



Improving Behavioral Health Services for Individuals with SMI in Rural and Remote Communities

Increasing Access to Crisis Services

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SAMHSA’s [National Guidelines for Behavioral Health Crisis Care—A Best Practice Toolkit](#) (National Guidelines) outlines the necessary services and best practices to deliver an effective crisis continuum of care, and recommends a comprehensive crisis service array that includes three essential services: 1) 24/7 crisis call centers that assess a caller’s needs and dispatch support, 2) mobile crisis response teams dispatched as needed in the community, and 3) crisis-receiving and -stabilization facilities that are available to “anyone, anywhere, anytime” (SAMHSA, 24 February 2020). The majority of states (98%) offer at least one of these services: 82 percent of SMHAs offer 24-hour crisis hotline services, 86 percent offer mobile crisis response, and 90 percent offer some kind of crisis-receiving and -stabilization beds (for either less than or more than 24-hours) (NASMHPD Research Institute, 2015/2020).

While it is promising that the vast majority of states offer some level of crisis care to their citizens, little is known about how widely available these services are in rural and remote areas, and whether they adhere to the best practices prescribed in the National Guidelines. Ensuring all components are available to “anyone, anywhere, anytime” is an ambitious goal, and is especially challenging in rural and remote areas where a lack of awareness, workforce shortages, distance to travel and transportation issues, cultural differences and stigma, sustainability challenges, and availability of broadband access present additional barriers to the effective delivery of these services.

According to the National Guidelines toolkit, the recommendation for centralized crisis hotlines made in the National Guidelines may be more difficult to implement in rural areas due to the beliefs by some in rural communities that people in the city would have no way to relate to their problems (Neylon, 2020). A study by the Pew Research Center found that “many urban and rural residents feel misunderstood and looked down on by Americans living in other types of communities [and that] people in other types of communities do not understand the problems people face in their communities” (Parker, 2018). This belief can affect the use and efficacy of a centralized crisis hotline. [CrisisNow.com](#) offers a variety of tools and resources to help states and providers implement an effective crisis continuum that aligns with SAMHSA’s National Guidelines.



Key Lessons for Policymakers:

- » Use the national implementation of 988 as the national suicide prevention and mental health hotline number to assure that evidence-based and culturally appropriate call centers are available to individuals in rural areas.
- » Help local stakeholders (e.g., law enforcement, providers, EMS, others) collaborate to create a coordinated crisis response system that allows those closest to an individual in crisis to respond first and immediately connect individuals in crisis via technology to mobile crisis response teams and/or transport the individual to the nearest, most appropriate setting for their needs.

Key Lessons for Providers:

- » Be creative with co-location. What is frequently missing for law enforcement in rural areas is a place to take someone other than jail when a person is in crisis. For example, in Texas, some mental health care providers share office space in law enforcement stations for screening and assessment to prevent someone from being booked.
- » Start a community conversation about medical clearance to maximize law enforcement’s time. Frequently, law enforcement officers get tied up waiting in EDs for medical clearance. Some states implement an algorithm that allow law enforcement officers to directly admit to facilities and bypass EDs.

During a phone interview, Colorado's Office of Behavioral Health that this sentiment applied to both individuals in need of care, and law enforcement officers in more rural communities. These groups expressed reluctance to call into an anonymous state crisis hotline number, because of a sense of resentment that someone "in the big city would actually know about my life and my problems," and have the audacity to believe "they can fix this." This has led to more after-hour emergency calls to local community providers, who are often already overburdened.

Higher utilization of a centralized hotline can help relieve the pressure of rural providers who are already overburdened with other responsibilities. A former Alaska Native Tribal Health Consortium Behavioral Health Aide (ANTHC BHA) provider working in a remote village shared a story about being the only clinician available to answer crisis calls in the community during a six-month period. During this time, he had to be constantly available and in reach of his phone, even when trying to spend time with his family. While the actual number of crisis calls he received was low, he did experience many misdials, which were disruptive to his life and led to his burnout. Centralized 24/7 crisis call centers that are promoted and utilized across the state can help absorb some of these misdials and alleviate some of the pressure and burnout on rural providers.

To encourage local providers to direct crisis calls to the state's centralized hotline, New Mexico waived the state's unfunded requirement for local providers to operate their own emergency call capability. The state created a memorandum of understanding with the statewide call center.

At the national level, the current SAMHSA-supported National Suicide Prevention Lifeline (1-800-273-TALK) provides free and confidential counseling support to callers experiencing a suicidal or emotional crisis. In addition to telephonic support, Lifeline crisis counselors are available through online chat. The National Suicide Prevention Lifeline is composed of a national network of over 180 accredited crisis call centers located throughout the United States. Lifeline callers are linked to the closest crisis call center to ensure callers are connected to local community support and services.

