Report of the Community Policing and Behavioral Health Advisory Council in accordance with Section 117 of Chapter 253 of the Acts of 2020 and Section 25 of Chapter 19

Crisis Services in the Commonwealth

Executive Office of Health and Human Services –
Executive Office of Public Safety and Security

Respectfully Submitted: Massachusetts Association for Mental Health –
Technical Assistance Collaborative

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Table of Contents

Executive Summary **5**
Background 5
Findings 7
Recommendations for Growing a Robust Crisis System 7

Study Background **9**
Methodology 9
Context and Limitations 11

National Best Practice Landscape **13**
Someone to Talk To 14
24/7 Crisis Call Centers 14
911/Public Safety Answering Points (PSAPs) 15
Someone to Respond 16
A Place to Go 18
Crisis Stabilization 18
State Best Practice Implementation Examples 18
Intentional Planning and Governance Structure 18
Integrated Crisis Components 18
Real Time Outcomes 20
Federal Guidelines for Emergency Responses to People with Behavioral Health or Other Disabilities 20

Overview of the Massachusetts Behavioral Health Crisis System **23**
Someone to Talk to — Massachusetts 25
The Behavioral Health Help Line 25
988 Suicide and Crisis Lifeline 26
Massachusetts 911/Public Safety Answering Points 27
Someone to Respond — Massachusetts 27
Mobile Crisis Teams: CBHCs 27
First Responder Intervention 27
Equitable Approaches to Public Safety 28
Use of Alternative Civilian Safety Programs in Massachusetts — No Police Involvement 29
A Place to Go in Massachusetts 31
Crisis Stabilization and Urgent Care: CBHCs 31
Massachusetts Emergency Departments 31

Findings **33**
There is a Need to Design and Implement a Unified Approach to Crisis Services across Sectors to Alleviate System Confusion, Implementation Inconsistencies, Service Delivery Gaps, and Cross-System Communication Challenges. 33
System Capacity Is Being Developed but Needs to Expand to Meet Demand and to be Managed in the Face of a Workforce Crisis. 34

Workforce-Related Capacity Issues 34
Underutilization of Community-Based Stabilization Programs 36
Transportation Issues 37
There is a Need for Better Utilization of Peer Supports in Crisis Prevention, Crisis Response, and Post-Crisis Care. 38
There is a Need for an Organized and Detailed Implementation Strategy to Support and Inform Ongoing Crisis System Operations. 39
Recommendations 40
Recommendation 1. Develop a Governance Entity that Enhances Cross-Sector Collaboration at the State and Regional Levels. 40
Recommendation 2: Create a Statewide Behavioral Health Workforce Strategy, which Enhances the Capacity and Ability of Behavioral Health Providers to Provide Alternative Emergency Services and Programs for Behavioral Health Crises Across the Commonwealth. 42
Recommendation 3: Develop an Organized and Detailed Implementation Strategy in Coordination with MassHealth, DMH, DPH, EOPSS, and Statewide 911. 43
Cost Guidance 47
Specific Recommendations on Crisis Response Systems Coordination and Integration 49
Conclusion 51
Appendix A: Key Informant Organizations 52
Appendix B: Key Informant Interview Guide 53
General Questions 53
Behavioral Health Provider 53
Individuals with Lived Experience 54
Law Enforcement/PSAPs 54
Systems/Government 54
All 54
Appendix C: Focus Group Interview Guide – Stakeholder Session Guide 55
Crisis Provider Focus Group: 55
Individuals with Lived Experience Focus Group 55
Individuals with Lived Family Experience Focus Group (modified for caregivers) 56
Law Enforcement/EMS Focus Group 56
Public Safety Answering Points (PSAPs) Focus Group 57
Appendix D: Literature Review Documents 59
National Best Practices 59
Massachusetts-Related Materials 61
Appendix E: ESP Survey 63
Appendix F: ESP SURVEY Q45 responses 69
ESP CPBHAC/911 survey 69
Appendix G: ESP/MCI Disposition 70
Appendix H: Crisis Intervention Response Time 71

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Executive Summary

Background

In 2020, the Massachusetts General Court charged the Community Policing and Behavioral Health Advisory Council (herein known as "the Council" or "CPBHAC") with studying and making recommendations for creating a crisis response and continuity of care system that delivers alternative emergency services and programs across the Commonwealth of Massachusetts.[1] The purpose of the current study was to conduct a comprehensive review and evaluation of existing crisis intervention, alternative emergency response and jail diversion models, services, and programs in the Commonwealth at the state, county, and municipal levels, and to consider models used effectively in other jurisdictions.[2]

On behalf of CPBHAC, the Massachusetts Department of Mental Health (DMH) contracted with the Massachusetts Association for Mental Health (MAMH) to develop the crisis services study, and MAMH selected the Technical Assistance Collaborative as its partner in the initiative. MAMH and TAC initiated the study in May of 2022. The primary focus of the study summarized in this report was to conduct an in-depth review of the Massachusetts crisis system, inclusive of the behavioral health system, law enforcement, emergency medical services, hospitals, and other social service supports. MAMH/TAC utilized a mixed methods approach, including literature reviews, key informant interviews, and interviews/focus groups with individuals with lived and living experience. As part of this process TAC conducted a landscape analysis and interviews with over 80 key informants, and facilitated seven focus groups, to identify strengths and areas for growth within the evolving crisis system. To meet reporting requirements, a significant amount of qualitative data collection was carried out prior to and during the early months of the launch of the Roadmap for Behavioral Health Reform, the Commonwealth's major reform effort detailed below. This report, in tandem with a companion report analyzing appropriate responders to 911 calls, makes recommendations that would bolster the state's existing infrastructure to provide more effective crisis response to persons experiencing a behavioral health crisis.

Numerous data points illustrate the growth in demand for behavioral health care in the Commonwealth, the gap between demand and capacity to serve; the delays in access to front line clinical care; and the increasing numbers of people — particularly young people flooding emergency rooms if delayed care results in clinical deterioration and crisis. In a 2020 survey, more than one in three Massachusetts adults (35%) reported needing behavioral health care for themselves or a close relative.[3] Only 50% of people in

[1] Massachusetts St.2020, c.253 - An Act Relative to Justice, Equity and Accountability in Law Enforcement in the Commonwealth

[2] Massachusetts St.2020, c.253 - An Act Relative to Justice, Equity and Accountability in Law Enforcement in the Commonwealth

[3] Walsh, K. K., Gottsegen, J., Long, S. K., Sirkin, J. T., Rasky, R., Newberry, M.,… & Figueroa, A. (2022). *Behavioral health during the first year of the COVID-19 pandemic: An update on need and access in Massachusetts*. Blue Cross Blue Shield of Massachusetts Foundation & NORC at the University of Chicago.

Massachusetts who have a mental health condition reported receiving treatment.[4] The demand for behavioral health services continues to increase across the Commonwealth while accessing services becomes more difficult. According to a study by the Association for Behavioral Health (ABH), the average wait time for children to start therapy is 15 weeks, and for adults 10 weeks.[5]

The Healey-Driscoll administration is currently implementing a redesign of the behavioral health system, based on the Roadmap for Behavioral Health Reform initiated during the Baker-Polito administration, which was designed to address existing barriers to care. In response to unmet needs for access to care when needed, Massachusetts made a commitment to improving access to quality behavioral health services for all residents. This included making significant policy changes, modifications to financing, and the implementation of Community Behavioral Health Centers (CBHCs), the Behavioral Health Help Line (BHHL), and Behavioral Health Urgent Care. Funding included successive investments in FY2021 and FY2022, including approval of the state's Section 1115 Medicaid Waiver[6] followed by passage of the FY2023 state budget and Chapter 177 of the Acts of 2022,[7] including a Behavioral Health Trust Fund.

In addition, $40 million was invested in FY2021 to expand inpatient bed capacity; $84 million from the FY2022 budget, plus an additional $70 million from the Substance Use Disorder Federal Reinvestment Trust Fund, were directed to support the public sector components of the Roadmap for Behavioral Health Reform.[8] The FY2022 budget provided for significant additional investments in behavioral health services. Some of the highlights include $14.7 million to DMH for child/adolescent services; $6 million for child/adolescent emergency department (ED) diversion services; $115 million to expand outpatient and urgent care services; $3.5 million in the DPH budget for evidence-based peer services; and $7 million for 10 new recovery centers.[9] The launch of the CBHCs and Behavioral Health Help Line (BHHL) in January of 2023 was a major step towards improving Commonwealth residents' access to behavioral health crisis services. While these investments are promising in terms of more timely access to care, the need for an effective crisis response system becomes even more critical given the delays and gaps in mental health care.

[4] Commonwealth of Massachusetts, Executive Office of Health and Human Services. (n.d.). *Roadmap for behavioral health reform: Helping residents access mental health and substance use treatment*. Retrieved September 24, 2023.

[5] Association for Behavioral Healthcare (2022, February 15). *Survey details behavioral health workforce crisis in Mass: Association for Behavioral Healthcare finds longer waitlists for patients, rising clinic job vacancies, stagnant reimbursement and serious need for higher compensation and benefits* [Press release].

[6] MassHealth (2021, July 15). *MassHealth 1115 Demonstration Waiver Extension Proposal* [Fact sheet].

[7] Massachusetts St.2022, c.177 - An Act Addressing Barriers to Care for Mental Health

[8] Commonwealth of Massachusetts, Executive Office of Health and Human Services. (n.d.). *Roadmap for behavioral health reform: Helping residents access mental health and substance use treatment*. Retrieved September 24, 2023.

[9] Massachusetts Association for Mental Health (2022). *The FY2023 Massachusetts State Budget: Implications for people living with behavioral health conditions* [Budget Brief]. Boston, MA: Massachusetts Association for Mental Health

Findings

Crisis services are currently provided by several systems in the Commonwealth including behavioral health, law enforcement, and other first responders such as paramedics and fire personnel. Implementation of the Roadmap for Behavioral Health Reform (Roadmap) includes several components related to strengthening the capacity of the behavioral health system's crisis response services. While the Roadmap is in early implementation, we identified several findings that, when addressed, may ensure that crisis services are accessible, rely more on behavioral health staff, decrease the use of law enforcement as the primary responder, and divert people from restrictive settings. Based on a review of literature, key informant interviews, and available data, the authors identified the following themes as key factors in building a robust crisis system that all individuals could access:

- Residents statewide will benefit from an organized approach to crisis services reform that more effectively addresses the roles, resources, and responsibilities of both public health and public safety systems. This would eliminate system confusion, fill gaps, standardize implementation, and address cross system communication challenges.
- Expansion of system capacity now in development will better meet demand for timely and robust crisis response.
- An organized cross system approach to data collection and outcome measurement is essential to assessing and informing optimal crisis system functioning.

Recommendations for Growing a Robust Crisis System

Based on the findings of the environmental scan and a review of national best practices, the authors have identified four overarching recommendations to help the Commonwealth achieve a crisis system that utilizes best practices and is organized, integrated, and accessible. Because the crisis services response in Massachusetts involves several systems and has diverse stakeholders, these recommendations may be applicable to several bodies, including the General Court (legislature), executive agencies like the Executive Office of Health and Human Services (EOHHS), Executive Office of Public Safety and Security (EOPSS), DMH, MassHealth, Department of Public Health (DPH), local police departments, and local 911/Public Safety Answering Points (PSAPs).

- ***Develop a Governance Entity that Enhances Cross-Sector Collaboration at the State and Regional Levels.***
  - *Identify or establish one entity under the co-direction of the Secretary of Health and Human Services and the Secretary of Public Safety and Security that would be responsible for overseeing crisis response planning and implementation.*
  - *Create opportunities for regional cross-sector planning and mutual understanding.*
- ***Create a statewide behavioral health workforce strategy that enhances the capacity and ability of behavioral health providers to provide alternative emergency services and programs for behavioral health crises across the Commonwealth****.*

- ***Develop an organized, detailed implementation strategy in coordination with MassHealth, DMH, DPH, EOPSS, and State 911.***
    - *Create a training curriculum in partnership with State 911, Municipal Police Training Committee (MPTC), Peace Officer Standards Training (POST), DMH, DPH, MassHealth, and persons with lived experience (PWLE).*
    - *Create a standardized framework or process for screening and triaging behavioral health calls received by 911 and continue to incentivize and regionalize PSAPs.*
    - *Establish cross-system data collection requirements/standards that can be used to assess and inform the capacity and performance of crisis services. This should include a statewide behavioral health crisis dashboard that is public-facing and integrates 988, BHHL, Mobile Crisis Intervention (MCI), hospital, and co-response data.*
- ***Continue, Expand, and Resource the Commonwealth's investments in emerging best practices by law enforcement and other first responders in managing behavioral health crisis encounters pursuant to 911 response by law enforcement.***
    - *Support law enforcement to continue and expand participation in the One-Mind Initiative.*
    - *Support the Municipal Police Training Committee (MPTC) to continue to develop and expand behavioral health-related training opportunities.*
    - *Support law enforcement and their partnerships with EOHHS agencies (DMH, DPH) to continue and expand participation in grant programs for training, co-response, and diversion services.*

Study Background

In 2020, the Massachusetts General Court (Legislature) charged the Community Policing and Behavioral Health Advisory Council (CPBHAC) with studying and making recommendations for creating a behavioral health crisis response and continuity of care system that delivers alternative emergency services and programs across the Commonwealth that meet the needs of local communities.[10] The purpose of this study was to conduct a comprehensive review and evaluation of existing crisis intervention, alternative emergency response, and jail diversion models, services, and programs at the state, county, and municipal levels. The legislative directive further prescribed an examination of models used effectively in other jurisdictions.[11]

In a related initiative in FY2021, the Massachusetts General Court directed the Executive Office of Health and Human Services (EOHHS) to collaborate with the Executive Office of Public Safety and Security (EOPSS) to conduct a study of "the disposition of 911 calls to determine how many calls and what types of calls were or could have been diverted to social service, behavioral health, community arbitration or other unarmed responders instead of law enforcement." The legislative directive specifically called for the analysis of computer-aided dispatch data, police incident reports, and any other information that local police departments and their respective public safety answering points (PSAPs) possess. The data was to be analyzed to document demographic, special needs, and housing status by jurisdiction.

Since the directives for both studies had considerable requirements for environmental scans, key informant interviews, and stakeholder engagement, EOHHS, EOPPS, and Department of Mental Health (DMH) executives determined to use the same entities to jointly conduct the studies on the same schedule, producing two interrelated reports for submission to the General Court on June 30, 2023. DMH, on behalf of the CPBHAC, contracted with the Massachusetts Association of Mental Health (MAMH), and MAMH engaged as its partners the Technical Assistance Collaborative, Inc. (TAC) and Human Services Research Institute (HSRI), to carry out these studies on CPBHAC's behalf in order to identify strengths and areas for growth within Massachusetts' evolving crisis system. This report on the broader crisis response system, in tandem with a companion report with findings regarding 911 calls, makes recommendations to help bolster the state's existing infrastructure to provide more effective crisis response to persons experiencing behavioral health crises.

Methodology

MAMH/TAC utilized a mixed methods approach which drew on an array of data sources.

Key Informant Interviews: MAMH/TAC conducted key informant interviews in two waves (See Appendix A for a complete list of key informants interviewed). The first, conducted in the summer of 2022,

[10] Massachusetts St.2020, c.253 - An Act Relative to Justice, Equity and Accountability in Law Enforcement in the Commonwealth

[11] Massachusetts St.2020, c.253 - An Act Relative to Justice, Equity and Accountability in Law Enforcement in the Commonwealth

included 30 one-hour context gathering interviews with representatives from state agencies, provider and advocacy organizations, law enforcement/PSAPs, individuals with lived and living experience, and other subject matter experts, using a semi-structured interview guide. These interviews informed development of a standard Key Informant Interview Guide (See Appendix B) used to conduct over 65 one-hour semi-structured interviews with service providers, organizational leaders, law enforcement personnel, state regulators and payors, and others selected by MAMH/TAC because of their knowledge about behavioral health crisis services in Massachusetts. Informants included behavioral health providers from 988, Community Behavioral Health Centers (CBHCs), and hospital personnel; individuals with living experience; advocacy organizations representing families and service recipients; state agencies (MassHealth, DMH, DPH, EOPSS); first responders (police chiefs, emergency medical services [EMS], Municipal Police Training Committee [MPTC]); and national leaders in behavioral health crisis response (Utah, Oklahoma, CIT International). This phase of the study also included a comprehensive dialogue with DMH to better understand the scope, strengths, and current challenges of the jail diversion program, including the public-facing data dashboard.

Focus Groups: MAMH/TAC conducted focus groups with critical partners, including families, law enforcement leadership, youth/young adults, dispatch teams, and hospitals, to obtain a deeper understanding of their experiences. The structure of these meetings was flexible to accommodate the preferences and experiences of each group. For participant ease, MAMH/TAC was embedded into preexisting meeting structures. Meeting length and number of participants were variable; however, a consistent series of questions were used, catalogued in the Focus Group Interview Guide (See Appendix C) that focused on the strengths and weaknesses of the current crisis delivery system. In total, MAMH/TAC heard from 180 individuals working in the crisis system, and 55 individuals with lived experience, through these focus groups.

Community Forums: MAMH/TAC attended listening sessions and community forums where state officials, law enforcement, individuals with lived experience, and behavioral health providers presented information on the implementation of the Roadmap for Behavioral Health Reform. Forums MAMH/TAC attended included: Crisis Now's National 988 Crisis Learning Community; Massachusetts's Association of Health Plans (MAHP) Virtual Policy Forum - Massachusetts Responds to the Crisis in Children's Behavioral Health; Health Policy Commission's hearing on the 2024 Health Care Cost Growth Benchmark;[12] Building a Robust Health Care Workforce in Massachusetts: Findings, Challenges, and Opportunities; Co-response symposium; and Crisis Response in Massachusetts Panel - NAMI Mass Advocacy Day.

