

Crisis Services: Effectiveness, Cost- Effectiveness, and Funding Strategies

Behavioral Health is Essential To Health • Prevention Works • Treatment is Effective • People Recover



ACKNOWLEDGMENTS

This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by Truven Health Analytics Inc. under SAMHSA IDIQ Prime Contract #HHSS283200700029I, Task Order #HHSS283200700029I/HHSS28342002T with SAMHSA, U.S. Department of Health and Human Services (HHS). Kevin Malone served as the Contracting Officer Representative.

DISCLAIMER

The views, opinions, and content of this publication are those of the author and do not necessarily reflect the views, opinions, or policies of the Substance Abuse and Mental Health Services Administration (SAMHSA) or the Department of Health and Human Services (HHS). The listing of non-federal resource is not all-inclusive and that inclusion on the listing does not constitute endorsement by SAMHSA or HHS.

PUBLIC DOMAIN NOTICE

All material appearing in this report is in the public domain and may be reproduced or copied without permission from SAMHSA. Citation of the source is appreciated. However, this publication may not be reproduced or distributed for a fee without the specific, written authorization of the Office of Communications, SAMHSA, HHS.

ELECTRONIC ACCESS AND COPIES OF PUBLICATION

This publication may be downloaded at <http://store.samhsa.gov>. Or, call SAMHSA at 1-877-SAMHSA-7 (1-877-726-4727) (English and Español).

RECOMMENDED CITATION

Substance Abuse and Mental Health Services Administration. Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

ORIGINATING OFFICES

Office of Policy, Planning, and Innovation, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

HHS Publication No. (SMA)-14-4848

Printed in 2014

TABLE OF CONTENTS

Executive Summary	5
Introduction.....	7
Effectiveness of Crisis Services	8
23-Hour Crisis Stabilization/Observation Beds.....	9
Short-Term Crisis Residential Stabilization Services.....	9
Mobile Crisis Services	10
24/7 Crisis Hotlines	11
Warm Lines	12
Psychiatric Advanced Directive Statements	12
Peer Crisis Services	13
The Economic Impact of Crisis Services	14
Crisis Stabilization.....	14
Community-Based Residential Crisis Care	14
Mobile Crisis Programs.....	15
Peer Crisis Services	15
Funding Crisis Services: Overview.....	15
Collaborative Funding: Case Studies.....	17
The Importance of Integrated and Collaborative Funding	17
State Experiences with Collaborative Funding	18
Types of Crisis Services Provided.....	22
Crisis Services Infrastructure and Collaboration.....	23
Funding Crisis Services	24
Summary and Conclusions.....	28
References	30
Appendix A. Crisis Services Continuum, Infrastructure, and Funding: State Responses.....	35
Appendix B. Sources of Medicaid Financing for Crisis Services—Environmental Scan of States	47
Appendix C. Authors	53

LIST OF TABLES

Table 1. Examples of Medicaid Funded Crisis Services by State	16
Table 2. Federal Agencies Providing Funding for Mental Health Crisis Services.....	17
Table 3. Crisis Services Funding Strategies: Case Studies—Interview Responses.....	19
Table 4. Medicaid Crisis Residential and Crisis Intervention Rates.....	25

Executive Summary

Crisis Services are a continuum of services that are provided to individuals experiencing a psychiatric emergency. The primary goal of these services is to stabilize and improve psychological symptoms of distress and to engage individuals in an appropriate treatment service to address the problem that led to the crisis. Core crisis services include: 23-hour crisis stabilization/observation beds, short term crisis residential services and crisis stabilization, mobile crisis services, 24/7 crisis hotlines, warm lines, psychiatric advance directive statements, and peer crisis services.

The research base on the effectiveness of crisis services is growing. There is evidence that crisis stabilization, community-based residential crisis care, and mobile crisis services can divert individuals from unnecessary hospitalizations and ensure the least restrictive treatment option is available to people experiencing behavioral health crises. Additionally, a continuum of crisis services can assist in reducing costs for psychiatric hospitalization, without negatively impacting clinical outcomes.

Our environmental scan revealed that most states provide a continuum of crisis services including residential, mobile crisis, and hotlines. Additional core crisis services are available in some states, including warm lines, crisis respite, and crisis intervention teams, depending upon available funding, state and local infrastructure, and state program and funding policies. In our interviews with states, states reported using several different strategies in the provision of crisis services including co-locating different crisis services in facilities that covered a specific geographic region, including trained mental health consumers (i.e. peers) in the provision of crisis services and collaborating with other partners, such as law enforcement.

Our interviews also revealed states are providing services using different payment mechanisms. Some states such as Massachusetts, Tennessee and Michigan have used Medicaid managed care waivers to expand their crisis services continuum, while other states have used purchasing contracts and collaborative relationships with other partners to support the crisis services continuum.

The most frequently reported funding sources for crisis services are state and county general funds and Medicaid. Although states finance crisis services in different ways, many are using multiple funding sources to ensure that a continuum of crisis care can be provided to all who present for services, regardless of insurance status. Each of the states indicated that using funding from multiple sources has been an effective way to support a continuum of crisis care.

States reported opportunities, challenges and lessons learned in implementing and financing crisis services. Opportunities included updating consumer information to streamline identification of payer source, including peers in various roles in the provision of crisis services and collaborating with other partners to improve crisis services. Challenges included difficulties in obtaining reimbursement for crisis services to individuals with dual mental health and substance abuse disorders and difficulties in obtaining crisis services reimbursement from private insurance due to differences in provider qualifications from Medicaid.

Finally, states provided valuable insight into lessons learned regarding providing crisis services. Some states reported that they were able to use the flexibility of Medicaid waivers to increase the provision of crisis services tailored to their specific delivery system while other states have used purchasing contracts and collaborative relationships with other partners to support the crisis services continuum. Particularly, states with Medicaid managed care behavioral health carve outs were better able to create a full

continuum of crisis services whereas states that operated under the Medicaid fee-for-service model faced challenges in implementing a full complement of crisis services. States also emphasized the value of collecting data on crisis services quality indicators to inform policy decisions around crisis care.

Introduction

Historically, individuals who experienced acute psychiatric or substance abuse symptoms, such as an acute disturbance in thought, mood, behavior, or social relations that required immediate attention, would be treated in a general hospital emergency department or admitted to a hospital. Subsequently, they would receive less intensive outpatient treatment. It has become increasingly apparent that this service mix is frequently inadequate and expensive. Emergency rooms often lack staff with specialized psychiatric training as well as the time and infrastructure to appropriately address the needs of individuals experiencing psychiatric or substance abuse crises. Furthermore, an emphasis on delivering the most appropriate care in the most appropriate setting has led to greater care provided in the community, lessening the reliance on admitting individuals to hospitals. While the move to community-based treatment has led to a reduction in the number of psychiatric beds, in some instances, it has led to an unintended shortage.

This situation has led to the development of a continuum of alternative psychiatric emergency services, or “crisis services” (Allen, M. H., Forster, P., Silver, J., & Currier, G, 2002). The primary goals of these services are to stabilize and improve psychological symptoms of distress and to engage individuals in the most appropriate course of treatment. In contrast to the traditional hospital inpatient-based care settings available to individuals in need of immediate attention for psychiatric or substance abuse symptoms, crisis services include an array of services that are designed to reach individuals in their communities through telephone “hotlines” or “warm lines,” and mobile outreach; and to provide alternatives to costly hospitalizations—such as short-term crisis stabilization units and 23-observation beds.

Like emergency medical services, crisis services are intended to be available to the entire community. Those receiving services may include individuals with a history of severe and persistent mental illness or a substance use disorder (SUD), or those who have never before used behavioral health services. They may be children, adults, or the elderly.

National statistics attest to the significant need for crisis services. In 2010, 2.2 million hospitalizations and 5.3 million emergency department visits involved a diagnosis related to a mental health condition (Agency for Healthcare Research and Quality, 2010). Moreover, in any given year approximately one-fourth of adult Americans will have a mental disorder and about five percent of children aged 4–17 years have serious emotional distress (National Center for Health Statistics, National Health Interview Survey, 2009).

Although not everyone with a mental health or substance use disorder will experience a need for crisis services, some factors may increase the risk of crisis and the need for individuals to access essential services and supports. These factors include poverty, unstable housing, coexisting substance use, and other physical health problems associated with mental illness (SAMHSA, 2009b).

The nature of comprehensive crisis systems, with their complex range of programs and services for addressing various individual situations, makes it difficult to finance crisis services within the constraints of one particular funding stream. Although many crisis services are provided from within the behavioral health system, some are hospital-based, and others are cut across the broader community (e.g., schools or the justice system). In many cases, crisis programs that are operated by different agencies or organizations have separate eligibility criteria and funding. In addition, there are multiple categorical funding streams to address specific problems or specific target populations, such as youth in foster care,

elders, or individuals with developmental disabilities. For certain individuals, categorical funding results in the receipt of intended and needed services. However, through collaborative funding, funders of categorical dollars could also play a role in addressing the broader fundamental situation that often surrounds a crisis.

Funding that is tied to serving a specifically defined population can limit the financial feasibility of a program, particularly in rural areas or other areas that have a limited population base to draw upon. Also, funding that is tied to delivering units of pre-defined treatment to individuals who are eligible for specific types of insurance make it difficult for communities to build a continuum of crisis services. Due to the nature of behavioral health crises, many communities require a program with a “fire-house” staffing model that needs to respond to individuals immediately, often prior to establishing insurance status. These issues present limitations to states and communities who wish to build a continuum of crisis services.

Overcoming eligible individual limitations imposed by categorical and single-service dedicated funding streams requires mobilizing multiple resources to address the diverse needs of individuals experiencing a behavioral health crisis. Such a collaborative funding approach would create an overall strategy that reconciles the many separate funding strands, and would have greater potential to meet the immediate needs of individuals in crisis, that extends beyond the scope of what a single system could have mobilized on its own (National Gains Center for People with Co-occurring Disorders in the Justice System, 2004).

This report summarizes the evidence base on the clinical effectiveness and cost-effectiveness of different types of crisis services, and then presents case studies of different approaches that states are using to coordinate, consolidate, and blend fund sources in order to provide robust crisis services.

Effectiveness of Crisis Services

The empirical evidence on the effectiveness of crisis services in addressing the needs of individuals with mental or substance use disorders is growing. In this section, we summarize the evidence on the effectiveness of the following types of crisis services:

- 23-hour crisis stabilization/observation beds
- Short term crisis residential services and crisis stabilization
- Mobile crisis services
- 24/7 crisis hotlines
- Warm lines
- Psychiatric advance directive statements
- Peer crisis services

The review was based on a systematic search of systematic reviews of the effectiveness of crisis services, which included the Cochrane Collaboration, the Campbell Collaboration, and SAMHSA’s National Registry of Evidence-Based Programs and Practices. In addition, studies were identified through searches of PubMed (U.S. National Library of Medicine and National Institutes of Health), Applied Social Sciences Index and Abstracts (ASSIA), Social Services Abstracts, and Google Scholar to identify relevant peer-reviewed studies or review articles. Search terms were specific to each service. To make the review as extensive as possible, the searches were not restricted to randomized controlled trials (RCTs). In addition, the research team manually reviewed references contained in the retrieved literature.

23-Hour Crisis Stabilization/Observation Beds

23-hour crisis observation or stabilization is a direct service that provides individuals in severe distress with up to 23 consecutive hours of supervised care to assist with deescalating the severity of their crisis and/or need for urgent care. The primary objectives of this level of care are prompt assessments, stabilization, and/or a determination of the appropriate level of care. The main outcome of 23-hour observation beds is the avoidance of unnecessary hospitalizations for persons whose crisis may resolve with time and observation (SAMHSA, 2012).

Two studies have evaluated the effectiveness of 23-hour crisis stabilization/observation beds. A quasi-experimental study by Gillig and colleagues (1989) compared two psychiatric emergency services and found that the service with the emergency evaluation unit had a significantly lower rate of hospital admissions (36 percent) compared to the one without the unit (52 percent). Clinicians in the program reported that 65 of the 134 patients admitted to the observation unit would have been admitted to the hospital if the unit had not been available.

An observational study by Francis and colleagues (2000) examined the effectiveness of a 23-hour observation program at a Veterans Affairs medical center. The program was designed to avoid unnecessary hospitalization of patients experiencing acute psychiatric crises. The most frequent psychiatric diagnosis among program participants was substance abuse or dependence (77 percent). During the 6 months before admission to the 23-hour program, 38 percent had been admitted at least once to an inpatient psychiatric unit. Following the program, only 12 percent of the patients were admitted to inpatient care. Reasons for the decrease in inpatient services were not systematically explored as part of the study design. However, participating staff members hypothesized that the short duration of the observation period facilitated rapid decision making and referrals to outpatient programs—such as residential substance abuse treatment and partial hospitalization programs—and capitalized on the fact that a high level of distress often motivates patients to accept treatment programs that are immediately available.

Short-Term Crisis Residential Stabilization Services

Crisis stabilization is defined as “a direct service that assists with deescalating the severity of a person’s level of distress and/or need for urgent care associated with a substance use or mental health disorder. Crisis stabilization services are designed to prevent or ameliorate a behavioral health crisis and/or reduce acute symptoms of mental illness by providing continuous 24-hour observation and supervision for persons who do not require inpatient services” (SAMHSA 2012). Short-term crisis residential stabilization services include a range of community-based resources that can meet the needs of an individual with an acute psychiatric crisis and provide a safe environment for care and recovery. Core attributes of residential crisis services include providing housing during a crisis with services that are short term, serving individuals or small groups of clients, and are used to avoid hospitalization (Stroul, 1988).

The current literature generally supports that crisis residential care is as effective as other longer psychiatric inpatient care at improving symptoms and functioning. It also demonstrates that the satisfaction of these services is strong, and the overall costs for residential crisis services are less than traditional inpatient care.

For the studies examined in this review, the populations range from late adolescence (aged 16-18 years) through adulthood. This review excluded programs in which substance use disorder was the primary diagnosis, as these programs are usually much longer in duration, and complicated by the need for medical detoxification. A substance use condition requiring inpatient care is often preceded by a period of detoxification in an appropriate facility. Studies on crisis residential service generally compare community-based or hospital facility programs with a time-limited intervention focus to traditional hospital care.

