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INNOVATIVE 988 CRISIS SERVICE SYSTEMS FOR CHILDREN, YOUTH, AND PEOPLE WITH DISABILITIES

KEY POINTS

- The introduction of 988 in 2022 raised questions about how best to serve special populations--including children, youth, people with intellectual and developmental disabilities, and older adults with neurocognitive disorders--and connect them to appropriate follow-up services. This brief describes partnerships and strategies of five states (Connecticut, Georgia, New Jersey, Pennsylvania, and Virginia) that have focused on developing crisis services for these populations.
- 988 and pre-existing crisis service lines are a common service entry point for special populations in crisis. In the five states in this study, call takers triage calls from special populations much the same as other 988 callers, but tailor the crisis response to the specific caller and circumstances of the crisis.
- Cross-agency collaboration at the state level facilitates development of common goals and procedures. Trusting relationships and free exchange of information between state agencies leading 988 implementation and contracted 988 providers is also critical.
- State political and legislative support influences and enhances states' abilities to serve special populations.
- States braid together many sources of funding to finance crisis services for special populations, and state officials highlighted this as a primary challenge. State appropriations often ebb and flow with changing legislative priorities, and grant funds are typically one-time or time-limited, making sustainability planning challenging.
- Hiring and staff retention challenges are pervasive, especially among staff with more specialized skills and training needed to serve special populations. However, states are thinking creatively about how to solve the problem by employing strategies such as cross-training, telehealth visits, and seeking ways to prevent burnout and support crisis response staff.

In 2020, Congress designated the new 988 dialing code to be operated through the existing National Suicide Prevention Lifeline. The 988 Suicide and Crisis Lifeline was established to improve access to immediate support to meet the behavioral health crisis needs of people in the United States (SAMHSA n.d.). In July 2022, the new 988 Suicide and Crisis Lifeline went live, along with an influx of funding for implementation of 988 and mobile crisis services (Saunders 2023). While these developments provide welcome opportunities to increase access to care for people experiencing crises, existing crisis services systems often lack interventions for populations that might require a more specialized crisis response, including children, youth, and people with intellectual, developmental, and neurocognitive disabilities. These groups might need more tailored responses to behavioral health crises that include referrals to services and supports across multiple service systems to promote sustained recovery.

Following the inception of 988, the Substance Abuse and Mental Health Services Administration (SAMHSA) produced *National Guidelines for Child and Youth Behavioral Health Crisis Care* and a companion technical guidance document, *A Safe Place to Be: Crisis Stabilization Services and Other Supports for Children and Youth*

(SAMHSA 2022; Schober et al. 2022). These resources identify best practices for 988 crisis services interventions for children and youth. However, they do not explore specific state tactics for supporting 988 implementation beyond partnerships with law enforcement and emergency medical services. There also is limited literature addressing promising approaches to specialized crisis services for people with intellectual and developmental disabilities (ID/DD), older adults with neurocognitive impairment, and other populations with more specialized needs.

To address these gaps and identify opportunities to promote equity of access to appropriate crisis services for populations who may benefit from more specific services and supports, the Office of the Assistant Secretary for Planning and Evaluation commissioned this study. Our aim was to identify innovative state approaches to providing crisis, stabilization, and recovery-oriented supports and services for children, youth, and people with disabilities through the integration and partnership of 988 crisis services systems with other systems beyond law enforcement and emergency medical services. We conducted group and individual key informant interviews with officials from state behavioral health, disability, and child welfare agencies and providers (including crisis call center leaders and providers of crisis, stabilization, and recovery services for special populations) in five states: **Connecticut, Georgia, New Jersey, Pennsylvania, and Virginia**. Interviews were semi-structured and tailored to each respondent's role. To inform selection of states for inclusion in the study, we consulted subject matter experts in federal agencies and national behavioral health organizations supplemented with targeted searches of the literature.

> *"Crisis services [weren't] given full attention due for many generations. But for the last… 20, 30 years we all are realizing [that] what we've been doing to serve people in crisis* ***of all demographics and abilities*** *is not appropriate, sufficient, [or] modern."*
>
> *- State official*

This brief presents five succinct case studies highlighting each state's approach to providing innovative 988 crisis services to special populations. Following the case studies, we present key findings across the five states related to protocols and procedures for serving special populations when 988 or a crisis line is called, approaches to funding these partnerships, strategies for tracking and monitoring processes and outcomes, significant challenges related to this work, and facilitators that support state efforts to integrate 988 crisis services with other systems and ultimately improve provision of crisis services to children, youth, people with ID/DD, and older adults with neurocognitive disabilities.

How are states tailoring 988 and crisis services for special populations?

The states included in this study take varied approaches to tailoring 988 and crisis services for special populations. Some states focus mainly on one special population and others have developed specialized services for multiple populations. Several factors--such as the structure and organization of states' broader crisis systems, the strength of partnerships across state agencies and between state agencies and crisis services providers, and state political support--affect how these states are approaching the work. We provide brief overviews of each state's innovative crisis services for special populations and highlight the key partnerships that are critical to support them.