Literature Review: MAMH/TAC conducted a national scan of best practices and policies and reviewed Massachusetts-specific planning, policy, and budget documents to inform a perspective on the Massachusetts system in a national context. The authors solicited Massachusetts information through interviews with state leaders, who directed the study team to review published reports, and acquired other policy and advisory documents detailing planned reforms (See Appendix D).

Survey of Crisis Teams: TAC conducted a statewide Emergency Services Program (ESP) Survey of Massachusetts's behavioral health crisis teams (See Appendix E). This survey was utilized to explore

[12] Massachusetts Health Policy Commission (n.d.). *Health care cost growth benchmark: Hearing to determine the 2024 health care cost growth benchmark*

coordination with law enforcement, to understand operational logistics (e.g., hours of operation, staff training), and crisis teams' successes and challenges related to planning and implementing an enhanced crisis model. Given that the crisis system was in transition during this assessment (see "Study Context and Limitations" section), there was constant scanning and reviewing of updated documentation as it related to the Roadmap for Behavioral Health Reform (Roadmap) implementation. This also included Community Behavioral Health Center (CBHC) documents, new requests for proposals, and information released by DMH, MassHealth, and the Massachusetts Behavioral Health Partnership (MBHP) throughout the assessment.

Site Visits to Innovative Programs Addressing Alternatives: MAMH/TAC visited several sites in the Commonwealth and in other states to review emerging innovations that address the challenges of providing timely, clinically directed crisis response. These included: the Amherst CRESS program; Cambridge HEART initiative; King County WA's Downtown Emergency Services Center (DESC) and Law Enforcement Assisted Diversion (LEAD) programs; and Denver, CO's Support Team Assisted Response (STAR) program partnership between Denver Health and the Denver Police Department.

Analysis Strategies

Qualitative data was collected from three primary sources — structured interviews, focus groups, and two surveys. The qualitative data went through a review process which included separation by informant type, clustered into system components, with interview content coded according to themes utilizing deductive coding. In addition, reviewers analyzed all interviews to compile best practices and challenges into themes which were utilized to inform recommendations. This analysis was performed by at least two peer reviewers. Themes were organized, cross-referenced, and reviewed to identify consistencies as well as points of variation. These findings were compared to national best practices as evidenced in the literature review (See Appendix D) to identify areas of alignment and divergence and further guide system-level recommendations. Quantitative data was reported with simple descriptive statistics, as inferential or associational methods are not appropriate for these data at this time.

Context and Limitations

Like other behavioral health systems across the United States, Massachusetts is working to improve behavioral health crisis services. The Healey-Driscoll administration is currently implementing a redesign of the behavioral health system, building from the Roadmap for Behavioral Health Reform conceived and initiated in the Baker-Polito administration. The State of Massachusetts has made a commitment to improving access to quality behavioral health services for all residents. This has included making significant policy changes, such as designing, funding, and implementing CBHCs, the Behavioral Health Help Line (BHHL), and Behavioral Health Urgent Care (see Massachusetts Overview below).

Significant resources were made available to facilitate and finance implementation of the Roadmap. These included successive investments in FY2021 and FY2022 including approval of the state's Section 1115 Medicaid Waiver,[13] followed by passage of the FY2023 state budget and Chapter 177 of the Acts of 2022,[14] including a Behavioral Health Trust Fund. For example, $40 million was invested in FY2021 to expand

[13] MassHealth (2021, July 15). *MassHealth 1115 Demonstration Waiver Extension Proposal* [Fact sheet].

[14] Massachusetts St.2022, c.177 - An Act Addressing Barriers to Care for Mental Health

inpatient bed capacity; $84 million from the FY2022 budget, plus an additional $70 million from the Substance Use Disorder Federal Reinvestment Trust Fund, were directed to support the public sector components of the Roadmap.[15] The FY2022 budget provided for significant additional investments in behavioral health services. Some of the highlights include $14.7 million to DMH for child/adolescent services; $6 million for child/adolescent emergency department (ED) diversion services; $115 million to expand outpatient and urgent care services; $3.5 million in the DPH budget for evidence-based peer services; and $7 million for 10 new recovery centers.[16] The launch of the CBHCs and BHHL in January of 2023 was a major step towards improving Commonwealth residents' access to behavioral health crisis services. While these investments are promising in terms of more timely access to care, the need for an effective crisis response system becomes even more critical given the delays and gaps in mental health care.

The designated period of study for both the CPBHAC review of crisis services and the EOHHS and EOPPS review of 911 began in May of 2022 with a requirement that both reviews be reported to the General Court by June of 2023. This system-wide assessment was completed over a 10-month period from July 2022 to May 2023, thus it should be noted that implementation of many components of the Roadmap occurred in the middle of the assessment and while the Commonwealth and EOHHS were in the process of planning and implementing significant reforms within the crisis system.

During the end of FY2022 and the first half of FY2023, following the launch of 988 as the new "Suicide and Crisis Lifeline" in Massachusetts, an extended procurement process for the CBHCs and BHHL was unfolding, and public communications about the details of the procurement were of necessity at a minimum. In the latter half of FY2023, as the CBHCs and BHHL went live in January of 2023, implementation took place during a staggering workforce crisis affecting both the public health and public safety systems. Moreover, although EOPPS had in recent years made development and training grants available, PSAP and other data collected related to the public safety dimension of crisis services was variable in depth and content due to decades of limited investment and the absence of statewide standards. The environment for delivery and receipt of crisis services was in flux throughout the period of study, and key informants and data sources from all sectors were constrained and concerned by the effects of a challenging change conducted in the face of a workforce crisis in the Commonwealth.

Various quantitative and qualitative metrics were gathered to inform the statewide assessment. While MAMH/TAC gathered as much information as possible on the planning and implementation, some previously collected metrics for the crisis system were being reevaluated during the crisis assessment and related quantitative data sets were not publicly available at the time of assessment, including Mobile Crisis Intervention (MCI) metrics. MAMH/TAC continuously engaged the Council and other key leaders in state agencies to ensure information was gathered routinely to keep up with changes in the landscape. MAMH/TAC evaluated the current state of implementation of the crisis system in relation to national best practices to inform opportunities and recommendations to enhance implementation efforts. As with any system transformation, the full implementation and impact of these changes may take years to actualize.

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[15] Commonwealth of Massachusetts, Executive Office of Health and Human Services. (n.d.). *Roadmap for behavioral health reform: Helping residents access mental health and substance use treatment*. Retrieved September 24, 2023.

[16] Massachusetts Association for Mental Health (2022). *The FY2023 Massachusetts State Budget: Implications for people living with behavioral health conditions* [Budget Brief]. Boston, MA: Massachusetts Association for Mental Health

National Best Practice Landscape

In recent years there have been several efforts to create national standards and to provide guidance to states on building responsive behavioral health crisis systems. The Substance Abuse and Mental Health Administration (SAMHSA) convened an expert panel in 2020 to examine the evidence base, profile emerging practices, and build consensus on a data-informed design for an effective crisis system. SAMHSA consequently issued a Best Practice Toolkit which defines the minimum core components of a crisis system to ensure crisis services are available for anyone, anywhere, anytime.[17] In order to implement this vision, full integration of substance use and mental health services throughout this continuum is imperative to provide a "no wrong door" approach to services. Each component engages to de-escalate the crisis and enhance stabilization to deflect from unnecessary hospitalization. These components include:[18]

- **Someone to Talk to:** Statewide or regional 24/7 clinically staffed crisis call centers that provide real-time coordination with services.
- **Someone to Respond:** Centrally deployed 24/7 mobile crisis response to provide assessment in the community and referral.
- **A Place to Go:** Crisis stabilization units that provide short-term (up to 23 hours) stabilization services in a non-hospital setting.

The SAMHSA guidelines further identified six essential care principles that should be embedded into a comprehensive crisis system:[19]

1. Addressing recovery needs
2. Significant use of peers
3. Trauma-informed care
4. "Suicide safer" care
5. Safety and security of staff and those in crisis
6. Collaboration with law enforcement and medical services

Other national best practice guidelines further define essential elements of effective behavioral health crisis response systems, which ideally put the person at the center and utilize clinical best practices, provide an array of services and capacity within the crisis continuum, and ensure accountability and financing to ensure the person's needs are met.[20] An ideal behavioral health crisis system is also marked as one committed to data collection that tracks structure, process, and outcomes of the system to guide

[17] Substance Abuse and Mental Health Services Administration (2020). *National guidelines for behavioral health crisis care best practice toolkit*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[18] Substance Abuse and Mental Health Services Administration (2020). *National guidelines for behavioral health crisis care best practice toolkit*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[19] Substance Abuse and Mental Health Services Administration (2020). *National guidelines for behavioral health crisis care best practice toolkit*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[20] Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry (2021). Roadmap to the ideal crisis system: Essential elements, measurable standards and best practices for behavioral health crisis response. Washington, D.C.: National Council for Mental Wellbeing

quality improvement.[21] Because these components are widely known as the framework for effective crisis response, this assessment evaluates the extent to which Massachusetts's practices align with these expectations and best practices.

Someone to Talk To

24/7 Crisis Call Centers

Crisis call centers are an essential component of the crisis system, can provide the first point of entry into a crisis system, and can provide an alternative to calling 911. Call centers play a significant role in de-escalating situations and connecting individuals to resources to prevent the need for further intervention.[22] These call centers can also serve as a centralized hub to facilitate direct connection to needed responses. Therefore, call center staff must be equipped to assess a wide range of situations affecting children, youth, adults, and older adults. This includes assessment of suicidality and risk of harm to self or others; and assessment of substance use, including acute intoxication, withdrawal requiring medical monitoring or management, or overdose. This assessment should guide intervention, response, and referral options. SAMHSA's best practice guidelines promote these entities serving as an "air traffic controller," utilizing strong triage processes, centralized deployment of mobile crisis teams (MCTs)[23] utilizing GPS technologies, and access to bed registries, with capacity to connect individuals to upstream services.[24] Bed registries are up-to-date electronic databases of bed availability in behavioral health settings, including but not limited to public and private psychiatric hospitals, psychiatric bed space within broader hospitals, crisis stabilization beds, crisis respite centers, detoxification units, and recovery homes.[25] While not all states currently have these technological infrastructures, many states are evaluating their capacity to build out these capabilities. The federal Centers for Medicare and Medicaid Services (CMS) elevated the best practice of integrating real-time GPS technology between call centers and MCTs, and authorizes Medicaid matching funds to be utilized to support information technology system integration activities for crisis systems.[26]

In July of 2022, the National Suicide Prevention Lifeline (NSPL) became the National Suicide and Crisis Lifeline and established one easy-to-remember number, 988, to connect individuals to a network of local crisis call centers across the U.S. The establishment of 988 built upon existing NSPL infrastructure,

[21] Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry (2021). Roadmap to the ideal crisis system: Essential elements, measurable standards and best practices for behavioral health crisis response. Washington, D.C.: National Council for Behavioral Health.

[22] Pinals, D. (2020). *Crisis services: Meeting needs, saving lives*. Alexandria, VA: National Association of State Mental Health Program Directors.

[23] In Massachusetts, Mobile Crisis Teams (MCTs) are called Mobile Crisis Intervention (MCI) teams.

[24] Substance Abuse and Mental Health Services Administration (2020). *National guidelines for behavioral health crisis care best practice toolkit.* Rockville, MD: Substance Abuse and Mental Health Services Administration

[25] Substance Abuse and Mental Health Services Administration. (2019, January 24). *Crisis bed registries to assist people with urgent mental health needs* [Press release].

[26] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (2021, December 28). *Re: Medicaid guidance on the scope of and payments for qualifying community-based mobile crisis intervention services*. State Health Official Letter #21-008

and now consists of over 200 call centers across the country. States have implemented 988 in a variety of ways, but it created the framework for a single point of entry into the behavioral health crisis system.

911/Public Safety Answering Points (PSAPs)

Every year, millions of calls are made to 911 nationally and it is estimated that anywhere from five to twenty percent of these calls involve situations related to behavioral health.[27, 28] The call taker plays a vital role in identifying and dispatching the appropriate response. However, there is great variation among telecommunicators in terms of approach to call triage, which plays a vital role in determining the fate of each subject of a 911 call.[29, 30] For many reasons, including the historic absence of a centralized, easily accessible number specific to behavioral health emergencies, there has been a reliance on 911 and law enforcement for a quick (although not always most appropriate) response to these situations. However, due to the existing reliance on 911, significant coordination with Public Service Answering Points (PSAPs) and public safety is necessary to ensure systems dispatch an appropriate behavioral health response regardless of the number called.

Models are unfolding across the country to identify and divert behavioral health crisis calls from 911 to the behavioral health system. While numerous jurisdictions are piloting programs, some promising practices are emerging and highlighted below.

- Chicago recently launched its Crisis Assistance Response and Engagement (CARE) pilot program, which deploys one of three response teams based on the needs of the caller. The three possible team deployment options are: 1) a multidisciplinary team which consists of a paramedic, a clinician, and a CIT officer; 2) an alternative response consisting of paramedic and a clinician; or 3) an opioid response, consisting of a paramedic and a peer recovery specialist.[31]
- In 2021, Austin, TX created an option in its 911 system to allow the person to specify at the outset of the call that they need behavioral health services, and Harris County, TX has embedded clinicians into its 911 call center since 2015.[32, 33]
- The STAR (Support Team Assisted Response) program in Denver, CO embedded a clinician into the PSAP to divert calls from law enforcement and created a systematic guide to support dispatch staff in efficiently triaging calls.[34] STAR has been in operation for almost three years, and recent studies

[27] National Emergency Number Association. (n.d.). 9-1-1 statistics. (Retrieved September 24, 2023)

[28] Abramson, A. (2021). Building mental health into emergency responses. *Monitor on Psychology, 52*(5).

[29] Neusteter, S. R., O'Toole, M., Khogali, M., Rad, A., Wunschel, F., Scaffidi, S.,… & Henessy, P. (2020). *Understanding police enforcement: A multicity 911 analysis*. New York, NY: Vera Institute of Justice.

[30] Federal Communications Commission (updated 2023, August 3). *911 Master PSAP Registry*.

[31] *(Note that the term "peer recovery specialist" pertains to the CARE pilot. In Massachusetts, this term is commonly referenced in the positions of Peer Specialists and Recovery Coaches.)*

[32] Jennifer Battle, VP, Harris Center for Mental Health and IDD in Houston TX, personal communication

[33] Houston Police Department Mental Health Division. (n.d.). *Crisis Call Diversion Program*. (Retrieved September 24, 2023)

[34] C. Sailon, personal communication, September 7, 2021 [videoconference]

have found it supported a 34% reduction in arrests for "low level" offenses (such as trespassing, intoxication, and resisting arrest).[35]

While states have made some advances to ensure 911 telecommunicators are equipped to identify and respond to behavioral health {emergency} calls, a recent study found that there is still a significant need for more training for PSAP telecommunicators.[36] Respondents to a Pew survey reported PSAP telecommunicators need several types of training and supports, including CIT training for themselves; access to behavioral-health-crisis-trained law enforcement partners; behavioral health system orientation and contacts; and adoption of and training on use of standardized scripts to properly identify behavioral health calls. Moreover, studies have found that telecommunicators can have a significant impact on the perceptions and responses of law enforcement to situations.[37]

ENHANCING LAW ENFORCEMENT RESSPONSE TO BEHAVIORAL HEALTH CRISIS

Best practice ensures response to behavioral health crisis without law enforcement when appropriate, but there may be times when law enforcement may be the first on the scene or part of the responding team. Two of the most utilized avenues to enhance police response to behavioral health crisis are:

Crisis Intervention Teams (CIT): A partnership between law enforcement and behavioral health professions to promote more effective response to behavioral health emergencies, which includes a foundational training for law enforcement on recognizing, responding, and de-escalating situations involving behavioral health conditions.

Co-response: Although there is great variability in how communities have operationalized the practice of co-response, this is a universal term in which a behavioral health clinician responds with a law enforcement officer to a behavioral health crisis call.

Someone to Respond

Mobile Crisis Teams

Effective MCTs are designed to utilize a multidisciplinary response, inclusive of clinical and peer support, and to provide response without law enforcement as often as possible.[38] These teams respond to

[35] Dee, T. S., & Pyne, J. (2022). A community response approach to mental health and substance abuse crises reduced crime. *Science Advances*, *8*(23)

[36] Pew Charitable Trusts. (2021, October 26). New research suggests 911 call centers lack resources to handle behavioral health crises.

[37] Gillooly, J. W. (2020). How 911 callers and call-takers impact police encounters with the public: The case of the Henry Louis Gates Jr. arrest. *Criminology & Public Policy, 19*(3), 787–803

[38] Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry (2021). Roadmap to the ideal crisis system: Essential elements, measurable standards and best practices for behavioral health crisis response. Washington, DC: National Council for Mental Wellbeing.

individuals in the community to provide screening, assessment, and linkage to appropriate services.[39] These teams should be co-occurring-capable, with specific policies and procedures for managing intoxication and assessing for substance use treatment needs, including connection to medication-assisted treatment (MAT).[40] For youth, MCTs should be youth- and family-driven, taking into account youth development and familial relationships. Youth MCTs should try to avoid both law enforcement involvement and removing a youth from their community and school.[41] In an effective crisis response system, MCTs ensure follow-up care and effective connection to community resources.[42] Many state systems have taken intentional steps to enhance partnerships with law enforcement and to reduce unnecessary law enforcement involvement in crisis situations. Examples include:

- Arizona created a dedicated law enforcement line in its call centers, which directly connects law enforcement to a behavioral health specialist for screening and support. The state also established standards that require MCTs to prioritize calls from law enforcement, with an average in-person response time of 30 minutes for calls from police.[43]
- Georgia has specific instructions for when law enforcement should be involved and what its role should be, from taking the lead in order to secure the scene, to following MCTs as a standby safety support.[44] These instructions also leave flexibility to allow for the clinical judgment of the responding clinician to discern if there is a safety risk that would warrant law enforcement support.