Regarding mental health and crisis residential, a recent systematic review examined the effectiveness of residential alternatives to hospital inpatient services for acute psychiatric conditions (Lloyd-Evans, et al., 2009). This review included randomized control trials or studies that provided specific quantitative comparisons of effectiveness of alternatives to standard acute inpatient care. Based on 9 out of the 27 studies reviewed, which were rated as of moderate or high quality methodological rigor, the authors concluded that there is preliminary evidence to suggest that residential alternatives may be as effective and potentially less costly than standard inpatient units. The authors note, however, that more research is needed given the heterogeneity of the services and patients studied to date, and rigor of the study designs.

Mobile Crisis Services

The American Psychiatric Association (APA) Task Force defines mobile crisis services as having the “capacity to go out into the community to begin the process of assessment and definitive treatment outside of a hospital or health care facility,” along with a staff including “a psychiatrist available by phone or for in-person assessment as needed and clinically indicated” (Allen et al., 2002). Mobile crisis teams provide acute mental health crisis stabilization and psychiatric assessment services to individuals within their own homes and in other sites outside of a traditional clinical setting (Scott, 2000).

The main objectives of mobile crisis services are to provide rapid response, assess the individual, and resolve crisis situations that involve children and adults who are presumed or known to have a behavioral health disorder (Allen et al., 2002; Fisher, Geller, and Wirth-Cauchon, 1990; Geller, Fisher, and McDermeit, 1995). Additional objectives may include linking people to needed services and finding hard-to-reach individuals (Gillig, 1995). Although most mobile crisis teams are a link between the community and the emergency department (ED), some are co-located in facilities that have both outpatient and ED services, fewer are co-located in inpatient services and outpatient services, and some operate in more than one of these domains (Allen et al., 2002; Gillig, 1995). The main outcome objective of mobile crisis teams is to reduce psychiatric hospitalizations, including hospitalizations that follow psychiatric ED admission. Some mobile teams are focused on reducing arrests of mentally ill offenders (Lamb, Weinberger, and DeCuir, Jr., 2002). Diversion is also a main goal of police-based teams, which may be staffed by mental health consultants or exclusively by police officers with mental health training (Compton, Bahora, Watson, and Oliva, 2008; Lamb et al., 2002; Steadman, Deane, Borum, and Morrissey, 2000).

Four studies were identified with empirical evidence on the effectiveness of mobile crisis services: one randomized controlled trial (Currier et al., 2010) and three that used quasi-experimental designs (Guo, Biegel, Johnsen, and Dyches, 2001; Hugo, Smout, and Bannister, 2002; Scott, 2000; Dyches, Biegel, Johnsen, Guo, and Min, 2002). The studies suggest that mobile crisis services are effective at diverting people in crisis from psychiatric hospitalization, effective at linking suicidal individuals discharged from

the emergency department to services; and better than hospitalization at linking people in crisis to outpatient services.

24/7 Crisis Hotlines

Crisis hotlines are defined as “a direct service delivered via telephone that provides a person who is experiencing distress with immediate support and/or facilitated referrals. This service provides a person with a confidential venue to seek immediate support with the goal of decreasing hopelessness; promotes problem-solving and coping skills; and identifies persons who are in need of facilitated referrals to medical, healthcare, and/or community support services” (SAMHSA, 2012).

The goals of most crisis hotlines are to provide support to callers who are feeling hopeless and overwhelmed and to help the caller find a plan for coping with the situation or other resources that can provide further assistance (Kalafat, Gould, Munfakh, and Kleinman, 2007). Most hotlines are available to entire populations, rather than to individuals with specific characteristics or diagnoses. Insurance is not required to use these services. They are available to individuals with mental illnesses and to those with substance use disorders.

An example of a crisis hotline in the United States is the National Suicide Prevention Lifeline, which is a national, toll-free hotline that combines 24/7 crisis centers into a single network. Calls originating from anywhere in the country are routed to the nearest available crisis center, based on capacity and availability. With few exceptions (for example, services that are created specifically for adolescents), crisis hotlines are available to all callers (Samaritans USA, 2010).

Investigators have been able to demonstrate that the mental status of many callers improves during and after calls to a hotline. Qualitative reports as well as some evaluative studies indicate that hotlines have value for numerous suicidal and troubled people—especially those with depression—and that the hotlines represent an asset in the service continuum.

Studies of crisis hotlines often focus on a reduction in suicide as their outcome. Early studies that aimed to assess the effectiveness of hotline services compared suicide rates in towns with and without suicide prevention facilities (Jennings, Barraclough, and Moss, 1978; Miller, Coombs, Leeper, and Barton, 1984). Miller et al. (1984) studied mortality data from the National Center for Health Statistics for 226 central city counties in the contiguous United States (except for those in New England and Virginia) for the years 1968 through 1973. The investigators found that young, white females demonstrated a significant ($p = .005$) difference in suicide rate between counties that initiated crisis centers and those that did not. Using 1980 census data, the authors concluded that each year these services saved the lives of 637 white females under the age of 25 years, per year.

A more recent study examined how individuals with serious mental illness and a history of suicidal behavior cope with suicidal thoughts (Alexander, Haughland, Ashenden, Knight, and Brown, 2009). Using the mental health system—including crisis hotlines, emergency services, or speaking to a therapist—was the fourth-most cited coping strategy. The first three coping strategies were: spirituality and religious practices; talking to someone and companionship; and positive thinking.

In 1983, Hoult, Reynolds, Charbonneau-Powis, Weekes, and Briggs found that 24-hour crisis hotlines combined with community treatment provided positive outcomes such as reduction in cost, and

patients and their families were satisfied with this combined approach. Participants in this program spent an average of 8.4 days in psychiatric hospitals, compared to an average of 53.5 days for controls.

Although few studies of crisis hotline services discuss individuals with substance use or co-occurring mental and substance use disorders, one review noted that callers who had “drug problems or more serious emotional/behavior disorders rated telephone counselors as significantly less effective” than did callers with other problems (Stein and Lambert, 1984, p. 120).

A rigorous study of crisis hotline outcomes was reported in two parts—one devoted to nonsuicidal callers and one to suicidal callers (Kalafat et al., 2007; Gould, Kalafat, Munfakh, and Kleinman, 2007). These investigators studied 240 counselors who worked at eight telephone crisis services across the United States, seven of which were members of the 1-800-SUICIDE National Suicide Prevention Lifeline network mentioned above. Suicidal and nonsuicidal callers completed baseline and follow-up assessments approximately two weeks following the use of the service. Among nonsuicidal callers, distress was significantly reduced from the beginning to the end of the call, and there was a significant reduction in callers’ distress levels from the end of the call to follow-up (Kalafat et al., 2007). Among suicidal callers, there was a significant reduction in suicide status from the beginning to the end of the call on intent to die, hopelessness, and psychological pain. There were also significant reductions in callers’ psychological pain and hopelessness from the end of the call to follow-up (Gould et al., 2007).

Warm Lines

Warm lines are telephone lines that are run by trained mental health consumers (i.e., peers) and staffed by people who are also in recovery (SAMHSA, 2010). A warm line is “a direct service delivered via telephone by a [peer] that provides a person in distress with a confidential venue to discuss their current status and/or needs SAMHSA, 2012). Unlike hotlines, warm lines are for situations that are not considered emergencies but could potentially escalate if left unaddressed. Peer telephone operators can offer compassion, and support callers on topics such as loneliness, anxiety, and sleeplessness. When individuals use warm lines, they are encouraged to talk through their concerns with operators and, in turn, operators may relate information about their own experiences to help the caller to address their own concerns. Operators can help callers that may feel isolated or “stuck” and, as a result, they may calm or reassure the callers. Operators refrain from offering advice; rather, they give a message of hope and provide resources. As a result of warm lines and their operators, situations that may have resulted in a crisis-related trip to a local ED before the call may be prevented (U.S. Department of Health and Human Services, 2010).

In 2011, Dalgin, Maline, and Driscoll administered telephone surveys to 480 warm line callers over a period of four years. They found that callers saw a reduction in both the use of crisis services and feelings of isolation. They also found that keeping telephone lines open after 5:00 p.m. was especially helpful, as they were available after most office hours.

Psychiatric Advanced Directive Statements

An advanced directive statement is a document that specifies a person’s future preferences for treatment, should he or she lose the mental ability to make treatment decisions. Advanced directives are typically used in end-of-life situations. However, people with mental illness may also benefit from having an advanced directive statement, in the advent of a crisis rendering them unable to make treatment or life decisions (Campbell and Kisely, 2009). Twenty-five states have statutes authorizing

psychiatric advanced directive statements (PADs). Minnesota was the first state to legislate for psychiatric advance directives in 1991. None of the statutes allow patients to use directives to avoid emergency involuntary detention (Morrissey, 2010).

A study by Flood and colleagues (2006) found that an advanced directive plan formulated by the patient, coordinator, psychiatrist, and project worker led to lower costs and less service use, but these findings were not statistically significant. A more recent review by Campbell and Kisley (2009) found no differences in hospitalization rates for those with advance directive statements and those without. Our review suggests that more research is needed to determine the impact of these statements on mental health costs or health outcomes.

Henderson and colleagues (2004) investigated the impact of a joint advanced directive plan developed by the patient and his or her outpatient treatment team on hospital admission outcomes. A group of psychiatric patients having the 'joint crisis or advanced directive plan' was compared to a group of psychiatric patients without a plan in place. Among those with severe mental illness, the use of an advanced directive plan reduced compulsory admissions and treatment compared to patients without a plan by 13 percent and 27 percent, respectively. In a similar study by Papageorgiou and colleagues (2002), patients who developed advanced directives (but without assistance from the outpatient mental health team) were compared to patients without an advanced directive plan in place. The study found no difference in the number of psychiatric hospital admissions. Findings from the two studies suggest that the involvement of facilitator and outpatient mental health team in the development of an advanced directive plan may be a critical factor for preventing compulsory hospital admissions.

Peer Crisis Services

An alternative to psychiatric ED or inpatient hospitalization, peer crisis services are operated by people who have experience living with a mental illness (i.e., peers) (Ostrow and Fisher, 2011). Peer crisis programs are designed as calming environments with supports for individuals in crisis. They are delivered in community settings with medical support. Services are intended to last less than 24 hours but may extend up to several days, if needed. Peer crisis services are generally shorter term than crisis residential services.

The number of research studies in this area is limited. However, the positive results from the few studies existing provide support for continued state and county mental health peer crisis services, and highlight the need for a more systematic study of the implementation efforts. Study populations in this review included adults with serious mental illness, as well as peer-run suicide prevention line callers for all ages. No literature was identified that discussed peer crisis services for consumers with substance use disorders.

In a randomized investigation of a five-bed crisis hostel in Tompkins County, New York, Dumont and Jones (2002) evaluated a two-year demonstration. The results of this study were presented at the 2001 meeting of the National Association of State Mental Health Program Directors, and were reported in the Human Services Research Institute Outlook publication. The authors reported that "in nearly all areas, persons who had been assigned access to the crisis hostel were associated with both better outcomes and lower costs." The program was not published in a peer-reviewed journal and the details of the study are not available.

In a more recent RCT on peer services, researchers found that the average rate of improvement in symptom ratings was greater in the peer services group than in the hospital comparison group (Greenfield, Stoneking, Humphreys, Sundby, and Bond, 2008). The Greenfield et al. study involved random assignment of individuals with serious mental illness to one of two conditions: a consumer-operated, short-term crisis residential program (CRP); or “usual care,” which in this case was a locked inpatient unit. CRP consumers had improved psychiatric symptoms, strengths, and treatment satisfaction. The peer-run alternative group had much greater service satisfaction compared to the usual care group. Findings suggest that short-term peer lead interventions, together with available community outreach, are a viable alternative to standard hospital care.

The Economic Impact of Crisis Services

As with the health care system overall, there is a growing need to control costs associated with the delivery of mental health services while maintaining or improving the quality of care. Several studies have examined the economic impact of various types of crisis services, relative to usual mental health care. As described below, these studies find that significant cost savings can result from crisis services, due to reduced inpatient utilization, emergency department diversion and more appropriate use of community-based behavioral health services.

Crisis Stabilization

In a recent study by Wilder Research (2013), the authors used claims data to calculate a return on investment of mental health crisis stabilization programs in the east metropolitan area of the Minnesota Twin Cities. The authors examined the impact of the program on utilization of health care including ED use, outpatient services, and inpatient psychiatric services. They also investigated the cost of inpatient hospitalization (all-cause and behavioral health only) post-crisis stabilization compared to costs prior to intervention. They compared the value of the resources invested in these programs and the benefits associated with this intervention. Programs served 315 patients at an average cost of mental health crisis stabilization of \$1,085. The study found that the net benefit for mental health crisis stabilization services was approximately \$0.3 million, with a return of \$2.16 dollars for every dollar invested.

Community-Based Residential Crisis Care

A study by Fenton, Hoch, Herrell, Mosher, and Dixon, (2002) found that acute treatment episode costs in residential crisis settings were 44 percent lower than in general hospitals. Hawthorne et al., (2005) found that a Short-Term Acute Residential Care (START) program for veterans aged 18–59 years with a diagnosis of affective disorder, bipolar disorder, or psychosis was 65 percent less costly than regular hospital care; while outcomes were similar to hospital care. As part of an effort in the Texas public mental health system to test certain key components of the peer crisis model in comparison to standard hospitalization (20–26 days length of stay in this usual care condition), Toprac, Sherman, and Holzer, (1996) found no significant differences between the groups in effectiveness. However, as hypothesized, a cost analyses found lower costs (hospital and community) for those who received crisis respite during the crisis period (through three months after initiation of crisis treatment) compared to those with standard hospitalization. Although the difference was not statistically significant, the total costs for those in the brief hospitalization plus respite care groups were also lower than those for the standard hospitalization group. Because there were no significant differences in effectiveness between the types of care, the differences in cost between the interventions suggest that respite care is more cost effective

than standard hospitalization. The data also suggest that brief hospitalization plus respite care may also be more cost effective than standard hospitalization.

Mobile Crisis Programs

Scott, (2000) analyzed the effectiveness and efficiency of a mobile crisis program by comparing it to regular police intervention. The average cost per case was \$1,520 for mobile crisis program services, which included \$455 for program costs and \$1,065 for psychiatric hospitalization. For regular police intervention, the average cost per case was \$1,963, which consisted of \$73 for police services and \$1,890 for psychiatric hospitalization. In this study, mobile crisis services resulted in a 23 percent lower average cost per case. In another study analyzing the cost impact of mobile crisis intervention, Bengelsdorf et al., (1993) found that mobile crisis intervention services can reduce costs associated with inpatient hospitalization by approximately 79 percent in a six-month follow-up period after the crisis episode.