In July 2020, the [Federal Communications Commission](#) (FCC) designated 988 as the new, easy-to-remember, dialing code for the current National Suicide Prevention Lifeline number (1-800-273-TALK). The FCC rule requires all telecommunication carriers to implement 988 by July 16, 2022. Shortly after the FCC ruling, the [National Suicide Hotline Designation Act](#) was signed into law on October 17, 2020. The Act specifies that all 988 calls will be answered by trained counselors of the Lifeline network who are competent in serving high-risk groups including LGBTQ youth, rural populations, and minorities. Rural communities were identified in the legislation as a high-risk population based on data indicating rural counties have higher suicide death rates than urban populations. According to Vibrant Emotional Health, administrator of the National Suicide Prevention Lifeline, 280 people seriously contemplate suicide for every suicide loss. The hope is that the new Lifeline number, 988, will reach more individuals, including rural populations, who are in a mental health or suicidal crisis.

In addition to crisis hotlines, rural individuals with SMI are supported by peer lines or warmlines that are operated by persons with lived experiences. As referenced in the Workforce section above, peer-run lines help a person in their recovery process with the goal of averting a mental health crisis. Access to this confidential service is an important resource for rural populations where mental health services are often limited, under-resourced, or viewed as stigmatizing. Because of the wealth of research supporting the efficacy of peer warmlines in enhancing the recovery process beyond the clinical scope, the majority of states offer that service. The [National Alliance on Mental Illness](#) (NAMI) provides an up-to-date online directory of peer-operated lines including service catchment area, operating hours, and any additional available communication modality, such as text and chat.

States and local communities have a long history of working together to address the unique mental health needs of rural residents, but strong evidence indicates a high prevalence of suicides among farming, ranching, and agricultural occupations in comparison to other occupations (Peterson, 2016). Farm life can be complicated by unpredictable weather, a decline in net farm income, farm debt, machinery breaking down, family dynamics, and the loneliness and social isolation surrounding farming. These extraordinary and sometimes uncontrolled sources of stress are contributing factors to the rising suicide rates in the farming, ranching, and agriculture communities.

There are several statewide and national initiatives focused on addressing the high-stress in the farming and ranching occupations, including Nebraska's [Rural Response Hotline](#) (800-464-0258), [NY FarmNet](#), and South Dakota's [Farm and Rural Stress Hotline](#) (800-691-4336). All three of these tailored hotlines are available 24/7 and provide free, confidential, telephonic support to farmers, ranchers, and rural callers. The Nebraska Rural Hotline was founded by the Interchurch Ministries of Nebraska in response to the 1980s farm crisis that led to widespread farm closures and farmer suicides. Currently operated by the Rural Response Council, the Nebraska Rural Response Hotline provides free mental health counseling, financial advice, debt collection assistance, and legal counseling provided by farm law interns. The NY FarmNet was founded in 1986 at Cornell University College of Agriculture & Life Sciences, growing out of the 1980s farm crisis. Services are provided by telephone, video conference, and walk-in appointments. South Dakota's Farm and Rural Stress Hotline is operated by Avera Health, a regional healthcare system that includes behavioral health services. The hotline was created by Karl Oehlke, an Avera physician assistant and farmer who wanted to share his personal struggles with farm life stressors in hopes of destigmatizing mental illness and providing a confidential resource that farmers would be comfortable calling for support.

The SAMHSA-supported [Mountain Plains MHTTC](#) is addressing rural mental health and farm stress by recognizing the unique challenges facing rural mental health related to accessibility, availability, and acceptability. The MHTTC operates the [Rural Mental Health and Farm Stress](#) site that offers tailored trainings, and provides technical assistance and products for mental health providers serving rural patients and their families. The MHTTC uses the term "farmers" as an all-encompassing category that includes ranchers, farmers, farm managers/owners, and agriculture workers. The resources are updated frequently and focus on practical strategies that mental health providers can use to address rural and agriculture mental health concerns.

Many cooperative extensions are offering farm stress management programs. For example, the University of Maryland Extension and University of Delaware Cooperative Extension has published [Farm and Farm Family Risk and Resilience: A Guide for Extension Educational Programming](#) (2020). The purpose of the guide is to provide tools and resources for health and finance professionals working with farmers to understand and address farming stress. The guide provides a multidisciplinary, integrated approach at the individual, family, community, and public policy level to promote farmers' and farm families' health, well-being, and resiliency.

Mobile crisis teams are the next critical component of an effective behavioral health crisis services continuum. However, their availability in rural and remote areas is often limited, and their ability to reach individuals quickly during a crisis is challenged by the need to travel great distances, challenges with terrain, and extreme weather events. Best practices put forth by SAMHSA in the [National Guidelines for Behavioral Health Crisis Care](#) (2020) indicate that Mobile Crisis Teams should incorporate peers, respond without law enforcement, and respond in a timely manner. Achieving these goals is often a challenge in rural and remote areas, where law enforcement may be the only entity available to respond in a timely manner, but states are taking unique approaches using technology and leveraging partnerships to provide Mobile Crisis Response to rural and remote individuals. Charleston County, South Carolina's approach is featured in the Spotlight below.