Law Enforcement and Other First Responders

Systems are evaluating avenues to reduce law enforcement involvement to better align with national best practice. While systems with more developed behavioral health crisis response can more effectively respond to these situations, there may still be instances in which law enforcement or other first responders (i.e., EMS and fire) respond. The nature and quality of the response is critical to positive dispositions and safe outcomes. As systems shift from first responders as the default response to a behavioral health response, close coordination is necessary between first responders and the behavioral health system. Data from specific alternative responder programs highlights that individuals were more likely to engage in and be receptive to services from an alternative response to law

[39] Pinals, D. (2020). *Crisis services: Meeting needs, saving lives*. Alexandria, VA: National Association of State Mental Health Program Directors.

[40] Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry (2021). Roadmap to the ideal crisis system: Essential elements, measurable standards and best practices for behavioral health crisis response. Washington, DC: National Council for Mental Wellbeing.

[41] U.S. Substance Abuse and Mental Health Services Administration (2022). *National guidelines for child and youth behavioral health crisis care*. Rockville, MD: U.S. Substance Abuse and Mental Health Administration

[42] Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry. (2021). *Roadmap to the ideal crisis system: Essential elements, measurable standards and best practices for behavioral health crisis response*. National Council for Mental Wellbeing.

[43] Gulley, J., Boss, R., Woodsby, A., Arienti, F., & Wachino, V. (2021). *Mobile crisis teams: A state planning guide for Medicaid-financed crisis response services* (p. 23) Boston, MA: Technical Assistance Collaborative.

[44] Georgia Department of Behavioral Health & Development Disabilities. (n.d.) Guide: Using Mobile Crisis Services in lieu of an Order to Apprehend.

enforcement/traditional first responders.[45] However, despite growing investment in behavioral health response, there is a lack of clear data regarding deflection practices, safety, and outcomes.[46]

A Place to Go

Crisis Stabilization

Crisis stabilization units or crisis receiving facilities provide short-term services for individuals experiencing a behavioral health crisis. Receiving centers should be available throughout a state, operate 24 hours, have a dedicated first responder drop-off, and coordinate with upstream community behavioral health and social services. Crisis receiving centers provide 23-hour crisis care and coordinate timely transitions to more intensive levels of care when needed. Numerous examples of crisis stabilization or restoration centers exist in states across the country, including those in King County, WA; Phoenix and Tucson, AZ; Denver, CO; Bexar County, TX; and Oakland County, MI.[47]

State Best Practice Implementation Examples

Intentional Planning and Governance Structure

988 and federal investment in crisis response services have provided states a prime opportunity to revamp their crisis response systems. Many states, such as Washington, utilized 988 planning to engage in cross-sector planning, forming a Crisis Improvement Strategy Committee (CRIS) with necessary community partners including state leaders, individuals with lived experience, advocacy partners, managed care organizations, provider associations, emergency services, commercial insurance, law enforcement, and tribal representation. CRIS has seven steering committees tasked with implementation support, evaluation of gaps, and creating recommendations related to specific areas of crisis services.[48] CRIS has a specific workplan and timeline for goals and a decision process to guide efforts to revamp the state's crisis system.[49]

Integrated Crisis Components

The environmental scan revealed some examples of how an integrated crisis system can provide timely access to the right care; reduce the number of transfers; and create a streamlined, trauma-informed

[45] New York City Mayor's Office of Community Mental Health (2022). *B-HEARD (Behavioral Health Emergency Assistance Response Division) January – March 2022 (FY22 Q3)* [Data brief.]

[46] Pinals, D. A. (2022). *Lending hands: Improving partnerships and coordinated practices between behavioral health, police, and other first responders*. Technical Assistance Collaborative Paper No. 10. Alexandria, VA: National Association of State Mental Health Program Directors

[47] Pinals, D. (2020). *Crisis services: Meeting needs, saving lives*. Alexandria, VA: National Association of State Mental Health Program Directors.

[48] Washington State Health Care Authority. (n.d.). *Crisis Response Improvement Strategy (CRIS) committees: Meeting schedule*. (Retrieved September 24, 2023)

[49] Health Management Associates. (2023, February 15). *HB 1477 Crisis Response Improvement Strategy Committee* [Meeting presentation].

experience for the individual in crisis by limiting unnecessary contact with law enforcement. States such as Oklahoma and Georgia have leveraged 988 to create centralized access to their statewide call centers, with the ability to dispatch mobile crisis units when the situation needs an in-person response, as well as to schedule follow-up appointments for the individual in crisis. [50, 51]

Other states have taken intentional steps to enhance integration through cross-sector collaboration between PSAPs and the behavioral health crisis system. Through state-level cross-sector collaboration, states such as Virginia and Utah have worked to create statewide standards for PSAPs to utilize. In 2020, Virginia legislation required the Department of Behavioral Health and Developmental Services and the Department of Criminal Justice Services to work together to create minimum standards that enforced best practices for police involvement in behavioral health crisis response.[52] Stemming from this collaboration, Virginia became the first state to issue a statewide matrix for 911 deflection support.[53] Similarly, Utah worked with its PSAP advisory board to create a statewide dispatch workflow to support more effective triage of behavioral health calls and warm transfers[54] to Utah's statewide crisis line, which then can directly dispatch a mobile crisis team.[55]

In some large municipalities, similar steps have been taken to integrate behavioral health crisis system and PSAP functions. In Denver, CO, PSAP staff and behavioral health crisis staff are co-located, sharing call screening, transfer, and disposition protocols. Broome County, NY enables 911 dispatch to do a warm handoff of non-emergent behavioral health calls to a crisis call line. In 2015, Houston, TX piloted a crisis call diversion model[56] that placed counselors in 911 call centers, leading to a decrease in the volume of non-emergency mental health-related calls for services for both law enforcement and fire personnel, and resulting in savings of approximately $860,000.[57]

[50] Sheamekah Williams personal communication. January 6, 2023

[51] Gulley, J., Boss, R., Woodsby, A., Arienti, F., & Wachino, V. (2021). *Mobile crisis teams: A state planning guide for Medicaid-financed crisis response services*. Boston, MA: Technical Assistance Collaborative.

[52] Virginia Legislative Information System. (2020). *2020 Special Session I Summary: HB 5043 Mental health awareness response and community understanding services (Marcus) alert system*.

[53] Virginia Legislative Information System. (2020). *2020 Special Session I Summary: HB 5043 Mental health awareness response and community understanding services (Marcus) alert system*

[54] A warm transfer or warm handoff is the process of transferring an individual from one provider to another in person and with the referring participant present, utilizing a foundation of trust and respect.

[55] Nicole Cunha personal communication. February 10, 2023.

[56] Houston Police Department Mental Health Division. (n.d.). *Crisis Call Diversion Program*. (Retrieved September 24, 2023)

[57] Krider, A., Huerter, R., Gaherty, K., & Moore, A. (2020). *Responding to individuals in behavioral health crisis via co-responder models: The roles of cities, counties, law enforcement, and providers*. Policy Research, Inc. & the National League of Cities.

Real Time Outcomes

Some states that utilize their centralized call center/988 to GPS-dispatch mobile crisis response have leveraged this technology to collect crisis system data. Utah[58] and Arizona[59] each created a public facing dashboard to create transparency in their systems' responses. Oklahoma's dashboard is accessible to the Oklahoma Department of Mental Health and Substance Abuse Services, which then can conduct real-time monitoring of the crisis system and identify any spikes in crisis response needs in a specific jurisdiction. This enables them to engage the crisis providers, identify the catalyst, and respond with targeted mental health outreach and services to mitigate the concern.[60] Leveraging of monitoring data has the potential not only to enhance response efficiency through streamlined deployment and identification of available resources, such as beds or upstream appointments, but also to support overall system accountability.

Federal Guidelines for Emergency Responses to People with Behavioral Health or Other Disabilities

In May of 2023, the U.S. Departments of Justice and Health & Human Services issued "*Guidelines for Emergency Responses to People with Behavioral Health or Other Disabilities.*"[61] These guidelines outline best practices for state and local officials who serve people with disabilities (including behavioral health, intellectual, developmental, cognitive, hearing, and vision disabilities) facing a behavioral health crisis. The guidelines address the prevalent crisis response model, which, in many communities across the U.S., continues to rely heavily on law enforcement.

Citing the legal obligations of the Americans with Disabilities Act (ADA),[62] the guidelines encourage the establishment of community-based crisis services — including mobile crisis and crisis stabilization services — as key means to prevent "needless institutionalization, law enforcement encounters, and incarceration of people with disabilities." Additionally, the guidelines recommend longer-term services, such as supported housing, Assertive Community Treatment (ACT), intensive case management, peer support, supported employment, and Medicaid home and community-based waiver services for people with intellectual and developmental disabilities, as means to satisfy the ADA's prohibition on needless segregation. The guidance notes that the ADA applies to public entities' emergency response and law enforcement systems; these services must make reasonable accommodations to serve people with

[58] Solari Crisis and Human Services. (n.d.). *Huntsman Mental Health Institute at the University of Utah - Public Dashboard: Utah crisis services data* [Tableau dashboard].

[59] Solari Crisis and Human Services. (n.d.). *CRN600 - Contact center overall dashboard* [Tableau dashboard].

[60] Sheamekah Williams personal communication January 6, 2023

[61] The guidelines are undated but were issued pursuant to Presidential Executive Order 14074, *Advancing Effective, Accountable Policing and Criminal Justice Practices to Enhance Public Trust and Public Safety* (May 25, 2022).

[62] Public entities cannot exclude individuals with disabilities from participation in services and programs or deny benefits on the basis of disability, and thus must make reasonable modifications to practice to avoid such discrimination. In addition, the ADA, as interpreted by the Supreme Court in *Olmstead v. L.C.*, 527 U.S. 581 (1999), requires states to avoid unjustified institutionalization and instead integrate people with disabilities into the larger community when appropriate and according to standards set out by the Court.

disabilities including by sending responders trained in behavioral health service provision rather than law enforcement when appropriate. In this way, people with behavioral health conditions receive the same types of accommodations currently provided to people with physical health conditions (who may now receive a health response rather than a police response).

The guidelines identify core principles informing best practices for responders:

- Relying upon person-centered approaches to help resolve incidents safely
- Diversion to behavioral health responders when appropriate, particularly the 988 Suicide and Crisis Lifeline and other local providers
- Inclusion of peer support specialists as team members in all crisis services
- Focusing on trauma-informed approaches that avoid retraumatization, maximize autonomy, and promote recovery
- Access to 24/7 crisis services that allow people to retain community and personal support connections
- Coordination across law enforcement and behavioral health systems, as well as with other support services and Medicaid
- Data-driven implementation to promote diversion and evaluate the efficacy of all potential services.[63]

Within each of the two primary models of crisis response, the guidelines identify specific elements that aid in the effective incorporation of a mental health component into the response. Regarding MCTs, the guidelines state that the success of the teams is dependent on multidisciplinary partnerships, cross-system training, data sharing, and follow-up for referrals. The guidance further emphasizes de-escalation as another best practice for law enforcement, noting that the Integrating Communications, Assessment, and Tactics training program from the Police Executive Research Forum has been shown to significantly reduce officer use of force.

These guidelines urge parity in the provision of crisis response (between behavioral health and medical emergencies); law enforcement training for dealing with mental health issues; promotion of alternative response models and diversion facilities; CIT training; cultural competence training; data collection assessment and improvements; introduction of de-escalation policies and trainings; and informed clinical decision-making.

[63] The guidelines also present ways to identify, respond, and provide referrals to individuals with disabilities in crisis: rerouting calls from 911 to 988 for a clinical response; establishing triage programs; raising awareness of warm lines; improving call taking, screening, and dispatch to promote diversion to 988; dispatch tracking to learn more about callers; and co-locating behavioral health staff at dispatch centers.

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Overview of the Massachusetts Behavioral Health Crisis System

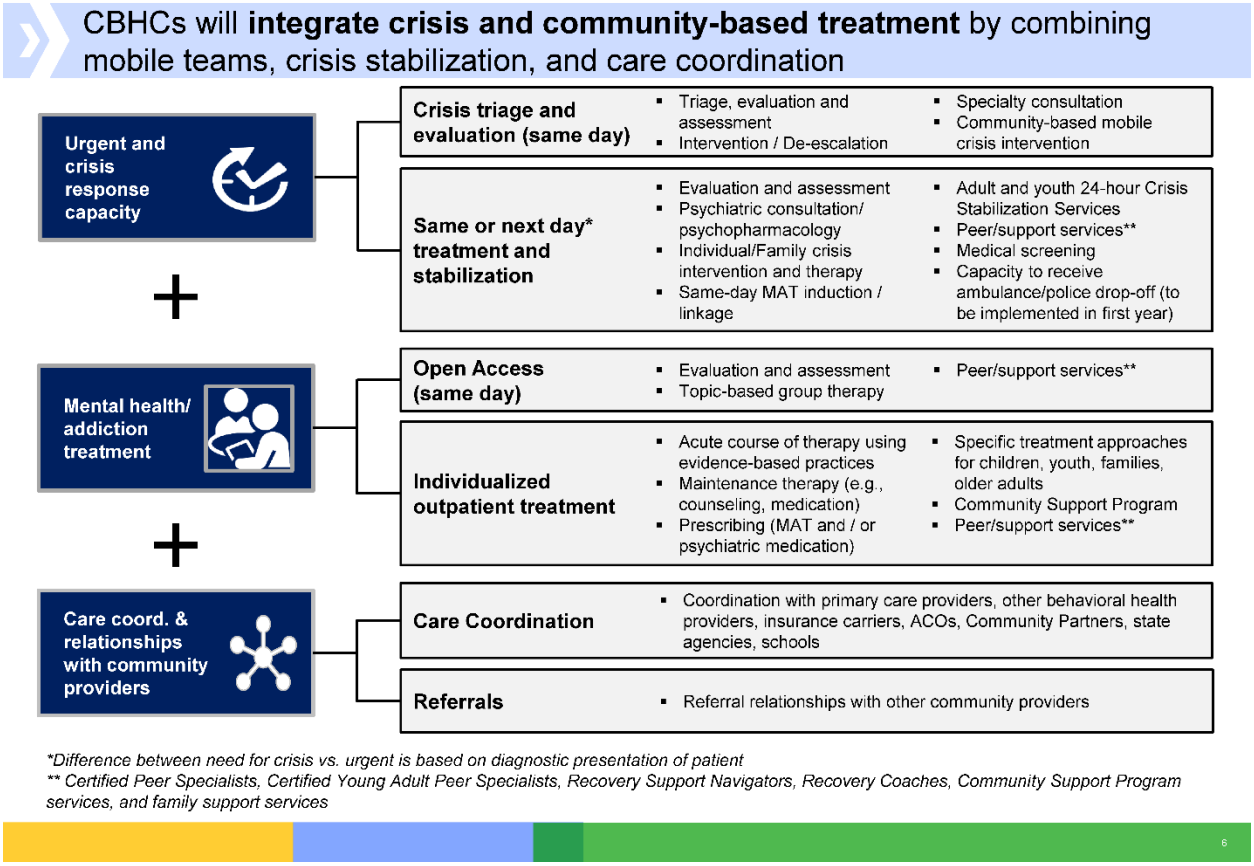
Many of the core components outlined in national best practices have been in operation in Massachusetts for more than 40 years. In 2021, the Executive Office of Health and Human Services (EOHHS) shared plans for the Roadmap for Behavioral Health Reform, which re-envisioned the behavioral health system. In January 2023, Massachusetts began implementing this Roadmap, a multiyear blueprint to increase access to expanded and more effective treatment, including crisis response services. The Commonwealth has a long history of providing crisis assessment, intervention, and stabilization services through Emergency Services Programs (ESPs). The ESPs historically were embedded in comprehensive home- and community-based services organizations or safety net hospital ambulatory care services, and offered mobile crisis intervention for both youth and adults; ESP community-based locations; and community crisis stabilization. The Roadmap initiative recently rolled these services into 25 Community Behavioral Health Centers (CBHCs) across the state, which are required to provide centralized access to crisis services, including mobile crisis intervention (MCI), assessments, and crisis stabilization units for both children and adults (regardless of insurance coverage) for the first 24 hours.[64] After the first 24 hours, MassHealth-covered individuals can receive extended services including MCI, in-home care, and crisis stabilization beds, followed by continuing care in outpatient settings. The multiyear transition to centralizing crisis services outlined in the CBHC Request for Responses[65] plans for police and ambulance drop-offs at designated CBHC locations to allow for diversion of individuals in crisis from hospital emergency departments or arrest.

Exhibit A illustrates a key feature of the Roadmap, the "EOHHS Illustration of Centralized Front Door to Treatment."

[64] Commonwealth of Massachusetts, Executive Office of Health and Human Services. (n.d.) *Community Behavioral Health Centers*. (Retrieved September 24, 2023)

[65] Massachusetts Behavioral Health Partnership (February, 2022). Procurement For Community Behavioral Health Centers [pdf].

