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Planning for Crisis Receiving and Stabilization Facilities

Prepared for

The Montana Department of Public Health and Human Services,

Addictive and Mental Disorders Division

August 2021

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Western Interstate Commission for Higher Education

Behavioral Health Program

Montana's Crisis Servcies
Planning for Crisis Receiving and Stabilization Facilities

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- Cascade County Strategic Alliance for the Crisis Intervention Program
- The Strategic Alliance for the Gallatin County Behavioral Health Crisis System (aka Gallatin County's Crisis Redesign Alliance)
- Lewis and Clark County's Behavioral Health System Improvement Leadership Team
- Mary Collins, Special Populations Section Supervisor, Montana Addictive and Mental Disorders Division, Montana Department of Public Health and Human Services
- Scott Malloy, Program Director, Montana's Healthcare Foundation
- Kirsten Smith, Principal/Bloom Consulting, Project Coordinator, The Strategic Alliance for the Gallatin County Behavioral Health Crisis System (aka the Crisis Redesign Alliance)
- Jolene Jennings, Behavioral Health Systems Improvement Specialist, Lewis and Clark County Behavioral Health System Improvement Leadership Team
- Terry Kendrick, Project Facilitator, Missoula Strategic Alliance for Improved Behavioral Health
- Trista Besich, Alluvion Health, Cascade County Strategic Alliance for the Crisis Intervention Program

Executive Summary

No one is immune from experiencing a mental health crisis. It can happen at any point in a person's lifetime regardless of their age, economic status, religious beliefs, family, relationships, race, ethnicity, education, marital status, social status, physical health, career, or location. A mental health crisis can be triggered by trauma, loss of a loved one, head injury, substance use, mental illness, financial hardship, health issues, isolation, and so many other physical, emotional, and mental health experiences that can happen over a lifetime.

Organization and formalization of services for people in crisis reportedly began in the United States in the 1940's after a tragic fire in a Boston nightclub devasted a community. Twenty years later in the 1960's, when the Community Mental Health Act was enacted, community mental health centers were required to provide crisis services. Twenty years after that, Crisis Intervention Teams (CIT) – a training program created in 1988 by Major Sam Cochran of the Memphis Police Department to effectively handle mental health related calls -- became a major milestone in the development of crisis services. Within the next 20 years, law enforcement agencies across the United States adopted CIT training and CIT became a best practice in law enforcement and community-based crisis intervention services. As a result of more and more police officers trained in CIT, pressure mounted on community organizations, especially community mental health centers, to provide professional, responsive, mental health crisis care 24 hours a day, every day of the year. That pressure, coupled with increasing rates of suicide, hospital emergency rooms overwhelmed with mental health and substance use patients, and the collective voice of mental health advocates, gradually changed the delivery of crisis care in our country. Crisis services began to unfold in urban and rural communities. Now, over 75 years after the first crisis service was organized in our country, the cornerstones of crisis services – CIT, Crisis Lines, Mobile Crisis, and Crisis Receiving and Stabilization Centers -- have become a standard in mental health programs and systems.

Adding to the continuing advancement of crisis services is the implementation of 988 -- a 911-like system that will be the national suicide prevention and emergency mental health phone number. Connected to local crisis lines across the country, 988 will operate in every state by July 2022. It will partner with local systems of care that specialize in crisis prevention, intervention and support and operate 24 hours a day, every day of the year. Needless to say, 988 is expected to have a dramatic impact on state and local crisis systems.

Preparing for 988 and building services to support people in crisis is a challenging endeavor, to say the least. Although there are models, resources and research to help guide the development of crisis services, each state, region, and community faces unique challenges as they mold and build their crisis systems. Fortunately, for the past 10 years the Montana Department of Public Health's Human Services Addictive and Mental Disorders Division (AMDD) has been facilitating and supporting the development of crisis services across the state. In addition, for the past three years the Montana Healthcare Foundation (MHCF) has supported the advancements of crisis services by funding and facilitating the development of community coalitions, system analysis, mapping, and strategic planning activities. Seeing the potential impact of joining forces and resources, in 2018, AMDD and MHCF joined together

to support implementation and advancements in crisis prevention, intervention, stabilization, and recovery services across the state. Their efforts continue to this day as they work together with local communities and stakeholders to support strategic planning and implementation of the three cornerstones of crisis services: 24/7 Crisis Lines, Mobile Crisis Teams, and Crisis Receiving/ Stabilization facilities. Along these lines, it should be noted that each City and County of Montana has been responsible for streamlining their efforts to examine the resources and collaborations necessary to build and strengthen these components of a functional crisis system in their respective region. This work has been both necessary and essential towards the goal of improved crisis management across the State

In yet another step toward supporting the development of crisis services in Montana, in July of 2021, Montana Department of Public Health's Addictive and Mental Disorders Division contracted with the Western Interstate Commission on Higher Education/Behavioral Health Program (WICHE/BHP) to support planning for Crisis Receiving and Stabilization Facilities for four counties: Cascade, Lewis and Clark, Gallatin, and Missoula. Envisioned as a two-phase project, Phase One[1] of the project was six weeks long; the deliverables (and the focus of this report) were fourfold:

1) Use currently available data to analyze crisis services operating in the four counties;
2) Compare the current operations in the four counties to model programs and national best practices for Crisis Receiving and Stabilization Facilities;
3) Project utilization and capacity needs for Crisis Facilities in the four counties; and,
4) Offer recommendations to inform the crisis system planning occurring within each of the four counties.

In addition, this report offers decision-making information for the state of Montana and the counties as they prepare plans for crisis facility (or facilities) compatible with their regional crisis systems and unique to their communities, including:

- Models of crisis facilities
- Expectations and best practices for crisis facilities
- Planning resources for crisis facility operations, etc.
- Crisis bed capacity projection and estimation tools

Importantly, although the focus of the following report is on Crisis Receiving and Stabilization Facilities, the significance of the findings and recommendations *within the context of a crisis system (*including the core services of 24/7 Call Center, Crisis Intervention Teams and Mobile Crisis) for each of the communities cannot be understated. Leading proponents and experts of crisis service systems uniformly agree that crisis facilities are an essential element of a crisis system; that is, they offer a crucial service within a system, as opposed to a sole source of crisis care and service.

[1] Subject to funding, Phase Two will entail review of the State's policies regarding crisis facilities to ensure the framework is in place to support best practices in crisis receiving and stabilization services. As outlined in the "Summary of Recommendations" of this report, Phase Two will also entail a deeper dive to support each county's unique plans and key decisions, ranging from facility location and staffing, to licensing and partner agreements.

For the past 30 years, crisis centers have opened in communities across the country. Behavioral health providers, hospitals, first responders, and human service organizations have discovered methods for operating crisis services and systems effectively with a “no wrong door” approach. Working in partnership, they have successfully diverted an untold number of people in crisis from unnecessary transfers to emergency rooms and jails to lifesaving and life changing behavioral health services.

Today, from community to community, Montana is progressively developing a crisis system. Many stakeholders and leaders are united in believing the time is right and the time is now for instituting crisis facilities in their communities. We applaud the many groups and individuals in Montana who are on a mission to serve people in crisis through a “no wrong door” approach with compassion and expertise.

Methodology

To assist AMDD and the four communities with their strategic planning endeavors, WICHE/BHP conducted an analysis of current crisis service offerings, strengths, needs, and gaps in the continuum of care for each of the four communities/regions. Per the Statement of Work, WICHE/BHP:

1. Worked in partnership with AMDD staff to identify key stakeholders.
2. Interviewed key stakeholders in each region using an AMDD approved interview template.
3. Gathered and analyzed available data, including: a) population of each county and its surrounding region; b) emergency room usage; and c) reports produced by JG Research and Evaluation.
4. Analyzed data on current continuum of care and gaps that exist in the continuum to ensure consistency between community leaders and consumers with regard to needs and gaps.