Connecticut

Connecticut's Crisis Services for Children and Youth

- The Connecticut Department of Mental Health and Addiction Services (DMHAS) and Department of Children and Families (DCF) fund the Connecticut 988 Contact Center, which handles 988 calls at the state level.
- The state also has a child/youth-specific crisis line, which pre-dates 988. The state's contracted call center answers both 988 and pre-existing crisis line calls and dispatches mobile response teams when appropriate.
- The Youth Mobile Crisis Intervention Services of Connecticut provides rapid face-to-face crisis response for children and their families, access to home and community-based services, short-term follow-up care, discharge collaboration, and more. Through mobile response, a clinician can be onsite within 45 minutes of a call, 24/7/365.
- The state's triage model relies heavily on in-person assessments. If a person calls 988 on behalf of a child or youth in crisis, the default is for mobile crisis response to visit and assess the situation face-to-face.
- Connecticut's School-Based Diversion Initiative (SBDI) increases access for students and families to mental health prevention and crisis services in the school and local community.
- The state is launching four urgent care crisis centers and a crisis stabilization program for youth in crisis who require intensive services. Youth can stay in crisis stabilization for up to a few weeks and then continue to receive support when they return home.

Connecticut's partnerships for supporting children and youth in crisis. Connecticut is often identified by subject matter experts and in the literature as a model for other states seeking to implement robust mobile crisis response and stabilization services for children and youth, due in part to the strength of its partnerships across state agencies and service systems (Hepburn 2022). The state has been intentional about building partnerships that support a high-fidelity crisis care coordination model tailored for children and youth. Officials reported that a primary goal is to help families avoid emergency departments and higher levels of care, which can introduce additional traumas to children in crisis. Mobile crisis response and provision of intensive in-home services after the acute crisis is stabilized are key components of the state's wraparound services for children and youth in crisis.

Connecticut's development of a crisis service system for children and youth has been enhanced by cross-agency collaborations. Following the 2012 Newtown tragedy, Connecticut established the Behavioral Health Plan for Children, a comprehensive blueprint that established cross-agency involvement in children's behavioral health. State officials noted that establishing roles and responsibilities across multiple state agencies resulted in a higher level of motivation and leadership involvement in addressing behavioral health policy and programmatic issues affecting children and youth. The blueprint also helped align the state's goals with those of the state's federal Children's Systems of Care grant and served as the basis for its planning grant application.

State officials from DMHAS and DCF also emphasized the importance of their strong partnership with the state Medicaid authority in establishing Connecticut's crisis services system for children and youth. Connecticut's DCF, DMHAS, the Department of Social Services, and the state Medicaid authority collectively formed a behavioral health carve-out[1] called the Connecticut Behavioral Health Partnership. According to state officials, this strategy, partnership, and cross-agency collaboration "has been key to a lot of what we've been able to do" in terms of developing innovative crisis services for children.

Families, youth, and schools are also key partners in Connecticut's crisis services system. Families and youth have been closely involved as members of the 988 statewide steering team and regional suicide advisory boards that generally focus on prevention, but also mobilize crisis service systems to offer support in schools and communities when a person under 25 dies by suicide. DCF has collaborated closely with the Department of Education and school districts throughout Connecticut to develop strategic plans related to youth behavioral

[1] Carve-outs are specialized managed care organizations that separate certain types of services (in this case, behavioral health services) from an overall insurance contract and apply specific expertise to manage those services (Frank 2021).

health (including multi-tiered social and emotional learning components), to identify youth who are struggling, and to connect them with services. Connecticut's SBDI (see ***Text Box*** above) provides schools with high arrest rates with a toolkit that walks staff through the process of reaching out to mobile crisis response in lieu of law enforcement. In addition, Connecticut's contracted call center is partnering with DCF to develop a suicide prevention curriculum for middle schools that includes information about crisis services and training for parents and guardians. Starting in the 2023-24 school year, a new state law requires all student IDs to include information on 988.

Georgia

Georgia's Crisis Services for People with ID/DD & Children and Youth

- Georgia has had a centralized crisis call line, the Georgia Crisis and Access Line (GCAL), in place since 2006. GCAL provides telephonic crisis intervention services, serves as the single point of dispatch for mobile crisis teams, assists people in finding an open crisis unit bed across the state, and links people with urgent appointment services.
- Georgia's Department of Behavioral Health and Developmental Disabilities (DBHDD) founded the 988 Planning Coalition and 988 Community Partners to plan implementation of 988 and statewide integration with existing crisis services. The 988 Planning Coalition has focused specifically on improving crisis response for children and people dually diagnosed with ID/DD and behavioral challenges, among other top priorities.
- Specialized crisis services in Georgia include mobile crisis response teams (with providers who have specialized ID/DD training), population-specific crisis stabilization units, and the High-Fidelity Wraparound program which aims to safely divert youth at risk of admission to a psychiatric facility by providing community-based alternatives and partnerships with child-serving systems.

Georgia's partnerships supporting crisis services for special populations. Similar to Connecticut, Georgia is often identified an exemplar in crisis services given the age and maturity of its crisis service system, and its specific efforts focused on children and youth and people with ID/DD. State officials noted that the state has taken the approach of a more generalized crisis service system with specialized response embedded at different levels of response. According to a GCAL leader, "everyone--schools, emergency departments, the public--knows to call GCAL." GCAL currently answers calls from both 988 and the state's pre-existing crisis line, and call center staff are trained to address the needs of special populations. State officials noted that some of the state's mobile crisis teams have board certified behavior analysts, registered behavior technicians, or other providers with expertise in serving people with ID/DD embedded on the team. If a caller or caregiver discloses to GCAL that a person in crisis has an ID/DD (or if the call taker suspects that is the case), the call taker dispatches a mobile crisis team that includes a provider with specialized ID/DD training if one is available. When an older adult or their caregiver calls, GCAL is likely to make a referral to another service system because most older adults are insured and often served in specialized facilities (such as skilled nursing facilities or other facilities offering inpatient, short-term crisis stabilization for geriatric populations). Other special populations served by the crisis line are often uninsured or underinsured. Specialized mobile crisis teams for children are not yet available, but Georgia has four child-specific crisis stabilization units.

