehensive Crisis Response System

NOVEMBER 2021

Authored by leaders from the undersigned organizations who worked closely on the development of this shared vision to achieve a common goal— improving lives for people with mental health and substance use disorders. These leaders aspire to create the vital conditions that promote well-being and a system of care where all people have readily available access to evidence-informed services across a full continuum.

American Foundation for Suicide Prevention

American Psychiatric Association

American Psychological Association

Massachusetts Association for Mental Health

Meadows Mental Health Policy Institute

Mental Health America

National Association for Behavioral Healthcare

National Alliance on Mental Illness

National Council for Mental Wellbeing

One Mind

Peg's Foundation

Steinberg Institute

The Kennedy Forum

Treatment Advocacy Center

Well Being Trust

For additional information, please contact **info@wellbeingtrust.org**.

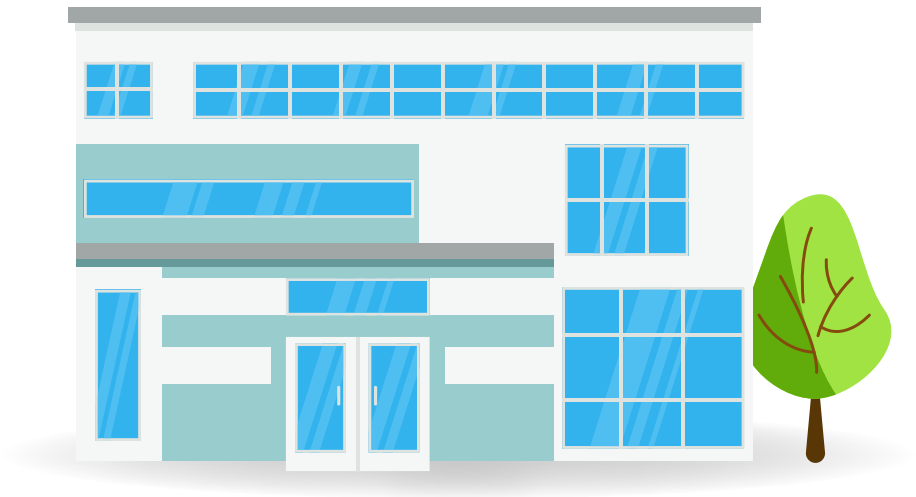
Table of Contents

Executive Summary

The United States needs a thoughtful and comprehensive response to mental health or substance use crises and suicide prevention. As it stands, there is no consistent pathway a person in crisis can access for help. And for many communities, 911 has become the default response, which has led to frustration, inappropriate care, and in many cases even death. Simply put, without a robust infrastructure that allows for the public to call for help and consistently get an appropriate response, these trends will not change.

> 988 is not just a new number to call – it is an opportunity to rethink how we approach mental health, substance use disorders, and suicide prevention in our communities.