As outlined below, WICHE/BHP also reviewed published reports and documents that inform strategic considerations and plans for crisis facilities. Of note is the comprehensive reports prepared for each of the four communities by JG Research and Evaluation; using the context of the model components of crisis services, their reports provide an impressive analysis of the current landscape of crisis services for each of the counties. In addition, WICHE/BHP utilized reports and papers on national best practices.

Source	Focus/Topics
TBD Solutions	Crisis Residential Best Practices Toolkit: Practical Guidelines and Solutions Crisis Residential Best Practices Toolkit (crisisnow.com)
MT Hospital Assoc.	ER Usage for Missoula, Cascade, Gallatin, and Lewis and Clarke Counties
NASMHPD	National Guidelines for Crisis Care 2020 Paper national-guidelines-for-behavioral-health-crisis-care-02242020.pdf (samhsa.gov)
SAMHSA	National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit Crisis Services: Meeting Needs, Saving Lives (Dec. 2020)
MT DPHHS	Crisis Facility Toolkit Report (2020)
National Council for Behavioral Health	Road Map to the Ideal Crisis System: Essential Elements Measurable Standards and Best Practices for Behavioral Health Crisis Response (3/2021) 031121_GAP_Crisis-Report_Final.pdf (thenationalcouncil.org)
JG Research and Evaluation (MT)	- Gallatin County Behavioral Health Crisis System Analysis (6/2020) - Analysis of the Lewis and Clarke Behavioral Health Crisis System (8/2021) - Analysis of the Missoula County Behavioral Health Crisis System (6/2021)

These comprehensive reports were invaluable for informing this report. Additionally, although we did not use the learning lessons webinars presented by Addictive and Mental Health Disorders Division and the Montana Healthcare Foundation, these webinars are an impressive resource for additional information on crisis models, as well as the application of

best practices in Montana. [2] We strongly encourage each of the Coalitions'/communities', as well as the state agencies who are influencing and supporting the development of crisis services (i.e., Montana Department of Public Health and Human Services and the Addictive and Mental Disorders Division, the Montana Healthcare Foundation, and the Montana Hospital Association) to utilize these resources in their individual and collective strategic planning for crisis facilities.

In addition, WICHE has interviewed and sought information, insight, and clarification from key informants, including:

- *Mary Collins*, Special Populations Section Supervisor, Montana Addictive and Mental Disorders Division, Montana Department of Public Health and Human Services
- *Scott Malloy*, Program Director, Montana's Healthcare Foundation
- *Kirsten Smith*, Principal/Bloom Consulting, Project Coordinator, The Strategic Alliance for the Gallatin County Behavioral Health Crisis System (aka the Crisis Redesign Alliance)
- *Terry Kendrick*, Project Facilitator, Missoula Strategic Alliance for Improved Behavioral Health
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Findings and Data Analysis

According to the National Council for Behavioral Health's "Road Map to the Ideal Crisis System":

> "Many communities across the United States have limited or no access to true "no wrong door" crisis services; defaulting to law enforcement operating as community-based mental health crisis response teams with few options to connect individuals experiencing a mental health crisis to care in real time. The available alternatives represent systemic failures in responding to those in need; including incarceration for misdemeanor offences or drop-off at hospital emergency departments that far too often report being ill-equipped to address a person in mental health crisis. Unacceptable outcomes of this healthcare gap are (1) high rates of incarceration for individuals with mental health challenges, (2) crowding of emergency departments that experience lost opportunity costs with their beds and (3) higher rates of referral to expensive and restrictive inpatient care with extended lengths of stay because lower levels of intervention that better align with person's needs are not available. For many others in crisis, individuals simply fail to get the care they need."[3]

[2] Montana Healthcare Foundation Crisis Videos on Vimeo. https://vimeo.com/search?q=montana%20healthcare%20foundation%20crisis

[3] Road Map to the Ideal Crisis System: Essential Elements Measurable Standards and Best Practices for Behavioral Health Crisis Response (3/2021).

Indeed, the absence of crisis services plays a heavy toll on communities – resulting in economic, social, and humanitarian hardship for health and human service providers, criminal justice systems, hospitals, first responders and (most importantly) individuals in crisis. Yet, that's not to say that developing crisis services and systems is easy. Indeed, it is a challenging and complex endeavor. Still, many communities across the United States have successfully formed collaborative and strategic partnerships that have resulted in the creation of effective crisis services for urban and rural communities.

Fortunately, Montana is also persevering and investing in the development of crisis services. For the purpose of this report, that "investment" includes developing a clear understanding of what would be required to institute crisis receiving and stabilization facilities for Cascade, Lewis and Clark, Gallatin, and Missoula counties. That understanding begins with an assessment of crisis receiving and stabilization services as they exist or operate today.

Crisis Receiving and Stabilization Facilities in the Four Counties

When operated within best practice standards, crisis receiving and stabilization facilities serve everyone who comes through their doors from all referral sources.

As reflected in the table below, apart from hospital emergency rooms, there are no crisis receiving units (defined as operating 24/7/365 and providing less than 24 hours of care) in any of the four counties. Further, only two counties, Gallatin and Missoula -- which have Western Montana Mental Health Center (WMMHC) Hope House and Dakota Place, respectively -- have standalone crisis stabilization facilities (defined as providing services 24/7/365 with a length of stay from 24 hours to [an average length of stay] of 3 - 5 days). However, currently both centers are operating under capacity due to staffing challenges.

Current Crisis Receiving and Stabilization Facilities

	Cascade	Gallatin	Lewis and Clark	Missoula
Crisis Receiving	NO	NO	NO	NO
Crisis Stabilization	NO	WMMHC/Hope House. 8 beds/2 involuntary Note: operating under capacity (due to staff shortage)	NO Note: WMMHC's Journey Home closed Jan. 2020	WMMHC's Dakota Place. 7 beds/2 involuntary Note: operating under capacity (due to staff shortage)

Given the absence of crisis receiving facilities in all four counties and that the two stabilization facilities in Missoula and Gallatin Counties operate under capacity, it is not surprising that hospital emergency rooms have become the De Facto mental health and substance use crisis receiving and (for those patients who stay longer than longer than 24 hours) stabilization facilities in all four counties – as indicated in the sheer number of mental health and substance use visits the hospitals reported in 2019.

2020 Behavioral Health Emergency Room Visits

COUNTY	Total Hospital Mental Health Visits	Total Hospital Substance Use Visits	Total Hospital Behavioral Health Visits
Cascade	1588	5647	7235
Gallatin	1335	3887	5222
Lewis and Clark	4025	7673	11,698
Missoula	1594	6995	8589

Clearly, the counties and communities are fortunate to have hospital emergency departments that serve as the communities' crisis receiving resource for first responders, families, and individuals. However, hospital emergency rooms (ERs) are not designed for behavioral health crisis intervention, management, or treatment. In addition to being one of the highest cost centers for healthcare, the facilities themselves are furnished, equipped, and staffed for rapid assessment, stabilization and treatment of medical emergencies. Although they may be capable of handling mental health and substance use emergencies, ER staff, physicians, and nurses are not typically trained in psychiatric or behavioral health assessments and clinical care. Further, when the emergency room serves as the community's or region's crisis receiving center, it can quickly become overwhelmed with behavioral health patients, some of whom may pose safety risks to ER staff and other patients. Finally, and most importantly, people in crisis who walk in or are transported to the emergency room for a mental health and/or substance use related crisis often will not receive the amount of time and the level of behavioral health care, expertise, and follow-up that may be needed to help stabilize their situation and connect them to services that can support their well-being post release. Hence, the not uncommon result of "streeting" in which people are released from the ER without supports and the ensuing "revolving door" of the same patient being seen multiple times for crisis and behavioral health related care.