Georgia's DBHDD has a strong partnership with GCAL. DBHDD holds monthly check-ins with GCAL teams (operations, data, technology). These meetings are open and transparent; as one respondent stated, they discuss "the good and the bad." Between meetings, the DBHDD team is easily available to GCAL via phone and email. A GCAL leader noted that this free exchange of information is vital to maintain crisis service systems and that "having the freedom to try new things and be supported by DBHDD is invaluable."

State officials also highlighted several other partnerships that are key to the provision of specialized crisis services and referrals for special populations. For example, DHBDD officials cited the role of the state's regional Community Services Boards (CSBs) in fostering partnerships that connect special populations in crisis with other service systems for ongoing care. CSBs are quasi-governmental safety net providers and serve as the first line in crisis stabilization and referrals for people in crisis once GCAL is called. DBHDD officials noted

that CSBs often offer school-based mental health services and ensure that teachers and school administrators are aware of 988 and other resources for children in crisis. Officials also emphasized the critical role of DBDD's partnership with the state's network of psychiatric hospitals as a referral partner for more specialized care.

New Jersey

New Jersey's Crisis Services for Children and Youth & People with ID/DD

- New Jersey has a robust Children's System of Care and has blended its behavioral health and developmental disability services systems to a greater extent than some other states. These three systems are now collaborating to integrate 988 into the state's pre-existing crisis system.
- New Jersey offers children's mobile response at the county level with a statewide mobile crisis response program for children in development.
- Through the Crisis Assessment Response and Enhanced Services (CARES) program, New Jersey's Division of Developmental Disabilities (DDD) offers crisis response and stabilization services (up to 120 days) for adults with ID/DD. Intensive In-Home Services are also available for youth with ID/DD experiencing a crisis.
- New Jersey's Department of Children and Families (DCF) recently funded work on intensive mobile treatment services for youth and young adults with ID/DD.
- Other notable projects in development include launching crisis receiving and stabilization centers throughout the state.

New Jersey's Division of Mental Health and Addiction Services (DMHAS, within the state's Department of Human Services) oversees 988 implementation in close collaboration with the DCF and DDD. State officials noted that New Jersey was "relatively ready" when 988 was introduced due to its longstanding history of crisis hotlines, existing crisis services infrastructure, and strong collaborative relationships across DMHAS, DCF, and DDD.

Specialized crisis services and partnerships for children and youth. New Jersey's Children's Systems of Care has 15 service areas. Each area has three core system partners: mobile crisis support; a care management organization (CMO), which implements High-Fidelity Wraparound services; and a family support organization, which provides direct family-to-family peer support, education, advocacy, and other services to family members of children who need emotional or behavioral support. Mobile response is accessed by contacting the systems administrator for New Jersey's Children's System of Care at a 1 800 number; however, if a child or caregiver calls 988, they receive a warm handoff to the System of Care administrator, which dispatches mobile response if appropriate.

DCF's crisis services for children are highly individualized. Following the creation of an initial crisis plan, the mobile provider agency can refer the child for CMO services (highest acuity) or provide intensive in-home services for up to several months. The state also has a special protocol for children in foster care in which mobile crisis is dispatched to the foster home to work with children and guardians to understand the needs of children who have had traumatic family separations. New Jersey is developing capacity within mobile response teams to work with children under age 4, particularly on supporting very young children who are pre-verbal. They are also training intensive in-home therapists in these early childhood services. Finally, if a child visits an emergency department after a suicide attempt, hospital staff throughout the state are trained to encourage families to call the Systems of Care administrator before leaving the hospital. Regional care coordinators then follow-up with these families.

Specialized crisis services and partnerships for people with ID/DD. New Jersey also has developed specialized approaches to serving people with ID/DD in crisis. The state's 988 implementation lead and DDD leaders collaborated on protocols to ensure warm handoffs of people with ID/DD to DDD services when appropriate. 988 call takers do not always know if a person has an ID/DD, but if a caller or caretaker discloses this information or shares they currently receive DDD services, a warm handoff is arranged. DDD leaders have also provided 988 educational sessions to staff and met with 988 call takers to discuss DDD's services and role within the crisis services system. Additionally, DMHAS initiated the CARES program in 2016, which serves individuals with developmental disabilities in mental health or behavioral crises. CARES staff work in regional

offices and provide direct, onsite crisis consultation (24-hour mobile response), residential placements, and day programs.

Pennsylvania

Pennsylvania's Crisis Services for Older Adults, Children and Youth & People with ID/DD

- Pennsylvania's behavioral health services for adult and older adult populations include a range of supports, such as Assertive Community Treatment and peer support specialists focused on older adults. Callers are referred to these supports from the initial 988 crisis contact.
- The Pennsylvania Department of Aging established a project in 17 counties called Healthy IDEAS (Identifying Depression and Empowering Activities for Seniors), to which 988 callers can be referred.
- Healthy IDEAS is an evidence-based program that integrates depression awareness and management into existing services for older adults in-person or virtually/telephonically by local Area Agencies on Aging. It promotes social connections for older adults experiencing isolation or loneliness that often occur with chronic illness and other losses later in life.
- Some counties have developed programs to support children and youth and their families immediately for up to 6-7 weeks after a crisis if recommended by mobile crisis response teams.
- The state entered a settlement with the Department of Justice in 2011 to end the unnecessary institutionalization of adults with disabilities including ensuring comprehensive mobile and crisis services.