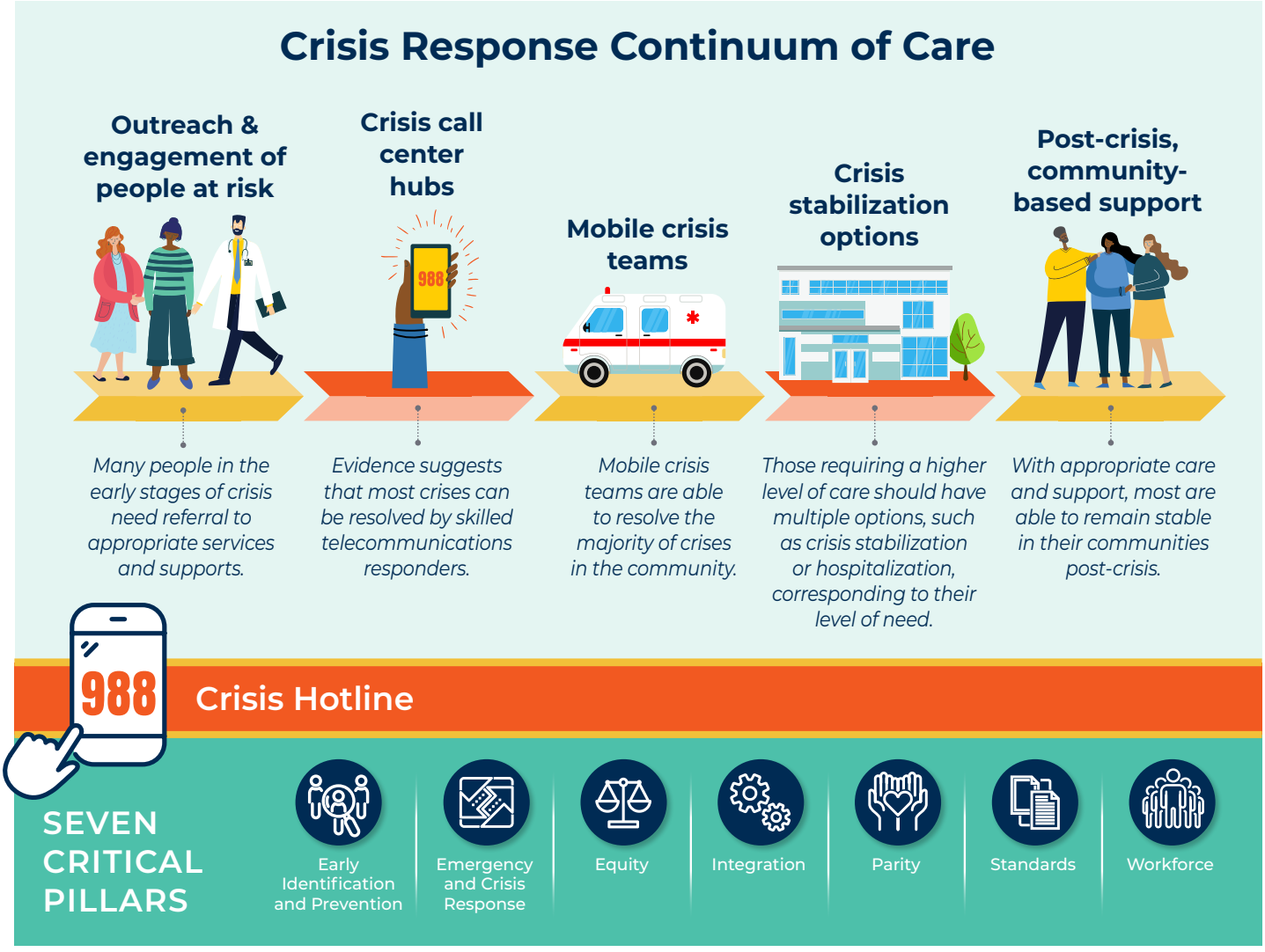
July of 2022 will officially introduce 988: a new telephone number people in our communities, states, and nation will be able to call or text when a crisis arises. However, like many changes for mental health and substance use disorders, if there is no comprehensive plan that outlines needed elements for a thorough and effective response, we run the risk of losing this precious opportunity to do better for everyone.



We cannot afford to fail.

This document provides a clear blueprint for building the continuum of care we need for a functioning crisis response system. Without a systems approach to transformation, simply implementing a new number to call will have little impact on those who are in need. As seen in the graphic below, as well as the corresponding document, we have identified seven critical pillars that must be built into any redesign if we are to achieve our goal of a timely, effective, safe and compassionate intervention for those in a mental health crisis.

988 is not just a new number to call – it is an opportunity to rethink how we approach mental health, substance use disorders, and suicide prevention in our communities.