Peer Crisis Services

The previously mentioned study conducted by Greenfield and colleagues regarding the comparison of individuals treated in a consumer-operated, short-term crisis residential program (CRP) or a locked inpatient unit showed that in addition to improved psychiatric symptoms and consumer satisfaction, the cost for treatment of consumers in CRP was also significantly less: \$211 per day for peer services and \$665 per day for hospitalization.

Funding Crisis Services: Overview

In 2009, the United States spent \$172 billion on mental health and substance abuse treatment (SAMHSA, 2013). The majority of mental health and substance abuse expenditures were supported by public funding (60 percent of mental health expenditures, 69 percent of substance abuse expenditures) with the remaining portion covered by private sources (Levit et al., 2013).^{1,2} While no data exists for the proportion of spending on crisis services specifically, as with behavioral health services in general, state and federal governments do provide a critical source of financing for crisis programs. Tables 1 and 2 summarize state use of Medicaid and other federal funding sources to finance crisis services, as compiled from an environmental scan of these services.

Truven Health Analytics examined crisis services covered under Medicaid State Plan benefits and other Medicaid demonstrations and waivers. As mentioned, although these services are sometimes covered by state funds, grant funds or private insurance, the scope of the environmental scan was limited to

¹ Public funding sources for mental health, represented as a percentage of total mental health expenditures, were distributed as follows: 27 percent Medicaid, 13 percent Medicare, 15 percent state and local and 5 percent other federal. Public funding for substance abuse expenditures were more heavily distributed towards state and local funding with the following distribution: 31 percent state and local, 21 percent Medicaid, 11 percent federal and 5 percent Medicare. The proportion of behavioral health expenditures for private payers is as follows: private insurance (26 percent of mental health expenditures and 16 percent of substance abuse expenditures), out-of-pocket payments (11 percent for both types of treatment), and other private sources (3 percent and 5 percent, respectively).

² A significant portion of total behavioral health spending was for treatment in hospital settings. Specifically, in 2009, 26 percent of mental health expenditures and 31 percent of substance abuse expenditures were for services delivered in a hospital setting, including general hospitals and specialty behavioral health hospitals.

Medicaid because, in many cases Medicaid covers these services and information about states' Medicaid benefit packages are accessible to the public. Data sources (Appendix B) used included Medicaid Provider Manuals; Medicaid Member Handbooks; Medicaid Billing Manuals; Medicaid Waiver manuals; and Medicaid agency websites. When these methods were not sufficient, we conducted internet keyword searches (e.g., state name, crisis type of services, Medicaid).

We found that all 50 states and the District of Columbia indicated that they use Medicaid funds to finance some form of crisis services in 2012. Identifying the specific types of crisis services that states cover under Medicaid proved to be more difficult; however. Many states do not post Medicaid crisis service definitions in one place online. Many states provide different manuals for different provider types; therefore, crisis services are found in many different locations.

Also, Medicaid regulations outline, but do not necessarily or consistently define, the types of services states can provide. Therefore, states vary widely in how they describe their services. Some states may offer a variety of services under a single program name. For example, "crisis intervention" may include mobile crisis. In some instances, services that are covered within a broad category are clearly delineated, and in other instances, there are no narrower definitions of services contained within. The term crisis stabilization was used by many states to describe crisis residential services; however, some other states, further defined crisis residential services, crisis respite services, and stabilization services.

Finally, different states use different mechanisms to publish Medicaid service definitions. While many states publish Medicaid crisis services in various Medicaid manuals, some states have defined services in state legislative code, which can be difficult to identify.

Table 1 provides information on some states that use Medicaid funding to support various types of crisis services. Due to the aforementioned reasons, this list is not exhaustive; however, it does show the variety of states that are funding crisis services through Medicaid.

Our environmental scan shows that many states are funding mobile crisis services through Medicaid. Short term crisis residential services and crisis stabilization are also funded by many states. Of note, 15 states are funding peer crisis services through Medicaid, while additional states are using Medicaid funding to support other types of peer support services.

Table 1. Examples of Medicaid Funded Crisis Services by State

Crisis Services	State
23-hour crisis stabilization/observation beds	FL
Short term crisis residential services and crisis stabilization	CA, HI, IL, MI, MN, MS, NM, OR, WI
Mobile crisis services	AZ, CT, DE, FL, HI, MS, NC, NJ, NM, OK, VT, WI
Psychiatric advance directive statements	IA, NC, WA
Peer crisis services	AK, AR, GA, IA, IN, KS, KY, MA, MN, MD, MI, MT, OK, SC, WA

³National Association of State Mental Health Program Directors Research Institute, Inc. (NRI), 2013.

In addition to Medicaid, Table 2 lists federal agencies that also provide funding for mental health crisis services. Examples of specific non-Medicaid federal funding sources include SAMSHA mental health block grants and social service block grants.

Table 2. Federal Agencies Providing Funding for Mental Health Crisis Services

Federal Agency	Services
Department of Veterans Affairs (VA) and Department of Defense (DoD)	Provide mental health benefits within their delivery system
Substance Abuse and Mental Health Services Administration (SAMHSA)	Provides for treatment through formula-based block grants and discretionary grant programs
Health Resources and Services Administration (HRSA)	Provides for treatment by funding community health centers
Centers for Medicare & Medicaid Services (CMS)	Administers the Medicaid, Children's Health Insurance Program (CHIP), and Medicare programs ^a

^a Medicare does not provide funds for crisis services.

Source: National Association of State Mental Health Program Directors Research Institute, Inc. (NRI), 2012

Other public funding sources for crisis services include county or local funding streams. These funds are typically used to cover indigent care or services with costs not fully covered by Medicaid, such as hotlines or facility-based crisis services. Private funding sources for crisis services include private insurance or other grants. Some private insurance benefit packages will cover limited amounts of crisis intervention; however, crisis services are typically not included in most benefit packages. Grants are used to cover specialized programs such as crisis intervention teams (CIT) or specialized crisis services programs for victims of trauma. To be effective, crisis care must leverage funding from all available sources. This becomes particularly important as the ongoing demand for crisis care is occurring in concert with a slowdown in growth of state public funding for mental health services during the recession (SAMHSA, 2013).

Collaborative Funding: Case Studies

The Importance of Integrated and Collaborative Funding

An integrated approach to providing and funding services is essential to address behavioral health crises, reduce the likelihood of future emergencies, and provide positive outcomes for those in need. Collaborative strategies allow states to utilize resources effectively by maximizing funds and staffing, providing service to as many individuals as possible, and filling service gaps. Perhaps most importantly, coordinated funding approaches ensure that services are driven by needs rather than by funding (Clare, 2013). Collaborative funding also promotes coordination of care among multiple agencies, and duplicative services are easier to identify and eliminate.

As described previously, crisis services are effective for treating individuals with mental health or substance use disorders, and significant cost savings can result from crisis services as a result of reduced

inpatient utilization. Thus, a comprehensive crisis system that increases coordination and collaboration across systems of care can reduce inefficiencies and potentially reduce overall costs of care.

In recent years, many states have been using a variety of funding sources to pay for crisis care. Examining how states are currently collaborating paves the way for future coordination and collaboration. Some of these examples are highlighted in this report.

Collaborative funding, for purposes of this document, is defined as the access to and coordination of multiple sources of financing to enhance the provision of crisis services. Collaborative funding to support crisis care is generally approached in one of two ways. In the first approach, crisis service is funded through multiple funding sources that are dependent on an individual's insurance coverage. In this situation, no one is turned away from crisis care, regardless of the funding that will be used to pay for the service. For example, an uninsured individual may receive services from a mobile crisis team that are funded by a grant or state general revenue. An individual with Medicaid or private insurance may receive services from the same crisis team, but the service is covered by their respective payers. In the second approach, state funds are used to provide certain aspects of crisis services that are not covered by a private insurer or a state's Medicaid program. These services include aftercare intervention and crisis support, links to follow-up services, and warm hand offs from primary care providers to behavioral health consultants. Medicaid and other payers are billed for the service provision. Both of these examples of collaborative funding fit within the general framework of *braided* funding. In braided funding, multiple funding streams that are originally separate are brought together to pay for more services than any one stream can support, and then they are carefully pulled apart to report to funders on how the money was spent (Spark Policy Institute, n.d.).

State Experiences with Collaborative Funding

The information in this section is based largely on interviews conducted in 2013 with officials from Mental Health Authorities in eight states. The eight states were selected based on their interest, availability, and experience using collaborative funding of crisis services. States provided information on the types of crisis services provided in their states, the infrastructure for delivering crisis services, types of collaboration with state agencies and other stakeholders, and sources of funding for crisis services. These eight states were: Illinois, Massachusetts, Maine, Michigan, Missouri, Tennessee, Texas, and Wisconsin. Seven of the eight states participated in telephone interviews and provided information regarding their crisis services system for adults and children. One of the eight states, Illinois, provided information in writing regarding crisis services for adults only. Detailed responses from the states are included in Appendix B. Table 3 summarizes the findings from each state and describes the services, service infrastructure, and funding.

Table 3. Crisis Services Funding Strategies: Case Studies—Interview Responses

State	Crisis Services Provided	Services Infrastructure and Collaboration	Funding Sources Reported
Maine	Crisis Stabilization Units Contain 81 crisis stabilization beds, 54 for adults and 27 for children Mobile Crisis Teams Office and Outreach Based Ambulatory Services Hotlines Warm Lines	Crisis services are purchased from private behavioral health organizations through an RFP process. Provides web-based training for emergency staff and emergency room visit reduction projects targeting individuals with multiple chronic conditions.	State General Funds Medicaid Funds - Medicaid Clinic Option - Medicaid Rehabilitation Option Mental Health Block Grant
Massachusetts	Residential Services - Include respite care (including one peer-run respite program) and crisis stabilization care Ambulatory Care - Includes the 21, 24-hour emergency service programs (ESPs) and mobile crisis services Warm Lines Jail Diversion Programs	Uses an Interagency Service Agreement between the state mental health agency and the state Medicaid agency to provide crisis services through MassHealth’s mental health and substance abuse vendor, Massachusetts Behavioral Health Partnership. The state mental health agency, public health agency, emergency department staff, and consumers have collaborated to develop emergency department alternatives for those in crisis. Convened workgroups to address ED wait times and access to acute care services.	State General Funds Medicaid Funds 1115 Waiver - Funds Available under the Medicaid State Plan Substance Abuse Block Grant Kids Planning Grant SMHA Funds

(continued)

Table 3. Crisis Services Funding Strategies: Case Studies—Interview Responses (continued)

State	Crisis Services Provided	Services Infrastructure and Collaboration	Funding Sources Reported
Michigan	Crisis Residential Units Intensive Crisis Stabilization Services Mobile Crisis Teams Ambulatory 24/7 Telephone Lines and Walk-ins	State mental health agency contracts with the Prepaid Inpatient Health Plans (PIHPs) to provide Medicaid managed behavioral health services and with Community Mental Health Service Providers (CMHSPs) to provide crisis services to non-Medicaid eligible individuals.	State General Funds Medicaid Funds • 1915(b) Waiver • 1915(c) Waiver
Missouri	Access Crisis Intervention (ACI) Services • Residential Crisis Services • Residential Respite Beds • 23 Hour Observation Beds • Mobile Response Services • Ambulatory Crisis Services • 24-Hour Crisis Hotline	Missouri is developing partnerships in providing crisis services where possible. The state is improving the links between regional Community Mental Health Centers (CMHCs) and the crisis system and Missouri's hospital association.	State General Funds Medicaid Funds • Medicaid Rehabilitation Option Mental Health Block Grant
Tennessee	Crisis Stabilization Units • Includes 7 units with walk-in centers, 3 respite units, and 5 medically monitored detoxification units Mobile Crisis Teams Crisis Intervention Teams	Provides all publically funded crisis mental health and substance abuse services through a managed care system. Have partnered with the state's largest employer of emergency department staff to provide updates on available crisis and non-crisis services and have partnered with the Tennessee Hospital Association in crisis workgroups. Collaborates with law enforcement through crisis intervention teams and with schools through school-based mental health liaisons.	State General Funds Medicaid Funds • 1115 Waiver Funds Mental Health Block Grant Local Government/Grants Private Insurance Self-Pay

(continued)

Table 3. Crisis Services Funding Strategies: Case Studies—Interview Responses (continued)

State	Crisis Services Provided	Services Infrastructure and Collaboration	Funding Sources Reported
Texas	Emergency Service Centers • Provide extended observation and jail diversion services Residential Crisis Services Crisis Stabilization Units Crisis Respite Rapid Crisis Stabilization Beds Mobile Crisis Teams Outpatient Crisis Services Crisis Hotlines Warm Lines	In 247 counties, the state delegates a community mental health center the responsibilities of a mental health authority which ensures the provision and continuity of services for individuals with mental illness, including crisis services. NorthSTAR, a behavioral health service system, through which mental health and substance abuse services are provided to eligible consumers, serves seven counties.	State General Funds Medicaid Funds • Medicaid Rehabilitation Option • Medicaid 1915(b) Waiver • Medicaid 1115 Waiver Mental Health Block Grant Local Government Funds Emergency Management Agency (FEMA) Funds
Wisconsin	Residential Crisis Services Programs combining Social Detoxification with Crisis Stabilization Walk-In Services Mobile Crisis Teams 24/7 Telephone Services	Counties are responsible for the development and delivery of crisis services. The state provides supervision, regulations and funding along with optional county support.	State General Funds Medicaid Funds • Medicaid Clinic Option • Medicaid Rehabilitation Option • Medicaid 1915(a) Waiver Mental Health Block Grant Local Government Funds Private Insurance Self-Pay
Illinois	Residential Care Services Emergency Disposition and Assessment (EDA) Services Acute Community Services (ACS) Mobile Crisis Teams Community Support Teams Hotlines	Illinois contracts with a limited number of hospitals for short-term acute treatment and funds community support, and Mobile Crisis Teams. Crisis residential services are funded by the state but operated by community mental health agencies. Each crisis residential center was developed according to the community's needs rather than using a single, predefined service model.	State General Funds Medicaid Funds • Medicaid Rehabilitation Option Local Government Funds Grant Funding

Types of Crisis Services Provided

The states interviewed for this project are funding a wide variety of services to meet the needs of individuals with behavioral health crises. Many of the states interviewed support the full continuum of core crisis services, with all states providing 23-hour crisis stabilization and observation beds, crisis stabilization services, mobile crisis services, and hotlines. Additional core crisis services are available in some states, depending upon available funding, state and local infrastructure, and state program and funding policies. These additional crisis services may include warm lines, crisis respite, and crisis intervention teams. Additional information regarding the specific services available in each state can be found in Appendix B.