Exhibit A: CBHCs as Centralized Access Points



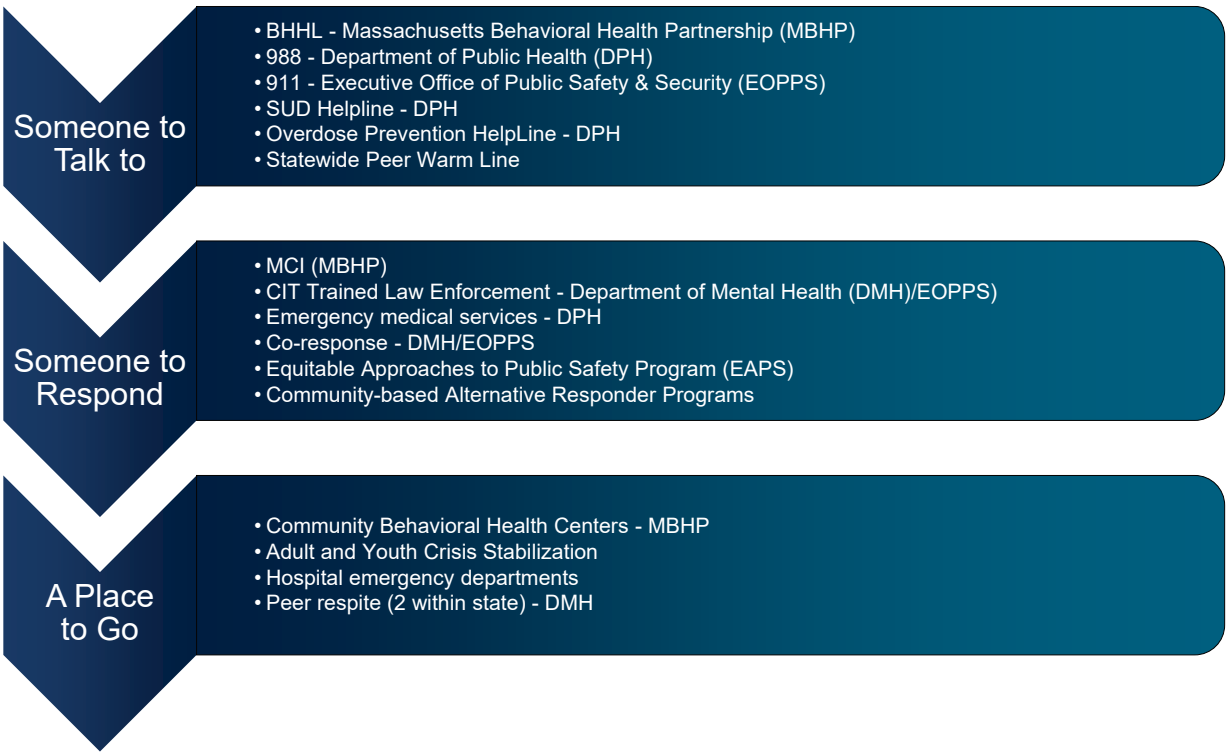
The vision and design of the Roadmap is to create a no wrong door approach to treatment by encouraging multiple points of entry with same-day access, integrating addiction and mental health services, and providing community-based crisis response alternatives to the emergency department using evidence-based practices. Five major components make up this reimagined behavioral health crisis response system within Massachusetts: The Behavioral Health Help Line (BHHL), 988 Suicide and Crisis Lifeline, CBHCs,[66] law enforcement intervention, and hospital emergency departments. EOHHS, through the MassHealth program, contracts with the Massachusetts Behavioral Health Partnership (MBHP) to operate the three core elements identified by U.S. Substance Abuse and Mental Services Administration (SAMHSA) 2020 Crisis Services Guidelines:

- The statewide BHHL that serves as a centralized crisis call center, and maintains bi-directional communication with other behavioral health lines, including the Statewide Peer Warm Line, the Substance Use Helpline, 988, and 911; a network of adult and youth MCI teams operated by CBHCs that serve as crisis mobile team response; and youth and adult crisis stabilization units functioning as crisis receiving and stabilization facilities as part of CBHCs.

[66] Commonwealth of Massachusetts, Executive Office of Health and Human Services. (n.d.) *Community behavioral health centers*. (Retrieved September 24, 2023)

Figure 1 outlines these and other elements of Massachusetts' core crisis system components, along with responsible entities, many of which are described further in the sections that follow.

Figure 1: Massachusetts Core Crisis System Components

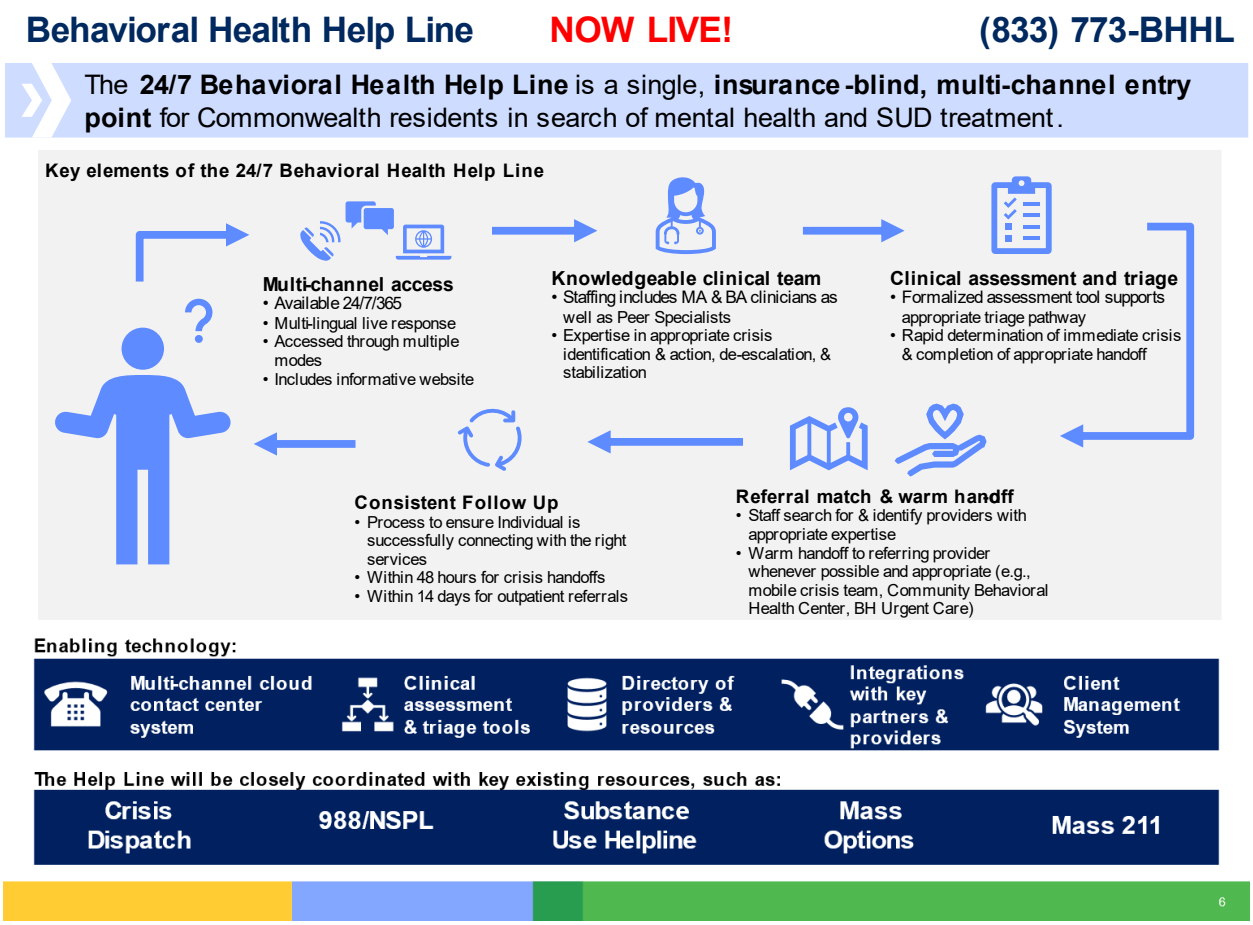


Someone to Talk to — Massachusetts

The Behavioral Health Help Line

The BHHL is a new, centralized information and referral service for people to call or text to find the right treatment for mental health and behavioral health when and where they need it. The BHHL helps people connect with a provider *before* there is a mental health emergency, for routine or urgent help in their community, or even right at home. The Department of Mental Health (DMH) oversees MBHP's implementation and operationalization of the BHHL. The BHHL employs both clinical and certified peer specialist staff 24/7. While still in the early phases of implementation, the BHHL will support identification and triage of crisis, and when appropriate, provide connection to MCI. The stated plan is for the BHHL to eventually be able to dispatch mobile crisis teams directly. Implementation details are under development as both the BHHL and the CBHCs are working to complete implementation of their respective functions before implementing additional practice changes as would be required for the BHHL to dispatch CBHC crisis teams directly. The BHHL maintains bi-directional communication with other behavioral health and emergency lines that a person in behavioral health crisis might call, including the Statewide Peer Warm Line, the Substance Use Helpline, 988, and 911. Exhibit B outlines the major features and channel entry points of the Behavioral Health Help Line.

Exhibit B. Behavioral Health Help Line



988 Suicide and Crisis Lifeline

988 launched across the country, including in Massachusetts, in July of 2022. As noted above, SAMHSA characterizes 988 as providing people in distress "someone to talk to." Massachusetts DPH received supplemental state budget funding and a federal SAMHSA grant, which allowed for the expansion of call center operational hours and workforce growth. The Department of Public Health (DPH) collaborated with 911, DMH, MassHealth, and the MBHP, among others, to establish key network partnerships, logistical and operational readiness, 988 website launch, and a workforce recruitment campaign. DPH developed warm transfer partnerships with ESPs, which preceded the implementation of the Roadmap and the BHHL, with lifelines referring callers in need to ESPs or 911. ESPs are what is now known as mobile crisis intervention, operating as part of the CBHCs. With the launch of CBHCs, 988 adapted its protocols to connect directly with CBHC MCI programs when a caller is in need of mobile crisis services. Massachusetts 988 call centers have received over 62,000 calls since the launch of the new number.[68] An estimated 98% of calls are resolved at the call center level without diversion to 911.

Massachusetts 911/Public Safety Answering Points

Throughout Massachusetts, there are 211 Public Safety Answering Points (PSAPs) that answer 911 calls and dispatch appropriate responses. Many of these are dedicated to a specific city/town, while others are regionally based and comprise many towns and jurisdictions. Massachusetts' landscape mirrors the national landscape regarding variation in identification, coding, and dispatching to behavioral health emergencies (see 911 companion study). MAMH/TAC's interviews and landscape analysis identified several jurisdictions exploring opportunities to deflect behavioral health calls from 911 to alternative responders (see below). During key informant interviews with Massachusetts law enforcement, several chiefs and telecommunicators identified concerns regarding the implementation of call diversion, reporting that they were compelled to respond to all 911 calls and had concerns regarding warm handoffs to 988 or a crisis line, citing unpredictability of calls, safety concerns, and liability questions.

Someone to Respond – Massachusetts

Mobile Crisis Teams: CBHCs

Mobile crisis intervention is embedded into the CBHCs and is accessible to all residents of the Commonwealth, both youth and adults; they are insurance-blind for the first 24 hours. Follow-up treatment after the initial 24 hours of crisis intervention is available depending on an individual's insurance coverage. MCI is available 24/7 at any CBHC site or in the community. MCI teams, which consist of trained professionals and include a behavioral health professional and a peer support specialist, may be dispatched to a community-based location, such as an individual's home, school, park, etc. to support a person in crisis. Within Massachusetts, mobile crisis teams are currently deployed by their respective CBHC organizations, not from a centralized center, as indicated in best practice and seen in other states such as Arizona, Georgia, Oklahoma, and New Hampshire.[67, 68] Massachusetts is considering centralized dispatching from the BHHL.

The CBHCs also provide urgent care, including same day outpatient evaluation, referral, and treatment, with evening and weekend hours, timely follow-up appointments, and evidence-based treatment in person and via telehealth. This provides MCI the opportunity for real-time coordination to ensure linkage to upstream services.

First Responder Intervention

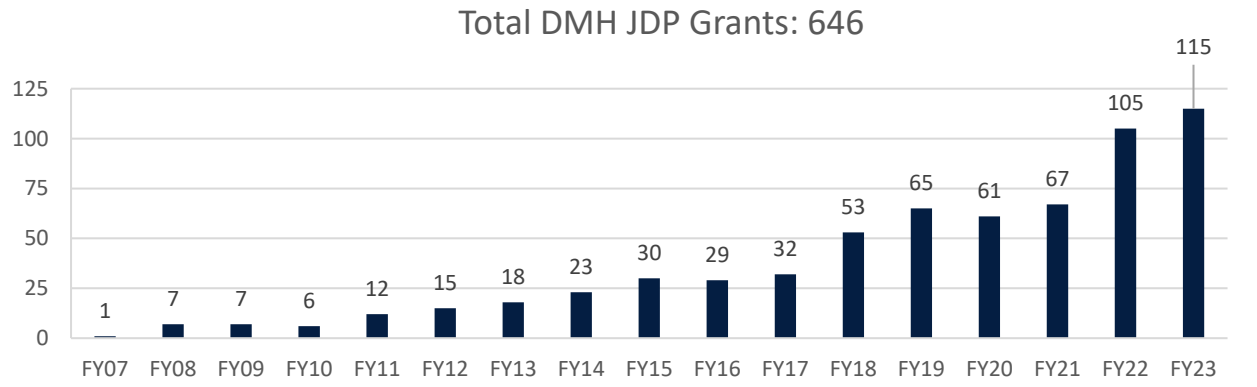
In response to the ongoing need to improve the quality of law enforcement's response to behavioral health crises, the Commonwealth, through DMH, has offered a range of grants and programs to law enforcement agencies throughout the state. The DMH Division of Forensic Medicine provides support to law enforcement and administers grants to police departments to develop pre-arrest, police-based jail diversion programs (JDPs) including Crisis Intervention Teams (CITs) and clinician/police co-responder programs. Since 2007, DMH has funded various co-response models, integrating law enforcement officers and clinicians. In FY2022, DMH awarded $9,355,696 in Jail and Arrest Diversion Initiative grant

[67] Gulley, J., Boss, R., Woodsby, A., Arienti, F., & Wachino, V. (2021). *Mobile crisis teams: A state planning guide for Medicaid-financed crisis response services*. Boston, MA: Technical Assistance Collaborative.

[68] Sheamekah Williams personal communication January 6 2023

funding to 105 distinct grant projects, 36 of which are new projects (See Figure 2).[69] DMH estimates the JDP initiatives produce a total cost savings of $16,380,543 by diverting individuals from hospitals and jails.[70] The grants DMH offers include funding for CIT training, co-response, training, and backfill grants and component funding for law enforcement entities to develop behavioral health programs specifically designed to meet the needs of individual communities. Since 2007, the jail diversion grants offered by DMH have grown from 1 to over 115 annually, totaling 646 grants.

Figure 2: Massachusetts Jail Diversion Program (JDP) Grants, 2007 to 2023



Massachusetts has made a commitment at the state level to enhancing law enforcement responses to behavioral health crises while simultaneously building out alternative responses. Over 156 law enforcement departments in the Commonwealth have pledged to implement the One Mind Campaign, which is a national initiative that strives to improve interactions between law enforcement and individuals experiencing a mental health crisis and is led by the International Association of Chiefs of Police. These departments committed to participate in the One Mind Campaign through enhancing policies and protocols, strengthening training, and establishing more defined partnerships with behavioral health providers. Other clinical integration models have been implemented as well, such as the Hub model in Chelsea and 19 other communities in the Commonwealth. There are a variety of trainings that law enforcement and dispatchers are required to undergo every year; these are evolving due to the recent Peace Officer Standards and Training (POST) requirements and the Policing Act of 2020. Some law enforcement officers receive Autism & Law Enforcement Education Coalition (ALEC) training, which is targeted to equip first responders with the knowledge and strategies to best serve individuals with autism spectrum disorders in a crisis. In addition, jurisdictions and municipalities are funding co-response teams, and there is federal funding that supports some co-response within the state.

Equitable Approaches to Public Safety

The Department of Public Health funds the Equitable Approaches to Public Safety (EAPS) program to support communities in identifying and implementing alternative approaches to traditional public safety

[69] Massachusetts Department of Mental Health (2023). *Jail & Arrest Diversion Grant Program: FY22 annual report*.

[70] Massachusetts Department of Mental Health (2023). *Jail & Arrest Diversion Grant Program: FY22 annual report*.

responses. This approach is equity-driven and engages in community-based collaboration to identify alternatives to police-led responses, and models of implementation range from co-response to a clinical alternative response. Current initiatives funded by DPH include:[71]

- The town of Winthrop embeds trained peer specialist and recovery coaches, mental health clinicians, and resource coordination staff with law enforcement to support diversion and deflection.
- The town of Amherst's Community Responders for Equity, Safety and Service (CRESS) provide community alternative response.
- The city of New Bedford, among other initiatives, utilized the funds to expand its co-response and law enforcement assistance diversion programming.
- The city of Northampton utilizes highly skilled and trained community care responder teams (CCRT) to respond to identified "third tier" non-emergency and emergency response needs.
- The city of Revere created a behavioral health unit within its police department to engage in clinical support to individuals who frequently encounter law enforcement.
- The city of Lawrence's LLEAPS n' Bounds initiative, which consists of an interdisciplinary response with multiple cross-sector partners and individuals with lived experience, provides resources and supports to individuals with behavioral health conditions.

Use of Alternative Civilian Safety Programs in Massachusetts — No Police Involvement

Across the state there are several initiatives to expand civilian responder programs and deflect behavioral health emergencies from law-enforcement-led responses. We offer descriptions here of a few of these programs:

In December of 2021, Amherst, MA created the Community Responders for Equity, Safety & Service (CRESS) department; after six months of staff recruitment, training, and protocol development, CRESS was operationalized in May of 2022. This department has the same standing in town government as the police and fire departments, and was established to provide community safety services as an alternative to police and fire response to situations that do not involve violence or serious crime. Staffed by a trained group of ten civilians with social service, behavioral health, and community support experience, the CRESS team collaborates closely with a range of town, county, and state services to best meet the needs of Amherst residents across the lifespan.

CRESS works closely with Amherst's police, fire, and public health departments, as well as Town Inspection Services, Zoning, Manager's Office, and the Senior Center to reach individuals in need of assistance across the lifespan, those who are housed and homeless, and those, like school students, who need a reliable touch point in town community services. In spring 2023, CRESS reported a range of individual case assistance addressing support to families, veterans, older adults, homeless and insecurely housed persons, and youth and adults struggling with behavioral health crises. CRESS also

[71] Massachusetts Bureau of Community Health and Prevention, Division of Violence and Injury Prevention (n.d.). Funded municipalities.

collaborates closely with behavioral health crisis and peer respite[72] and support services in the area. The CRESS team is explicitly dedicated to early, preventive intervention designed to assist community members to avoid crisis leading to public safety involvement. CRESS is funded in the Town of Amherst budget, and includes local tax dollars, as well as state and federal funds to municipalities. Recent reports on staffing, costs, and services provided indicate that CRESS receives $620,000 from the Town of Amherst, $449,000 from the DPH Equitable Approaches to Public Safety fund, and $150,000 from federal American Rescue Plan Act of 2021 (ARPA) funds.