Preamble

As leading organizations in the United States dedicated to improving outcomes for people with mental health conditions, suicide risk, and substance use disorders*, we have committed to speaking with one voice on the way forward. We have consolidated our subject matter expertise and diverse constituencies behind this common purpose. We offer here our consensus approach and recommendations for the creation of a comprehensive crisis response system, presented as a clear and unified statement.

An Opportunity and a Responsibility

The ravages of the COVID-19 pandemic have put a harsh and unforgiving focus on the way we respond to crisis. Each state, county and city operates its own localized version of crisis response with wildly varying results. This reality made coordinating COVID response (mental health/substance disorder/suicidal crisis response) very difficult to approach systematically. Many places are doing no better at successfully resolving crisis despite the best efforts of individuals struggling to succeed with ineffectual tools, lack of funds and inadequate capacity along the entire continuum of care.

In a major victory for those with mental health and substance use disorders, Congress included a historic increase in funds within the American Rescue Plan Act—the largest increase in decades.

While lawmakers began investing in mental health programs, numerous high-profile incidents of lethal law enforcement encounters involving those in acute crisis brought attention to a reality advocates have spoken of for years. Unlike medical conditions, our response to psychiatric, behavioral, trauma-based or substance use crisis is inappropriately rooted in law enforcement and criminal justice. These encounters further highlight long-standing racial discrimination and a need to apply an equity lens to crisis response. This does not need to be our status quo anymore. Reliance on law enforcement, jails and prisons is a result of our collective failure to provide an appropriate alternative.

The ravages of the COVID-19 pandemic have put a harsh and unforgiving focus on the way we respond to crisis.

** Throughout this document, the terms mental health conditions and substance use disorders will be used to encompass the whole range of conditions associated with these illnesses.*

Continuum of Crisis—A Systemic Approach

In September 2020, the National Suicide Hotline Designation Act passed Congress. This legislation made a landmark decision to transition the current National Suicide Prevention Lifeline or 1-800-273-TALK to 988. Advocates and leaders alike are seizing on an opportunity to reimagine crisis care in the United States.

In September 2020, the National Suicide Hotline Designation Act passed Congress.

Crisis is the most acute stage of need for individuals with mental health and substance use disorders (MH/SUD) and for those at risk of suicide. A continuum should exist in providing crisis care just as there is a continuum of care for other types of health. When we think about heart health, there is an understanding that a heart attack is late in the continuum of care. Emergency treatment of a heart attack is preceded, and hopefully prevented, by regular check-ups, heart health screenings, preventative health care and non-emergency interventions. Discharge after treatment of a heart attack likewise requires follow-up care and monitoring to prevent another emergency from arising and to adjust care as needed.

Similarly, a mental health or suicidal crisis begins well before it escalates to an emergency that could warrant a law enforcement response, or inappropriately relying on an emergency department for help. The crisis may begin when a person is unable to get needed services, medication or supports, experiences a traumatic event, a relapse or symptoms are triggered, or stressors begin to compound. 911 response will continue to be an integral component of a full continuum of crisis response, but alternative interventions and an understanding of existing resources for this earlier stage of crisis must be included in planning efforts for 988 as will the thoughtful coordination between 911 and 988 responses. An all-emergency crisis response, even if successful in shifting from over-reliance on law enforcement, will overwhelm the mental health and medical systems.

We must also require that post-emergency aftercare and support be included in plans for 988 implementation. The period following the resolution of an emergency intervention, such as response by a mobile crisis team or admission to a hospital or crisis stabilization unit, is often equally critical to continued stabilization and pathway to recovery of the person, as is coordination with the patient's clinician whenever possible.

What we need and what we must build is a crisis response system that follows this continuum of crisis and is informed by what we know about how to reach the individuals we intend to serve. This is an opportunity to create a re-envisioned crisis system convened and run by state or regional-level authorities.