Specialized crisis services and partnerships for older adults. Pennsylvania's Office of Mental Health and Substance Abuse Services (OMHSAS), Department of Aging, Office of Long-Term Living, and Area Agencies on Aging have been at the forefront of developing crisis services tailored to the needs of older adults. As Pennsylvania state officials noted, when an older person calls 988, there is often call taker uncertainty around whether the caller's crisis is a behavioral health crisis or due to dementia. This issue sparked conversations between Pennsylvania's Area Agencies on Aging and SAMHSA's E4 Center of Excellence for Behavioral Health Disparities in Aging around the importance of designing educational modules to support appropriate crisis care for seniors. Subsequently, the partners designed four 15-minute modules to prepare 988 call takers to handle calls from older adults. Originally developed for use in Pennsylvania, the modules will now be used nationally. The state also is working with the E4 Center to create a 50-minute module on anti-agist practices for mobile teams, walk-in crisis centers, and 988 call centers.

OMHSAS partners closely with Pennsylvania's Office of Long-Term Living through the Community HealthChoices (or CHC) Partnership. This collaboration involves quarterly meetings with nursing facilities where OMHSAS staff presents educational sessions on topics such as access to crisis services for older adults. State officials added that the Pennsylvania Department of Aging is developing a strategic plan for the aging population over the next year, which OMHSAS views as an opportunity to further strengthen the crisis services system for the aging population.

Specialized crisis services and partnerships for children and youth. Pennsylvania state officials noted that children with complex needs historically have not been well-served by existing crisis services. To improve this, officials said they are working to improve collaboration among service systems and community partners. OMHSAS collaborators include the state Department of Education, the Bureau of Child and Family Services, the Department of Human Services, and community partners. OMHSAS also partners closely with schools and jointly funds the Student Assistance Program with the Department of Education.

Pennsylvania has limited child-specific mobile crisis providers and crisis residential programs for children and adolescents. State officials noted that child-specific mobile crisis response is not currently feasible or appropriate across all areas in the state due to its diversity of urban, rural, and suburban areas and differences in community needs. Some communities have developed specific services to supplement acute crisis services for youth. For example, Philadelphia has two programs serving children and youth immediately after an acute crisis. One program supports the child and their family in-home for 72 hours and the other supports the family for 6-7 weeks. Mobile crisis teams refer families for these services.

Specialized crisis services and partnerships for people with ID/DD. Using Money Follows the Person dollars, OMHSAS is partnering with the Office of Developmental Programs to develop pilot programs for ID/DD crisis response. Pennsylvania counties and behavioral health managed care organizations are developing dual diagnosis treatment teams that serve specific geographic regions and provide direct support and services, including crisis services, in homes and ID/DD group homes.

Virginia

Virginia's Crisis Services for Children and Youth & People with ID/DD

- Virginia's Department of Behavioral Health and Developmental Services' (DBHDS) Office of Crisis Supports and Services is the state's first cross-agency, disability, and generational crisis services coordinator centered on the principles of recovery and trauma-informed care. It emphasizes coordination and collaboration with state agencies, organizations, partners, existing crisis services, and local governments.
- Virginia's Regional Education Assessment Crisis Services Habilitation (REACH) program provides people with ID/DD access to appropriate and effective crisis stabilization, intervention, and prevention services including mental health treatment services and linkages to other service systems for follow-up care.
- The state's mobile crisis response program includes teams trained to respond specifically to crisis calls involving children.
- Virginia's five regional call centers were created prior to 988 implementation as part of the state's Marcus Alert legislation enacted after the death of a young man in crisis by law enforcement. Call centers respond to both 988 and pre-existing crisis lines and deploy mobile crisis services when needed.
- Virginia's 2012 settlement with the Department of Justice has led to development of robust services for people with ID/DD who are at risk of institutionalization, including ensuring comprehensive crisis response and follow-up.

State partnerships and a new office focused on crisis services for special populations. Virginia recently established a new Office of Crisis Coordination Services within DBHDS to focus specifically on crisis services. The office is growing, and ultimately will include an operations team and a services team to support service providers. The services team likely will comprise full-time staff dedicated to supporting specialized crisis services for children and youth and people with ID/DD. Currently, the Office of Crisis Coordination Services is partnering with Virginia's 40 Community Service Boards (CSBs), which provide a range of services, including crisis services, across the state. The CSBs are organized into five regional hubs. The hubs manage mobile crisis services, prevention services, crisis therapeutic homes, and the REACH program for people with ID/DD. The hubs also manage contracts for Virginia's regional call centers. All five hubs meet regularly with DBHDS leadership to discuss 988 implementation and crisis services. The Office of Crisis Coordination Services and the CSBs collaborate to provide cross-training in ID/DD and behavioral health for crisis responders. Responders also receive specialized training to assist children and youth in crisis, but there are few mobile crisis teams specialized for children at this time.