Initiatives with similar intent are emerging in Cambridge and Northampton. In May of 2023, the City of Cambridge published its FY2024 budget, which included a substantial new investment for an internal-to-city-government Community Safety Department. The Community Safety Department will have a $3.7M budget to support internal department operations, staffed by a new Director of Community Safety, civilian crisis response specialists, an administrative coordinator, and a data analyst. The focus of the work is to provide community engagement and crisis response to vulnerable populations in the city, including persons with disabilities and behavioral health conditions. The city budget will also support funding to the Cambridge Holistic Emergency Alternative Response Team (HEART), a community-led alternative to the city's public safety services, including police. Funded mainly through grants and donations, HEART directs its efforts to "people in conflict or crisis" including people with behavioral health conditions.[73] Northampton secured a $450,000 grant from DPH in 2022 to establish the Division of Community Care (DCC) in the City's Department of Health and Human Services. The Division was designed to provide civilian responders, including peer response, as an alternative to police for a range of community needs and crises. Northampton's vision for the DCC team's work is to assist people experiencing difficult and traumatic moments, regardless of the source of that difficulty, with immediate connection to a civilian response team that can meet them where they are, offering counsel, resources, and support to resolution.

WestComm Regional Dispatch, which serves the Massachusetts municipalities of Chicopee, East Longmeadow, Longmeadow, Monson, and Ware, utilizes an Emergency Medical Dispatch system, which includes Behavioral Health Priority Dispatch.[74] Utilizing this system, WestComm has established protocols for when a call can be transferred out to the behavioral health provider, which is a CBHC. Dispatch staff have the capacity to upgrade the response (to include first responder) if they feel it is not appropriate to transfer out.[75] The CBHC also has a dedicated law enforcement line as well as a police radio. WestComm has made CIT mandatory for its telecommunication personnel at time of hire. This 911 call diversion process started two years ago and has not had a call come back to 911 yet. The

[72] Peer respite is a voluntary overnight community-based program that is operated by individuals with lived experience and offers non-clinical support in a home-like environment to individuals experiencing emotional distress or a behavioral health crisis. More information can be found at https://power2u.org/directory-of-peer-respites/.

[73] City of Cambridge. (n.d.). *Budget department*.(Retrieved September 24, 2023)

[74] Emergency Medical Dispatch (EMD) is a proprietary program that systematically guides telecommunicators through questions and prompts to determine the nature and priority of the call quickly and properly, to accurately dispatch the appropriate responder. This is software that PSAPs can buy to support their call triage process. Recent iterations have included behavioral health dispatching questions and prompts to provide opportunities to identify and dispatch non-law enforcement response when appropriate.

[75] E. Hastings. Personal Communication March 10 2023.

response in the community has been positive, allowing for a more streamlined process of referring individuals who do not need a law enforcement response. There has been a steady increase in calls transferred from 911 to the behavioral health provider as personnel become more comfortable with the process.

A Place to Go in Massachusetts

Crisis Stabilization and Urgent Care: CBHCs

In addition to providing adult and youth mobile crisis intervention, CBHCs are responsible for community crisis stabilization (CCS), a 24/7 community-based treatment which serves as a diversion away from hospital level of care. Adult CCS has been available in the Commonwealth for over 30 years, and youth CCS became available as of January 2023. As previously noted, in addition to crisis services, CBHCs are designed to provide urgent care, including same day outpatient evaluation, referral, and treatment, including integrated behavioral health and substance use treatment, with evening and weekend hours, timely follow-up appointments, and evidence-based treatment in person and via telehealth. These changes in service composition and practice respond to the vision of the Roadmap to provide a public health response to behavioral health crises and an alternative to emergency department care in urgent and emerging situations.

In addition, Massachusetts will release in June 2023 a Request for Responses to establish a pilot crisis stabilization and restoration center in Middlesex County. The Middlesex County Restoration Center is designed to be embedded or closely affiliated with a CBHC, to offer 24/7 walk-in or drop-off capability for individuals, families, clinicians, police, or other first responders as an alternative to arrest or diversion from hospital emergency departments. Upon arrival, individuals aged 18 or older will be provided clinical assessment, treatment resumption or initiation, care planning, and referral, while either remaining for up to 23 hours in the Center's restoration area, or being admitted to one of three types of beds provided by the Center — respite care, crisis stabilization (Adult CCS), or sober support (Residential Rehabilitation).

Massachusetts Emergency Departments

Massachusetts' emergency departments (EDs) are flooded with behavioral health patients. Since 2021, there are routinely between 500 and 700 patients boarding in acute care hospitals each day awaiting inpatient behavioral health placement.[76] DMH and many of the hospitals with boarding patients maintain that many of these patients might have avoided an ED stay, had they been able to access earlier routine care, urgent care, or even crisis intervention in community settings. DMH posits that the number of delayed ED boarding cases is reduced due to recent ED diversion efforts, which may be reflected in more recent Expedited Psychiatric Inpatient Admission monthly reports that DMH posts on

[76] Massachusetts Health & Hospital Association (n.d.). *Capturing a crisis: Massachusetts behavioral health boarding metrics October 2021 – September 2022*.

Mass.gov. Reports for the month of April 2023 indicate that 510 individuals waited longer than 48 hours for disposition, of whom 185 were ages 0 to 17, 279 were ages 18 to 64, and 46 were age 65 or above.[77]

In Massachusetts, patients find their way to EDs through several access points: self-referral, family, ambulance, referral by a professional, behavioral health crisis team, and law enforcement. MBHP data from July to September 2022 shows that individuals assessed by an emergency service provider in a hospital ED were approximately 24% more likely to be admitted to an inpatient mental health unit than those evaluated in the community (see Appendix G). Prior to January 2023, any MassHealth member who presented in the ED for a behavioral crisis was assessed by an emergency service provider, even with the predisposition to hospital admission. Alternative approaches to managing urgent and emerging crisis situations will benefit individuals, their families, and the emergency system, as there are a number of cases in EDs that could be better served elsewhere, as indicated by data from a 2020 Middlesex County Restoration Center Commission study of ED dispositions. Utilizing MassHealth data, the research found that fewer than 45% of those waiting in EDs for crisis evaluation were admitted to inpatient care.[78]

As of January 2023, MassHealth issued guidance requiring EDs to provide crisis assessments for individuals presenting with behavioral health needs.[79] Some hospitals have chosen to subcontract crisis assessment to behavioral health crisis providers, while others have brought this function in house. Commonwealth hospitals have experienced tremendous backup and pressure in their EDs as more people who experience difficulty with timely access to behavioral health care go to EDs seeking assistance. The wait time problem, known as ED boarding, is considerable and reflects problems not only for the patients waiting in EDs for screening, disposition, and/or admission, but also for individuals who are waiting in acute inpatient and detox units for discharges dependent on either housing and recovery support services or continuing care inpatient unit admission. In FY2023, DMH instituted adult and child ED Diversion Teams in certain emergency departments with high volumes of behavioral health emergency cases. The ED Diversion Teams are tasked with a brief assessment to determine the feasibility of diversion, followed by wraparound care and, where feasible, disposition of children and adults boarding in EDs to alternative community-based care. Since the inception of the ED Diversion Teams (Child and Adult), from July 2022 through February 2023, a total of 542 children and 1,225 adults were served. Weekly reports filed since July of 2022 indicate that the volume of weekly cases increased steadily from 117 children served in the first week of July 2022 to 139 children served in the second week of February 2023, and from 218 adults served in the first week of July 2022 to 668 adults served in the second week of February 2023.

[77] Massachusetts Department of Mental Health (n.d.). *Expedited Psychiatric Inpatient Admission (EPIA) dashboards*. (Retrieved September 24, 2023)

[78] Commonwealth of Massachusetts, Restoration Center Commission (2020). *Middlesex County Restoration Center Commission Year Two findings and recommendations*.

[79] Commonwealth of Massachusetts, Executive Office of Health and Human Services, Office of Medicaid (2022). *Behavioral health crisis evaluations in emergency departments and inpatient mental health services rate updates*. MassHealth Managed Care Entity Bulletin 93.

Findings

Based on key informant interviews and a national landscape analysis conducted for this study, four major themes emerged regarding the need to build a robust behavioral health crisis response system in Massachusetts: the need for enhanced cross-sector collaboration; challenges with system capacity and a workforce shortage creating additional system strain; the need for better utilization of peer support services; and the need for an organized and detailed implementation strategy. Throughout the study interviews and focus groups, support was uniformly expressed for the Roadmap for Behavioral Health Reform vision that Massachusetts has created for a community-based behavioral health system to help all people in Massachusetts get mental health and substance use care from trained behavioral health professionals when and where they need it. Through the creation of the Behavioral Health Help Line (BHHL) and the Community Behavioral Health Centers (CBHCs), the state is working to bring its vision to fruition.

There is a Need to Design and Implement a Unified Approach to Crisis Services across Sectors to Alleviate System Confusion, Implementation Inconsistencies, Service Delivery Gaps, and Cross-System Communication Challenges.

Major changes are underway in the behavioral health system to strengthen and expand crisis intervention and resolution services and to lower barriers to timely access through the new 24/7 telephonic front door and behavioral health urgent care. When fully implemented, these reforms position the behavioral health system to provide timely and responsive care as an alternative to the reliance on public safety response to behavioral health crises. However, there is not a concomitant coordinated, statewide, or standardized change on the public safety side. Throughout the course of the study, stakeholders expressed concerns regarding the variability of approaches and implementation of crisis reforms throughout the Commonwealth and on the quality of cross-system communication and collaboration. Inadequate communication creates confusion regarding both the purpose of crisis services and how to access them. While some sectors invested significantly in crisis services reform, the staggered implementation, combined with the lack of a unified approach across all sectors involved in responding to behavioral health crises, poses challenges to the effective use of existing resources.

The Commonwealth's behavioral health crisis system has many overlapping programs and requirements which operate with highly decentralized authority and different entry points for individuals. While the Roadmap for Behavioral Health Reform moves towards more alignment, transparent communication is crucial to support trust and utilization of the system. Throughout key informant interviews and focus groups, there was a reoccurring theme of limited communication and cross-system collaboration, creating and exacerbating community confusion. We note again that this study began in May of 2022, eight months before the launch of the CBHCs, BHHL, and enhanced crisis services in the Commonwealth, now accompanied by a public communications campaign.

As part of the Roadmap, steps are underway to address regulatory, financing, and program changes in alignment with the reform vision. Key informant interviewees expressed concern that implementation of the crisis system was taking place on a local and regional basis with limited infrastructure from the

state. For example, each CBHC is responsible for creating policies with each hospital and law enforcement entity, instead of implementing one statewide standard policy or framework. There are 25 CBHCs, 136 hospitals, and over 350 law enforcement entities in the Commonwealth. Reviewers from the Executive Office of Health and Human Services (EOHHS) and the Executive Office of Public Safety and Security (EOPSS) stressed the importance of addressing statutory, regulatory, policy, and procedure changes to support the envisioned reform.

National best practices emphasize the importance of a clearly defined accountable entity to serve as the central coordinator of efforts across the various components of the crisis system at large.[80] While many key informants expressed the need for ownership of the crisis system by one governmental entity with authority to integrate participation and response across sectors, many had differing opinions on the approach which would allow the Commonwealth to streamline the process and minimize challenges and reduce risks for individuals experiencing a behavioral health crisis. Crisis response in Massachusetts communities involves both the public health and public safety entities. Since the start of 2023, communications about crisis services reforms have been communicated through EOHHS, DMH, and DPH regarding the design of the CBHCs, BHHL, and crisis services enhancements. However, key informants on the ground report continuing confusion about what if anything may be different in the public safety arena, in the operation of hospital emergency departments (EDs), and in the operations of crisis response in the Commonwealth.

System Capacity Is Being Developed but Needs to Expand to Meet Demand and to be Managed in the Face of a Workforce Crisis.

Workforce-Related Capacity Issues

Across the nation, there has been an increase in behavioral health diagnoses and rising demand for system partners, including behavioral health and medical providers and law enforcement. These are partners already struggling to meet needs for behavioral health services in a timely manner.[81, 82] They are asked to do more with a limited workforce and resources. [83, 84] Massachusetts has created a vision to enhance behavioral health access for residents, but the workforce has not grown in line with the expanded vision. Community behavioral health providers report competing for workers with schools, hospitals, residential providers, primary care, and law enforcement. Throughout the study, both

[80] Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry (2021). Roadmap to the ideal crisis system: Essential elements, measurable standards and best practices for behavioral health crisis response. Washington, DC: National Council for Mental Wellbeing.

[81] American Psychological Association (2022, November 15). *Increased need for mental health care strains capacity* [Press release].

[82] Association for Behavioral Healthcare (2022, February 15). *Survey details behavioral health workforce crisis in Mass.* [Press release].

[83] Bipartisan Policy Center. (2023). *Filling the gaps in the behavioral health workforce*. Washington, DC: Bipartisan Policy Center

[84] International Association of Chiefs of Police (2019). *The state of recruitment: A crisis for law enforcement*. Alexandria, VA: International Association of Chiefs of Police

behavioral health providers and law enforcement personnel expressed concerns about workforce capacity. For example, responses to the mobile crisis provider survey indicated that the biggest concern among MCI providers in implementing the enhanced mobile crisis service was workforce.

Throughout stakeholder interviews, law enforcement agencies reported challenges related to the behavioral health workforce. Multiple municipalities reported that the community mental health provider with whom they collaborated was having difficulty finding qualified clinicians for co-response. One jurisdiction reported it had been waiting over a year for a co-response clinician to be hired. Law enforcement consistently noted that they are taking on more responsibilities related to behavioral health, as they are required to be open 24/7 and to respond immediately. A key theme among law enforcement was a level of frustration that responses to behavioral health emergencies are routinely diverted to law enforcement because behavioral health providers are understaffed or not open 24/7. This has driven some law enforcement agencies to question the reliability of the behavioral health crisis system. Many departments hired clinicians in-house as part of their first responder or co-responder teams. Other stakeholders, including the BHHL and 988 providers, also expressed concerns about workforce challenges.

During the May 22, 2023 meeting of the Community Policing and Behavioral Health Advisory Council (CPBHAC), Executive Director Robert Ferullo of the Massachusetts Municipal Police Training Committee (MPTC) described plans to develop and deliver both baseline and specialized training for police in the Commonwealth. The MPTC will develop a standard curriculum to incorporate orientation not only to mental health and crisis intervention, but also to the expanded crisis services system in Massachusetts. That training curriculum will be delivered to every new officer, and eventually to all 23,000+ police officers in continuing education in the state between July 1, 2024 and December 31, 2025. In addition, the MPTC will undertake specialized training for police departments, partnering with leaders in CBHCs and EOHHS, the Department of Mental Health (DMH), and the Department of Public Health (DPH) to advance crisis system reforms.[85] As a result of a combined effort, in fall 2023, MA State 911, DMH, and the Massachusetts Behavioral Health Partnership (MBHP) will offer training for certified telecommunicators on the Massachusetts Roadmap for Behavioral Health Reform.

Individuals receiving services talked about accessibility and timeliness issues, which led them to seek treatment in EDs. The January 2023 implementation of behavioral health urgent care at 25 CBHCs and more than 30 additional clinics across the state is designed to provide earlier and alternative intervention for emerging crises. Repeated delays in timely response created a lack of faith in the efficiency of the system. In addition, the lack of workers has exacerbated challenges with crisis teams providing mobile response in the community.[86] Individuals with lived experience reported being told to go to the mobile crisis location, observing that the mobile crisis intervention (MCI) team did not have staff to deploy to a community-based location and that the response times were long (See Appendix H). In Massachusetts, there is not yet a statewide, systematic behavioral health workforce approach; Between 2021 and 2023 there have been substantial tactical investments in rate increases, recruitment and retention incentives, scholarships and loan forgiveness, and new workforce pipeline development

[85] CPBHAC meeting, May 22, 2023.

[86] Massachusetts Behavioral Health Partnership. (n.d.). *Emergency Services Program (ESP)/Mobile Crisis Intervention (MCI) location of intervention volume and percent by age: Calendar years 2019, 2020, and 2021* [Data set].

initiatives but these have yet to resolve the underlying workforce shortage.[87] In May of 2023, the Behavioral Health Advisory Commission filed its recommendations to spend $192 million of the $198 million Behavioral Health Trust Fund appropriation on workforce development investments.[88] Based on key findings concerning depletion of the behavioral health workforce, the Commission developed the following recommendations for utilizing the Trust Fund to bolster the Commonwealth's behavioral health delivery system: 1) Loan Forgiveness: $80 to $100 million; 2) Scholarships: $20 to $30 million; 3) Paid Internships, Practicums, and Field Placements: $20 to $30 million; 4) Reimbursement for Clinical Supervision: $20 to $30 million; 5) Professional Fees and Practice Costs: $2 to $5 million; 6) Behavioral Health Support for Health Care Workers: $5 to $10 million; 7) Commercial Rate Analysis: $500,000 to $1 million; and 8) Youth and Schools: $5 to $10 million.

Massachusetts is actively engaged in administrative and legislative efforts to evaluate avenues to increase system efficacy, while simultaneously working to create a pipeline of behavioral health workers who can be employed in the system through competitive salaries.