> *Data suggests that a high proportion of people in crisis who are evaluated for hospitalization … can be safely cared for in a crisis facility and that the outcomes for these individuals are at least as good as hospital care while the cost of crisis care is substantially less than the costs of inpatient care and accompanying emergency department "medical clearance" charges.* - NBHCC, "Road Map to the Ideal Crisis System", 3/2021

On the other hand, Crisis Receiving and Stabilization Facilities (or Centers) can provide the appropriate level of behavioral health crisis intervention, assessment, and stabilization. Unlike hospital emergency rooms, crisis facilities are purposefully intended to serve people experiencing mental health and or substance use related crisis. The facilities themselves are designed to be a comforting, home-like, environment while also adhering to the health and safety standards of hospital-like operations. Rather than staffed by emergency medical teams, they are staffed by behavioral health experts including psychiatrists and/or psychiatric nurses, licensed counselors and clinicians, and peer support specialists. In delivering services, the staff at crisis facilities can use a combination of the facility environment, their collective behavioral health expertise, and their vast knowledge of

community and financial resources to help stabilize people in crisis and connect them to appropriate levels of care.

Models: Receiving, Stabilization and Receiving/Stabilization Centers

In determining the type of crisis facility that a community needs, it's important to understand the differences between the three models of crisis facilities or centers: 1) *Receiving Center/Facility*; 2) *Stabilization Center/Facility*; and 3) *Combined Receiving & Stabilization Center/Facility.*

Note that regardless of the model adopted, all three models operate within a collaboration of crisis service providers (including 24/7 Crisis Call Lines, Mobile Crisis Teams, First Responders) to create a "no wrong door" service for people seeking crisis care who:

- may have a mental health, substance use, or co-occurring diagnosis;
- may be experiencing their first psychiatric episode; and/or
- may need supportive counseling or outpatient care as opposed to more intensive behavioral health or psychiatric services.

The documents and reports referenced on page six of this report provide in-depth descriptions of the components and operational requirements for each of the crisis facility models. The following tables are intended to provide a high-level comparative overview of the models.

Model Type: Crisis Receiving Center

Purpose	▪ In-person, 24/7, 365 days a year ▪ Support, Assessment, Rapid Stabilization (including Sobering) ▪ ER and Jail Diversion ▪ Refer/Link to Care
Length of Stay	▪ Under 24 hours
Capacity	▪ Typical: 4 – 24 Observation Reclining Chairs/Beds
Intake/Access	▪ Referral Sources: Law Enforcement, Mobile Crisis, Emergency Room, Healthcare, Behavioral Health Providers, Crisis Call/Text Lines ▪ Law Enforcement and Mobile Crisis Portal/Hand Off ▪ Walk in
Admissions Policies/Criteria	▪ All people, often related to mental health, substance use, and co-occurring issues ▪ Voluntary and/or Involuntary Care (Unlocked and/or Locked facility) ▪ Medical status appropriate for setting; i.e.; Medical Clearance
Staffing	▪ Professionally licensed/credentialed staff: Prescribing Nurse Practitioners, Psychologists, Clinicians, Addiction Counselors, Social Workers, consulting Psychiatrist (including tele-psychiatry) ▪ Administrative Support and Security
Licensing	▪ If operated by licensed Mental Health Center: Meets requirements of Admin. Rule MT (ARM) 37.106.1976, "Outpatient Crisis Stabilization Facility" and endorsed as Outpatient Crisis Facility. ▪ If operated by licensed Hospital: Endorsed as Outpatient Crisis Facility.

Model Type: Crisis Stabilization Center

Purpose	▪ In-person, 24/7, 365 days a year ▪ ER and Jail Diversion, Alternative to Inpatient Behavioral Health Hospitalization ▪ Assessment, Stabilization, Support, Treatment ▪ Refer/Connect to Care
Length of Stay	▪ 24 hours to 10 days (average length of stay, 3 days)
Capacity	▪ Typical: 4 – to no more than 16 Beds
Intake/Access	▪ Referral Sources: Hospital, Healthcare, Behavioral Health Providers ▪ Mobile Crisis, Law enforcement, Ambulance Transfer
Admissions Policies/Criteria	▪ Behavioral health patient needing/seeking 24 hour+ treatment but not needing hospital-level acute inpatient care ▪ Typically, both Voluntary and Involuntary Treatment (Locked facility) ▪ Medical Status and Clearance Appropriate for Setting
Staffing	▪ Professionally licensed/credentialed staff: Psychiatrist, prescribing Nurse Practitioners and/or Physicians Assistants, Psychologists, Clinicians, Addiction Counselors, Social Workers ▪ Peer Specialists ▪ Administrative Support and Security Staff
Licensing	▪ Licensed MHC endorsed as an Inpatient Crisis Facility per the standards for BH Inpatient Facilities (ARM Subchapter 37.106.17) plus requirements specified in ARM 37.106.1946.

Model Type: Combined Crisis Receiving & Stabilization Center

Purpose	▪ In-person, 24/7, 365 days a year ▪ ER and Jail Diversion, Alternative to Inpatient Behavioral Health Hospitalization ▪ Assessment, Stabilization, Support, Mental Health and Co-occurring Treatment ▪ Seamless transfer from Receiving Facility to Stabilization Facility/Services ▪ Refer/Connect to Care
Length of Stay	▪ Receiving: under 24 hours. Stabilization: 24 hours up to 10 days (avg. LOS, 3 days)
Capacity	▪ 4 – 24 Observation Recliners (Receiving). 6 – 16 Beds (Stabilization)
Intake/Access	▪ Referral Sources: Hospital, Healthcare, Behavioral Health Providers ▪ Mobile Crisis Teams, Law enforcement, Ambulance Transfer
Admissions Policies/Criteria	▪ Persons in crisis needing rapid stabilization, support, assessment and/or sobering ▪ Behavioral health patient needing/seeking 24+ treatment but not needing hospital-level inpatient care ▪ Typically, both Voluntary and Involuntary Treatment (Locked facility) ▪ Medical Status/Clearance Appropriate for Setting
Staffing	▪ Professionally licensed/credentialed: Psychiatrist, prescribing Nurse Practitioners and/or Physicians Assistants, Psychologists, Addiction Counselors, Social Workers ▪ Peer Specialists ▪ Admin. Support and Security Staff
Licensing	▪ Licensed MHC endorsed as an Inpatient Crisis Facility per the standards for BH Inpatient Facilities (ARM Subchapter 37.106.17) plus requirements specified in ARM 37.106.1946.

Crisis facilities are designed to operate in a home-like environment as opposed to a medical or clinical environment. Notably, the receiving facilities (referred to in some literature as "psychiatric emergency rooms") are most often furnished with recliner-type chairs, which are conducive to rapid assessments (including observation), shorter lengths of stay (i.e., under 24 hours), as well as increased communication between staff and "guests" (i.e., patients) and between guests.

On the other hand, given longer lengths of stay (over 24 hours), stabilization facilities are furnished with beds rather than recliners. According to RI International (a consulting organization specializing in crisis system development and operations), stabilization units "serve approximately 30% of the population that are not stabilized in the 23-hour observation unit during the first day, with an average length of stay between 2.5 and 3 days." Both the receiving and stabilization facilities may be operated by a community behavioral health provider in affiliation with the hospital, or as a standalone facility operated by another organization.