REACH services for people with ID/DD. Virginia's REACH program is a statewide system of care that supports people with ID/DD (both children and adults) who are experiencing a crisis. Services offered by REACH include 24/7 crisis assessment and intervention (including mobile response); post-crisis mobile or community-based support services; brief residential crisis therapeutic services at an Adult or Youth REACH Crisis Therapeutic Home for stabilization of a crisis, a planned prevention, or as a step-down from a state hospital, training center, or jail; creation of individualized Crisis Education and Prevention Plans; individualized training to support the individual and their support system; and linkages to other services and supports. REACH also offers training and education to CSBs, families, providers, law enforcement, and hospitals.

How do states serve special populations when 988 is called?

988 or pre-existing crisis service lines are a common service entry point for special populations in crisis. Call takers are trained to recognize if a caller or caregiver is calling on behalf of someone who has a disability or is under 18. 988 call takers treat special populations much the same as other 988 callers; each call is triaged and

the response is tailored to the specific person and circumstances of the crisis. However, states have developed various procedures and protocols to identify and effectively serve special populations when they call 988. Typically, 988 call takers ask for the age of the person in crisis as part of a brief set of screening questions so they are aware when children, youth, or caregivers of young people in crisis are calling and can proceed accordingly. In some states, most notably New Jersey and Connecticut, specialized mobile teams serving children and youth are dispatched. Other states lack specialized mobile teams for children and youth, but tailor the follow-up services they provide to this population. For example, Georgia state officials shared that they are able to provide mobile response in the state's 159 counties (including rural areas) by developing capacity for general mobile crisis teams to respond to all needs rather than creating specialized mobile teams, including for children and youth. However, the state offers child-specific crisis stabilization units and a High-Fidelity Wraparound program, which aims to safely divert youth at risk of admission to a psychiatric facility by providing community-based alternatives and partnerships with child-serving systems.

> *"So there are certain nuances, obviously, to intervening with an older adult versus a child that come up. But I believe skilled crisis responders can have some of that general intervention, knowledge and tools in their toolbox and then facilitate the warm handoff to ensure that people remain safe."*
>
> *- Regional crisis coordinator*

Approaches to identifying whether a caller has ID/DD vary across states. In most of the states included in this study, call takers typically do not ask directly if the caller has an ID/DD diagnosis. However, if this information is disclosed by the caller or if the 988 call taker suspects a caller might have ID/DD, call takers follow specific protocols to ensure the caller is connected to appropriate services. For example, in Virginia, when a person with ID/DD requires mobile response, a REACH team is dispatched in lieu of a standard mobile crisis team when possible. New Jersey's CARES program provides mobile response, residential placements, and day programs for individuals with ID/DD. In non-emergency situations, 988 call takers in New Jersey can do a warm transfer of people with ID/DD to the DDD to discuss services available to the person.

States have also created special protocols for older adults in crisis. For example, in Virginia, if a mobile crisis team is dispatched to help stabilize an older adult in crisis, a geriatric team comprising nurses and psychiatric providers with experience serving older adults and people with dementia can subsequently follow-up and connect them with resources, including preventive services and in-home care. In Georgia, call center representatives from Area Agencies on Aging have a script to assist older adults in crisis and do a warm transfer to the GCAL.

How are states funding and governing crisis services for special populations?

Crisis services in respondent states are funded through a patchwork of federal, state, and local dollars. State officials and providers in all states described a complex web of funding for crisis services in general and noted that the funding landscape becomes even more complicated when serving special populations. Respondents shared that this is due, in part, to differences in the penetration of certain types of insurance coverage among certain populations and the intersection and overlap of service system responsibilities and their respective funding streams. As one respondent put it, 988 serves as the front door for anyone in crisis who needs services, regardless of diagnosis, and it is up to states to determine how to weave funding together "behind the curtain." Georgia state officials highlighted that sophisticated financial modeling and tracking systems are

> *"Our centralized call center vendor [receives] ID/DD money, autism spectrum disorder/children's money, as well as adult mental health, behavioral health, and SUD funds… and you have to braid these funds into a blended product… [and] when you think about appropriations, you end up with a very sophisticated financial modeling that supports the unique accountabilities for each of the line items."*
>
> *- State official*

required to offer an integrated crisis response that is seamless for end-users while enabling proper accounting when drawing down funds from different funding streams.

Respondents across states mentioned three primary sources of funding for innovative crisis services for special populations:

- **Federal grant funds**. Officials in each state shared the importance of leveraging federal block grant funding to launch and sustain crisis services for special populations. Respondents frequently mentioned SAMHSA Community Mental Health Services and Substance Use Prevention, Treatment, and Recovery block grants, and some noted using other federal grant funds to develop innovative crisis services for special populations. For example, several communities in Georgia have received Cooperative Agreements for Innovative Community Crisis Response Partnerships grants from SAMHSA to further develop crisis and diversionary services for children and youth. Connecticut officials mentioned using substance use and mental health block grant[2] dollars to seed innovative programs, such as crisis services for children and youth. Pennsylvania and New Jersey officials noted using funding from the American Rescue Plan Act dispersed through the Substance Use and Mental Health services block grant programs, although it was unclear to what extent these funds were used to specifically serve special populations.
- **State discretionary funds**. Officials in all states noted appropriations of state general funds as a critical source of funding for crisis services, and one that is particularly important for developing services for special populations given the ability to use them more flexibly than federal sources to meet the unique circumstances and needs of communities and stakeholder priorities within the state. One state official noted, for example, that because SAMHSA has primary federal responsibility for 988 implementation and oversight, and given the agency's focus on serving people with mental health and substance use disorders, the state has found SAMHSA grant funds less flexible to meet the crisis service needs of people without mental health or substance use diagnoses, such as people with ID/DD. States can therefore use state funds more flexibly to finance targeted services for special populations that do not fall as squarely under SAMHSA's mandate. Officials in several states stressed the importance of recent investments made by the state legislative and executive branches in services targeted for special populations. In Virginia, providers also noted availability of revenue from a state 988 tax that is pushed down to the state's five regions to fund services that benefit special populations.[3]
- **Medicaid funding**. Officials in most states commented on partnerships between state Medicaid agencies and other service systems as key to funding innovative crisis services for special populations. Officials in Georgia, for example, shared that in their state, people in certain special populations, such as those with ID/DD (for example autism) are more likely to have Medicaid than other populations, making Medicaid funding a key source for the financing of more specialized crisis services. In New Jersey, every child that connects with mobile response is assessed for Medicaid eligibility and the state's Section 1115 demonstration waiver allows the state to draw federal Medicaid matching funds for services for children who are not eligible for Medicaid but who meet a certain level of clinical need. Officials in Connecticut noted that partnerships between the state's child-serving systems and the state's Medicaid authority allow for innovation in child mental health services, including crisis services.

A few states mentioned other, less common sources of funding for crisis services, but the extent of their use for serving special populations is unclear. For example, officials in New Jersey and Virginia mentioned some

[2] See https://www.samhsa.gov/grants/block-grants for additional information on federal substance use and mental health block grants.

[3] Virginia was the first state to pass a law that adds a surcharge on wireless phone plans to help fund 988. Prepaid plans have an eight-cent fee and postpaid plans have a 12-cent fee.

private insurance funding for mobile crisis services but did not note the degree to which private insurance funds specialized mobile crisis response teams. Officials in Connecticut reported pursuing philanthropic support to augment state general funds and other reimbursement streams.

While state officials were able to provide some detail on sources of funding for crisis services and partnerships that serve special populations, states clearly are still refining their approaches to funding crisis services, both for a general population and for those with more specialized needs. Several states cited grant applications that were outstanding at the time of interviews, and others shared being early in the process to allocate state general funds and procuring call center vendors and crisis service providers.

State respondents also shared certain policies or features of their states' policy landscape that influence provision of crisis services for special populations. For example, in Georgia, the state's crisis line operator shared that mobile crisis providers are required by contract to have an ID/DD clinician available. Similarly, in Virginia, there is a requirement that any time a Community Service Board has contact with an individual with ID/DD in crisis they must engage REACH. In addition, several respondents in Virginia cited the state's 2012 settlement agreement with the Department of Justice to ensure compliance with the Americans with Disabilities Act and the U.S. Supreme Court's Olmstead Decision as a primary facilitator of crisis services for people with ID/DD. One state respondent suggested that the settlement "has substantially impacted the availability of services to individuals with intellectual and developmental needs, which is why REACH exists and is a better built out system than [the state's] current mental health crisis response."

States featured in this study take different approaches to formalizing and governing the types of partnerships described. For example:

- In some states, partnerships across state agencies that typically work together (such as departments of mental health, children and families, and developmental disabilities) involve no formal inter-agency agreements. Rather, agency leaders have an understanding that they must collaborate to best serve children and youth, people with ID/DD, and older adults.
- However, in situations involving payment transfers or other funding arrangements, states typically establish a Memorandum of Agreement or Memorandum of Understanding.
- States establish contracts with call centers to operate 988 and call centers are required to have affiliation agreements with 911 and other organizations they are required to work with.
- As part of 988 planning grants, states established stakeholder advisory groups to help guide decision-making. In some states, these groups continue to play substantial advisory roles. For instance, in New Jersey, a coalition of 25-40 representatives from state agencies, call centers, crisis service providers, advocacy groups, and people with lived experience continue to weigh in on 988 crisis services, including services tailored to special populations.

How are states tracking efforts to meet the crisis service needs of special populations?

State officials in most states highlighted the use of databases and other data systems to track use of 988 and crisis services, with some capabilities for tracking receipt of services by special populations. States shared that tracking generally is done by 988 call centers and includes data collected as calls come in. For example, Georgia's centralized crisis line has a database for managing and tracking calls with extractable fields that allow analysis of use of services by special populations. Virginia respondents shared that the state is working to build a statewide call management and data collection platform based on a platform used by Georgia that will have sophisticated data tracking capabilities. In Connecticut, the call center operator collects data and provides the state with reports on call volume, rate of calls answered, caller demographics, and outcomes of visits by

mobile crisis teams. The call center shares its data system with mobile crisis teams. New Jersey officials also described call center tracking capabilities, noting that each of the state's five contact centers has their own data collection system for collecting caller demographics and presenting issues. Officials noted that the state's DCF has "a massive amount of data" on children's crisis services. These data are used by a data analytics and research team to assess variations across the state's service areas in referrals and other performance which might suggest a disparity in practice between areas.

While respondents in all states reported some tracking, state officials shared that the quality of data collected by call takers often varies and age or disability status is not always disclosed by a 988 caller or their caregiver. Tracking receipt of follow-up care and outcomes of referrals to other service systems also is particularly challenging for states. One official noted that this is due in part to long wait times for certain types of referral appointments, which makes them less likely to be captured. Respondents in Virginia also noted that it is sometimes difficult to gather consent from crisis line callers for follow-up, and callers sometimes wish for the call to stay anonymous. Several states mentioned efforts to improve tracking of referrals and follow-ups, but that this work was still nascent.