Underutilization of Community-Based Stabilization Programs

One issue exacerbating system incapacity and increasing ED boarding is the underutilization of community crisis stabilization.[89] EDs have historically been overutilized for a variety of reasons, including hospitals being easily accessible in Massachusetts and a crisis system that has relied on 911/law enforcement for response to behavioral health emergencies. Law enforcement representatives from 58 jurisdictions reported that they do not drop off at local CBHCs/Emergency Services Programs (ESPs) and usually transport to hospitals if additional need exists.[90] Some reasons cited in interviews were distance to travel across jurisdictions for drop-off, and frustration with the perception that the individual would just be released without follow-up care.[91] Once someone is taken to a hospital, emergency department doctors stated concerns about liability and the assumed risk of stepping the member down to care in the community, such as crisis stabilization, instead of ensuring a 24-hour level of care. As noted above, there have been recent changes to require hospitals to staff their EDs with licensed behavioral health clinicians and physicians to conduct their own assessments on MassHealth members, a task previously performed by the ESPs, and the impact of this change on the potential for redirection to community-based services is yet to be seen. It should be noted that some EDs are contracting with CBHCs to provide them with licensed behavioral health clinicians to complete the required assessments.

As of January 2023, there are youth crisis stabilization units to expand community access; however, key informants reported that many people are unaware of the purpose and intent of the units, and that due to workforce constraints, challenges remain in timely access and sufficient capacity for youth crisis services in the state. There has also been community confusion around the difference between crisis

[87] Substance Abuse and Mental Health Services Administration (2020). *Behavioral health workforce report*.

[88] East Boston Times–Free Press. (2023, May 10). *State commission releases recommendations to bolster behavioral health*.

[89] Massachusetts Behavioral Health Partnership (n.d.). *Community Crisis Stabilization (CCS) Average Daily Census, CY2022 (January)*.

[90] Massachusetts 911 Call Study: Assessing the Potential to Divert Behavioral Health Calls to Alternative Responses

[91] PSAP Survey

stabilization and community-based acute treatment.[92] Additional guidance and more systematic outreach and education from MassHealth could aid in clarifying expectations, ensuring fidelity to the model, and increasing access to stabilization and support.

Transportation Issues

Though CBHCs are currently working to support ambulance drop-offs, the study team routinely heard during the earlier data gathering process about challenges associated with transportation for individuals experiencing a behavioral health crisis and the inability to drop off individuals at non-hospital locations. Some interviewees cited the importance of what was, at the time of the data gathering, a plan to include ambulance drop-off/reception as a function of the CBHCs in the EOHHS Roadmap.

DPH regulations now specifically permit ambulances to drop off at CBHCs with an approved DPH Point of Entry Plan (see 105 CMR 170.020, definition of "Appropriate Health Care Facility"), which would set out triage criteria to identify patients appropriate for drop-off at a CBHC location rather than an ED. Following passage of this regulatory amendment in January 2023, DPH issued guidance to emergency medical service (EMS) providers and also shared it with CBHCs, clarifying that ambulance drop-offs at CBHCs could not occur until a DPH-approved point of entry (POE) plan was released. Point of entry plans are developed and issued by DPH, but information must be provided on the services and supports provided in the facility type including, at a minimum, capacity to provide clearly designated medical services and ensure patient safety and security.

DMH, DPH, and MassHealth's Office of Behavioral Health have coordinated throughout the development and launch of CBHCs, and are in agreement that under current program specifications, services provided at CBHCs are not comprehensive enough to accept patients with acute or chronic medical needs. DMH and MassHealth plan to engage DPH and CBHCs on the potential POE, including identifying feasibility challenges and safety concerns, developing program specifications to address those concerns, and ensuring clarity on what the CBHCs are licensed for and provide. Key informant interviews highlighted that CBHCs, local law enforcement agencies, and EMS providers often find that addressing transportation challenges had been left to them to address independently, which reportedly created frustration. DPH regulations do not address other forms of transport between health care facilities, including chair cars or medical Ubers, which should be utilized when ambulances are not medically necessary given the statewide ambulance shortage.

Law enforcement also highlighted the challenges of dropping individuals off at community-based crisis sites when they were not in the same town as the local police jurisdiction. Research has shown that that for every 1-mile increase in the distance between the call location and the crisis center, law enforcement was 1% less likely to take the individual to the crisis center.[103]

[92] Massachusetts Behavioral Health Partnership (2014). *Performance specifications: Community-Based Acute Treatment (CBAT) for children and adolescents*.

There is a Need for Better Utilization of Peer Supports in Crisis Prevention, Crisis Response, and Post-Crisis Care.

Peer support is an integral component of crisis response, and expert advisors and local stakeholders agree that peers should be actively engaged throughout the continuum.[93] Evidence demonstrates that peer support specialists (including peer specialists and recovery coaches in Massachusetts) can play a meaningful role, including by reducing inequities in service access across the crisis continuum, enhancing support, and reducing the recurrence of hospitalization.[94, 95] Massachusetts has historically relied on master's level staff for crisis service provision and there is opportunity to further integrate peer support specialists and family partners into crisis prevention and de-escalation. Based on interviews and focus group feedback, the role is not clearly understood and has not been leveraged to align with best practices. For example, MAMH/TAC was told that family partners and peer support staff were primarily used for follow-up calls but not actively engaged in initial contacts or crisis assessments. In addition, the BHHL is utilizing certified peer specialists for follow-up, but does not currently employ family partners. Focus group participants confirmed that utilization of family partners was extremely helpful for families experiencing a crisis; however, several reported that often the family partner service is unavailable when connecting with mobile crisis.

Currently in Massachusetts, there are two peer respite centers and a peer warmline.[96] Stakeholder input underscores that CBHCs/988 could connect in a more consistent and meaningful way to the peer support line, peer bridging programs, and organizations that provide peer respite for individuals wanting to be treated in the community. While there is coordination reported at a local level, these services are operating mostly outside of the rest of the crisis response system. The peer respite programs are funded through DMH and available to all people struggling with their mental health;[97] however, it was reported MCI teams do not have access to refer an individual to peer respite programs. Increasing the number of peer respites and expanding access to them could support system capacity by diverting individuals away from unnecessary hospitalization.

Again, professionals and family members emphasized the importance of integrating peer support services across all components of the crisis continuum as these services can play a vital role in prevention, crisis response, and post-crisis care.[98] In Oklahoma, the peer workforce is the first to

[93] Substance Abuse and Mental Health Services Administration (2022). *Peer support services in crisis care*. Advisory. SAMHSA Publication No. PEP22-06-04-001.

[94] Corrigan, P. W., Pickett, S., Batia, K., & Michaels, P. J. (2014). Peer navigators and integrated care to address ethnic health disparities of people with serious mental illness. *Social Work in Public Health, 29*(6), 581–593

[95] O'Connell, M. J., Sledge, W. H., Staeheli, M., Sells, D., Costa, M., Wieland, M., & Davidson, L. (2018). Outcomes of a peer mentor intervention for with recurrent psychiatric hospitalization. *Psychiatric Services*, *69*(7), 760–767

[96] A peer-run hotline that offers callers emotional support and resources and is staffed by individuals who have lived experience of recovery.

[97] Massachusetts Department of Public Health. (n.d.). *Recovery Learning Communities*.

[98] Substance Abuse and Mental Health Services Administration. (2022). *Peer support services in crisis care*. Advisory. SAMHSA Publication No. PEP22-06-04-001.

respond and contact the individual experiencing the crisis, offering crisis intervention under the direction of a master's level clinician. The master's level clinician then offers treatment in coordination with the intervention. However, CBHCs and other crisis providers reported difficulty in hiring peer support workers due to a workforce shortage and concerns around access to a certification process.

There is a Need for an Organized and Detailed Implementation Strategy to Support and Inform Ongoing Crisis System Operations.

MassHealth is in the process of developing metrics and outcomes by which to measure the crisis system. Massachusetts has multiple sets of data being produced by 988, BHHL, and co-response teams, and there is no one place that captures behavioral health crisis data, making transparency impossible. This results in the inability to measure the true capacity needs of the crisis system to be able to respond effectively to people experiencing behavioral health crises. A single database would enable efficient deployment of the Commonwealth's limited resources, such as assessing how many mobile teams (adult and youth) are needed for a geographic area to respond in a timely manner and reduce law enforcement response.

States like Oklahoma, Utah,[99] and Missouri[100] have developed single platforms that overlay multiple data sets and display transparent crisis metrics; such as volume, demographics (such as gender, race, and age) geography, response time, disposition, and collaboration with law enforcement. The identification of outcome measures and data collection in crisis systems is essential to evaluating the effectiveness of crisis response and identifying the value and utility of each component. Prior to the launch of the MCI teams in January 2023, MBHP, on behalf of MassHealth, collected behavioral health crisis response data on crisis response time, diversion from hospitals, and percentage of crisis response in the community, as well as use of peers and family partners. As of March 2023, MassHealth stopped collecting this data due to the administrative burden placed on providers. MassHealth has indicated that it will begin to use claims-based data at some point in the future. In general, provider electronic health records and Medicaid claims databases do not include data elements specific to MCI implementation, and are therefore insufficient to support a robust continuous quality improvement approach that is consistent with best practice approaches.[101] At this point there is no publicly reported outcome/data measurements for the MCI system. Stakeholders indicated there has been a lack of clarity and transparency around the collection of outcome and measurement data related to MCI, limiting the assessment of its efficacy.

Currently there are metrics tracked by several departments in different databases. For example, federal grants require that grantees permit the national administrator of 988, currently Vibrant Emotional

[99] Huntsman Mental Health Institute at the University of Utah. (n.d.). *Community crisis intervention & support services, Salt Lake City area.* Retrieved September 24, 2023.

[100] Kelly, L., & Brykman, K. (n.d.). *Planning for Certified Community Behavioral Health Clinic program sustainability: Lessons from state Medicaid leaders*. Center for Healthcare Strategies and National Council for Mental Wellbeing.

[101] Vanderploeg, J. J., Randall, K. G., Becker, S., & Theriault, K. (2023). *Mobile response for children, youth, and families: Best practice data elements and quality improvement approaches*. Child Health and Development Institute of Connecticut & Innovations Institute at the University of Connecticut School of Social Work.

Health, to collect 988 data, including call answer rate, call abandonment rate, and average length of time to answer. Vibrant analyzes this data nationwide and reports findings back to the states and call centers. The BHHL reports the number, duration, triage, and disposition of calls to its 24/7 assistance line, and is required to have client management system data capabilities. PSAPs are coding 911 calls triaged to have a behavioral health component in a variety of ways in the absence of standardization, and as a result, there is no process and limited capacity to quantify those calls at a state level (See companion 911 report). DMH's co-response programs collect a variety of data points, such as call type, disposition, and demographic information. DMH makes this information publicly available for review, and is in the process of streamlining documentation processes to enhance data quality. This captures only a small fraction of the calls that are coming into 911 related to behavioral health emergencies.

Through a contract with MassHealth, the University of Massachusetts will conduct an evaluation of the CBHC system, which would best be accelerated to offer rapid cycle feedback. Its impact would be enhanced by gathering, among other data points, community input on CBHC system performance. Currently, it is unclear whether and how all these data points are being integrated and used to inform larger system planning. The current lack of common metrics that cut across the crisis system (988, BHHL, co-response, MCI) makes integration and transparency a challenge.

Recommendations

Recommendations flow from the findings outlined above and incorporate the contributions of research on best practices, the input of key informants to the study process, and the reforms in development across Commonwealth of Massachusetts governance and service delivery entities. These recommendations, as reviewed with the Community Policing and Behavioral Health Advisory Council (CPBHAC), must be followed by planning that maps out the administrative, policy, regulatory, and budget actions and timelines required to achieve implementation.

Recommendation 1. Develop a Governance Entity that Enhances Cross-Sector Collaboration at the State and Regional Levels.

1.1 Identify or establish one entity under the co-direction of the Secretary of Health and Human Services and the Secretary of Public Safety and Security that would be responsible for overseeing crisis response planning and implementation.

The bifurcation of crisis response and the multiple entry points have created a patchwork of overlapping programs and interventions housed under different state agencies and departments within the Executive Office of Health and Human Services (EOHHS) and the Executive Office of Public Safety and Security (EOPSS). There are multiple planning commissions and taskforces focused on portions of the system (988 commission, the Community Policing and Behavioral Health Planning Council, the Behavioral Health Advisory Commission). A consistent theme in key informant interviews was the need to break down barriers between agencies, and to intentionally take steps to strengthen trust and coordination among the community partners. To effectuate change, leadership and accountability are essential. The authors recommend that the state identify an accountable entity or body with a defined

role of coordinating efforts related to behavioral health crisis across state agencies and departments. This governance structure would provide the oversight needed for strategic planning, alignment across departments, and data review; it will need the authority to support implementation across the various departments. This governing body or entity would be tasked with overseeing and orchestrating efforts across commissions and with reducing siloing among agencies. The governing body would coordinate with representatives who have decision-making authority from EOPSS, public safety answering points (PSAPs), and law enforcement, as well as EOHHS entities at the Department of Mental Health (DMH), the Department of Public Health (DPH)/988, emergency medical services (EMS), CBHCs, MassHealth, the Massachusetts Behavioral Health Partnership (MBHP), and managed care entities (MCEs). It is critical to include people living with behavioral health conditions and experienced with crisis services response in the Commonwealth as members of this body.

An accountability structure is essential to aligning stakeholders around common system goals, and provides a forum to monitor data and performance in order to make adjustments that improve quality. The U.S. Substance Abuse and Mental Health Services Administration's (SAMHSA) national crisis care guidelines address the importance of monitoring system and provider performance. These guidelines stress that in addition to monitoring fidelity to best practice, states and other funders should develop a systemic process to continuously analyze data for performance evaluation.

With centralized governance, the behavioral health reform occurring within the state can streamline the process for people with behavioral health care needs to get the right care at the right time from the right providers in the right place. A singular unit responsible for all aspects of behavioral health crisis response will support the Commonwealth to effectively implement its behavioral health crisis vision. The unit, with EOHHS and EOPSS leadership, will be effectively positioned to address statutory, regulatory, policy, and procedure changes to support the envisioned reform.

1.2 Create opportunities for regional cross-sector planning and mutual understanding.

To support uniformity in process but allow for local implementation to meet the needs of the community, it is recommended that the state define and set broad expectations through collaboration on a regional level, recognizing the geographic coverage of respective CBHCs. The state has existing infrastructure that can be leveraged and enhanced to promote these collaborations. For example, DMH currently has training and technical assistance centers (TTACs) that are focused on providing technical support for co-response and Crisis Intervention Teams (CITs). These TTACs are tasked with enhancing collaboration between police departments, the peer community, and health providers. However, the cross-system coordination can be enhanced to work more effectively with the newly re-envisioned mental health system, hospitals, and EMS. Additionally, it was flagged that the concept of safety is different when talking to a police officer versus a mental health professional. Therefore, a shared understanding, standardized protocols, cross-training, and intentional efforts to create and sustain trust between behavioral health providers, PSAPs, and first responders are imperative to facilitate successful implementation and sustainability of the crisis system.

An effective implementation of crisis system reforms would be enhanced by release of an aligned statement from public safety leadership, which keys into the unified message now coming from health and human services government leaders and provider organizations regarding the role of CBHCs, the function of the BHHL, and the expectations of local working agreements between CBHCs and their public

safety partners.

Recommendation 2: Create a Statewide Behavioral Health Workforce Strategy, which Enhances the Capacity and Ability of Behavioral Health Providers to Provide Alternative Emergency Services and Programs for Behavioral Health Crises Across the Commonwealth.

Through the Mental Health ABC Act in 2022[102] the state of Massachusetts dedicated $198 million to address challenges in the behavioral health workforce. The Behavioral Health Advisory Commission advised the legislature in an early May 2023 commission meeting of its priorities for expenditure of the $198 million to retain, train, recruit, and reengage licensed behavioral health professionals in the Commonwealth. In a recent report, the Blue Cross Blue Shield of Massachusetts Foundation[103] recommended that Massachusetts create a 10-year behavioral health workforce strategy. Authors recommend that this strategy prioritize a workforce pipeline to crisis services. To prevent overuse of hospitals, a crisis system should be able to respond in appropriate timeframes, which requires having adequate staff. Within the overall behavioral health workforce strategy there should be specific attention to address the workforce shortage within the BHHL, CBHCs, and emergency departments.

Massachusetts could better define the role of peers and family partners, so they are one of the first responders when an individual is in crisis. This should include taking steps to diversify the behavioral health workforce to reflect the racial, ethnic, cultural, sexual orientation, and gender identity diversity of the communities served. Peer workers should reflect the lived experiences of people in the communities they serve, including Black, Indigenous and Persons of Color (BIPOC) communities.[104] Acceleration of these workforce efforts, as well as regulatory and program change efforts, is urgently needed. Exploration of additional avenues to streamline processes or enhance efficacy could also mitigate the impact of delayed crisis response caused by the workforce shortage. States like Oklahoma have made this culture change. To make this shift clear, metrics need to be developed for the use of peers in crisis.

[102] Massachusetts St.2022, c.177 - An Act Addressing Barriers to Care for Mental Health

[103] Lipson, M., Boozang, P., Rozario, N. (2022). *Creating a robust, diverse, and resilient behavioral health workforce in Massachusetts: Executive summary*. Blue Cross Blue Shield of Massachusetts Foundation and Manatt Health.

[104] NAMI STAR Center and the University of Illinois at Chicago, National Research & Training Center (2010). *Cultural competency in mental health peer-run programs and self-help groups: A tool to assess and enhance your services.* National Alliance for Mental Illness and University of Illinois, Chicago, National Research & Training Center.

Recommendation 3: Develop an Organized and Detailed Implementation Strategy in Coordination with MassHealth, DMH, DPH, EOPSS, and Statewide 911.

An implementation strategy that specifies actions related to law enforcement, EMS, fire departments, and 911/PSAPs will strengthen EOHHS and EOPSS reforms. The strategy would include alignment of DMH Forensic Unit goals and outcomes aligned with the overarching crisis system, inclusive of refining DMH co-response data collection. In addition, there is a need to define the role of EMS and opportunities for EMS to partner with the behavioral health crisis system, including CIT training for paramedics. The implementation strategy will be aided by curriculum development underway in the EOPSS 911 Department, and by EOHHS crisis intervention reform implementation and training activities.

3.1 Create a training curriculum in partnership with State 911, MPTC, the Peace Officer Standards and Training Commission, DMH, DPH, MassHealth, and people with lived experience.