Spotlight on Charleston County, South Carolina

South Carolina offers mobile crisis response teams in all 46 of its counties, where Master’s degree-trained clinicians are available to respond to crisis calls 24-hours a day, seven days a week. In Charleston County, a large county encompassing both large rural and densely populated areas, the mobile crisis response team only receives an average of five calls per month from local law enforcement and EMS. After discussions between the county and the EMS teams, it was revealed that EMS did not reach out to the mobile crisis response teams because it often took too long for the team to respond. It was easier and faster for EMS to transport individuals in crisis to an ED,

which is usually not the most appropriate setting unless the individual in crisis is also experiencing a medical emergency. To establish a better solution to crisis response, a partnership between the state and the EMS program was formed.

Now, when EMS is called to respond to a psychiatric emergency in Charleston County, EMS first evaluates whether the crisis is medical or psychiatric in nature. If medical, the ambulance transports the individual to the appropriate level of care, which may be the ED. If the crisis is psychiatric in nature, the EMS crew calls their supervisor to respond in an SUV. Once the supervisor responds, EMS conducts a handoff of the individual in crisis to the supervisor, and the ambulance is sent back out into service. The EMS supervisor then connects the individual in crisis through the VIDYO telehealth app on their tablet to the mobile crisis response team. The mobile crisis response team is then able to evaluate and triage the crisis virtually and make recommendations on next steps for care. Service is immediate, allows for more appropriate use of EMS time and resources, and reduces the number of referrals to EDs in the county. Further, by reducing the need for mobile crisis teams to travel long distances, it allows the individual in crisis to receive services more quickly.

Since this program has been implemented, the county has experienced an increase in calls from EMS to mobile crisis from five times per year to nearly 85 per month, and the county has seen a 58 percent decrease in ED use for individuals experiencing a psychiatric emergency. (Blalock, D., personal communication, July 7, 2020)

The third core element of a crisis delivery system is access to crisis receiving and stabilization centers. According to the [National Guidelines](#), these facilitating centers offer “a no-wrong-door access to mental health and substance use care; operating much like a hospital ED that accepts all walk-ins [and] ambulance, fire and police drop-offs.” Services are delivered within a 24-hour window and focused on the client’s immediate behavioral health crisis. These services may include assessment, suicide prevention screening, treatment planning, prescribing and monitoring of medications, case management, and referral to community-based supports. Crisis care experts note that most patients in behavioral health crisis can be stabilized within 23 hours, thereby diverting from costly inpatient hospitalization. Patients also report a higher level of satisfaction and improved treatment outcomes than when admitted to an ED (Colman, et al., 2017).

An illustration of crisis stabilization centers operating effectively in rural communities is evident in southern Indiana, according to a case study conducted by Mukherjee and Saxon (2018). A community-based mental health organization coordinated with three hospital systems’ EDs to set up a crisis stabilization unit (CSU) in a 17-county rural region of southern Indiana. The purpose of the CSU was to better serve ED patients with behavioral health emergencies through an integrated delivery model. The CSU was comprised of two units: (1) crisis intake and assessment; and (2) a crisis intervention and stabilization with a unit capacity to serve eight clients. CSU services included peer support, psychological evaluation through telepsychiatry conducted by nursing staff, counseling support, and medication management. A psychiatrist was available for telehealth consultation as needed. At the time of the study, the CSU had implemented the first service stage—ED clients given a clinical assessment and transferred to the CSU based on the assessment. Mukherjee and Saxon reported that patient’s average length of stay in the ED decreased from 7.3 hours to 4.1 hours with an annual savings of \$1.1 million. In addition, CSU staff conducting the behavioral health screenings at the three EDs reported a cost-analysis savings of about \$4.1 million (Mukherjee & Saxon, 2018).

At the time of the study, there were plans to expand the CSU model to a second service stage that would accept first responders and law enforcement dropping off patients experiencing a behavioral health crisis, similar to the core functions outlined in the National Guidelines for crisis receiving and stabilization models.

Crisis Services Key Lessons:

- » Build on the implementation of the new 988 National Suicide Prevention and Mental Health Hotline to support evidence-based crisis call centers across the country. The 988 call centers, and any related warm lines or other call services, should be culturally competent for rural and remote needs and be adequately funded to support their operation. Marketing to rural and remote communities should emphasize a tailoring to the community's needs.
- » Collaborate with local first responders (e.g., law enforcement, EMS) to triage crisis calls and virtually connect individuals to mobile crisis response teams. This allows EMS and law enforcement to quickly return to responding to health and public safety needs and provides a quicker response time for individuals in crisis.

References

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