The Scope of 988 Implementation

An ineffectual crisis response system is expensive and yields bad outcomes. We believe that our nation must seize this once-in-a-lifetime chance to do right for all our communities. We also believe that 988 implementation will falter and fall short of its mandate if our focus is too narrow. We will need the cooperation of state and federal policymakers as well as public and private payers. We seek to successfully and compassionately meet the needs of those at the height of an emergency and also recognize the importance of preventing crisis. By serving all, we prevent unnecessary human suffering and promote the well-being of underserved people who deserve better than what we have delivered to date. To do this, however, we must be bold. **Let's be bold.**

7 Pillars for Transforming Mental Health and Substance Use Care

Early Identification and Prevention

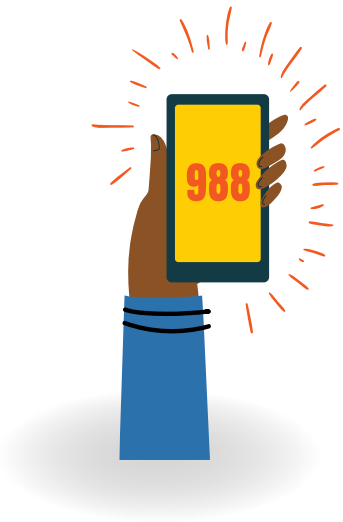
Pillar 1: Crisis begins earlier than our system has been set up to acknowledge and continues long after an emergency is resolved. A successful 988 implementation must incentivize intervention in early stages of crisis before a full-blown emergency and also incentivize continued support and stabilization afterward. Early identification and prevention also includes:

- Investment in research.
- Consistent quality data available to allow for meaningful analysis and accountability and understanding of why people are coming into crisis.
- Support warm lines to avoid crisis and address post crisis needs.
- Public education campaigns to aid in early identification, including campaigns focused on young adult populations.
- Universal mental health and substance use screening across all medical settings and schools.
- Creating special Medicaid eligibility coverage for early psychosis and those in juvenile justice system.
- Ensure availability of peer navigators and in-network, readily available care.
- Invest in supportive housing, both transitional and permanent.
- Integrate trauma-informed practices, social emotional learning, and multi-tiered systems of support in schools.
- Expand youth mental health services by ensuring states take advantage of all available Medicaid funding.
- Invest in prevention and early intervention in schools.

Emergency and Crisis Response

Pillar 2: The ultimate goal of 988, shifting crisis response away from law enforcement and the criminal justice system and to our public health, medical, and mental health systems, will require infrastructure investment and an expansion of capacity that must be built into the planning process. This will also include:

- Ensuring new investment, including community-based care, residential crisis options, and inpatient care adequate to meet needs of those diverted from hospital emergency departments and criminal justice involvement.
- Lifeline call centers and crisis services should be subject to consistent and timely data requirements.
- Requiring all federally-regulated health plans to cover the crisis continuum of care.
- Funding the training of call center staff to effectively answer a wide range of mental health, suicide risk and substance use calls.
- Expanding mobile crisis outreach teams and ensure collaboration with other emergency response systems.
- Creating exception to the IMD exclusion for short-term crisis stabilization services that extend more than 23 hours.



- Requiring recipients of crisis response funding to have close relationships with local mental health and substance use disorder treatment providers to ensure connections with on-going treatment and care for those who need it following a mental health crisis.
- Ensuring capacity of National Suicide Prevention Lifeline call centers for calls, texts, and chat abilities.
- Ensuring statewide availability of effective crisis stabilization programs.
- Planning efforts must include how 911 and 988 responses will interact to ensure the two systems operate in a complementary fashion, not as parallel or exclusive systems.

Equity and Inclusion

Pillar 3: Commitment to equity for underserved communities and inclusion of those with lived experience must extend beyond aspirational statements and rhetoric. To do this, we must:

- Involve people with lived experience using crisis care and families, especially from diverse communities, in the planning and implementation process.
- Reject artificial distinctions for who can be served with crisis services, e.g., "violent" versus "non-violent".
- Require that research and data collection include data to assess and address health equity.
- Develop and promote best practices for culturally and linguistically appropriate evaluation and care.
- Fund recruitment and cultivation of a diverse workforce throughout the continuum.
- Incentivize programs and policies with the effect of better getting people connected to care instead of incarceration.
- Implement culturally competent and multilingual public education campaigns and outreach efforts.