One strategy employed by states in our sample was the grouping of different crisis services in facilities that covered a specific geographic region. The 24-hour emergency service programs (ESPs) located across the state of Massachusetts exemplify this approach. These ESPs serve as the “front door” to the Massachusetts public behavioral health system. They provide behavioral health crisis assessment, intervention, and stabilization services via the following service components: mobile crisis services for children and adolescents, mobile crisis services for adults and geriatric population, ESP community-based locations, and community crisis stabilization services for adults aged 18 years and older.

Tennessee supports a similar program. The state has seven crisis stabilization units with walk-in centers (one for each planning region), three respite units, and five medically-monitored detoxification units. The crisis stabilization units, which only serve adults, are 15-bed facilities where walk-in triage is available and the typical stay is 3–4 days. The mobile crisis teams are based in these units and are available statewide.

Missouri supports access crisis intervention (ACI) services, which are provided statewide by designated CMHCs. ACI includes a 24-hour crisis hotline and mobile response services as well as residential crisis and ambulatory crisis services. ACI services also include residential respite beds and 23-hour observation beds. There are also respite beds that serve children and are located predominately in the eastern part of the state.

Finally, Illinois has developed specialized programs that are located in regions of the state where the state psychiatric hospitals have been closed. These programs—Emergency Disposition and Assessment (EDA) services and Acute Community Services (ACS)—provide immediate assessment, intervention, and referral to appropriate levels of care for individuals with no other funding for such care. ACS also provides aftercare in order to reduce the reoccurrence of crises.

Wisconsin relies on state policy to ensure a crisis services continuum. Wisconsin’s administrative rule requires counties to provide a minimum of mobile crisis services, a crisis hotline, and a crisis walk-in center for Medicaid funding. Crisis stabilization may also be provided, but it is optional for counties.

Although all states interviewed provide mobile crisis services, geographic accessibility varies from state to state. Many states struggle with provision of mobile crisis services in rural areas. Michigan has mobile crisis teams, but they are available in urban areas only. Tennessee services are structured so that there is mobile crisis team coverage for the entire state. However, in situations in which the individual in crisis is too far away for the mobile crisis team to provide timely services, the individual can go to the regional mental health center for telemedicine or other treatment services. Texas reports having at least one mobile crisis team in each county, and larger counties have more than one team.

Many states are involving peers in the operation of crisis services. Peers are included in a variety of roles, including certified peer specialists who are included on mobile crisis teams in Tennessee, and peers who staff the central crisis call line along with mental health professionals in Maine. Peers also play a central role in the operation of crisis service in some states. Massachusetts supports a peer-run respite program, and Wisconsin has 11 peer-run warm lines across the state.

Some form of a crisis hot line or warm line is provided by all states interviewed. Their 24-hour crisis hotlines are provided via a central statewide line or contractually required for local entities. Warm lines staffed by trained peers are available in Maine, Massachusetts, Missouri, Texas, and Wisconsin.

Many states have a variety of programs that include work with law enforcement as an adjunct to the crisis services continuum. The Massachusetts state mental health agency is partnering with police for jail diversion programs. Some partnerships with police follow the model of including a mental health worker who rides along with the police to respond to crisis 911 calls. Other states including Maine, Missouri, and Tennessee partner with law enforcement through Crisis Intervention Teams (CIT), which are teams of police officers who have received specialized training in mental illness and crisis intervention techniques.

Crisis Services Infrastructure and Collaboration

Provision of crisis services occurs in a variety of manners. States with Medicaid managed care—such as Massachusetts, Tennessee, and Michigan—provide crisis services to individuals who are eligible for Medicaid through contracts with managed care organizations. Services for individuals who are not Medicaid eligible are covered under contracts or agreements between state mental health agencies and managed care organizations.

In Massachusetts, The Massachusetts Department of Mental Health (DMH) and MassHealth (the state Medicaid agency) are key partners in the provision of crisis services. Through an Interagency Service Agreement between DMH and MassHealth, most emergency services are provided through MassHealth's mental health and substance abuse vendor, Massachusetts Behavioral Health Partnership. Community-based services are provided by DMH directly or through contracted vendors.

Tennessee provides all publically-funded mental health and substance abuse crisis services through a managed care system. The state has reported that, because of the flexibility of their TennCare Medicaid waiver and use of state funds, they have a mental health crisis system that works well. The overarching goal of crisis services is to serve people in the least restrictive setting. The Tennessee system serves all who present for services, regardless of their insurance status.

The Michigan Department of Community Health (the state mental health agency) contracts with the Prepaid Inpatient Health Plans (PIHPS) to provide Medicaid managed behavioral health services and with Community Mental Health Service Providers (CMHSPs) to provide crisis services to individuals who are not eligible for Medicaid using allocated state general funds. CMHSPs and PIHPs are funded at a capitated rate, and performance and service standards are delineated in the contracts. Medicaid health plans are responsible for individuals with mild to moderate symptoms; however, if these individuals are in crisis, responsibility for treatment transfers to the behavioral health carve-out plan.

States that do not have Medicaid managed behavioral health care use a variety of mechanisms to provide crisis services. In Maine, crisis services are purchased from private behavioral health

organizations through a request for proposal (RFP) process. Services are managed via performance contracts and a formal review of crisis services is conducted every two years.

Illinois contracts with a limited number of hospitals for short-term acute treatment, and funds community support, and Mobile Crisis Teams. Crisis residential services are funded by the state but operated by community mental health agencies. In Wisconsin, counties are responsible for the development and delivery of crisis services. The state provides supervision, regulations, and funding along with optional county support. Counties can also collaborate with one another where the economies of scale call for more shared services across less densely populated areas. Medicaid pays for most of the services, and there are Medicaid-certified, level-two crisis programs in 56 of the 72 counties. The remaining level-one counties provide limited walk-in, hotline, and crisis triage services.

Many states are developing collaborative relationships in order to improve the delivery of crisis services. Missouri reports that the state is spearheading efforts to improve linkages between regional community mental health centers, the crisis system, and Missouri's hospital association. In Massachusetts, the state has developed ED alternatives for individuals with behavioral health crises, and has also assembled best practice committees, which include representatives from the Department of Mental Health, The Department of Public Health, ED staff, and consumers. The Department of Mental Health has also convened workgroups to address ED wait times and access to acute care services. They also seek to improve the service referral process, including a new, statewide referral process for inpatient specialty units. Finally, they promote community-based medical screening. In Massachusetts, there are also routine regional meetings among community-based providers, inpatient facilities, and EDs.

Maine reports that both the size of the state and the remote nature of some of the state's population pose challenges to geographic accessibility for individuals in crisis. Thus, individuals often use hospital EDs to receive services because they are closer than the crisis stabilization units. To address this, Maine provides web-based training for emergency staff. The state also has ED visit reduction projects that target individuals with multiple chronic conditions.

Funding Crisis Services

The states are using a wide variety of funding sources to provide a core continuum of crisis services. All states participating in this project reported using state general funds, state Medicaid match, and Medicaid, including Medicaid Rehabilitation Option and 1115, 1915(b), and 1915(c) waiver funds. Some states reported using other funding sources to various degrees, including federal grants (e.g., SAMHSA's mental health and substance abuse block grants, Projects for Assistance in Transition from Homelessness [PATH] grants, and Cross Area Service Program [CASP] grants), local government, first-party payments (self-pay), and third-party payments (private insurance). A summary of crisis services and funding sources by states is provided in Table 4.

As reported by the states, each funding source presents opportunities and challenges in providing crisis services. These issues are summarized by funding source below.

State Funding. State funding, along with Medicaid, represents the largest proportion of crisis services funding for states. States reported using state funding for many purposes and to fill in gaps from other funding sources. State funding is used to finance services for which there are no other billable insurance sources. Examples include the operation of crisis hotlines and warm lines; mobile crisis programs in states that do not bill Medicaid for these services; and services for individuals with Medicare, the

uninsured, or those seeking services outside of their catchment area. State funds are also used for infrastructure for crisis services to fund facilities or pay staff salaries. For example, four of the 21 ESPs in the state of Massachusetts are operated by state personnel and are therefore primarily SMHA funded, although Medicaid-eligible services provided by the programs are billed to Medicaid.

Some states earmark state funds for specific crisis services. For example, many individuals in Massachusetts with behavioral health crises experience lengthy ED wait times because they lack health insurance. To ameliorate this, the state spends approximately \$10 to \$12 million to support the uninsured and Medicare-only populations. The state also gives \$18 million to the state's Medicaid agency (MassHealth), which uses some of this funding to provide services to individuals with Medicare. For those without insurance, SMHA funding is issued to fund crisis services for the uninsured through an inter-agency transfer of funds to the Medicaid PIHP. There are plans in the future for funding to serve the uninsured to run through all of the six Massachusetts managed care programs.

Medicaid. Medicaid covers a significant amount of crisis care for interviewed states. States with Medicaid managed care tend to combine state and Medicaid funds to operate their crisis services programs. For example, Massachusetts uses two main funding streams for its emergency crisis services program: state general funds and Medicaid funds. Medicaid funds include 1115 Waiver funds and funds available under the Medicaid state plan. The two streams of funds are combined to operate one program. In Tennessee, state funding and Medicaid are woven together to create a crisis services system that is mandated to serve all who present for services, regardless of their insurance status. Crisis residential and emergency crisis services are provided through the state's 1115 Medicaid waiver. The crisis stabilization units receive a base amount of funding. The mobile crisis teams are funded at a flat, per capita rate through Medicaid waiver funds and with state general funds. The crisis stabilization units are funded through state general funds, although they can also use Medicaid waiver funds.

Some states are working to ensure appropriate use of Medicaid funds for crisis services. For example, Michigan has established an electronic system allowing the center to immediately determine if the individual is covered by Medicaid. Maine reports that the Maine State Mental Health Agency is working with the State Medicaid Agency for increased Medicaid coverage for crisis services.

Some states publish their Medicaid crisis services rates. Table 4 provides information on the available Medicaid crisis services rates for the states interviewed.

Table 4. Medicaid Crisis Residential and Crisis Intervention Rates

State	Medicaid Crisis Residential Rates	Medicaid Crisis Intervention Rates
Maine	Billed a per diem basis (rates not currently available)	Billed in 15-minute increments (rates not currently available)
Massachusetts	Not available	Medicaid is billed a single rate per episode—currently \$500 per episode
Michigan	Billed at \$288 per day	Billed at \$53 per 15 minutes

(continued)

Table 4. Medicaid Crisis Residential and Crisis Intervention Rates (continued)

State	Medicaid Crisis Residential Rates	Medicaid Crisis Intervention Rates
Missouri	Not available	Not available
Tennessee	Not available	Not available
Texas	Not available	Maximum allowable rate is \$31.33 per 15 minutes
Wisconsin	Medicaid per diem rate is \$139.54.	Medicaid maximum allowable contracted rate for crisis intervention ranges from \$47.42 per hour for a paraprofessional, \$88.90 per hour for an individual with a bachelor's or master's degree, to \$148.16 per hour for a nurse practitioner or psychiatrist.
Illinois	Billable on a per diem basis (rates not currently available)	Billed from \$29.97 to \$47.77 per 15 minutes, depending upon staff credentials and place of service (i.e., mental health site, home-based location, or off site)

Private Insurance. States reported that their ability to use private insurance to cover crisis services is mixed. Tennessee and Michigan have reported some success in billing private insurance. In Tennessee, private insurance pays for about two percent of those receiving services. In Michigan, freestanding centers have set up contractual agreements with private insurers to bill for services; at times, they have requested prior authorization to transfer individuals to hospitals. However, most individuals served by freestanding centers do not have third-party insurance.

In Wisconsin, the reluctance of private insurance companies to pay for crisis services is a continuing problem. Under Wisconsin law, crisis programs are eligible for third-party reimbursement, but private insurance companies are not required to provide or reimburse for such services (although some reimburse under contracts with crisis programs). The insurance companies and county service providers define medical necessity differently. The insurance companies require that services be provided by individuals with a master's level or above, and decline payment for services given by providers that are not part of their list of plan providers (even if the consumer is suicidal). The state has informed insurers that they are required to pay for crisis services, but have had limited success in getting them to meet their obligations.

Massachusetts and Missouri would also like to maximize private insurance for crisis services; however, current funding practices prohibit this. In Massachusetts, crisis services are funded through a pool, and private insurance currently does not contribute to it. In Missouri, the main mechanism for delivering crisis services, ACI, is billed as a nonconsumer-specific service. Therefore, private insurance cannot be billed.

Uninsured. Some states are impacted by the number of uninsured who access crisis services. In Tennessee, 70 percent of those accessing crisis services are uninsured and are covered through general funds. Texas reported that approximately 60 percent of those accessing crisis services did not have

insurance. Services for these individuals are covered by state and local funds. Wisconsin respondents noted their primary funding challenges are related to the number of uninsured individuals who use services. Conversely, in Massachusetts the number of uninsured in the state is small and projected to decrease. The state is interested in tracking the number of uninsured and has asked providers to track the insurance status of individuals receiving crisis services.

Additional Funding Sources. Milwaukee has a wraparound program that uses a unique funding approach. The Milwaukee Wraparound program grew out of a SAMHSA Systems of Care grant and provides services to children and adolescents. The target population is youth who have mental health needs and are identified by the child welfare or juvenile justice system as being at immediate risk of residential or correctional placement or psychiatric hospitalization (served in two or more child-serving systems). The base funding for the Milwaukee Wraparound program is from Medicaid, with a mix of additional dollars from juvenile justice funds and child welfare. Crisis service providers include the Mobile Urgent Treatment Team (MUTT)—a mobile crisis team that is available to meet the needs of youth and families when a care coordinator might not be available—an 8 bed crisis respite group home or a short-term intervention provided in or outside the youth’s home, designed to stabilize and support the youth’s well-being and appropriate behavior. The purpose of the program is to prevent or minimize the use of hospitals for individuals in crisis and to provide alternatives to out-of-home placements in foster care and correctional facilities. The program has also recently expanded its role and now provides services to the local school district for children in schools who are experiencing crises.