Despite differences in the role of each call center, there are core components that will benefit each call center training initiative. These components include de-escalation, suicide assessment, and understanding of available resources and behavioral health processes. It is useful to develop standardized partnership memoranda, employing standard terms and standardized operating and clinical protocols, and referencing standardized curricula to support mutual understanding. This will foster shared responsibility and enhance complementary action to address the crisis intervention and crisis resolution needs at all levels of the public health and public safety systems.

Furthermore, it is critical that all first responders, including EMS/paramedics, be trained in clinical protocols for engaging with individuals experiencing a behavioral health crisis. The state has trained some 911 dispatchers in behavioral health crisis response through diversion program grants, but there is a need for more consistent, comprehensive, and standardized training available to PSAPs. Enhanced training will support PSAP staff to evaluate calls, determine behavioral health relevance, and provide clear dispatch and response guidance. Training would be enhanced by providing PSAPs with standardized tools including call scripts and reporting frameworks.

3.2 Create a standardized framework or process for screening and triaging behavioral health calls, and continue to incentivize and regionalize PSAPs.

There are 211 PSAPs across the Commonwealth with wide variability in how behavioral health calls are screened, triaged, and dispatched for response. As identified in the CPBHAC-directed examination of 911 calls, there is wide variation in the quality, quantity, and types of information collected by 911/PSAPs, resulting in an incomplete picture of how behavioral health calls are managed. While the structure of 911/PSAPs varies statewide (e.g., local, regional, managed by police departments, standalone), a core set of protocols could be established that incorporates guidelines and best practices for screening, triaging, and reporting calls for the right response, particularly as the behavioral health crisis system expands its capacity to respond to calls. This should include EOPSS guidance on which calls can be transferred to the BHHL or mobile crisis intervention services, as well as bi-directional interoperability of 911/PSAPs with behavioral health crisis providers. In developing guidance, consideration should be given to alignment with the National Emergency Number Association standards

currently in revision. State 911 is currently working with BHHL to develop a two-hour workshop to educate PSAPs and support meeting their certification requirements.

It is important that EOPSS and the 911 Department continue to incentivize and regionalize PSAPs to streamline and standardize operations. Incentivizing increased regionalization allows for better standardization, promotes interoperability, and addresses workforce challenges occurring within dispatch. This includes supporting funding for regionalized PSAPs and assessing funding streams for independently operated PSAPs.

3.3 Establish cross-system data collection requirements/standards that can be used to assess and inform the capacity and performance of crisis services. This should include a statewide behavioral health crisis dashboard that is public-facing and integrates 988, BHHL, MCI, hospital, and co-response data.

Chapter 177 of the Acts of 2020[105] tasks the CPBHAC to review and evaluate current and potential crisis intervention models including evaluating the effectiveness of the crisis response system and its components. Effective crisis systems should have data systems to support evaluation and quality improvement, to examine the use of measures within and across systems, and to encourage regular examination of cross-system data. Adult and youth data should inform team capacity decisions, illuminate trends regarding crisis calls and response, guide strategies for sustainability of programs, and help measure efficacy of the behavioral health system. All metrics should be inclusive of member and stakeholder engagement and incorporate member satisfaction surveys.

[105] Massachusetts St.2020, c.253 - An Act Relative to Justice, Equity and Accountability in Law Enforcement in the Commonwealth

The creation of a statewide crisis dashboard can allow for real-time interventions in areas that may have a spike in crises. With a functioning system, the data would also allow the system to apply a plan-do-study-act (PDSA) cycle and "tweak" it as it evolves. Massachusetts should strive to strike a balance when considering national best practices approach to what makes since at a local level to meet the needs of a community. As more attention and research are being dedicated to crisis intervention, the field is evolving on developing more standardized approaches to measure MCIs. Massachusetts should be thinking beyond the Medicaid claims database for ways to measure system performance. There is a need to define expectations and set standards for statewide data collection to measure performance for youth and adults in several areas:[106]

- Average response time for mobile crisis intervention
- Percentage of individuals who receive follow-up care within 24 or 48 hours
- Disposition of cases (i.e., number of individuals taken to a psychiatric hospital voluntarily and the number taken involuntarily; individuals connected to crisis stabilization units; individuals connected to respite)
- The number and percentage of crisis calls for which the MCT engages/requests police response
- The number and percentage of individuals who receive mental health and/or community-based substance use disorder services within a defined period following a mobile crisis team intervention
- The number and percentage of individuals who receive follow-up contact by the mobile crisis team within a defined period
- The number and percentage of encounters that included a peer support specialist as part of the MCI format and number of sessions: i.e., in person, telehealth, phone, community vs. site-based

The national administrator of 988 collects 988 data, including call answer rate, call abandonment, and average length of time to answer, analyzes these data nationwide, and reports it back to the states and call centers. In addition to the current BHHL, the state can take steps to create simple, more uniform metrics across the broader crisis continuum. States and counties need to promote coordination with other agencies, such as state hospital associations, law enforcement, and first responders, through creation of memoranda of understanding to effectively track data across sectors, assess MCI performance, and promote quality improvement.

[106] O'Brien, J., Wachino, V., Gulley, J., & Martone, K. (2021). *Federal policy recommendations to support state implementation of Medicaid-funded mobile crisis programs*. Boston, MA: Technical Assistance Collaborative

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Cost Guidance

In the legislative directive to the Community Policing and Behavioral Health Advisory Council (CPBHAC) for this crisis services study, Section VII specified development of "an estimate of the additional costs or cost savings of implementing the council's recommendations under this section and possible sources of funding for delivering the crisis response and continuity of care system at the state, county, and municipal levels."[107]

The respective cost and cost avoidance associated with implementing these services are outlined below. It is important to note that the financing for these Roadmap reforms is already embedded in Massachusetts state budget lines for MassHealth, the Department of Mental Health (DMH), and the Department of Public Health (DPH), and in Medicaid program federal revenue plans. However, information from the peer-reviewed literature and public policy reports provides guidance on the relative costs and potential cost savings of these services. Results of the authors' review are as follows:

There are challenges to developing a comprehensive cost savings analysis associated with an alternative crisis response system, due primarily to the lack of a comprehensive set of pre-implementation data across the case studies reviewed. However, most case studies suggest that significant cost savings can result from a comprehensive crisis response system that includes a 24/7 Behavioral Health Help Line (BHHL), mobile crisis intervention (MCI) teams, and crisis stabilization units. These savings are due to reduced emergency department (ED) visits and inpatient hospital utilization in favor of more appropriate use of community-based behavioral health services. In addition, there are savings noted in the cost of police interventions. We present herein some of this data.

Massachusetts Cost Data

Below is a chart of key Massachusetts cost components to illustrate the potential health care costs incurred when an individual with a behavioral health condition requires crisis intervention services and there is no alternative crisis stabilization and diversion system. The average cost of an emergency department visit alone with the ambulance totals $4,597. If an individual is further admitted to an acute inpatient bed, the average cost could be $12,262. According to the Middlesex County Restoration Center Commission report, the average cost of an arrest on the public safety side is $2,500.

	MASSACHUSETTS COST DATA	Cost $
1	MassHealth Payment for Ambulance Trip	$ 397
2	Average Mental Health ED Visit	$ 4,200
	Subtotal of Ambulance Trip and ED Visit	$ 4,597
3	Average Inpatient Psych Hospital Per Diem	$ 1,057
4	Estimated Avg Cost per Inpatient Stay	$ 7,665

[107] Massachusetts St.2020, c.253 - An Act Relative to Justice, Equity and Accountability in Law Enforcement in the Commonwealth

Sources:

1 *MassHealth Regulations*

2 *Middlesex Country Restoration Center slide deck, UMass Chan Medical School, Commonwealth Medicine, March 2022*
Notice of Final Action, Payment for Privately Owned Psychiatric Hospital Services

3 *Effective Oct. 1, 2022, EOHHS*

4 *Letter from Mike Levine to the Legislature on Psych Inpatient Rates, May 2, 2023*

Case studies of similar community stabilization initiatives in other states and cities have reported findings that point to discernible reductions in health care utilization and costs. The Crisis Now 2014 report by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA)[108] includes a business model and a toolkit derived from reviewing data from crisis programs in a number of states. The toolkit includes a calculator that may be used to estimate potential savings from implementing a robust crisis diversion and stabilization program. In this model, inpatient bed utilization could theoretically be reduced by 71.2% and the net savings after accounting for the cost increases associated with the new crisis stabilization services was estimated to be 52%.

The following are some examples of cost savings from crisis stabilization program case studies and research papers:

- Minnesota Twin Cities — Within six months following the start of crisis stabilization engagement, ED visits were reduced by 13% (from 56% to 43%) and inpatient hospitalizations declined by 8% (from 24% to 16%). The net benefit for mental health crisis stabilization services was approximately $0.3 million, with a return of $2.16 for every dollar invested.[109]
- In 2000, researcher analyzed the effectiveness and efficiency of a mobile crisis program by comparing it to regular police intervention.[110] 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%lower average cost per case.
- In another study analyzing the cost impact of mobile crisis intervention, researchers found that mobile crisis intervention services could reduce costs associated with inpatient hospitalization by approximately 79% in a six-month follow-up period after the crisis episode.[111]

[108] U.S. Substance Abuse and Mental Health Services Administration (2014). *Crisis services: Effectiveness, cost effectiveness, and funding strategies*. Rockville, MD: Substance Abuse & Mental Health Services Administration.

[109] Bennett, A. L., & Diaz, J. (2013). ***Crisis stabilization claims analysis: Technical report assessing the impact of crisis stabilization on utilization of healthcare services***. St. Paul, MN: Amherst H. Wilder Foundation

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

[111] 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.

Specific Recommendations on Crisis Response Systems Coordination and Integration

The steps for change outlined in the Recommendations section above are repeated below, followed by guidance on, and considerations for, establishing relative costs and cost savings or value impact.

- ***Recommendation: Develop a Governance Entity that Enhances Cross-Sector Collaboration at the State and Regional Levels.***
    - *Identify or establish one entity under the direction of the Secretary of Health and Human Services and the Secretary of Public Safety and Security that would be responsible for overseeing crisis response planning and implementation.*
    - *Create opportunities for regional cross-sector planning and mutual understanding.*
    - ***Cost Guidance:*** *Solicit input from EOHHS and EOPSS on cost parameters.*

- ***Recommendation: Create a statewide behavioral health workforce strategy which enhances the capacity and ability of behavioral health providers to provide alternative emergency services and programs for behavioral health crises across the Commonwealth.***
    - ***Cost Guidance:*** *Adopt parameters established in Executive Office of Health and Human Services (EOHHS) FY2023 and FY2024 budgets and Chapter 177 investments in workforce development, recruitment, and retention.*

- ***Recommendation: Develop an organized, detailed implementation strategy in coordination with MassHealth, DMH, DPH, the Executive Office of Public Safety and Security (EOPSS), and statewide 911.***
    - *Create a training curriculum in partnership with State 911, Municipal Police Training Committee (MPTC), POST, DMH, DPH, MassHealth, and people with lived experience.*
    - *Create a standardized framework or process for screening and triaging behavioral health calls.*
    - *Establish cross-system data collection requirements/standards that can be used to assess and inform the capacity and performance of crisis services. This should include a statewide behavioral health crisis dashboard that is public-facing and integrates 988, BHHL, MCI, hospital, and co-response data.*
    - ***Cost Guidance:*** *Seek input during public forums to be scheduled following posting of this report. Following input received, engage EOHHS and EOPSS entities in defining cost of executing the implementation strategy.*

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Conclusion

Massachusetts is engaged in the reform of its behavioral health system, an undertaking driven by a vision of providing the people of the state with access to mental health and substance use care when and where they need it. Because of the breadth and depth of need found among the population at risk for or experiencing behavioral health conditions in the Commonwealth, the envisioned system is composed of a complex set of health promotion, prevention, treatment intervention, and recovery support services. For those with deeper needs, recovery is not only dependent on a continuum of behavioral health services but also on other health and human services that address the social determinants of their well-being. And, for those with serious and disabling conditions who may have been unable to get a timely response from a historically under-resourced behavioral health system, other public systems may have become their de facto care response. Most often, those other systems are the social welfare and public safety systems, as reflected in the disproportionate number of people with behavioral health conditions found among those who are homeless or incarcerated.

Achieving the envisioned reform demands tackling numerous policy, regulatory, financing, program, and service delivery challenges. While workforce is a significant challenge, it is nevertheless essential to coordinate policy, protocol, and practice across the health and human services, social welfare, and public safety systems upon which individuals living with behavioral health conditions now depend.

For those experiencing a behavioral health crisis in Massachusetts there have for too long been too many access points, resulting in often fragmented responses in disparate systems. There is no more critical aspect of the Roadmap reform than creating a unified telephonic front door to the system through the BHHL and establishing urgent care and expanding crisis services if we are to guarantee that those in greatest need will get a timely response. However, law enforcement, 988, and hospital emergency departments, among other services, will continue to play a role. And if the role and resources of those functions are not well defined and carefully coordinated with the reformed behavioral health response, Massachusetts will not be able see the full promise of the Roadmap reform. As this system transformation rolls out over the next few years, the Commonwealth must concurrently strengthen cross-sector coordination with public safety and law enforcement to define roles, protocols, and processes that will strengthen the implementation process and ensure accountability for better outcomes for the individuals served and the systems who serve them. And because Massachusetts has a long tradition of acknowledging the importance of what goes on at a local level in creating a successful public and political response, it is important to build on collaborations at the area and regional levels, making investments in local and regional structures that represent the range of stakeholders who will make reform achievable for the people who are their constituents. These are essential to a more robust and accountable behavioral health crisis system.

Appendix A: Key Informant Organizations

Advocates
The Arc of Massachusetts
Assistant Undersecretary, Law Enforcement & Criminal Justice, EOPSS
Association For Behavioral Healthcare
Behavioral Health Network
BEST - Boston Emergency Service Team
Boston University researcher
Bournewood Hospital
Cambridge Health Alliance
Caregiver(s)
Cataldo Ambulance
Center for Crisis Response and Behavioral Health at William James
Chelsea Police Department - Hub program
Director of Children, Family and Youth Services Oklahoma MHSA
Director of Jail/Arrest Diversion Initiatives
Diverse People United
DMH - Adult Services
DMH Area Forensic Director
DMH - Behavioral Health Help Line
DMH Consumer Liaison
DMH - Child, Youth and Family Services
DMH, JDP staff
DMH - Statewide Young Adult Council
DPH - 988 Staff
DPH - BSAS Staff, Substance Use Helpline
DPH - Office of Emergency Medical Services
DPH - Statewide Recovery Support Coordinator
DPH - Suicide Prevention Program
Eliot Human Services
EOHHS staff
EOPSS staff
Executive Director of Community Intervention Teams International
Executive Office of the Trial Court staff
Fitchburg Police Department
Fostering Hope & Recovery
Framingham Police Department
Framingham Statewide Dispatcher
Gandara
H&J cofounder and principal
Hamilton Police Department
Health Lab (University of Chicago), Senior Director, 911 Portfolio
Health Management Associates
Insurance Resource Center for Autism and Behavioral Health
International Association of Chiefs of Police
Kiva Centers
Massachusetts Association of Behavioral Health Systems
Massachusetts State 911 Department
Massachusetts Behavioral Health Partnership
Massachusetts Chiefs of Police Association
Massachusetts Peace Officer Standards and Training
MassHealth - Office of Behavioral Health
Municipal Police Training Committee
National Alliance on Mental Illness - MA
National Association of Social Workers - MA
Office of Research and Development, Boston Police Department
Office of State Senator William Brownsberger
Parent Professional Advocacy League
Pittsfield Police Department
Professional Fire Fighters of Massachusetts, President Richard MacKinnon
Riverside Community Care
Samaritans of Cape Cod
Somerville Police Department, Director of Community Outreach and Harm Reduction
Utah Crisis Administrator
WestComm Regional Dispatch

Appendix B: Key Informant Interview Guide

Script: TAC was retained by MAMH, which was contracted by the Community Policing and Behavioral Health Advisory Council (CPBHAC) to conduct two separate but parallel studies on the behavioral health crisis response system in Massachusetts. The objectives are to study and make recommendations for creating a crisis response and continuity of care system that delivers alternative emergency services and programs across the Commonwealth and to study the disposition of 911 calls to determine how many calls and what types of calls were or could have been diverted to social service, behavioral health, community arbitration or other unarmed responders instead of law enforcement. If you would like, we can send to the information with the full language of the amendment.

(Explain the common definition): For the purposes of this interview, when we refer to the crisis response system, we are speaking to all facets of the response system ranging from call centers, mobile/alternative responses, crisis stabilization units, respite services, and hospital and emergency response partners. Do you have any questions?

General Questions

- What do you see as the strengths of the *current* crisis response system?
- What are the major challenges within the *current* crisis system (call centers, mobile response, and stabilization options, respite, etc.)
- What opportunities do you see for the Roadmap for Behavioral Health to impact the current crisis system?
- Can you discuss the current implementation of these changes to the BH system to align with the Roadmap's vision?
    - Have you seen or experienced any success or challenges in the implementation?
- What metrics do you think will be important to measure with the new CBHCs/Crisis system?
- Can you speak to cross-sector collaboration to support effective crisis response? Are there additional opportunities for the state to support ongoing efforts?

Behavioral Health Provider

- What coordination is happening between law enforcement, EMS, and other community services such as housing providers? (i.e. formal agreements/MOUs, ongoing coordination meetings, ad hoc coordination)
    - Can you speak to successes and challenges?
- What is your coordination with 988 and the behavioral health help line (BBHL)?
- Describe the process for crisis response from call to provision of post-crisis care.
    - Prompts: Utilization of technology for dispatching, deployment protocols, access to crisis stabilization services, transportation for behavioral health emergencies, post-care follow up, connection to SUD services/MAT etc.
    - Does this process differ for rural response? If so, how?