Integration and Partnership

Pillar 4: Law enforcement should take a secondary role in crisis response through a paradigm shift that recognizes the warning signs of suicidal behavior, mental health conditions and substance use disorders as matters of health care, not criminal justice. This will require training, partnership, coordination, and thought leadership geared toward law enforcement and the courts, medical and mental health systems and the public at large. This will also require:

- Incorporating multi-disciplinary trainings and ensuring planning efforts encompass the overlapping of 911 and 988 responses to encourage clarity of roles and protocols for cross-system referrals.
- Mental health and substance use services should be integrated throughout the various touch points in a system—from emergency departments to primary care.
- Incentivize and provide technical assistance for the integration of MH and SUD systems and departments both at an administrative and clinical level.
- Promulgate national standards of psychiatric crisis care similar to those laid out in the 2021 GAP report.
- Support for peer outreach to high-risk individuals and upon discharge from hospitals and crisis settings.
- Support ongoing coordination of emergency response, hospital and mental health crisis response systems to improve outcomes for individuals in crisis.
- Structure federal investments through states to promote adoption of national standards and development of a comprehensive crisis continuum of care at statewide and local levels.

Parity: Fair and Equivalent Coverage

Pillar 5: Enforcing parity using all available means will prevent many individuals from ever escalating to crisis and will prevent those re-entering the community after stabilization from revolving-door, emergency-only treatment. This will also require:

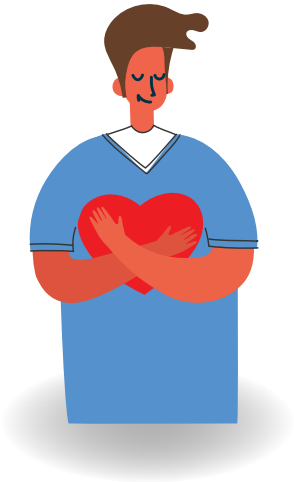
- Applying the federal parity law to all federally-regulated plans including Medicare Advantage.
- Requiring all health plan medical necessity determinations to be fully consistent with generally accepted standards of care for MH/SUD.
- Increasing funding for enforcement of state and federal parity laws.
- Eliminating reimbursement rate disparities that dis-incentivize timely and adequate care.
- Enforcing Federal telehealth parity law.
- Revising parity regulations to establish an intermediate level of care classification to improve access to partial hospitalization and intensive outpatient programs and residential treatment.

- Eliminating restrictions on MAT for SUD or co-occurring disorders.
- Eliminating lifetime caps for Medicare.
- Eliminating Medicaid inmate exclusion.
- Establishing Medicaid state plan option to cover short-term acute care in specialized inpatient and residential settings, including IMDs.
- Make Certified Community Behavioral Health Clinic services available through Medicaid in all states and territories.

Standards for Care

Pillar 6: The historic investment in our nation's mental health and substance use system made by Congress must be tied to a commitment to improve the quality of treatment provided at all stages of the continuum of care. This will require investment in infrastructure, financing that incentivizes evidence-based practices and rewards good outcomes, as well as:

- Incentivizing services, such as sub-acute care and alternatives to hospitalization, that fill gaps in the continuum of care.
- Federal legislation to direct the Secretary of HHS to establish standards for a crisis continuum of care.
- Funding and incentivizing evidence-based treatment modalities.
- Removing barriers to filling in gaps to continuum of care, such as sub-acute care and alternatives to hospitalization, peer-run respite and in-home crisis stabilization and intensive in home services, especially for children.
- Assessing adequacy of inpatient infrastructure and address shortages.
- Incentivizing evidence-based interventions for severe MH/SUD and co-occurring disorders.
- Promoting measurement-based care for mental health and substance use conditions and value-based financing that supports effective management of MH/SUD conditions similar to what's occurring in primary care.