Crisis Services Funding Challenges States also mentioned other challenges in securing funds to pay for services for individuals in crisis. Texas reports that providing crisis services to individuals with mental and substance use disorders can be complicated. Texas has limits on what substance abuse services Medicaid will cover. Providers bill Medicaid when possible; however, Medicaid cannot be billed if an individual is determined to have a substance use-related crisis. The SMHA perceives that these unreimbursed crisis services divert individuals from hospitalizations.

Texas state officials report that facility licensure can be problematic in providing crisis services to individuals with comorbid mental and substance use disorders. The state would like those facilities able to address both mental health and substance abuse services to provide detoxification and crisis residential levels of care. However, negotiating between these two types of services is difficult because of licensing and billing rules. Texas is working to develop a new licensing category that will cover both detoxification and crisis residential services.

Regulations from the Institutes of Mental Disease (IMD) are seen as a barrier to providing crisis services in Texas. Crisis facilities are used to serve multiple populations and purposes. However, there is concern that increasing facility capacity to over 16 beds may cause these programs to receive IMD classification and become ineligible for Medicaid reimbursement. For example, some programs see a need to add beds for competency restoration and crisis residential services; however, this expansion could cause facilities to be reclassified as IMDs.

The Texas SMHA agency perceives that current rates for crisis services are a barrier to their successful implementation. Rates are insufficient (particularly in rural areas) to pay for the “fire-house” staffing model that is needed for most crisis service programs.

Summary and Conclusions

This report presents evidence in support of crisis services and the experiences of crisis service delivery and financing for eight states. The research literature presents evidence that crisis services such as crisis stabilization, community-based residential crisis care, and mobile crisis can reduce costs for psychiatric hospitalization. Additionally, crisis stabilization has been found to reduce the costs of criminal justice involvement.

There are a wide variety of intervention services available to assist individuals experiencing a crisis. Examples include 23-hour observation, short-term crisis residential services, 24/7 crisis hotlines, mobile crisis services, peer crisis services, warm lines, and advance directive plans. The evidence base for these services is growing, and research has shown that these services can have an impact on health care costs as well as quality of life.

Our interviews revealed that the eight states provide a continuum of crisis services including residential, mobile crisis, and hotlines. In addition, Massachusetts described a 24-hour emergency services program that is specific to their state, and Wisconsin described a wraparound program of crisis services for families living in Milwaukee County who have a child with serious emotional or mental health needs.

The most frequently reported funding sources for crisis services are state and county general funds and Medicaid waivers. Although states finance crisis services in different ways, many are using multiple funding sources to ensure that a continuum of crisis care can be provided to all who present for services, regardless of insurance status. Each of the states indicated that using funding from multiple sources has been an effective way to support a continuum of crisis care.

Through state interviews, we identified some opportunities and challenges in implementing and financing crisis services, outlined below:

Opportunities

- **Identification of payer source.** While many states require that all those who present to crisis services programs be served, regardless of insurance status, programs often struggle with identifying payment sources for individuals who present in crisis. One state reported investing in updated electronic systems with consumer insurance information. This allowed the system to be better equipped to bill Medicaid or other appropriate insurance when a consumer presents at a crisis services center. This solution could be investigated by other states to assist in maximizing crisis services revenue sources.
- **Peer services.** Many states reported using peers in various roles in the provision of crisis services. Peers are employed to provide as well as run services in some states. There is a growing research base demonstrating that peer services are an effective component of mental health care (Davidson et al., 2006; Repper and Carter, 2011), with some studies showing that peer support workers are associated with a reduction in psychiatric admissions among those with whom they work. States could explore strategies to fund the employment of peer workers in various roles in crisis services.
- **Collaboration with other partners.** Many states were involved in collaborative efforts to improve crisis services. Some states reported collaborating with hospitals, EDs and hospital associations in order to reduce ED wait times and develop alternatives to ED utilization for those in crisis. Some states also reported that providers and local advocacy groups partnered with law

enforcement to support Crisis Intervention Teams. These partnerships provide very effective services and require little funding. States could explore additional ways to collaborate with state and local partners to support more effective utilization of behavioral health services for those in crisis.

Challenges

- **Individuals with comorbid disorders.** Many states report that providers experience difficulty being reimbursed for individuals who present with a mental health and substance abuse crisis. Because of facility licensure and reimbursement regulations, services to individuals with substance abuse crises are often not reimbursed. This presents a further challenge because individuals with a substance use disorder often have frequent hospitalizations or frequent ED use. States could assist providers by providing them with a careful review of facility licensure and reimbursement regulations.
- **Different insurance regulations and policies.** Many states reported that providers have difficulties in obtaining reimbursement for crisis services for individuals who are covered by private insurance. Private insurance often has more stringent requirements for provider qualifications than those required for Medicaid reimbursement. State funds or funds targeted for the indigent often were used to cover services provided to these individuals. While this is a challenge, states could explore ways to partner with private insurance agencies and educate them regarding effective behavioral health crisis services.

Lessons Learned

- **Medicaid Waivers can be helpful in structuring crisis services.** States have reported that waiver such as 1115 waivers(in the case of Massachusetts) and 1915b waivers (Michigan and Tennessee) have provided flexibility in building and sustaining a crisis services continuum while other states have used purchasing contracts and collaborative relationships with other partners to support the crisis services continuum
- **Data collection is important.** States are collecting data on a number of crisis services quality indicators such as response time to crisis calls, percentage of services provided in the community and percent of individuals diverted from inpatient hospitalization. These data provide key information to states to improve crisis service delivery.

References

- Agency for Healthcare Research and Quality. (2010). *Healthcare Cost and Utilization Project (HCUP). Custom data query*. Retrieved from <http://www.hcup-us.ahrq.gov/>. Accessed June 12, 2013.
- Alexander, M.J., Haugland, G., Ashenden, P., Knight, E. & Brown, I. (2009). Coping with thoughts of suicide: Techniques used by consumers of mental health services. *Psychiatric Services*, 60(9), 1214–1221.
- Allen, M. H., Forster, P., Silver, J., & Currier, G. (2002). APA Task Force on Psychiatric Emergency Services. *Report and recommendations regarding psychiatric emergency and crisis services: A review and model program descriptions*. Washington, DC: American Psychiatric Association.
- Alwan, N. A., Johnstone, P., & Zolese, G. (2008). Length of hospitalisation for people with severe mental illness. *Cochrane Database of Systematic Reviews*, CD000384.
- Bengelsdorf, H., Church, J. O., Kaye, R. A., Orlowski, B., & Alden, D. C. (1993). The cost effectiveness of crisis intervention: Admission diversion savings can offset the high cost of service. *Journal of Nervous and Mental Disease*, 181(12), 757–762. doi:10.1097/00005053-199312000-00008
- Campbell, L. A., & Kisely, S. R. (2009). Advance treatment directives for people with severe mental illness. *Cochrane Database of Systematic Reviews*, 1:CD005963.
- Caplan, G. (1961). *An approach to community mental health*. New York: Grune and Stratton.
- Clare, SC. (2013, April). *Blending and braiding funds to support a system of care*. Presentation at the Second Annual Commonwealth of Virginia CSA Conference, Roanoke, VA.
- Compton, M. T., Bahora, M., Watson, A. C., & Oliva, J. R. (2008). A comprehensive review of extant research on Crisis Intervention Team (CIT) programs. *Journal of the American Academy of Psychiatry and Law*, 36, 47–55.
- Currier, G. W., Fisher, S. G., & Caine, E. D. (2010). Mobile crisis team intervention to enhance linkage of discharged suicidal emergency department patients to outpatient psychiatric services: A randomized controlled trial. *Academic Emergency Medicine*, 17, 36–43.
- Dalgin, R. S., Maline, S., & Driscoll, P. (2011). Sustaining recovery through the night: Impact of a peer-run warm line. *Psychiatric Rehabilitation Journal*, 35(1):65-8. doi: 10.2975/35.1.2011.65.68.
- Dumont, J. & Jones, K. (2002). Findings from a consumer/survivor defined alternative to psychiatric hospitalization. *Outlook*, Spring, 4–6.
- Dyches, H., Biegel, D. E., Johnsen, J. A., Guo, S., & Min, M. O. (2002). The impact of mobile crisis services on the use of community-based mental health services. *Research on Social Work Practice*, 12, 731–751.
- Fenton, W. S., Hoch, J. S., Herrell, J. M., Mosher, L., & Dixon, L. (2002). Cost and cost-effectiveness of hospital vs residential crisis care for patients who have serious mental illness. *Archives of General Psychiatry*, 59(4), 357–364.

- Fisher, W. H., Geller, J. L., & Wirth-Cauchon, J. (1990). Empirically assessing the impact of mobile crisis capacity on state hospital admissions. *Community Mental Health Journal*, 26(3), 245–253.
- Flood, C., Byford, S., Henderson, C., Leese, M., Thornicroft, G., Sutherby, K., & Szmukler, G. (2006). Joint crisis plans for people with psychosis: economic evaluation of a randomised controlled trial. *British Medical Journal*, 333(7571), 729.
- Francis, E., Marchand, W., Hart, M., Carter, A., Schinka, J., Feldman, A., & Ordorica, P. (2000). Utilization and outcome in an overnight psychiatric observation program at a Veterans Affairs Medical Center. *Psychiatric Services*, 51(1), 92-95.
- Geller, J. L., Fisher, W. H., & McDermeit, M. (1995). A national survey of mobile crisis services and their evaluation. *Psychiatric Services*, 46, 893–897.
- Gillig, P. M., Hillard, J. R., Bell, J., Combs, H. E., Martin, C., & Deddens, J. A. (1989). The psychiatric emergency service holding area: Effect on utilization of inpatient resources. *American Journal of Psychiatry*, 146, 369–372.
- Gillig, P. M. (1995). The spectrum of mobile outreach and its role in the emergency service. *New Directions for Mental Health Services*, 1995, 13–21.
- Gould, M., Kalafat, J., Munfakh, J. & Kleinman, M. (2007). An evaluation of crisis hotline outcomes. Part 2: Suicidal callers. *Suicide and Life-Threatening Behavior*, 37(3), 338–352.
- Greenfield, T. K., Stoneking, B. C., Humphreys, K., Sundby, E., & Bond, J. (2008). A randomized trial of a mental health consumer-managed alternative to civil commitment for acute psychiatric crisis. *American Journal of Community Psychology*, 42, 135–144.
- Guo, S., Biegel, D., Johnsen, J., & Dyches, H. (2001). Assessing the impact of community-based mobile crisis services on preventing hospitalization. *Psychiatric Services*, 52, 223–228.
- Hawthorne, W.B., Green, E.E., Gilmer, T., Garcia, P., Hough, R.L., Lee, M., ...Lohr, J. (2005). A randomized trial of short-term acute residential treatment for veterans. *Psychiatric Services*, 56, 1379–1386.
- Hopkins, C., & Logan, L. (2006). *Texas mental health and substance abuse crisis services redesign*. Austin, TX: Texas Department of State Health Services.
- Henderson C, Flood C, Leese M, Thornicroft G, Sutherby K, Szmukler G. Effect of joint crisis plans on use of compulsory treatment in psychiatry: single blind randomized controlled trail. *BMJ*. 2004;329:136–138.
- Hoult, J., Reynolds, I., Charbonneau-Powis, M., Weekes, P., & Briggs, J. (1983). Psychiatric hospital versus community treatment: the results of a randomised trial. *Australian and New Zealand Journal of Psychiatry*, 17(2), 160–167.
- Hugo, M., Smout, M., & Bannister, J. (2002). A comparison in hospitalization rates between a community-based mobile emergency service and a hospital-based emergency service. *Australian and New Zealand Journal of Psychiatry*, 36, 504–508.

- Ianzito, B. M., Fine, J., Sprague, B., & Pestana, J. (1978). Overnight admission for psychiatric emergencies. *Hospital and Community Psychiatry*, 29, 728–730.
- Jennings, C., Barraclough, B. & Moss, J. (1978). Have the Samaritans lowered the suicide rate? A controlled study. *Psychological Medicine*, 8, 413–422.
- Johnson, S., Gilburt, H., Lloyd-Evans, B., Osborn, D. P. J., Boardman, J., Leese, M., ... Slade, M. (2009). In-patient and residential alternatives to standard acute psychiatric wards in England. *The British Journal of Psychiatry*, 194, 456–463.
- Johnson, S., Lloyd-Evans, B., Morant, N., Gilburt, H., Shepherd, G., Slade, M., ... Osborn, D.P.J. (2010). Alternatives to standard acute inpatient care in England: roles and populations served. *British Journal of Psychiatry*, 197, s6–s13.
- Joy, C. B., Adams, C. E., & Rice, K. (2006). Crisis intervention for people with severe mental illnesses. *Cochrane Database of Systematic Reviews*, CD001087.
- Kalafat, J., Gould, M., Munfakh, J., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes. Part 1: Nonsuicidal crisis callers. *Suicide and Life-Threatening Behavior*, 37(3), 322–337.
- Koyanagi, C., Boudreaux, R., Lind, E., & Carty, L. (2003). *Mix and match: Using federal programs to support interagency systems of care for children with mental health care needs*. Issue brief. Washington, D.C.: Bazelon Center for Mental Health Law.
- Lamb, H. R., Weinberger, L. E., & DeCuir, W. J., Jr. (2002). The police and mental health. *Psychiatric Services*, 53, 1266–1271.
- Levit, K. L., Mark, T. L., Coffey, R. M., Frankel, S., Santora, P., Vandivort-Warren, R., & Malone, K. (2013). Federal spending on behavioral health accelerated during the recession as individuals lost employer insurance. *Health Affairs*, 32(5), 952–962.
- Lloyd-Evans, B., Slade, M., Jagielska, D., & Johnson, S. (2009). Residential alternatives to acute psychiatric hospital admission: systematic review. *British Journal of Psychiatry*, 195, 109–117.
- Lutterman, T. & Shaw, R. (n.d.). Funding and characteristics of State Mental Health Agencies. Unpublished raw data. Alexandria, VA: National Association of State Mental Health Program Directors Research Institute, Inc.
- McCabe, L., Butterill, D., & Goering, P. (2004). Residential crisis units. Are we missing out on a good idea? *Canadian Journal of Community Mental Health* [Revue canadienne de santé mentale communautaire], 23(1), 65-74.
- McCrone, P., Johnson, S., Nolan, F., Pilling, S., Sandor, A., Hoult, J., ... Bebbington, P. (2009). Economic evaluation of a crisis resolution service: A randomised controlled trial. *Epidemiologia e Psichiatria Sociale*, 18(1), 54–58.
- Miller, H., Coombs, D., Leeper, J. & Barton, S. (1984). An analysis of the effects of suicide prevention facilities on suicide rates in the United States. *American Journal of Public Health*, 74(4), 340–343.