What challenges do states encounter when trying to meet the crisis service needs of special populations?

Officials in all states reported significant challenges associated with the complexity of braiding different funding streams together. Respondents noted that state appropriations often ebb and flow in alignment with changing legislative priorities, and grant funds are typically one-time or time-limited, making planning challenging. Several officials shared a desire for a single, consistent (that is, annualized and dedicated) federal funding stream to reduce uncertainty about states' ability to sustain and enhance crisis services for special populations. In addition to a more consistent source of funding, one state official suggested that funding needs not only to support services, but also the infrastructure and technology that allows crisis centers to address the needs of callers in a way that is most effective and appropriate.

Officials in three states highlighted that there is no federal requirement that private insurers or other private payers help fund 988 and crisis services more broadly. Officials noted that because of this, the public sector is, in their view, subsidizing the crisis service system (using state funds and federal block grant funds) for the private sector. The legislature in Virginia has recently passed a law requiring private insurers to cover mobile crisis response, which other states have taken note of. However, officials in several states reported feeling strongly that a federal standard for private payer participation would help reduce financing fragmentation and burden on public systems and allow for more robust services for special populations.

> *"We can develop all the services in the world and we can develop all the infrastructure and tools in the world. [But] if we don't have people to provide the service... I don't know that we're in control of that. I can't create people."*
>
> *- State official*

Workforce challenges were top-of-mind for respondents in every state and affect crisis services for all populations, inclusive of special populations. Hiring challenges include finding people with the right skillsets to work as crisis call takers or mobile crisis response team members. As a Connecticut state official noted, crisis responders are "jacks of all trades" and require a unique combination of skills and knowledge to do their jobs well. A Georgia state official emphasized that hiring mobile crisis response workers with specialized knowledge of ID/DD is particularly challenging, and a Virginia provider reported that workforce shortages specifically preclude creation of geriatric-specific mobile crisis services. Also in Virginia, a provider stated that some peers and bachelor-level staff are the "most skilled individuals" in resolving crises and these individuals are often more open to overnight shift work. However, licensing rules that require clinician involvement in crisis response hinders the expansion of peer-driven crisis response

services. The distribution of crisis response workers also is concentrated in urban areas, leaving rural areas with shortages. In states like Virginia, which has a more decentralized crisis response system, this can be particularly challenging because people prefer to work for their local CSB rather than for a hub that is further from their homes. This issue is compounded when states attempt to recruit crisis response workers with specialized knowledge of children and youth or ID/DD to work in non-urban areas.

Across several states, respondents acknowledged perceptions among the general public that calling 988 might result in involvement of law enforcement, child welfare, or adult protective services. State officials and providers in New Jersey and Connecticut said that people frequently express fear that law enforcement will come when they call 988; in some cases, this fear is based on people's previous experiences with 911 and the suicide prevention lifeline. While 988 has been marketed as a new service to assist people in de-escalating a crisis and avoiding law enforcement involvement and hospitalization, that message has not yet reached everyone successfully. Regarding child welfare and adult protective services, providers in Georgia and Virginia noted that as mandated reporters they cannot promise callers that they will not report, but call center workers are trained to reassure callers that they are there to help and not to dig for Information that might lead to a mandated report. In Connecticut, a provider shared that involvement of child protective services is rarely raised as a concern among callers because the contracted call center is a trusted entity among the general public and DCF was not included in the branding or marketing of crisis services for children.

Warm handoffs and referrals pose challenges to crisis service providers. While warm handoffs from 988 to mobile crisis response teams is a relatively seamless and automated process in the states included in this study, respondents shared challenges with other types of warm handoffs and referrals. For example, in Virginia, call takers often attempt to connect crisis line callers to referral organizations that can assist with housing, general behavioral health services, sexual assault, and domestic violence, but referral organizations are not always familiar with 988. This results in call takers spending several minutes explaining the reason for the call while the person in crisis is waiting on hold. This is stressful for both the crisis line workforce and for callers. New Jersey state officials added that developing and maintaining an accurate referral database containing information needed to connect callers to services is very difficult due to constantly changing information. For example, organizations merge, contact information changes, or locations are added or closed. Referral databases must be updated frequently to account for changes.

Following up with special populations post-crisis, particularly in rural areas, is difficult. For example, in parts of rural Georgia, the nearest provider could be 100 miles away from a person who would benefit from follow-up services. Despite providing referrals to care, Georgia crisis services providers worry that some callers might not follow-up post-crisis--and even if they do, they might not sustain treatment due to lack of providers in their area. New Jersey respondents added that it is also difficult to track whether someone who called 988 and got a referral to follow-up services connected with and received those services. Some types of services, such as peer-to-peer wellness connections and recovery supports, are easier to track because they tend to take place more quickly than other types of follow-ups, for which there might be a long wait time for appointments. In Virginia, a provider noted that for adults with dementia and mental illness, it can be extremely challenging to determine the appropriate type of follow-up support for the individual and their family.