Medical clearance for people with substances "onboard" are often a major concern of communities and providers who are developing crisis facilities. Crisis center providers across the country have established medical clearance criteria, practices, and protocols to accept and serve people at crisis receiving and stabilization facilities who have indications of substance use, intoxication and/or addiction-related complications.

Importantly, crisis facilities serve all people, regardless of whether they present with mental health, substance use, or co-occurring (i.e., mental health and substance use) needs. Both those people who arrive voluntarily and those who are placed on involuntarily holds are served. The culture and guiding principles of both receiving and stabilization facilities reflect a "no wrong door" service, in which all "guests" who are brought to, or walk-in to, the facilities are welcomed and served with compassionate, supportive, professional care. Services are provided by medical and behavioral health professionals, including psychiatrists, psychiatric nurse practitioners, nurses, licensed and credentialed mental health and addiction clinicians, as well as peer recovery specialists. These facilities are licensed as residential sub-acute and or hospital beds.

Notably, medical clearance for people with substances "onboard" are often a major concern of communities and providers who are developing crisis facilities. SAMHSA's National Survey on Drug Use and Health (NSDUH) report from 2018 notes that approximately 3.7% of adults had a combination of any mental illness and a substance use disorder (9.2 million adults)[4]. Given the number of people who will use crisis services and who may likely have recently

[4] *Substance Abuse and Mental Health Services Administration. (2019). Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Publication No. PEP19-5068, NSDUH Series H-54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://store.samhsa.gov/sites/default/files/d7/priv/pep19-5068.pdf

used or over-used substances, crisis facilities must -- as opposed to "weeding out" people who have indications of intoxication when they arrive at the crisis center -- adopt best practices in admission and medical clearance protocols. Indeed, to avoid unnecessary transports to emergency departments, providers across the country have established medical clearance criteria, practices, and protocols to accept and serve people at crisis receiving and stabilization facilities who have indications of substance use, intoxication and/or addiction-related complications. However, best practices include protocols that if, after being initially assessed by a medical professional at the crisis facility (or an EMS provider), a person has indications of needing life-saving medical care, the crisis facility prepares for immediate transport to medical emergency facilities.

Additional Considerations

Minimum Expectations and Best Practices

In 2020, the National Association of State Mental Health Program Directors (NASMHPD) adopted the "NASMHPD National Guidelines for Crisis Care". Within the Guidelines is a review of "minimum expectations and best practices to operate crisis receiving and stabilization services", as outlined below. We strongly recommend each of the communities encourage (if not require) their crisis facility provider(s) meet the National Guidelines' expectations and best practices.

NASMHPD Minimum Expectations and Best Practices for Crisis Receiving and Stabilization

	Expectations and Best Practices
Operations	✓ Operate 24/7 365 days a year. ✓ Include beds within a real-time regional bed registry system to support efficient connection to needed resources.
Intake	✓ Offers walk-in and first responder drop-off options. ✓ Offers capacity to accept all referrals at least 90% of the time with a no rejection policy for first responders. ✓ Does not require medical clearance prior to admission; provides assessment and support for medical stability while in the program.
Staffing	✓ 24/7 multidisciplinary team able to meet needs of individuals experiencing all levels of crisis. ✓ Includes psychiatrists or psychiatric nurse practitioners, nurses, licensed/credentialed clinicians, peers with lived experience.
Services	✓ Addresses mental health and substance use crisis issues. ✓ Assesses physical health needs and deliver care for most minor physical health challenges with an identified pathway to transfer the individual to more medically staffed services if needed. ✓ Screen for suicide risk and violence risk and, when clinically indicated, complete comprehensive suicide risk and/or violence risk assessments and planning. ✓ Incorporate some form of intensive support beds into a partner program (within the services' own program or within another provider) to support flow for individuals who need additional support. ✓ Coordinate connection to ongoing care.

Collaboration, Communication, Transparency

Although this report and corresponding recommendations are focused on crisis receiving and stabilization facilities for each of the communities/regions, the *importance of the findings and recommendations within the context of a crisis system* (which includes the three foundational elements: call center, mobile crisis response, and crisis facilities) *cannot be understated*. While crisis facilities offer a crucial service and link in the system, they are just one factor in a comprehensive "no wrong door" behavioral health crisis system that operates graduated levels of intervention, care, and treatment. High levels of service coordination, collaboration, and transparency between first responders, hospitals, health and medical providers, and behavioral health treatment providers is crucial to the success of any "no wrong door" crisis systems.

High levels of service coordination, collaboration, and transparency between first responders, hospitals, health and medical providers, and behavioral health treatment providers is crucial to the success of the "no wrong door" crisis system.

County Comparisons

A shared mission and agreement between providers to the "no wrong door" philosophy is pivotal to the design and operation of crisis receiving and stabilization facilities. Collaborative communication and transparency between the entities that will operate, support and utilize the services must exist for both functionality and the intended impact. The fact that four coalitions -- The Strategic Alliance for the Gallatin County Behavioral Health Crisis System (aka the Crisis Redesign Alliance), Missoula Strategic Alliance for Improved Behavioral Health, Lewis and Clark County's Behavioral Health System Improvement Leadership Team, and the Cascade County Strategic Alliance for the Crisis Intervention Program --- shared resources to conduct an analysis and develop plans is remarkable and most certainly a testament to their commitment to collaboration.

Crisis receiving, stabilization and support services are especially robust if mutual goals, agreements, understanding, and transparency exists – especially between providers and first responders. The Crisis Response Center in Pima County, Arizona, reflects how the power of community determination and collaboration can lead to the creation of a crisis stabilization center that has grown to become a national model in crisis services. (Story next page)

Solving the Mental Health Crisis Through Community Collaboration

(*Joint Commission **. Blog Post. 6/8/21*)

"Our colleagues in behavioral health are all too familiar with the saying, "it's easier to get into heaven than to access psychiatric care." This is especially the case during a crisis.

Unlike medical emergencies, a 911 call for a behavioral health emergency often results in a police response. Individuals in mental health crisis account for a quarter of officer-involved shootings, and the prevalence of individuals with mental health conditions in jails and prisons is three to four times that of the general population.

Those who make it to the hospital don't fare much better. More than 80% of emergency departments (EDs) report boarding psychiatric patients on any given day, and 64% report they have no psychiatric services available while patients are awaiting admission or transfer, according to a survey by the American College of Emergency Physicians. All of this comes at a high cost—approximately $2,300 per patient and a poor experience for patients, families, and ED staff.

Our community wanted to change that.

In 2009, the citizens of Pima County, Arizona, voted to build a crisis center to meet the community need for psychiatric emergency care. The Crisis Response Center (CRC) opened in 2011, eight months after the Jan. 8 shooting that occurred outside a Tucson grocery store in which six people were killed. In addition, the former U.S. Representative, Gabrielle Giffords and 12 others were wounded by the gunman who was diagnosed with schizophrenia.

"No Wrong Door" in a Crisis

The revolutionary mission of the CRC is to reduce the number of individuals with mental illness in jails and EDs by making it easier and faster for law enforcement to bring them to the crisis center for treatment. The CRC's "no wrong door" policy means that officers are never turned away, eliminating the need for them to navigate a complicated system of hospitals, detox centers or clinics. The drop off process is less than 10 minutes, which is considerably faster than what it would be at a jail or ED.

Today, the CRC serves 12,000 adults and 2,400 youth annually. Services include 24/7 walk-in urgent care and 23-hour observation. About half of our patients are brought directly from the field by law enforcement, with the remainder arriving via mobile crisis teams, walk-in or transfer from emergency rooms. Reasons for presentation include:

- danger to self/others
- acute agitation
- psychosis
- substance intoxication and withdrawal

Even highly acute and potentially violent patients are accepted in care without the use of security staff. Care is provided by an interdisciplinary team of psychiatric practitioners, social workers, nurses, behavioral health technicians, peer support specialists

To rapid assessment, early intervention, proactive discharge planning and close collaboration with community providers, the majority of patients are stabilized and connected to appropriate community-based care without the need for hospitalization. For those who need it a 15-bed adult sub-acute unit provides three to five days of continued stabilization.