Morrissey, F. (2010). Advance directives in mental health care: hearing the voice of the mentally ill. *Medico Legal Journal of Ireland*, 16, 1.

National Alliance on Mental Illness. (2009). *Mental Illness: Facts and Numbers*. Available from http://www.nami.org/factsheets/mentalillness_factsheet.pdf. Accessed June 18, 2013.

National Association of State Mental Health Program Directors Research Institute, Inc. (2013). *State mental health agency profiles systems (profiles) and revenues expenditures study*. Retrieved from <http://www.nri-inc.org/projects/profiles/>. Accessed June 18, 2013.

National Center for Health Statistics. (2009). National Health Interview Survey. Retrieved from <http://www.cdc.gov/nchs/nhis.htm>. Accessed August 2, 2013.

National Gains Center for People with Co-occurring Disorders in the Justice System. (2004). *Blending funds to pay for criminal justice diversion programs for people with co-occurring disorders*. Retrieved from http://gainscenter.samhsa.gov/pdfs/jail_diversion/Blending_Funds.pdf. Accessed June 18, 2013.

National Institute of Mental Health. (2010). *The numbers count: Mental disorders in America*. <http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml#KesslerPrevalence>. Accessed June 17, 2013.

Olfson, M., Plotke, G. S., Harding, C., Jones, J., & Mayfield, V. W. (1990). A controlled evaluation of inpatient crisis treatment for acute schizophrenic episodes. *Psychiatric Quarterly*, 61, 143-154.

Ostrow, L. & Fisher, D. (2011). *Peer-Run Crisis Respite: A review of the model and opportunities for future developments in research and innovation*. Retrieved from <http://www.power2u.org/downloads/Ostrow-Fisher-PRCR-12.20.2011.pdf>. Accessed August 1, 2013.

Papageorgiou A, King M, Janmohamed A, Davidson O, Dawson J. Advance directives for patients compulsorily admitted to hospital with serious mental illness. *Brit J Psychiatry*. 2002;181:513–519.

Samaritans USA. (2010). *Always There...* Retrieved from <http://www.samaritansusa.org/>. Accessed August 1, 2013.

Scott, R. L. (2000). Evaluation of a mobile crisis program: effectiveness, efficiency, and consumer satisfaction. *Psychiatric Services*, 51(9), 1153-1156.

Spark Policy Institute. (n.d.). *Understanding blending and braiding*. Retrieved from <http://www.sparkpolicy.com/blendandbraid.htm>. Accessed June 18, 2013.

Steadman, H. J., Deane, M. W., Borum, R., & Morrissey, J. P. (2000). Comparing outcomes of major models of police responses to mental health emergencies. *Psychiatric Services*, 51, 645–649.

Stein, D. M., & Lambert, M. J. (1984). Telephone counseling and crisis intervention: A review. *American Journal of Community Psychology*, 12(1), 101-126.

Stroul, B.A. (1988). Residential crisis services: a review. *Hospital & Community Psychiatry*, 39, 1095–1099.

Substance Abuse and Mental Health Services Administration. (2012) Behavioral Health Service Definitions- A Supplement to *SAMHSA Description of a Modern Addictions and Mental Health Service System* Brief. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2009a). Office of Applied Studies. *National Survey on Drug Use and Health*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2009b). *Practice guidelines: Core elements in responding to mental health crises*. (HHS Publication No. SMA09-4427). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2010). *Recovery to practice (RTP). Weekly highlights*. (November 12, Issue 26). Retrived from http://www.warmline.org/SAMHSA_highlight_nov_12.pdf. Accessed June 18, 2013.

Substance Abuse and Mental Health Services Administration. (2013). *National expenditures for mental health services and substance abuse treatment, 1986–2009*. (HHS Publication No. SMA-13-4740). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (in press). *The Medicaid handbook: The interface with behavioral health*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Tansella, M. (2010). Alternatives to standard acute in-patient care for people with mental disorders: From systematic description to evaluative research. *British Journal of Psychiatry*, 197, s1-s3.

Toprac, M. G., Sherman, P. S., & Holzer, C. E. (1996). *Crisis alternatives project: Cost effectiveness of 9 crisis residential modalities. Final Report—Executive Summary, May 1996*. Retrieved from http://www.power2u.org/downloads/Crisis_Alternative_Project_Texas.pdf . Accessed June 18, 2013.

U.S. Department of Health and Human Services. (2010). *Recovery to Practice Weekly Highlights*. Retrieved from http://www.warmline.org/SAMHSA_highlight_nov_12.pdf. Accessed August 1, 2013

Virginia Association of Community Services Boards. (2011). *Investing in People and Communities: the Best Return on Investment*. Retrieved from http://www.vacsb.org/pdfs/VACSB_2011_Annual_Report.pdf. Accessed August 1, 2013.

Wilder Research. (2013). Crisis stabilization claims analysis: Technical report, assessing the impact of crisis stabilization on utilization of healthcare services, April 2013. Retrieved from <http://www.wilder.org/Wilder-Research/Publications/Studies/Mental%20Health%20Crisis%20Alliance/Crisis%20Stabilization%20Claims%20Analysis%20-%20Technical%20Report.pdf>. Accessed August 1, 2013.

Appendix A. Crisis Services Continuum, Infrastructure, and Funding: State Responses

The following section provides additional detail based on interview responses from each state.

Maine

Types of Crisis Services Provided

Maine provides a variety of crisis services for its residents including consumer-operated residential and nonresidential crisis intervention services. The state has 81 crisis stabilization beds in units across the state, 54 of which are for adults and 27 for children. These beds are typically in stand-alone facilities (with eight or fewer beds) and are generally connected to a community mental health agency. Maine also funds children's home and community-based treatments to reduce hospitalizations. The state supports office- and outreach-based ambulatory services and mobile crisis services. There is one central crisis call line for the state, staffed by mental health professionals and peers. Another crisis services component in Maine includes the Crisis Intervention Team (CIT) in which local NAMI chapters work with law enforcement to provide training.

Providing Crisis Services

Crisis services are purchased from private behavioral health organizations through a request for proposal (RFP) process. Services are managed via performance contracts and a formal review of crisis services is conducted every two years.

Due to the size of the state and the remote nature of some of the state's population, geographic accessibility can be a challenge. Because of this, individuals in crisis often use hospital emergency rooms to receive services as they are closer than the crisis stabilization units. To address this, the state provides web-based training for emergency staff and emergency room visit reduction projects targeting individuals with multiple chronic conditions. Transportation to services is also problematic in some parts of the state. In rural areas, individuals are often transported to services by friends, family members or law enforcement. The SMHA and Medicaid do not reimburse for transportation.

Funding Crisis Services

Crisis services are funded via the state general funds (\$9.8 million), the state's Medicaid match, the Medicaid clinic option, and SAMHSA's mental health block grant. Maine primarily relies on the Medicaid Rehabilitation Option to fund community mental health services, including crisis services. Maine uses the Rehabilitation Option to pay for services after an assessment by a crisis program; however, with the exception of the crisis stabilization units, Medicaid does not reimburse for other crisis services such as mobile crisis or hotlines/warm lines. The mobile crisis system is almost entirely financed by state general funds and does not bill insurance. CIT training is funded through state general funds and grants. As a whole, crisis services account for approximately 8 percent of the SMHA's total behavioral health service expenditures.

Maine is currently working to reorganize their crisis services system. The State Mental Health Agency is also working with the State Medicaid Agency for increased Medicaid coverage for crisis services. In Maine, Medicaid rates for crisis residential services are billed a per diem basis and crisis intervention is

billed in 15 minute increments; however, rates are not currently available on the state's published rate schedule.

Massachusetts

Types of Crisis Services Provided

Massachusetts funds a comprehensive array of emergency services, including residential services, ambulatory care and other crisis services. Residential services include respite care—including one peer-run respite program—and crisis stabilization care.

Ambulatory care includes the 21, 24-hour emergency service programs (ESPs) located across the state. These serve as the “front door” to the Massachusetts public behavioral health system, providing behavioral health crisis assessment, intervention and stabilization services via the following service components: Mobile Crisis Services for Children and Adolescents, Mobile Crisis Services for Adults and Geriatric population, ESP Community Based locations, and Community Crisis Stabilization Services for ages 18 and over.

Other crisis services include warm lines, which are funded through general revenues. There is a central warm-line number as well as other warm lines throughout the state.

The state mental health agency is also partnering with police for jail diversion programs. Some partnerships with police follow the model of including a mental health worker who rides along with the police to respond to crisis 911 calls.

Providing Crisis Services

The Massachusetts Department of Mental Health (DMH) and MassHealth, the state Medicaid agency, are key partners in the provision of crisis services. Through an Interagency Service Agreement between DMH and MassHealth, most emergency services are provided through MassHealth's mental health and substance abuse vendor, Massachusetts Behavioral Health Partnership. Community-based services are provided by DMH either directly or through contracted vendors. To address issues with crisis services, the state has developed emergency department alternatives and best practice committees, which include representatives from the Department of Mental Health, The Department of Public Health, emergency department staff, and consumers. The Department of Mental Health has also convened workgroups to address ED wait times and access to acute care services. They also seek to improve the service referral process, including a new, statewide referral process for inpatient specialty unit. Finally, they promote community-based medical screening. There are also routine regional meetings among community-based providers, inpatient facilities, and EDs.

Funding Crisis Services

Massachusetts uses two main funding streams for its emergency crisis services program, including state general funds and Medicaid funds. Medicaid funds include 1115 Waiver funds and funds available under the Medicaid state plan. The two streams of funds are combined to operate one program. Currently, private insurance funds and substance abuse funds are not contributed to this pool.

Additional funding sources for crisis services in the state include: a substance abuse block grant; a project for assistance in transition; jail diversion (funded through state general funds) and trauma

recovery; the Kids Planning Grant; Shelter Plus Care Program; and comprehensive services for children. Crisis residential services, including respite care, are provided through the state's 1115 Medicaid waiver. Ambulatory care is funded, in part, through \$12 million from the SMHA and Medicaid. Four of the 21 ESPs in the state are operated by state personnel and therefore primarily SMHA funded, though Medicaid eligible services provided by those 4 programs are billed to Medicaid.

Many individuals in Massachusetts with behavioral health crises experience lengthy ED wait times because they lack health insurance. To ameliorate this, the state spends approximately \$10 to \$12 million to support the uninsured and Medicare-only populations; however, as in the past, when state general funds have been reduced, services and administrative functions have been cut. The state also gives \$18 million to the state's Medicaid agency, MassHealth, which uses some of this funding to provide services to individuals with Medicare. For those without insurance, SMHA funding is issued to fund crisis services for the uninsured through an inter-agency transfer of funds to the Medicaid PIHP. There are plans in the future for funding to serve the uninsured to run through all of the six Massachusetts managed care programs.

Michigan

Types of Crisis Services Provided

Michigan's Prepaid Inpatient Health Plans (PIHPs) are required to fund crisis residential, ambulatory, and intensive crisis stabilization services as part of the continuum of services for all Medicaid enrollees. Each of the 46 Community Mental Health Service Providers (CMHSPs) are also required to support 24-hour, 7 day per week telephone lines and walk-in centers, some of which work in partnership with Michigan's 211 system—a health and human services information line. Individuals in crisis have access to a psychiatric inpatient and crisis residential units. Urban areas also have mobile crisis teams. Local PIHPs are given flexibility to determine if a full-time mobile crisis team is needed.

Providing Crisis Services

The Michigan Department of Community Health, the state mental health agency, contracts with the PIHPS to provide Medicaid managed behavioral health services and with CMHSPs to provide crisis services to non-Medicaid eligible individuals using allocated state general funds. CMHSPs and PIHPs are funded at a capitated rate, and performance and service standards are delineated in the contracts. Medicaid health plans are responsible for individuals with mild to moderate symptoms; however, if these individuals are in crisis, responsibility for treatment transfers to the behavioral health carve-out plan.

Funding Crisis Services

Crisis services are funded via the state general funds, the state's Medicaid match, and concurrent Medicaid 1915(b) and 1915(c) waivers. Crisis residential and emergency or crisis services, including substance abuse, are provided through the state's 1915(b) waiver. Michigan has established an electronic system so that when someone walks into a crisis center, the center can immediately determine if the person is covered by Medicaid.

Crisis Residential services are billed to Medicaid at \$288 per day. Crisis Intervention is billed to Medicaid at \$53 per 15 minutes. Intensive crisis stabilization-enrolled programs are billed to Medicaid at \$277 per hour.

Missouri

Types of Crisis Services Provided

Access crisis intervention (ACI) services are provided statewide by designated CMHCs. ACI includes a 24-hour crisis hotline and mobile response services as well as residential crisis and ambulatory crisis services. ACI services also include residential respite beds and 23 hour observation beds. There are also respite beds that serve children, which are located predominately in the eastern part of the state.

Providing Crisis Services

ACI services are provided through a variety of mechanisms: over the telephone, in the office, and in the community. Each CMHC is given a capped allotment based upon a per capita rate to provide these services and state standards require that ACI services are provided to everyone who presents for services. All calls to ACI are resolved by referral to new or existing service providers or civil involuntary commitment, if appropriate. The hot and warm lines, a requirement of each CMHC, are either staffed by CMHC personnel or contracted out. These lines are operated by staff members with a bachelor's degree and experience with crisis services and are supervised 24 hours per day, 7 days per week, by qualified mental health professionals. Staff members who man the crisis lines are also trained in co-occurring disorders.

The state is developing partnerships in providing crisis services where possible. The state is improving the links between regional CMHCs and the crisis system and Missouri's hospital association. Additionally, CIT is available in parts of the state and funded by state general and federal funds.

Funding Crisis Services

Crisis services are funded via state general funds, the state's Medicaid match, the Medicaid Rehabilitation Option, Medicaid Targeted Case Management, and SAMHSA's mental health block grant. The state has developed an enhanced community psychiatric rehabilitation rate within their Medicaid waiver program. Medicaid can only be billed if the consumer is currently being served by the particular CMHC where they seek services; otherwise, those services are paid by state general funds.

Because ACI services are billed as nonconsumer specific, they cannot bill Medicaid or Medicare because of billing regulations. The state is not able to bill private insurance; therefore, services for individuals covered by private insurance are funded by general funds. Residential respite beds are funded through grants with the exception of youth residential respite beds, which are funded by the state.