- Do you have a current mechanism for feedback from individuals with lived experience?
- Can you discuss the role and utilization of peer support staff in your programs?
- Is your agency making any changes to its BH services post 1/1/23?
  - If so, what type of changes?
  - How do you see those changes enhancing the crisis system for members?

Individuals with Lived Experience

- Can you describe your experience with the behavioral health emergency response system?
  - Potential prompts: Sometimes police respond if someone is having a mental health or substance use crisis. If you've been in a situation where (**police, ESP/CBHCs, others responded)**, how was your experience?
- What supports are most helpful for your wellbeing and recovery and getting through crises?
- Are there any services or supports you would like but haven't been able to get?
- Are you aware of upcoming changes to the system?
- In your experience, what would be one change that would enhance behavioral health emergency response in Massachusetts?

Law Enforcement/PSAPs

- Can you describe your experience with the behavioral health emergency response system?
- Can you talk about how you respond if someone appears to be experiencing a behavioral health crisis?
  - Potential prompts: Do you have specific behavioral health response protocols?
  - Does your agency require behavioral health training?
    - What components are included in the training? (Training on engaging individuals with developmental disabilities, autism spectrum disorder, and substance use disorder, cultural sensitivity, LGBTQIA+ etc.)
- How are you currently coordinating with behavioral health services?
  - Prompt: Please talk about any coordination with 988/with the BHHL that may be happening?

Systems/Government

- What mechanisms are in place to support the provider network as new changes roll out?
- How are you planning to evaluate implementation of BH roadmap?
- How was the community engaged in the planning process, including individuals with lived experience?
- How do you assess the behavioral health needs in the state?

All

- Is there anyone else with whom it would be helpful for us to discuss this issue?
- Is there anything we did not ask that you feel would be helpful for our analysis?

Appendix C: Focus Group Interview Guide – Stakeholder Session Guide

Overview: TAC was retained by MAMH, the contractor selected by the Community Policing and Behavioral Health Advisory Council (CPBHAC) to conduct two separate but parallel studies on the behavioral health crisis response system in Massachusetts. The objectives are to study and make recommendations for creating a crisis response and continuity of care system that delivers alternative emergency services and programs across the commonwealth and to a study of the disposition of 911 calls to determine how many calls and what types of calls were or could have been diverted to social service, behavioral health, community arbitration or other unarmed responders instead of law enforcement. If you would like, we can send to the information with the full language of the amendment: https://malegislature.gov/Bills/GetAmendmentContent/192/S3/420/Senate/Content

Script: MAMH/TAC will be holding stakeholder groups in order and key informant interviews in order to inform the assessment. As members of a stakeholder group, we would like to gather your input on a series of questions. Before we begin, we would like to know everyone who is present. Can you please provide your name, agency, and where you are located?

Crisis Provider Focus Group:

- What opportunities do you see for the roadmap for behavioral health to impact the current crisis system? (15 minutes)
- Can you discuss the current implementation of these changes to the BH system and any challenges in implementation you've seen or experienced? (15 minutes)
- What opportunities do you see for the state to better support cross-sector collaboration to support effective crisis response? (15 minutes)
- What are your policies/triage process when there is no team available for deployment? (15 minutes)
- What effective strategies have you utilized to support programming during a workforce challenges? (10 minutes)
- How are you currently tracking outcomes and how do you monitor effectiveness of your program? (15 minutes)
- Is there anything you think it would be helpful for us to know as we move forward with this assessment? (5 minutes)

Individuals with Lived Experience Focus Group

- When you (or a loved one) are having a tough time, where do you turn to first? Where do you find information about options for help or support? (10 minutes)
- Can you describe your experience with the behavioral health emergency response system? (55 minutes)
    - Potential prompts: Sometimes police respond if someone is having a mental health or substance use crisis. If you've been in a situation where **police responded**, how was your experience?

    - ESP/CBHC
    - Hospital
- What supports are most helpful for your wellbeing and recovery and getting through crises? (10 minutes)
- Are there any services or supports you would like but haven't been able to get? (10 minutes)
- Is there anything you think it would be helpful for us to know as we move forward with this assessment? (5 minutes)

Individuals with Lived Family Experience Focus Group (modified for caregivers)

- When your child/young adult is having a tough time, where do you turn to first? Where do you find information about options for help or support? (10 minutes)
- Can you describe your experience with the behavioral health emergency response system (with regards to your child's needs)? (55 minutes)
    - ED
    - Mobile Crisis
    - CBHC (new as of January 1)
    - Law enforcement/911

- What supports are most helpful for you and your child's wellbeing/recovery? (10 minutes)
- Are there any services or supports you would like for your child/young adult but haven't been able to get? (10 minutes)
- Is there anything you think it would be helpful for us to know as we move forward with this assessment? (5 minutes)

Law Enforcement/EMS Focus Group

- Please describe your experience with the behavioral health emergency response system in Massachusetts. (15 minutes)
- What would be a more effective strategy to ensure appropriate response to individuals who are experiencing a behavioral health emergency? (15 minutes)
- Can you speak to any diversion programming that is happening? (15 min)
- How the effectiveness of your diversion/co response program is currently evaluated? (15 min)
    - Where is that data/information sent?
- How are you currently coordinating with behavioral health services or providers? (15 minutes)
- What opportunities do you see for the state to better support cross-sector collaboration to support effective crisis response? (15 minutes)

Public Safety Answering Points (PSAPs) Focus Group

- Please describe your experience with the behavioral health emergency response system in Massachusetts. (15 minutes)
- Can you talk about your response if someone appears to be experiencing a behavioral health crisis? (prompt do you have specific behavioral health response protocols?) (15 min)
- Please talk about any coordination with 988/with the BHL that may be happening? (prompt Are any of your doing warm transfers to either?) (15 min)
- What opportunities do you see for the state to better support cross-sector collaboration to support effective crisis response? (15 minutes)

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Appendix D: Literature Review Documents

The following reports, publications, and studies were reviewed to support recommendations made in this report.

National Best Practices

Applied Research Services (2020). *Report of analysis of 911 calls for services inform pre-arrest diversion and other expansion efforts*.

Balfour, M. E., Hahn Stephenson, A., Delany-Brumsey, A., Winsky, J., & Goldman, M. L. (2022). Cops, clinicians, or both? Collaborative approaches to responding to behavioral health emergencies. *Psychiatric Services, 73*(6), 658–669.

Bazelon Center for Mental Health Law (2022). *A new day or more of the same? Our hopes and fears for 988 (and 911)*.

Center for Policing Equity (2023). *Redesigning public safety: Mental health emergency response recommendations*.

Committee on Psychiatry & the Community for the Group for the Advancement of Psychiatry (2021). *Roadmap to the ideal crisis system: Essential elements, measurable standards, and best practices for behavioral health crisis response*. National Council for Behavioral Health.

Compton, M., & Watson, A. (n.d.). *Research to improve law enforcement responses to persons with mental illnesses and intellectual/developmental disabilities*. Bureau of Justice Assistance.

Council of State Governments Justice Centers (2021). *Expanding first response: A toolkit for community responder programs.*

Department of Justice & Department of Health & Human Services (2023). *Guidance for emergency responses to people with behavioral health or other disabilities*.

Gillooly, J. W. (2020). How 911 callers and call-takers impact police encounters with the public: The case of the Henry Louis Gates Jr. arrest. *Criminology & Public Policy, 19*(3), 787–803.

Gulley, J., Arienti, F., Boss, R., Woodsby, A., & Wachino, V. (2022). *Mobile crisis teams: A state planning guide for Medicaid-financed crisis response services*. The Technical Assistance Collaborative and the California Health Care Foundation.

Gulley, J., Arienti, F., Martone, K, & De Voursney, D. (2021). *Implementation of the 988 hotline: A framework for state and local systems planning*. Technical Assistance Collaborative.

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- Review of International Association of Chiefs of Police's Academic Training to Inform Police Responses Initiative Training curriculum, retrieved from: CRIT Toolkit | Academic Training (informedpoliceresponses.com)
- Review of The Academic Training to Inform Police Responses Best Practice Guide Materials, retrieved from Products & Resources (informedpoliceresponses.com)
- Council of State Governments Justice Centers (2021) materials
  - Tips for Successfully Implementing a 911 Dispatch Diversion Program
  - Keys to Building a Strong Call Triage Process
  - Building a Comprehensive and Coordinated Crisis System
  - Preparing 911 Dispatch Personnel for New First Responder Teams

- Substance Abuse and Mental Health Services Administration's 988 Suicide and Crisis Lifeline
- Substance Abuse and Mental Health Services Administration's 988 Lifeline Performance Metrics

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Appendix E: ESP Survey

ESP CPBHAC/911 survey

Brief Overview of Purpose of the Survey: The Massachusetts Legislature directed the Executive Office of Health and Human Services (EOHHS) to undertake two studies: assess 911 functions in preparation for implementation of 988 and Roadmap reforms; and assess behavioral health crisis services functions in the Commonwealth. These studies are under the direction of the Community Policing and Behavioral Health Advisory Council and the Department of Mental Health. EOHHS and DMH contracted with the Massachusetts Association for Mental Health (MAMH) and partner, the Technical Assistance Collaborative (TAC) to carry out and integrate the studies. Thank you in advance for your assistance in providing information to the study effort.

1. Team Name:

2. Catchment area

3. Any subcontracts for ESP/MCI?

   ☐ Yes

   ☐ No

4. If yes, what services and who is the subcontractor?

5. Does your crisis team provide co-response with Law Enforcement? ? (i.e., deploying with Law enforcement)

   ☐ Yes

   ☐ No

6. If yes, in what towns are you providing co-response?

7. If you have a mental health co-responder, who funds the position(s)? (please check all that apply)

- ☐ Law Enforcement
- ☐ Department of Mental Health
- ☐ Town/Municipality
- ☐ Other

8. Do you coordinate training with any 911 call centers?

- ☐ Yes
- ☐ No

9. If yes what trainings are co-lead? CIT or equivalent?

10. Are you or have you ever been involved in any sequential intercept mapping (SIM)in your area

- ☐ Yes
- ☐ No

11. If yes, how has that process helped shape your ESP/MCI response?

12. If yes, was the SIM effort in coordination with the Massachusetts Trial Court? Another sponsor? Please explain

13. Do your peers/family partners interact with law Enforcement?

- ☐ Yes
- ☐ No

14. Does your ESP/MCI program have a formal MOU with all the 911 call centers in your catchment area?

- ☐ Yes
- ☐ No
- ☐ Some

15. If not all, what are the challenges coordinating with other 911 call centers?

16. Does your ESP/MCI program share a PSAP or 911 call center (i.e., regional PSAP) with an adjacent catchment area/ESP/MCI program?

- ☐ Yes
- ☐ No

17. If yes, does your agency have formal or informal mechanisms for coordination with the neighboring catchment area/ESP/MCI program?

- ☐ Yes
- ☐ No

18. Is your ESP/MCI location open 24/7?

- ☐ Yes
- ☐ No

19. If no, what are your current hours?

20. How is your ESP/MCI coordinating with 988?

21. Does your staff carry and administer Narcan?

- ☐ Yes
- ☐ No

22. Does your ESP/MCI location accept police drop offs?

- ☐ Yes
- ☐ No

23. If yes, approximately how many a month do you receive?

- ☐ Yes
- ☐ No

24. If no, why not?

25. How are you expecting police drop-offs to change come 1/1/23 if you are a CBHC?

26. Does your CCS accept police drop offs?

- ☐ Yes
- ☐ No

27. If no, why not?

28. Does you ESP/MCI location accept ambulance drop offs?

- ☐ Yes
- ☐ No

29. If no, why not?

30. Do your staff transport individuals for emergency behavioral health treatment?

- ☐ Yes
- ☐ No

31. If no, why not?

32. Are you using GPS enabled dispatching for your ESP/MCI teams?

- ☐ Yes
- ☐ No

33. If no, do you have plans in the future to use it?

- ☐ Yes
- ☐ No

34. Does your staff receive specialty training to work with any of the following communities:

- ☐ Children/adolescents
- ☐ Individuals experiencing homelessness
- ☐ Persons with physical disabilities
- ☐ Persons with autism spectrum disorders (ASD)
- ☐ Persons with intellectual disabilities (IDD)
- ☐ LGBTQ populations
- ☐ Individuals from Indigenous communities
- ☐ Individuals with primary substance use disorder

35. Does your ESP/MCI team provide services to, please check all that apply:

- ☐ Non-English speakers
- ☐ Individuals that are deaf/hard of hearing

36. How is your ESP/MCI team using data to improve quality, outcomes, response time?

- ☐ Routine monitoring of response times
- ☐ Monitoring call responses to amend staffing to meet demand
- ☐ Evaluation of demographics served
- ☐ Other

37. Is there a formal mechanism to allow individuals who receive services to provide feedback/quality improvement suggestions?

38. What current challenges does ESP/MCI face that you expect the new CBHCs to be better equipped to manage?

39. Does your current team possess competencies in assessing the needs of person with substance use conditions and directing dispositions for care?

40. What about for persons with co-occurring substance use and mental health conditions?

41. Is your staff training curriculum changing with the new CBHC crisis model?

- ☐ Yes
- ☐ No
- ☐ Other

42. If yes or other please explain?

43. Has your agency started discussions with local 911 call centers around ESP/MCI changes for 1/1/23?

- ☐ Yes
- ☐ No

44. What are you most excited about with the new CBHC model for crisis?

45. What challenges are you most worried about with the new CBHC crisis model?

46. What is the most important thing your ESP/MCI team needs to address before the CBHC model goes live?

47. Do you have any additional information that you feel would be useful to us?

Appendix F: ESP SURVEY Q45 responses

ESP CPBHAC/911 survey

Q45. What challenges are you most worried about with the new CBHC crisis model?

Answered: 13
Skipped: 1

Number of Responses:

1. "Ping pong" effect with individuals back and forth to the EDs and community. at current, this is challenging even with communication paths set up appropriately. Lack of additional bed capacity and lack of boarding capacity funding external to the ED. There are weeks long waits for beds for some members.
2. Staffing
3. Staffing-Staffing-Staffing-also not sure about how much additional volume, and how quickly may occur, after 1/3 change
4. Staffing
5. Staffing, retention
6. Workforce, Workflow between EDs and CBHCs, Financial Sustainability.
7. Staffing shortages
8. Staffing. Unknowns - quality measures, pay for performance, etc.
9. Appropriately staffing in order to ensure needs are met within the expected timeframes
10. Staffing
11. Staffing
12. legislative changes being completed for police and EMS drop offs to the CBHC/MCI
13. Workforce challenges and shortages

Appendix G: ESP/MCI Disposition

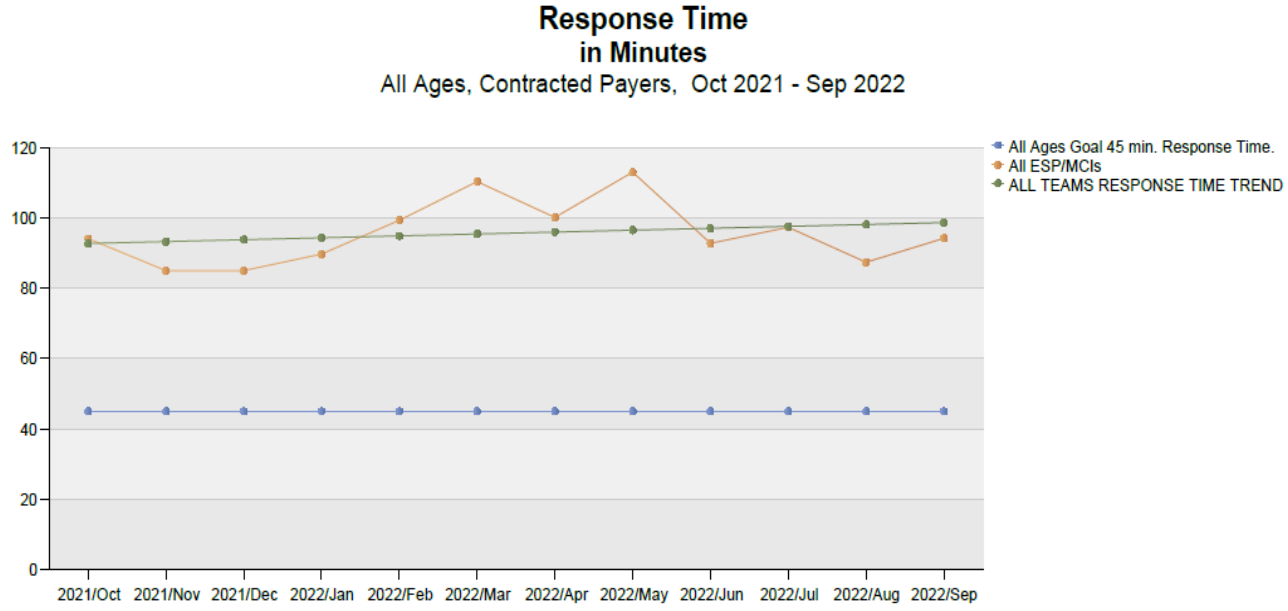
FOR OBH/MBHP/ESP/MCI USE ONLY. DO NOT DISSEMINATE.

Disposition
by Intervention Location
All Ages, Contracted Payers, July 2022 – Sep 2022
(FY' 2023)

ESPs	DIVERSIONARY LOCATION	INPATIENT LOCATION
Community Based	73.00%	13.84%
All ED	55.38%	37.59%

- Across ALL ESP/MCIs individuals of All Ages, if a person receives ESP/MCI services in a hospital ED, they are approximately 24 percentage points more likely to be admitted to inpatient mental health services.
- Across All ESP/MCIs, individuals of All Ages, if a person receives ESP/MCI services in a community setting, they are approximately 18 percentage points more likely to be referred to a diversionary level of care.

Appendix H: Crisis Intervention Response Time



FY' 2023

	2022/Jul	2022/Aug	2022/Sep	FY 2023 YTD AVG
All ESP/MCIs	97	87	94	93

All Teams ESP/MCIs response time is trending up and ranges from 85 min to 113 min; FY'2023 avg 93