** *The Joint Commission accredits over 22,000 hospitals and health care organizations in the US. The Commission develops performance standards to address crucial elements of operation including patient care, medical safety, infection control, and consumer rights.*

Current Crisis Services

Crisis receiving and stabilization facilities are pivotal in a crisis system. The plans, design and capacity of the facilities should take into consideration the full spectrum of crisis services operating (or in development) in the community. Toward that end, the WICHE/BHP team considered both the crisis services and behavioral health services in operation and/or actively being developed in the four communities/regions. The table below offers a snapshot of those services; it includes hospital ERs as they have a major role in the crisis continuum and seem to be the only active, 24/7, receiving facility for the four counties at this point in time.

Snapshot: Current Crisis Services

	Cascade	Gallatin	Lewis and Clark	Missoula
Crisis Line (24/7)	Voices of Hope MT (serves 43 counties and MT's Native American communities)	The Help Center	Voices of Hope	WMMHC Crisis Line (new)
CIT Officers	PD and SO	PD and SO	PD and SO	PD and SO
Mobile Crisis	Alluvion(FQHC) with Great Falls Police Dept. and Cascade County Sheriffs Office	Western Montana Mental Health Ctr, with Gallatin Police Dept.	St. Peter's Mobile Crisis Response Team	Partnership Health (FQHC) and Missoula Fire Dept.
Crisis Receiving	NO Receiving Facility	NO Receiving Facility	NO Receiving Facility	NO Receiving Facility
Crisis Stabilization	NO Stabilization Facility	WMMHC/Hope House. 8 beds vol./2 involuntary	NO Stabilization Facility	WMMHC's Dakota Place. (7 beds/2 involuntary)
Hospital ER*	Great Falls Clinic ER Benefis Hospital ER	Bozeman Health ER Big Sky Med. Ctr ER	St. Peter's Medical Center ER	Providence St. Patrick's ER Community Medical Center
Behavioral Health Inpatient	Benefis (10 beds) for adults	NO Behavioral Health Inpatient Unit	St Peter's BH Inpt. (24 beds) Shodair Children's Inpt. psychiatric services	Providence St Patrick's Psych Inpt. (22 adult + 14 adolescent beds)

Crisis Services in the Counties

Pathways Into Crisis Facilities/Centers: There are multiple pathways into crisis receiving and stabilization facilities. Typically, those pathways include: Crisis Call Center referrals, Law Enforcement and (when allowed per insurance and regulatory agencies) EMS first responders, Mobile Crisis Teams, Hospital Emergency Room staff, Community Healthcare Providers and Walk Ins.

Post Crisis Pathway: Pathways out of crisis receiving and stabilization services to follow-up treatment and/or support services once the crisis has been resolved or stabilized, are a second cornerstone of the crisis systems. Those options include referrals to comprehensive/intensive outpatient treatment (Program for Assertive Community Treatment -PACT), connections, and/or transfers to inpatient care or recovery centers.

Indeed, connecting people experiencing a crisis to appropriate levels of care and, post-crisis, to continued services and support, is a cornerstone of all crisis systems. Hence the crucial need for collaboration and cooperation between first responders, human/social service agencies, and healthcare (including behavioral health) providers.

Mapping the pathways into the crisis facilities, and pathways to services once the crisis has been stabilized, is vital to crisis system flow. In determining the model each community will adopt, the strengths and gaps of each community's pathways, as well as strategies to build upon strengths and minimize gaps, will be critical.

Although 24/7 call centers, community-based mobile crisis teams, and crisis receiving and stabilization centers have been shown to dramatically decrease the number of people who use or are transported to emergency rooms for crisis services, crisis receiving and stabilization centers do not replace or eliminate a community's need for inpatient behavioral health services.

Although there are not community-based crisis receiving and stabilization services operating in all four counties, there are other important crisis services that are in place, being expanded, and being developed in each of the counties, including 24/7 Call Centers, Crisis Intervention Team (CIT) trained officers, and Mobile Crisis. An additional important piece of this system are Programs for Assertive Community Treatment (PACT) teams. These teams provide comprehensive wrap-around services to clients providing clinical support by psychiatrists and nurses, access to employment and housing specialists, and peer specialists. PACT teams are operating within all four communities and AMDD is ensuring, through regular fidelity reviews, that services on these teams are being delivered to national standards. These teams can help reduce the need for the crisis system by providing comprehensive treatment which can significantly

reduce the frequency of behavioral health crisis; the PACT teams also deliver services to clients in crisis, often de-escalating the situation and helping the client to remain in the community and with their natural supports. In addition to being able to reduce the likelihood of current PACT clients needing crisis services, these teams are an ideal outpatient treatment model for people who have experienced a crisis and need support when they return to the community. The fact that these crisis services are in place and are being developed is very positive.

As pathways in and out, each of the services will be instrumental in interfacing with and collaborating with the crisis receiving and stabilization provider(s) once they are in place. The programs and services shown in the proceeding table will have a major impact on crisis response and services – including both the pathways in and the pathways out of the Crisis Receiving and Stabilization facilities.

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Snapshot: Behavioral Health Programs and Services

**This table highlights primary "public" or "public/private" behavioral health providers' services that may play a key role or function in developing and operating crisis centers. The table is not a complete overview of all behavioral health services or providers in the four counties. Montana and the four counties listed here have a wide range of private practices, practitioners, clinicians, clinics, recovery services and treatment centers.*

COUNTY	MENTAL HEALTH	SUBSTANCE USE	BH/PSYCH INPATIENT
Cascade	Center for Mental Health Alluvion (FQHC): Mobile Crisis, Jail Diversion, Jail Service, Integrated BH Urban Indian Ctr: Integrated BH	Gateway- currently moving under Center for Mental Health Sober Living: Peer Support Services	Benefits inpatient unit for adults with SUD and co-occurring"
Gallatin	Western Montana Mental Health Center (WMMHC) Community Health Partners (FQHC/integrated BH) Bozeman Health, integrated BH Gallatin Mental Health Center/ BH Urgent Care Center Intermountain and CHP: School-Based Health Services	Community Health Partners (FQHC: integrated BH) Bozeman Health, integrated BH Alcohol and Drug Services of Gallatin County	
Lewis and Clark	Center for Mental Health: PACT AWARE: PACT Intermountain: child and family MH services Shodair Children's Hospital: psychiatric services Fort Harrison VA Medical Center Urban Indian Ctr integrated BH	Fort Harrison VA Medical Center All Nations Health Center, Urban Indian Health Center: Recovery/SUD Treatment Boyd Andrews Instar Community Services	St. Peter's Health Behavioral Health Unit Shodair Children's Hospital, Psychiatric Inpatient
Missoula	WMMHC (including PACT) Providence St. Patrick's Fort Harrison VA Med. Ctr. Clinic All Nations Health Center, Winds of Change MG Center	WMMHC Recovery Center Missoula: Inpatient SUD Open Aid Alliance: Peer Support	Providence St Patrick Hospital

Facility-based Behavioral Health Crisis and Urgent Care Services: Current and Planned

Given this report is focused on facility-based crisis services, it's especially important to note the services/providers that are currently operating (or are planning to operate in the near future), *facility-based* urgent, inpatient, and/or stabilization services in each of the counties. Those providers include:

Cascade:

- ✓ Benefis Hospital: Inpatient unit for Substance Use and Co-occurring Treatment

Gallatin:

- ✓ WMMHC Campus:
  - → Gallatin Mental Health: Behavioral Health Urgent Care Center
  - → Walk-In Center
  - → Hope House Stabilization Facility
- ✓ *Bozeman Health Deaconess Hospital:*
  - → *Psychiatric ER Unit (planning/future)*
  - → *Crisis Receiving/Stabilization Facility (planning/future)*

Lewis and Clark:

- ✓ St. Peter's Health Regional Medical Center: Behavioral Health Inpatient Unit
- ✓ Shodair Children's Hospital: Psychiatric Inpatient and Outpatient Services

Missoula:

- ✓ WMMHC: Dakota Place Crisis Stabilization Facility
- ✓ Providence Saint Patrick's Inpatient Psychiatric Unit

State:

- ✓ Montana State (psychiatric) Hospital, Warm Springs

Agreements and MOU's

To ensure there is "no wrong door" for accessing crisis care, services are well-coordinated, and resources are used wisely in the region and across the state, Operating Agreements and/or Memorandums of Understanding between providers and the Crisis Receiving/Stabilization providers will be crucial. We suggest the topics that should be addressed in the Agreements include (at a minimum):

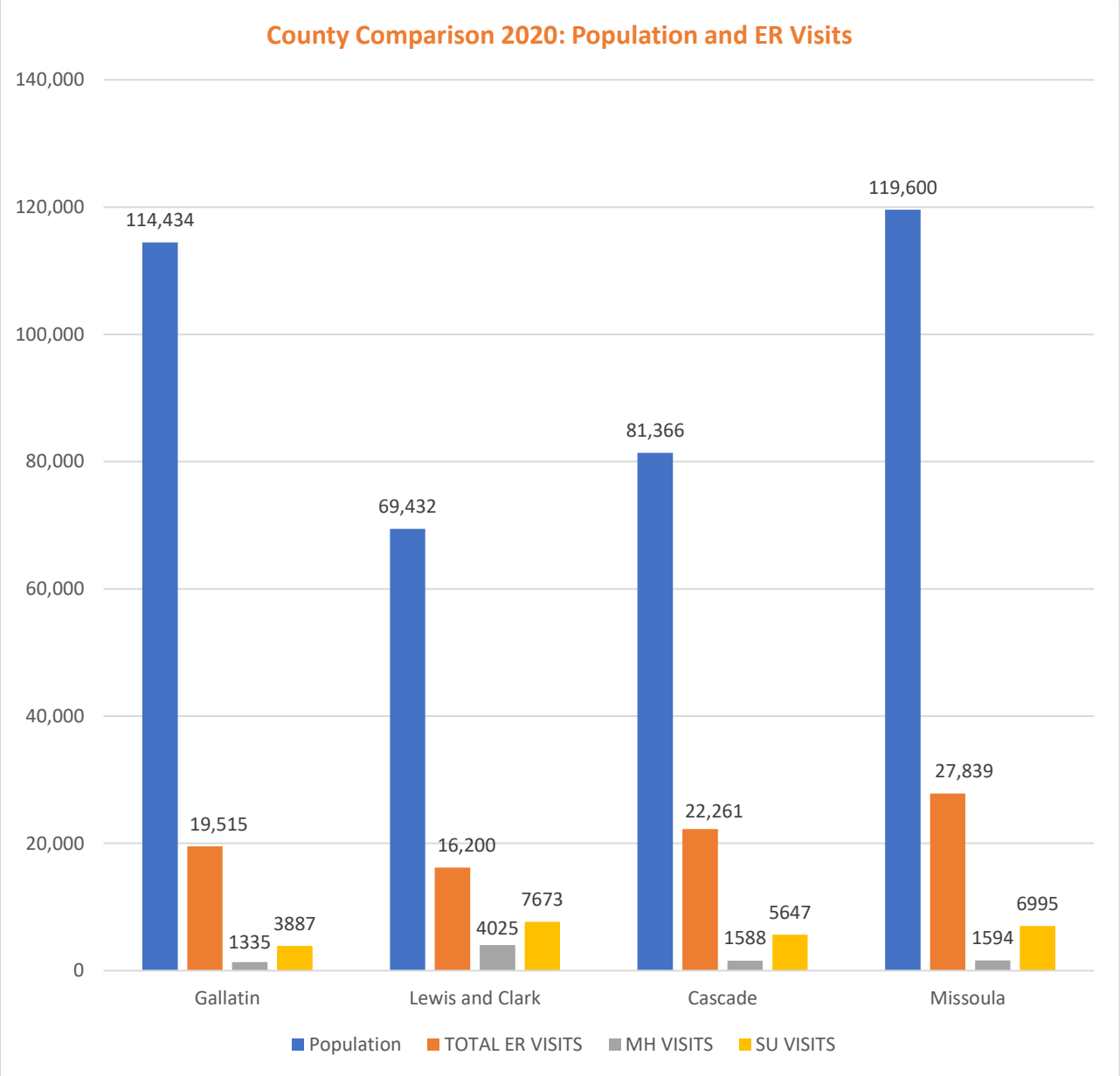
- the role of each of the facility-based and community-based crisis providers;
- their referral, intake and admissions practices;
- their patient/consumer transfer practices;
- the services they are committed to delivering;
- their contributions (i.e., resources) to the region's/community's crisis system; and
- their approach and agreement to track and share information regarding their service utilization, service availability, and capacity (this will be especially important if/when a crisis and inpatient bed tracking program is instituted).

Comparison of Populations and Emergency Room Utilization

As part of this project, WICHE/BHP was asked to review the populations and emergency room usage data for each of the four counties.

COUNTY	POPULATION (2020)	POP. OF PRIMARY LOCATION FOR BH SERVICES
Cascade	81,366	Great Falls: 58,434 (2019)
Gallatin	114,434	Bozeman: 49,831 (2019)
Lewis and Clark	69,432	Helena: 33,124 (2019)
Missoula	119,600	Missoula: 75,516 (2019)

NOTE: City population numbers are the 2019 estimate, as currently reported in 2020 US Census Report.



1. **Population**
2. **Emergency Room (ER) Visits**
3. **Mental Health related ER Visits**
4. **Substance Use related ER Visits**

Clearly, hospital emergency room visits related to substance use far exceeds mental health related visits. The data, system analysis reports, and key informant input point to the fact that withdrawal management and sobering services for people in crisis is a major gap in all four counties. Community-based withdrawal management and sobering facilities could help fill that gap. However, we would suggest the communities begin to address this need by initially focusing on developing and operating the one crisis service that does not exist in any of the counties: Crisis Receiving facilities. If operated under the best practice models and protocols of crisis care, people who have indications of substance use will be served at the Crisis Receiving facilities. Consequently, once those crisis facilities are operating, each of the counties will be able to reassess the need for community-based withdrawal and/or sobering facilities.

Withdrawal management and sobering services for people in crisis is a major gap in all four counties. Sobering facilities could help fill that gap. However, we would suggest the communities begin to address this need by initially focusing on developing and operating the one crisis service that does not exist in any of the counties: Crisis Receiving facilities.

Forecasting Need and Utilization

Paramount in planner's and stakeholder's minds is the question: "How many 'beds' will our crisis centers need?" In researching forecasting tools and formulas specific to crisis centers, we identified three calculation methods cited by SAMSHA, NASMHPD, and the National Behavioral Health Council -- all of which included the "Crisis Now Crisis System Calculator" and tools developed by RI International, a national consulting firm specializing in crisis services. Based on those sources, we were able to provide preliminary forecasting for each of the counties.