Children do not always have the support of their parents or legal guardians when requesting help through 988. Children can request lower-acuity services without parental consent (age of consent for lower-acuity services varies between 14-16 years of age among the states in this study). However, parental consent is required for higher-acuity services, including provision of medication. In addition, Virginia and New Jersey state officials and providers shared that even when a child is over the age of consent, service providers are not always willing to work with the child without a legal guardian's involvement. When children call 988 to ask for help and either do not want to involve their guardians or do not have the support of their guardians, they can

run into barriers. A Virginia provider added that policy guidance on how best to serve children in crisis in school settings when guardians are not present needs more clarification.

What has facilitated states' work to serve special populations effectively?

Strong cross-agency partnerships are key to the successful provision of 988 crisis services to special populations. Every state emphasized the complexity of integrating 988 with existing systems and the critical importance of robust partnerships in providing 988 crisis services to special populations. In particular, state officials in New Jersey and Connecticut underscored the importance of cross-agency collaboration in developing effective approaches to serving children, youth, and people with ID/DD in crisis. In those states, agencies responsible for mental and behavioral health, children's systems of care, and developmental disabilities have strong working relationships that pre-date 988 implementation. Agency leaders have a common understanding that they must collaborate to best serve special populations. Trusting relationships between state agencies leading 988 implementation and contracted 988 providers are also critical. Connecticut, Georgia, New Jersey, and Virginia respondents noted that building these relationships takes time, transparency, and frequent information exchange. A Connecticut state official stated that after significant time spent investing in relationship-building with their call center vendor, the two entities now "speak each other's language."

State political and legislative support enhances states' abilities to serve special populations in crisis. Virginia, New Jersey, and Connecticut state officials highlighted political and legislative support that has increased their capacity to serve special populations in crisis. Virginia's Department of Justice settlement spurred improvements in crisis services for ID/DD (including the creation of REACH) and the state's Marcus Alert legislation helped build a strong crisis services infrastructure prior to the introduction of 988. In New Jersey, state officials noted the Attorney General's office has a keen interest in 988 and ensuring its effective implementation for all state residents, including special populations. Finally, Connecticut's Newtown tragedy led to strong executive and legislative support for children's mental and behavioral health services. Multiple state agencies have now assumed more formal roles in children's behavioral health services, and these collaborations have resulted in an improved crisis services system for young people because agency leaders are committed to and held accountable for this work.

> *"We learned… providers for ID/DD transferred well to… serve a TBI population that had brain injuries that manifested as very specific behavioral needs… [and] might have impacted communication ability. Understanding how to help aid in communication to minimize the amount of anxiety or frustration that an individual feels because they can more clearly communicate their needs is an effective strategy for remedying a crisis with both TBI and ID/DD individuals."*

988 call taker training and education centered on working with special populations increases staff confidence and capacity to connect callers to appropriate crisis services. Georgia, New Jersey, and Connecticut, and Pennsylvania respondents highlighted training opportunities for 988 call takers to enhance their ability to work effectively with special populations. A Georgia provider noted that managing crisis calls can be very challenging, especially when the caller has ID/DD. Call takers are trained to exercise patience and understanding of the situation and deploy mobile response for an in-person assessment when needed. In New Jersey, state officials described developing protocols to help ensure adherence to regulations related to consent, while also promoting access to care for young callers. 988 call takers are trained to encourage youth who are reaching out on their own to connect their parent or guardian to the call. Connecticut state officials noted that cross-training of 988 call takers helps them triage calls from special populations and there is always a supervisor with a clinical degree available to assist with decision-making if needed.

Hiring challenges are pervasive, but states are thinking creatively about how to solve the problem. For example, Virginia is cross-training ID/DD and behavioral health staff, acknowledging that even though underlying medical causes of behaviors vary, approaches to addressing the behaviors are similar. In addition, Virginia is exploring whether and how telemedicine could be used as part of its mobile crisis response strategy. A state official noted this is not a permanent solution to hiring challenges, but it might help augment the state's capacity to provide mobile crisis services to some degree. The state is also collaborating with universities on ways to increase the behavioral health worker pipeline as part of the Governor's initiative Right Help, Right Now. Georgia, a national leader in peer support implementation, is seeking to maximize peer specialists' roles on mobile crisis teams. However, as respondents clarified, clinicians are still needed on mobile teams to perform clinical functions. Georgia respondents also noted that they hire non-licensed clinicians and train them to provide crisis services, which allows the state to hire more masters-level clinicians and bolster their workforce. Georgia state officials shared that some mobile teams include board certified behavior analysts and registered behavioral technicians to work with the ID/DD population. This has expanded the knowledge base and capacity of other clinicians and paraprofessionals on the teams as they observe the specialists' work.

Finally, states also shared promising practices to improve staff retention. Several states reported seeking ways to support crisis response staff on an ongoing basis, knowing that the potential for burnout is high. Connecticut state officials described significant investments in workforce development, coaching, supervision, and debriefing. All of these efforts help retain crisis service workers because they help people feel more competent and cared for in their work. Connecticut state officials added that sharing positive stories and data back to crisis response workers and celebrating successes is important for retention. Pennsylvania state officials highlighted the importance of ongoing training of crisis workers on topics such as suicide prevention, ideation, and needs of special populations (particularly people with ID/DD). In addition, making other services systems aware of the role of crisis response services is important for retention. For example, educating school staff on what crisis response workers can and cannot do avoids putting crisis response workers in the uncomfortable position of being asked by school staff to restrain a student. Ultimately, when organizations serving special populations understand crisis response services better, crisis response workers can do their jobs more efficiently and effectively, and with less stress.

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