- Eliminating the use of "fail first" policies for medication therapies.
- Training providers in assessing, managing, and treating suicidal ideation and behavior and the role of mental health, substance use and overdoses in suicidal behaviors.
- Incentivizing and promoting integrated and coordinated comprehensive MH/SUD care by expanding the Certified Community Behavioral Health Clinics Medicaid demonstration program to allow any state the opportunity to apply.

Workforce Capacity

Pillar 7: A successful shift away from law enforcement response will require an increase in all parts of the already-stretched mental health workforce. 988 implementation will falter if insufficient planning and investment is made in cultivating and training the workforce that will be needed. Additionally, resources that meet individuals' needs where they show up have been shown to avoid unnecessary deterioration that can lead to crisis in the first place.
Effectively addressing workforce capacity will also require:

- Encouraging 988 and 911 response planning to view those responding to MH/SUD and suicide calls and incidents as mental health crisis responders with relevant skill sets rather than focusing on triage or dispatch functions.
- All health plans, including Medicare, to reimburse the full range of mental health/substance use providers, including peer support specialists.
- Enacting federal telehealth legislation that makes permanent and builds on COVID-19 flexibilities, including audio-only tele-mental health/substance use disorder treatment and removing in person requirements.
- Mandating that insurers cover virtual mental health services at the same rate as in-person services.
- Allowing inter-state licensing for mental health and substance use providers to ensure access to care.
- Addressing inadequate pay for mental health workforce.
- Expanding loan repayment assistance/forgiveness programs including those that incentivize providers to practice in rural and/or underserved areas.
- Incentivizing programs that promote diversity in all mental health and substance use professions.
- Ensuring all settings where mental health services are provided, including in homes, schools and the community, are eligible sites for workforce incentive and loan forgiveness programs.
- Increase funding for mental health training programs to ensure a diverse and robust workforce pipeline into the future.

Conclusion

Now is the time to create a truly comprehensive crisis response system for mental health, substance use disorders, and suicide prevention.

Our nation has failed those in crisis, and without thoughtful and thorough planning, the roll out of 988 may have the same problems as the current system. Our goal as leaders in the field is to help prevent that from happening and in doing so, develop a better system for mental health and substance use disorder.

By adopting a full continuum of care that takes into account the 7 pillars outlined here we allow for local communities, states, and our nation to be prepared to consistently transform how we respond to mental health and substance use needs, including those in crisis. Each of the organizations listed will be leveraging this document in our policy discussions with the goal of remaining united as a field and achieving robust transformation for our nation's crisis response system.

Together, we believe it is the time for our nation to put all the pieces together in a thoughtful way to help families in crisis everywhere.

References

A Unified Vision for Transforming Mental Health and Substance Use Care

ROADMAP TO THE IDEAL CRISIS SYSTEM Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response

Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies


American
Foundation
for Suicide
Prevention


AMERICAN
PSYCHIATRIC
ASSOCIATION


AMERICAN
PSYCHOLOGICAL
ASSOCIATION


MAMH
Massachusetts Association
for Mental Health


MEADOWS
MENTAL HEALTH
POLICY INSTITUTE


MHA
Mental Health America


National Association
for Behavioral Healthcare
Access. Care. Recovery.


NAMI
National Alliance on Mental Illness


NATIONAL COUNCIL
for Mental Wellbeing
HEALTHY MINDS • STRONG COMMUNITIES


ONE MIND


Peg's
FOUNDATION


STEINBERG
INSTITUTE
ADVANCING BRAIN HEALTH POLICY & INSPIRING LEADERSHIP


THE KENNEDY
FORUM


TREATMENT
ADVOCACY
CENTER


WELL
BEING
TRUST