Tennessee

Types of Crisis Services Provided

Tennessee's crisis services can be divided into two main types: crisis stabilization units and mobile crisis teams. The state has seven crisis stabilization units with walk-in centers (one for each planning region), three respite units, and five medically monitored detoxification units. The crisis stabilization units, which serve only adults, are 15-bed facilities where walk-in triage is available and the typical stay is 3–4 days. The mobile crisis teams are available statewide and staff include certified peer specialists. The state also has planned respite programs for individuals with co-occurring mental and substance use disorders, medically monitored detoxification centers, and crisis intervention teams.

Providing Crisis Services

Tennessee provides all publically funded crisis mental health and substance abuse services through a managed care system. The state has reported that, because of the flexibility of their TennCare Medicaid waiver and use of state funds, they have a mental health crisis system that works well. The overarching goal of crisis services is to serve people in the least restrictive setting. The system serves all who present for services, regardless of their insurance status.

The state has reached out to several stakeholders to improve services for those in behavioral health crisis. They have partnered with the state's largest employer of emergency department staff to provide updates on available crisis and noncrisis services and have partnered with the Tennessee Hospital Association in crisis workgroups. The state also collaborates with law enforcement through crisis intervention teams—a program that originally began in Memphis—and with schools through school-based mental health liaisons.

Tennessee has noted barriers in providing timely crisis services to rural areas compared to suburban and urban areas. To address this, in situations where a mobile crisis team is too far away from the individual in crisis to provide timely services, the individual can go to a regional mental health center for telemedicine or other treatment services. The state notes that telemedicine can only be billed if the consumer is physically located in a mental health center, and the state would like to be able to bill for telemedicine to directly contact a consumer in his or her home or place of crisis.

Funding Crisis Services

Crisis services are funded via the state general funds, SAMHSA's mental health block grant, local government, first-party payments (self-pay) and third-party payments (private insurance). Crisis residential and emergency or crisis services are provided through the state's 1115 Medicaid waiver. The crisis stabilization units receive a base amount of funding. The mobile crisis teams are funded at a flat, per capita rate through Medicaid waiver funds and with state general funds. The crisis stabilization units are funded through state general funds, although they can also use Medicaid waiver funds. Approximately 70 percent of the individuals served are uninsured. In Tennessee, Medicare typically does not cover crisis services, so those covered by Medicare only and uninsured consumers are covered through general funds. Private insurance pays for about two percent of those receiving services. Warm lines are funded through state general funds and Medicaid managed care funds. The crisis intervention teams are funded through local grants.

Texas

Types of Crisis Services Provided

The Department of State Health Services (DSHS) funds 14 facility-based emergency service centers with a budget of \$30 million. These centers provide extended observation and jail diversion services, and they are developing community alternatives to state-funded psychiatric hospitalization. These psychiatric emergency centers also assist individuals in psychiatric crisis in general hospital waiting rooms. The state hospitals also have an "over capacity" plan that diverts individuals to other state psychiatric hospitals when that hospital is full, thus allowing for full utilization of all service system beds.

DSHS funds crisis hotlines, mobile crisis outreach, outpatient crisis services, residential crisis services, extended observation, crisis stabilization, and crisis respite. The state also has rapid crisis stabilization beds, in which state funds are used to pay for private hospital beds for crisis stabilization.

Providing Crisis Services

In Texas, all counties have mobile crisis teams with the larger counties hosting multiple teams. Each county also hosts a locally run hotline, which also work as warm lines. Some counties have mental health deputy programs that work with local law enforcement. As previously mentioned, there are 14 facility-based emergency service centers located across the state.

Although Texas utilizes telemedicine, very little telemedicine is applied to crisis services. Rural areas are typically served by on-call crisis clinicians who are deployed from their homes.

The Texas SMHA is also responsible for substance abuse services and notes that provision of substance abuse crisis services can be more difficult than mental health crisis services. There is a dearth of funding and services for detoxification in many parts of the state.

Funding Crisis Services

In Texas, crisis services are funded in a variety of ways including state general funds, state Medicaid match, the Medicaid Rehabilitation Option, a Medicaid 1915(b) waiver, a Medicaid 1115 waiver, Federal Emergency Management Agency (FEMA) funds, and local government funding. In FY 2012, there were over \$82 million in general funds for crisis services. This figure includes services for adults and youth, but excludes state and community hospital beds.

Individuals who receive services through the state's Medicaid waiver programs are provided with crisis services through the waiver. Emergency and crisis services are provided through the state's 1115 Medicaid waiver and the 1915(b) waiver. The 1915(b) waiver also covers crisis residential services in Texas. About 40 percent of those served by crisis services programs are covered by Medicaid, with the remaining 60 percent being uninsured and covered by state general and local funds.

In Texas, hotlines are funded through state general and local funds and warm lines are typically funded through state general funds and the mental health block grant. Medicare does not reimburse for crisis services in Texas.

Texas reports that providing crisis services to individuals with mental and substance use disorders can be complicated. Texas has limits on what substance abuse services Medicaid will cover. Providers bill Medicaid when possible; however, Medicaid cannot be billed if an individual is determined to have a substance use-related crisis. The SMHA perceives that these unreimbursed crisis services divert individuals from hospitalizations.

State officials report that facility licensure can be problematic in serving those with comorbid mental and substance use disorders who are in crisis. The state would like to have facilities that are able to address both mental health and substance abuse services—to provide detoxification and crisis residential levels of care. However, negotiating between these two types of services is difficult because of licensing and billing rules. Texas is working to develop a new licensing category that will cover both detoxification and crisis residential services.

Regulations regarding Institutes of Mental Disease (IMD) are seen as a barrier to providing crisis services in Texas. Crisis facilities are used to serve multiple populations and purposes. However, there is concern that increasing facility capacity to over 16 beds may result in these programs receiving IMD classification and becoming ineligible for Medicaid reimbursement. For example, some programs see a need to add beds for competency restoration and crisis residential services; however, this expansion could cause facilities to be reclassified as IMDs.

The Texas SMHA agency perceives that current rates for crisis services are a barrier to their successful implementation. Rates are insufficient, particularly in rural areas, to pay for the “fire-house” staffing model that is needed for most crisis services programs. The currently published maximum allowable Medicaid rate for Crisis Intervention is \$31.33 per 15 minutes.

Wisconsin

Types of Crisis Services Provided

In Wisconsin’s Administrative Code for Crisis Services, there are two levels of certification. Each county is required to provide a basic level of crisis services (level one). Most counties are certified to provide more extensive services (level two), although they are not required to do so. This certification is required if a county wants to be eligible for Medicaid and other third-party reimbursement. Level two counties are required to provide walk-in services 5 days per week and telephone services 24 hours per day, 7 days per week, and 365 days per year. They must also provide mobility services 7 days per week that are not available 24 hours per day but are available at times of peak use, which is generally between 7 a.m. and 11 p.m. For level two counties, residential crisis services are optional for qualifying for Medicaid certification. Screening, Brief Intervention, and Referral to Treatment (SBIRT) is used for alcohol and drug abuse issues. Some counties provide medically monitored, nonhospital-based, social detoxification programs with crisis stabilization.

Providing Crisis Services

Counties are responsible for the provision of most services, and Medicaid pays for most of the services. There are Medicaid-certified, level-two crisis programs in 56 of the 72 counties. Individual Peer support is often provided by the counties as part of the staffing, but it is not a requirement. In addition to individual peer support, the governor is proposing funding for three peer-run centers. Warm lines exist in just a few large urban areas of the state because of limited availability of funding. Individuals can obtain services regardless of their insurance status if there is an emergency. There is no central warm line, but there are 11 peer-run warm line programs.

Milwaukee has a Wraparound program that takes a systems-of-care approach. The Milwaukee Wraparound program grew out of a SAMHSA Systems of Care grant and is focused on children and adolescents. The base funding for the Milwaukee Wraparound is from Medicaid, with a mix of additional dollars from juvenile justice funds and child welfare. The program members have expanded their role and now work with the local school district to provide services for children in schools who are experiencing crises. Wisconsin also has CIT programs in a number of regions. Milwaukee is about to initiate CIT trained officers used as second responders which will be funded by state general funds.

Wisconsin created a new state statute in 2009 that requires law enforcement to consult with county mental health authorities—which often means the county crisis service—before emergency detentions

can be initiated. As a result, Wisconsin has seen a 32 percent decrease in emergency detentions, a 73 percent increase in the use of crisis services, and a decrease in state hospital admissions.

Funding Crisis Services

Crisis services are funded via the state general funds, Medicaid FFP matched by local funds under the Medicaid Rehabilitation Option, the Clinic Option, and waivers. Other funding sources include SAMHSA's mental health block grant, local government, first-party payments (self-pay), and third-party payments (private insurance). Counties are responsible for the total cost of hospitalization for persons who are civilly committed between the ages of 22 and 64, although counties are also responsible if there is no other source of funding regardless of the individual's age. Milwaukee's Wraparound services are funded through a Medicaid 1915a waiver.

Wisconsin respondents noted many challenges in funding crisis services. The primary funding challenges are related to the number of uninsured individuals who use services and the difficulties experienced by the smaller, less-populated counties in funding and organizing services. An additional cited challenge was the reticence of private insurance companies to pay for crisis services. Under Wisconsin law, crisis programs are eligible for third-party reimbursement, but private insurance companies are not required to provide or reimburse these services. Some private insurance companies do have contracts with crisis programs. Additionally, insurance companies define medical necessity differently than do the county service providers. They often require that services be provided by individuals with a master's degree or higher and decline payment for services that are not part of their list of plan providers, even if the consumer is suicidal. The state has informed insurers that they are required to pay for crisis services, but they have had limited success in getting insurers to meet these obligations.

In Wisconsin, counties bill the most appropriate funding source for the episode. In instances where there is a gap in funding for a particular service episode, counties use their own resources or general state funding. Collaborations with law enforcement have been funded by general funds, in part through hospital diversion funds that became available as a result of state psychiatric hospital closures.

In Wisconsin, the Medicaid maximum allowable contracted rate for crisis intervention ranges from \$47.42 per hour for a paraprofessional, to \$88.90 per hour for an individual with a bachelors or master's degree to \$148.16 per hour for a nurse practitioner or psychiatrist. The Medicaid per diem rate for crisis intervention is \$139.54.

Wraparound Milwaukee: A Model of Blended Funding

We also interviewed the director of the blended funding program known as Wraparound Milwaukee and provide a description below as an example of blended funding used in support of crisis services.

The expansion of children's mental health services has been a long-standing goal of the Wisconsin Council on Mental Health (WCMH), parents, providers, advocates, and the Department of Health Services. Through increased funding from the Mental Health Block Grant, the CST initiative began in December 2002 with collaboration between multiple systems: mental health, child welfare, substance abuse, juvenile justice, and public instruction. Initiative funding is made available through a blend of mental health block grant and substance abuse block grant funds, state general purpose revenue, and child welfare dollars. Current funding is approximately \$42 million and serves over 1400 children with serious emotional disturbance annually. This funding is being used to transform service delivery to families who require substance abuse, mental health, and/or child welfare services.

Target Population

The target population for Wraparound Milwaukee is youth who have mental health needs who are identified by the child welfare or juvenile justice system as being at immediate risk of residential or correctional placement or psychiatric hospitalization (served in two or more child-serving systems). However, the program is designed to provide limited services to families of any child who presents in crisis.

Service Description

The program has several core components including care coordination, the child and family team, the Mobile Urgent Treatment Team (MUTT)—a mobile crisis team that is available to meet the needs of youth and families when a care coordinator might not be available—and a provider network with more than 170 agencies that responds to the multiple needs of youth and families.

Youth can be referred to Wraparound Milwaukee from any system (e.g., mental health, child welfare, juvenile justice, and soon also the school system). Eligibility is then determined by a screening or assessment. Following eligibility determination, care coordinators are assigned to each family through one of nine agencies under contract to Wraparound Milwaukee. Care coordinators conduct an inventory, convene the child and family team, and develop the care or treatment plan. Wraparound Milwaukee contracts with nine community agencies for the approximately 72 care coordinators who facilitate the delivery of services and other supports to families. Wraparound Milwaukee has also organized an extensive provider network of 204 agency and individual providers that can offer an array of over 80 services to families.

The program covers specialized mobile crisis, mobile crisis one-on-ones, and crisis group home services. Wraparound Milwaukee also operates all mobile crisis services for Milwaukee County with specialized contracts with child welfare and the Milwaukee Public Schools System. All families that are enrolled in Wraparound Milwaukee also have access to the Wraparound Milwaukee MUTT, which also serves as a “gate keeper” on all inpatient psychiatric hospitalizations. The team includes psychologists, social workers, nurses, a case manager, and a consulting physician. These individuals provide crisis intervention services on a 24-hour basis to families enrolled in the Wraparound Milwaukee Program. In addition, the MUTT provides services to any family in Milwaukee County with a child who is having a mental health crisis when the behavior of the child threatens his or her removal from home, school, etc. The MUTT team goes to where the crisis is occurring, assesses the situation, and determines if the child's behavior or mental health condition can be met with interventions in the home, or whether temporary placement in a crisis group home or other emergency setting is required. The MUTT team also assesses whether the child's behavior constitutes a danger to that child or others requiring possible psychiatric inpatient hospitalization. In addition to crisis intervention services, the Team can provide short-term case management and can link the child and family to other community services. The MUTT team oversees the operation of an 8-bed crisis/respite group home, which can serve as an alternative to inpatient hospitalization or resource for the child to transition from the inpatient facility.

Blended Funding Approach

The Wraparound Milwaukee program is funding through multiple systems including: Medicaid, child welfare, delinquency, and court services. The use of blended funding has been particularly important to the success of the program. The project is sustained by pooled funds that come from the system partners. Blending from these multiple sources allows for a flexible and comprehensive array of services.

The program receives a flat monthly fee for each client and must pay for all treatment services, including incarceration and residential care. The Milwaukee County Behavioral Health Division operates Wraparound Milwaukee, pools the funding streams, and the funds are managed using managed care principles with providers. Wraparound Milwaukee manages the disbursements of funds which are “decategorized,” so that the program can use them to cover any services that families need, in a mix of formal and informal services.

Medicaid provides for the highest proportion of funds through a capitated arrangement per child per month and some fee-for-service funds that are billed for crisis services. Child welfare provides case rate funding for youth who are active within the system. Delinquency and court services provide funds through fixed budget and case rate.