Utilization Projections: Per RI International's Crisis Now guidelines, it is estimated that:

> "For every 100,000 members of a representative population, 200 of those population members will experience a crisis that requires something more than a typical outpatient or phone intervention. Research has enabled the utilization of data to stratify the service level needs of those individuals; and that data can be applied to most efficiently design a cost-effective service delivery system."

As reported by RI International, if the ratio of 200 individuals per 100,000[5] will experience a crisis that requires a service level more acute than can be accommodated by outpatient services or a phone intervention, Montana (with a population in 2020 of 1,084,225) would be expected to have over 2,168 individuals annually who would be in need of more intensive crisis services. If 54% of those individuals are expected to require admission to a crisis facility, the number of admissions would be 1,170. Similarly, if 32% require a Mobile Crisis Team intervention, that annual number would be 694 individuals. Further, if 14% require acute psychiatric care, that would equal 304 admissions to inpatient care.

[5] RI International / Crisis Now Consultation to Alaska. *Transforming Crisis Services is Within Our Reach*.

When the utilization formula is applied to the four counties, the data in the following tables are produced[6].

COUNTY	POPULATION (2020 Census)	PROJECTED # NEEDING INTENSE CRISIS SERVICES **	EXPECTED TO REQUIRE ADMISSION TO CRISIS FACILITY (54%)	REQUIRE MOBILE CRISIS TEAM INTERVENTION (32%)	REQUIRE ACUTE INPATIENT (14%)
Cascade	81,366	163	88	52	23
Gallatin	114,434	229	124	73	32
Lewis and Clark	69,432	139	75	45	20
Missoula	119,600	239	129	77	34

*** Population, divided by 100,000 x 200*

Level of Care Utilization (LOCUS) Projections: Using the statewide crisis line data set[7], Georgia conducted an analysis of over a decade of Level of Care Utilization System (LOCUS) data. The analysis included a total of 1.2 million records, 431,690 of which met the criteria of individuals being engaged by a face-to-face crisis response service by facility-based or mobile team providers. According to SAMSHA's "National Guidelines for Behavioral Health Crisis Care" the Georgia LOCUS analysis resulted in a "breakdown that can be used to inform optimal initial referral paths within a system of care that includes a continuum of crisis services."

- 14% (59,269 of 431,690) LOCUS 6: Direct Referral to Acute Hospital.
- 54% (234,170 of 431,690) LOCUS 5: Referral to Crisis Receiving and Stabilization Facility.
- 32% (138,251 of 431,690) LOCUS 4-1: Evaluation by Crisis Mobile Team/Referral to Care.

Using the 2019 hospital emergency room visits for behavioral health data, and the Georgia LOCUS analysis cited by SAMHSA, we were able to make very preliminary assumptions regarding projected utilization of Receiving/Stabilization Centers.

COUNTY	*# MH Visits in Hospital*	*# SU Visits in Hospital*	*Total # BH Visits in Hospital*
Cascade	1588	5647	7235
Gallatin	1335	3887	5222
Lewis and Clark	4025	7673	11,698
Missoula	1594	6995	8589

Assuming the key functions of crisis services (i.e., 24/7 Call Center, Mobile Crisis Teams, CIT, and Receiving/Stabilization Facilities) are operating, behavioral health visits to the ER would be triaged more broadly rather than in the one "crisis facility" (i.e., hospital ER) that currently exists. In that case, utilization may be projected as shown in the tables below.

[6] The numbers shown are based on county population. In a state like MT, the facilities would be serving a broader population from surrounding counties.

[7] National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit, Knowledge Informing Transformation. national-guidelines-for-behavioral-health-crisis-care-02242020.pdf (samhsa.gov)

LOCUS MODEL Monthly Utilization Projections:

Based on annual total Behavioral Health ER Visits

COUNTY	Refer to Acute Hospitalization (14%)	Refer to Crisis Facility (54%)	Refer to Mobile Crisis/ Follow up (32%)
Cascade	84	325	193
Gallatin	61	235	139
Lewis and Clark	136	526	312
Missoula	100	386	229

LOCUS MODEL Monthly Utilization Projections:

Based on annual total Mental Health ER Visits

COUNTY	Refer to Acute Hospitalization (14%)	Refer to Crisis Facility (54%)	Refer to Mobile Crisis/Follow up (32%)
Cascade	19	71	42
Gallatin	16	60	36
Lewis and Clark	47	181	107
Missoula	19	72	43

LOCUS Model (Annual and Monthly) Projections:

Based on Annual Total Behavioral Health ER Visits

CASCADE

Annual Projections:

- 14%: 1,013 interactions directly referred to *Acute Hospitalization*
- 54%: 3,907 interactions referred to *Crisis Receiving/Stabilization*
- 32%: 2,315 interactions evaluated by *Crisis Mobile Team with Referral to Care as needed*

Monthly Projections:

- 14%: 84 interactions directly referred to *Acute Hospitalization*
- 54%: 326 interactions referred to *Crisis Receiving/Stabilization*
- 32%: 192 interactions evaluated by *Crisis Mobile Team with Referral to Care as needed*

LEWIS AND CLARK

Annual Projections

- 14%: 1,632 interactions directly referred to *Acute Hospitalization*
- 54%: 6,312 interactions referred to *Crisis Receiving/Stabilization*
- 32%: 3,744 interactions evaluated by *Crisis Mobile Team with Referral to Care as needed*

Monthly Projections:

- 14%: 136 interactions directly referred to *Acute Hospitalization*
- 54%: 526 interactions referred to *Crisis Receiving/Stabilization*
- 32%: 312 interactions evaluated by *Crisis Mobile Team with Referral to Care as needed*

GALLATIN

Annual Projections:

- 14%: 731 interactions directly referred to *Acute Hospitalization*
- 54%: 2,820 interactions referred to *Crisis Receiving/Stabilization*
- 32%: 1,671 interactions evaluated by *Crisis Mobile Team with Referral to Care as needed*

Monthly Projections:

- 14%: 61 interactions directly referred to *Acute Hospitalization*
- 54%: 235 interactions referred to *Crisis Receiving/Stabilization*
- 32%: 139 interactions evaluated by *Crisis Mobile Team with Referral to Care as needed*

MISSOULA

Annual Projections:

- 14%: 1,202 interactions directly referred to *Acute Hospitalization*
- 54%: 4,636 interactions referred to *Crisis Receiving/Stabilization*
- 32%: 2,747 interactions evaluated by *Crisis Mobile Team with Referral to Care as needed*

Monthly Projections:

- 14%: 100 interactions directly referred to *Acute Hospitalization*
- 54%: 386 interactions referred to *Crisis Receiving/Stabilization*
- 32%: 229interactions evaluated by *Crisis Mobile Team with Referral to Care as needed*

It is important to note that while the LOCUS projections may seem overwhelming for a crisis facility and crisis services, *the data reflect "engagements" and "visits" rather than individuals who will present with a wide range of needs and levels of acuity*. Further, although 24/7 call centers, community-based mobile crisis, and crisis receiving and stabilization centers have been shown to dramatically decrease the number of people who use or are transported to emergency rooms for crisis services, crisis receiving and stabilization centers do not replace or eliminate a community's need for inpatient behavioral health services.

The National Council for Behavioral Health's publication, "Capacity Projections for Crisis Residential Settings[8]" also references RI International's Crisis Now projections to forecast capacity, bed days, and utilization. According to the Council, the composition of the crisis continuum can be determined by the size and geographical distribution of the population to be served:

> "Based on the Crisis Now "How Does Your Crisis Flow?" diagram, a significant percentage of the total adult crisis presentations (200 individuals per 100,000 residents per month) were served in crisis residential settings. If that percentage is even as low as 30%, a community of 500,000 people would generate 300 residential crisis admissions per month and, if we assume an average length of stay of five days, that would require 50-60 residential crisis beds (5 x 300 = 1,500 bed days, divided by 30 for approximate utilization)."

[8] The National Council for Mental Wellbeing's Roadmap to the Ideal Crisis System, "Capacity Projections for Crisis Residential Settings", pgs. 108 – 109

That is, in the example cited by the National Council, the assumptions used are:

- ✓ Adult Presentations in Crisis: 200 individuals per 100,000 residents per month = 0.2%
- ✓ Thirty percent (30%) of the 200 (0.2%) adults need crisis facility
- ✓ Average Length of Stay (LOS) is 5 days

Based on those assumptions, we calculate the number of "bed days" and crisis "beds" needed per population size (which can be useful in terms of projecting "days and beds" for a region) would be:

Population	Adults in Crisis per month (pop. x 0.2%)	Needing Crisis Facility per Month (x 30%)	Bed Days (Admissions x 5 day LOS)	# Crisis "beds" (Bed Days/30 Approx. Utilization)
125,000	250	75	375	13
100,000	200	60	300	10
65,000	130	40	200	7

RI International has also developed a calculator to project capacity needs as well as the projected costs, and cost savings, of operating crisis services and centers. In preparing this report, WICHE/BHP reached out to RI International who, in turn, entered Montana's total population into the calculator to demonstrate the tool's value, as shown on the following page.

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Crisis Now Crisis System Calculator (Basic)		
	No Crisis Care	**Crisis Now**
# of Crisis Episodes Annually *(200/100,000 Monthly)*	24,000	24,000
# Initially Served by Acute Inpatient	16,320	3,360
# Referred to Acute Inpatient From Crisis Facility	-	1,336
Total # of Episodes in Acute Inpatient	16,320	4,696
# of Acute Inpatient Beds Needed	**348**	**100**
Total Cost of Acute Inpatient Beds	**$ 97,104,000**	**$ 27,938,820**
# Referred to Crisis Bed From Stabilization Chair	-	5,342
# of Short-Term Beds Needed	**-**	**41**
Total Cost of Short-Term Beds	**$ -**	**$ 11,352,600**
# Initially Served by Crisis Stabilization Facility	-	12,960
# Referred to Crisis Facility by Mobile Team	-	2,304
Total # of Episodes in Crisis Facility	-	15,264
# of Crisis Receiving Chairs Needed	**-**	**48**
Total Cost of Crisis Receiving Chairs	**$ -**	**$ 16,218,000**
# Served Per Mobile Team Daily	4	4
# of Mobile Teams Needed	**-**	**8**
Total # of Episodes with Mobile Team	-	7,680
Total Cost of Mobile Teams	**$ -**	**$ 2,160,000**
# of Unique Individuals Served	**16,320**	**24,000**
TOTAL Inpatient and Crisis Cost	**$ 97,104,000**	**$ 57,669,420**
ED Costs ($520 Per Acute Admit)	**$ 8,486,400**	**$ 2,441,712**
TOTAL Cost	**$ 105,590,400**	**$ 60,111,132**
TOTAL Change in Cost		**-43%**

Per our communications with Wayne Lindstrom, PhD, Vice President for the Western US for RI International, "*From this, you can glean a variety of capacity and cost projections. However, we would urge any locality to further refine the data so that the Calculator takes into account current crisis resources and costs. For example, projections will vary based on a nascent system versus one that is mature and has been optimized over time.*"

Summary of Recommendations

As outlined in this report, we offer the following guidelines and recommendations for the creation of crisis receiving and stabilization facilities for Cascade, Lewis and Clark, Gallatin and Missoula Counties.

- Crisis facilities are designed to operate within *a crisis system,* which includes the additional core services of 24/7 Call Center, CIT Team (and/or trained) Law Enforcement Officers, and Mobile Crisis. Mapping the pathways into the crisis facilities, and pathways to services once the crisis has been stabilized (or if the crisis center guest/patient requires higher levels of care), is vital to crisis system flow. In determining the crisis receiving and/or stabilization facility model each community will adopt, the pathways should be taken into consideration.

- Seeing, first-hand, model crisis facilities and systems is invaluable. Walking though the facilities (noting location, design and layout), seeing intake and operations, meeting with staff, and seeing demonstrations of reporting and system tracking tools will inform both practical and forward-thinking plans customized for communities. We strongly recommend Montana organize site visits to model crisis facilities/systems by teams of interprofessional organizational leaders and decisionmakers who represent the communities' primary stakeholder groups, including: CIT and law enforcement leaders, hospital ERs, psychiatric and substance use inpatient hospitals, community behavioral health providers (including FQHC's), elected officials, funders, and consumer/family advocates.

- Each community/county should consider developing a crisis facility/center business plan specific to the model their community/county will adopt. National Council for Behavioral Health's 2021 publications, "Map to the Ideal Crisis System: Essential Elements Measurable Standards and Best Practices for Behavioral Health Crisis Response", is an excellent reference tool for business planning.

- Tools exist to project crisis facility utilization, "beds", and capacity. The base data used to create the projections should be analyzed and updated to reflect the nuances of population needs, community resources, and funding. RI International is most often cited as the organization that has developed and tested calculation tools based on the Crisis Now best practices.

- High levels of service coordination and transparency between first responders, hospitals, health and medical providers, and behavioral health treatment providers is crucial to the success of any "no wrong door" crisis systems. Agreements and/or Memorandums of Understanding between the Crisis Facility provider(s) and primary community organizations/agencies that provide/support crisis and behavioral health services will help define expectations and support a cohesive system of crisis care.

- Withdrawal management and detoxification services is a major gap in all four counties. However, if operated under the best practice models and protocols of crisis care, people who have indications of substance use will be served at the Crisis Receiving facilities. Consequently, once the crisis facilities are fully operational, each community should reassess the need for additional substance withdrawal and/or sobering facilities.

- Staffing and workforce development is a major concern for organizations that are currently operating community-based crisis stabilization facilities in Gallatin and Missoula counties (i.e., WMMHC), as well as for those agencies evaluating the possibility of developing/operating crisis facilities. SAMSHA, the National Council for Behavioral Health, and RI international offer resources and ideas to help communities forecast staffing needs based on the model of care as well as other determinants. Training and employing Peer Specialists is another best practice in crisis services and centers we strongly recommend. In addition, telehealth (for medical clearance and evaluations), and telepsychiatry (for evaluation, psychiatric consultation, prescribing) are approaches that should be considered.

Next Steps

Stakeholders of all four counties are eager to begin planning for crisis facilities based specifically on their community's resources and needs. Toward that end, subject to funding, Phase Two of this project and the future consultation will focus on the following for each county within their local systems:

- Facility: Recommendations regarding the crisis receiving and stabilization facility/facilities within the scope of each county's resources and needs, including consideration of existing resources such as a currently closed facility or services that may be repurposed and/or strategically positioned.
- Agreements: Recommendations regarding partnership agreements and MOU's unique to each county.
- Program Flow and Pathways: Mapping and definition of programmatic and systematic flow as well as service pathways for each county – from initial assessment to connection to services.
- Policies: Review of State policy landscape of crisis receiving and stabilization services and facilities to ensure that policy framework (licensing, regulations, etc.) are in place to support best practices crisis receiving and stabilization models.
- Staffing: Crisis Facility staffing projections and recommendations (i.e., credentials, licenses, expertise, etc.) to ensure coverage and capacity to receive individuals (without any additional routing to the ER for medical concerns) – including applications and utilization of telehealth.
- Expenses: Facility expense forecasts, including start-up expenses, staffing, operational, and administrative cost projections.
- Funding: Analysis of sustainable funding sources and/or needed policy changes. For example, Medicaid coverage for "ineligible" persons and safety net funding.