Wraparound Milwaukee has proved to be a successful endeavor in that it has reduced the number of youth in high-end residential treatment centers in Milwaukee from an average of 375 youth to 80 youth annually. Additionally, the program has reduced the utilization of inpatient Medicaid psychiatric hospitalization days from over 5000 to 500 days per year, significantly reducing inpatient treatment costs. Finally, child welfare & delinquency services have not had to put additional monies into the care of youth in residential treatment since 1997—their base level of funding has remained at the same \$18.5 million, additional evidence of system savings. Wraparound Milwaukee is a nationally recognized model program that has successfully used blended funding to provide crisis services for children at risk of out of home placement.

Illinois

Types of Crisis Services Provided

The Illinois Medicaid policy defines crisis intervention services as including preliminary assessments, brief therapy, and case management/linkage services that are necessary for the resolution of the crisis. These services may be provided in an office or within the community.

In addition, Illinois provides residential care services and hotlines that are operated by community mental health centers. They have also developed specialized programs that are located in regions of the state where the state psychiatric hospitals have been closed. These programs—Emergency Disposition and Assessment (EDA) services and Acute Community Services (ACS)—provide immediate assessment, intervention, and referral to appropriate levels of care for individuals with no other funding for such care. ACS also provides aftercare in order to reduce the reoccurrence of crises.

Providing Crisis Services

Illinois contracts with a limited number of hospitals for short-term acute treatment and funds community support, and Mobile Crisis Teams. Crisis residential services are funded by the state but operated by community mental health agencies. Each crisis residential center was developed according to the community’s needs rather than using a single, predefined service model.

The Division of Mental Health and Division of Substance Abuse have created a dual-disorder crisis residential program serving two areas of the state. The Division of Mental Health is also working with a task force to develop specialized crisis intervention services, such as working with sexual assault services providers on crisis interventions. Some of these partnerships are funded through grant money from the state general funds, and some pursue federal grants.

Funding Crisis Services

In Illinois, crisis services are funded via state general funds, the state's Medicaid match, the Medicaid Rehabilitation Option and local government funds. In State Fiscal Year 2012, Illinois expended the following on crisis services: \$6.8 million in Medicaid, \$5.4 million in non-Medicaid funding, \$10.6 million in capacity grant funding, and \$4.2 million in crisis residential grant funding. Crisis services accounted for approximately 4.4 percent of the total SMHA service expenditures. The state uses a capitated rate for its EDA and ACS services. Often, the individuals receiving crisis services are not Medicaid eligible.

Illinois noted difficulty with providing crisis services in rural areas where adequate coverage is an issue, whereas wait times are a problem in the densely populated areas. Another challenge noted is the shortage of highly skilled clinicians, particularly psychiatrists. The state is working to improve access to crisis services provided by peers. The state is also working to expand the use of telemedicine within crisis services.

Medicaid rates for crisis residential services are billable on a per diem basis; however rates are not provided. Crisis Intervention is billed to Medicaid from \$29.97 to \$47.77 per 15 minutes, depending upon staff credentials and place of service (i.e., mental health site, home-based or off-site).

This page intentionally left blank

Appendix B. Sources of Medicaid Financing for Crisis Services— Environmental Scan of States

State	Source
All States/Peer Services	YouthPeerSupportMatrix052512.pdf">http://nationalwraparoundinitiative.shuttlepod.org/Resources/Documents/CHCS-Family>YouthPeerSupportMatrix052512.pdf
Alabama	http://medicaid.alabama.gov/documents/6.0_Providers/6.7_Manuals/6.7.7_Provider_Manuals_2013/6.7.7.3_July_2013/Jul13_105.pdf
Alaska	http://dhss.alaska.gov/dhcs/Documents/PDF/Recipient-Handbook.pdf http://dhss.alaska.gov/suicideprevention/Pages/default.aspx
Arizona	http://www.azdhs.gov/bhs/documents/covserv/CovBHsvsGuide.pdf
Arkansas	https://www.medicaid.state.ar.us/InternetSolution/provider/docs/rspmi.aspx http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html
California	http://www.dhcs.ca.gov/services/MH/Documents/Mental_Health_Medi-Cal_Billing_Manual_v1-0_07-17-08.pdf http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Plan-Amendments/Downloads/CA/CA-09-023A-Att.pdf
Colorado	http://www.cbhc.org/news/wp-content/uploads/2011/05/Colorado-Training-and-Reference-Manual-for-Clinicians.pdf http://www.coloradohealthpartnerships.com/members/resilience/mbr_medicaid_benefits.htm http://downloads.cms.gov/cmsgov/archived-downloads/MedicaidGenInfo/downloads/CO-10-041-179.pdf
Connecticut	http://www.ct.gov/dss/lib/dss/pdfs/medicaidservicesv3kk.pdf http://www.ct.gov/dmhas/lib/dmhas/msd/BHRPproviderManual.pdf http://www.ct.gov/dmhas/cwp/view.asp?q=378578 http://www.ct.gov/sustinet/lib/sustinet/board_of_directors_files/resources/ct.medicaidprimer_longversion.final.pdf
Delaware	http://dhss.delaware.gov/dsamh/crisis_intervention.html http://www.namidelaware.org/community-resources/mobile-crisis http://dhss.delaware.gov/dsamh/files/dsamhactandicmstandards2013.pdf

(continued)

State	Source
Florida	http://www.dcf.state.fl.us/programs/samh/ruledvelopment/documents/C65E-14/Crisis%20Stabilization%20Reimbursement%20Transition%20Plan%201-1-13.pdf http://www.compcare.com/ProvManuals/FL/FL-MedicaidSupplementalToProviderManual-Medica.pdf http://www.myflfamilies.com/service-programs/mental-health/crisis-services
Georgia	https://georgia.wellcare.com/WCAssets/georgia/assets/ga_medicaid_provider_manual_11_2012.pdf http://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/imported/DBHDD/Files/FY12%204th%20Quarter%20Provider%20Manual%203-30-2012.pdf
Hawaii	http://sphhs.gwu.edu/departments/healthpolicy/CHPR/nnhs4/GSA/States/HIBH.html https://www.wellcare.com/WCAssets/hawaii/assets/hi_ohana_medicaid_provider_manual_07_2013.pdf http://www.med-quest.us/PDFs/Provider%20Manual/PMChp1502.pdf http://www.pascenter.org/state_based_stats/medicaid/medicaid_waivers_info.php?state=us http://health.hawaii.gov/amhd/files/2013/06/SCR117-Appendix-2.pdf
Idaho	http://www.healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/Idaho%20Health%20Plan%20English.pdf http://www.medicaidmattersinidaho.com/2012_update_week8.html http://news.yahoo.com/rural-suicides-medicaid-cuts-204257613.html
Illinois	http://www.hfs.illinois.gov/assets/cmhs.pdf http://www.dhs.state.il.us/page.aspx?item=32490 http://www.nrvcs.org/newhorizons/default.htm http://www.dhs.state.il.us/page.aspx?item=56881
Indiana	http://www.indianamedicaid.com/ihcp/bulletins/bt200925.pdf
Iowa	http://www.dhs.state.ia.us/policyanalysis/policymanualpages/Manual_Documents/Provman/B_HlthInter.pdf http://www.magellanoof Iowa.com/about-magellan-of-iowa.aspx http://ir.magellanhealth.com/releasedetail.cfm?ReleaseID=583229 http://www.magellanoof Iowa.com/media/327625/2013_iowa_member_handbook_final.pdf
Kansas	https://www.kmap-state-ks.us/Documents/Content/Provider%20Manuals/Non-PAHP_08312010_10104.pdf https://providers.amerigroup.com/ProviderDocuments/KSKS_Prov_Manual.pdf
Kentucky	https://www.caresource.com/documents/kentucky-provider-manual/ https://kentucky.wellcare.com/WCAssets/kentucky/assets/ky_provider_manual_03_2013.pdf

(continued)

State	Source
Louisiana	http://new.dhh.louisiana.gov/assets/docs/BehavioralHealth/LBHP/ServicesManual-Current.pdf
Maine	http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s065.docx
Maryland	http://dhmh.maryland.gov/mha/SitePages/adultservices.aspx , http://maryland.valueoptions.com/provider/handbook/MTS_Assertive_Community_Treatment_.pdf http://maryland.valueoptions.com/provider/handbook/Emergency_Services_in_a_Licensed_Hospital_Emergency_Room.pdf http://maryland.valueoptions.com/provider/handbook/Respite_Services.pdf http://maryland.valueoptions.com/provider/handbook/5.11_ApprovedByState_Residential_Crisis.pdf http://dhmh.maryland.gov/mha/Documents/Advance%20Directive%20for%20Mental%20Health%20Treatment%20july%202008.pdf http://dhmh.maryland.gov/mha/Documents/PMHS_Reimbursement_Schedule.pdf http://maryland.valueoptions.com/provider/prv_man.htm
Massachusetts	http://www.mass.gov/eohhs/docs/masshealth/regs-provider/regs-mentalhealthctr.pdf
Michigan	http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf
Minnesota	http://www.health.state.mn.us/injury/topic/suicide/ http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&dID=163664#P131_9401 http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_058151 http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_058038#
Mississippi	http://www.medicaid.ms.gov/Manuals/Title%2023%20Part%20206%20Mental%20Health%20Services.pdf
Missouri	http://manuals.momed.com/collections/collection_dmh/DMH_Waiver_Section13.pdf
Montana	http://www.dphhs.mt.gov/amdd/services/adultMentalHealthFeeSchedule.pdf
Nebraska	http://www.sos.state.ne.us/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-471/Chapter-35.pdf
Nevada	https://www.medicaid.nv.gov/Downloads/provider/NV_BillingGuidelines_PT14.pdf http://mhds.state.nv.us/index.php?option=com_content&view=article&id=21:southern-nevada-adult-mental-health-services&catid=53:sn-global-content&Itemid=49

(continued)

State	Source
New Hampshire	https://nhmmis.nh.gov/portals/wps/wcm/connect/ea4ed88040ce6501aabeff3e8fa48611/NH+Medicaid+Final+CMH+Provider+Billing+Manual+20130401+.pdf?MOD=AJPERES
New Jersey	http://www.state.nj.us/humanservices/dmahs/info/state_plan/Attachment3_Services_including_Scope_and_Limitations.pdf
New Mexico	http://www.hsd.state.nm.us/uploads/PressRelease/2f473c14ee654f868b5a25b3cfd15a6d/Behavioral_Health_Resources_and_Information.pdf http://www.bhc.state.nm.us/pdf/H2011%20Crisis.pdf
New York	http://www.omh.ny.gov/omhweb/clinic_restructuring/part599/guidance.pdf https://www.wellcare.com/WCAssets/newyork/assets/ny_medicaid_provider_manual_05_2013.pdf
North Carolina	http://www.ncdhhs.gov/dma/mp/8a.pdf
North Dakota	http://www.nd.gov/dhs/services/medicalserv/medicaid/docs/gen-info-providers.pdf
Ohio	http://codes.ohio.gov/oac/5101%3A3-27
Oklahoma	http://ok.gov/odmhsas/Mental_Health_/Crisis_Services/ http://www.okhca.org/xPolicyPart.aspx?id=562&chapter=30&subchapter=5&part=21&title=OUTPATIENT%20BEHAVIORAL%20HEALTH%20SERVICES
Oregon	http://www.oregon.gov/oha/amh/mho/codes/amh-rates2012-01.pdf
Pennsylvania	http://dbhids.org/community-behavioral-health/ http://dbhids.org/assets/Forms--Documents/MemberHandbook2005.pdf http://www.dpw.state.pa.us/provider/mentalhealth/index.htm
Rhode Island	http://www.dhs.ri.gov/ForProvidersVendors/ServicesforProviders/ProviderManuals/Rehab/RehabilitationServicesPolicy/tabid/677/Default.aspx#15.1
South Carolina	https://www.scdhhs.gov/internet/pdf/manuals/Physicians/Section%202.pdf https://www.scdhhs.gov/internet/pdf/manuals/RBHS/Manual.pdf
South Dakota	http://dss.sd.gov/sdmedx/docs/providers/feeschedules/Comm%20BH%20CD%20FY14%20Rate%20Sheet.pdf

(continued)

State	Source
Vermont	http://www.vtmedicaid.com/Downloads/manuals/New%20Consolidated%20Manual/ProvManual%20Consolidated%209-1-13.pdf http://dvha.vermont.gov/for-providers/psychiatric-inpatient-authorization-manual-3-12-13-revision.pdf
Virginia	http://www.dmas.virginia.gov/Content_pgs/obh-home.aspx
Washington	http://www.hca.wa.gov/medicaid/billing/documents/guides/mental_health_svc_mpg.pdf http://www.dshs.wa.gov/dbhr/mhpact.shtml http://www.dshs.wa.gov/ca/services/srvadlsfaq.asp#SCRC http://www.dshs.wa.gov/pdf/dbhr/mhbbenglish082013.pdf
West Virginia	http://www.dhhr.wv.gov/bms/Documents/Chapter502_BHCS.pdf http://www.dhhr.wv.gov/bms/Documents/Chapter503_BHRS.pdf
Wisconsin	https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/provider/medicaid/typeSpecialtyCodes.htm.spage?id=cco#cco https://www.forwardhealth.wi.gov/WIPortal/Online%20Handbooks/Display/tabid/152/Default.aspx?ia=1&p=1&sa=44&s=2&c=10&nt=Procedure%20Codes
Wyoming	http://wyequalitycare.acs-inc.com/MHSA.html http://wyequalitycare.acs-inc.com/manuals/Manual_MHSA.pdf

This page intentionally left blank

Appendix C. Acknowledgements

This publication was produced under SAMHSA IDIQ Prime Contract #HHSS283200700029I, Task Order #HHSS283200700029I/HHSS28342002T with the Substance Abuse and Mental Health Services Administration by Truven Health Analytics Inc. and National Association of State Mental Health Program Directors Research Institute. Numerous people contributed to the development of this publication and SAMHSA would like to acknowledge the individuals below.

Truven Health Analytics

Julie Seibert, Ph.D.

Emily Ehrlich, M.P.H.

John Easterday, Ph.D.

Tami Mark, Ph.D.

Melina Imshaug, B.S.

NASMHPD Research Institute

Ted Lutterman, B.A.

Robert Shaw, M.A.

Substance Abuse and Mental Health Services Administration

Kevin Malone, B.A.

Suzanne Fields, MSW, LICSW

This page intentionally left blank



SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities

HHS Publication No. (SMA)-14-4848
Printed 2014