2024

Connected and Strong

Strategies for Accessible and Effective Crisis and Mental Health Services

First in a Series of Ten Technical Assistance Briefs to Foster Unity and Strengthen Continuity Across Crisis Response and Treatment Systems

SAMHSA
Substance Abuse and Mental Health Services Administration

Connected and Strong

Strategies for Accessible and Effective Crisis and Mental Health Services

Acknowledgments

Authors: Debra A. Pinals, MD & Genna Schofield, MPH

Connected and Strong: Strategies for Accessible and Effective Crisis and Mental Health Services was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) under Task 2.2 of NASMHPD's Technical Assistance Coalition contract/task order, HHSS283201700024I/75S20321F42001. Tison Thomas served as contracting officer representative.

Disclaimer

Public Domain Notice

Electronic Access

This publication may be downloaded from https://store.samhsa.gov

Recommended Citation

Pinals DA, Schofield G: *Connected and Strong: Strategies for Accessible and Effective Crisis and Mental Health Services*. Publication No. PEP24-01-018. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2024.

Originating Office

Substance Abuse and Mental Health Services Administration, 5600 Fishers Lane, Rockville, MD 20857, SAMHSA. Publication No. PEP24-01-018. Released 2024.

Nondiscrimination Notice

The Substance Abuse and Mental Health Services Administration (SAMHSA) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity). SAMHSA does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity).

Publication No. PEP24-01-018

Released 2024

Abstract

There is an urgent need for mental health services at all levels of care in the United States. The transition to the 988 Suicide & Crisis Lifeline and efforts at the federal, state, and local levels to bolster and build the mental health continuum of care have been momentous steps forward. President Biden's Unity Agenda aims to galvanize a unified approach and strengthen the nation's mental well-being by strengthening system capacity, connecting individuals to care, and creating healthy environments. Guided by this agenda, this technical assistance brief delves into prominent areas of current need. These include building the behavioral health workforce; optimizing and matching people to appropriate levels of care; paying heed to the risks of the pandemic "unwind" with regard to funding and regulatory changes that could impact care and how it is delivered; safeguarding the mental wellness of youth; remedying the justice and behavioral health interface; attending to social determinants of health, the suicide crisis, and drug-related overdose death rates; and others. To help address these challenges, five core principles are set forth: (1) engaging in multiperspective partnerships, (2) strengthening and connecting social services with a focus on addressing social determinants of health, (3) facilitating social connection, (4) ensuring trauma-informed approaches that are accessible to diverse populations, and (5) joining efforts to achieve accessible care by prioritizing sustained engagement in care. In harmony with the Unity Agenda, these principles offer behavioral health system leaders and others a robust framework to foster the development of accessible, effective, strong, and connected crisis and mental health services.

Highlights

- The COVID-19 pandemic has exposed disparities and challenges in mental health care, affecting individuals of all ages and all walks of life. The emotional toll and the urgent need for crisis and mental health services is evident.
- Mental health crisis services are a national priority, evidenced by widespread efforts to implement the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2023-2026 Strategic Plan, SAMHSA's National Guidelines for Behavioral Health Crisis Care and President Biden's Unity Agenda's emphasis on strengthening mental health systems, promoting accessibility, and creating healthy environments.
- The successful transition to the 988 Suicide & Crisis Lifeline and bipartisan efforts have led to significant advancements in crisis services, fostering collaborations between behavioral health, law enforcement, emergency responders, and other sectors to improve crisis response and prevention, but more is needed to ensure better mental health outcomes.

- Current challenges include behavioral health workforce shortages, the youth mental health crisis, a flawed justice–to–behavioral health care pipeline, the overdose epidemic and increasing rates of suicide, difficulty matching level of care to level of acuity, the end of pandemic-era flexibilities that may affect access to care, poor social determinants of health among individuals served, social isolation, and lack of sustainable funding.

Recommendations

Work to achieve accessible and effective crisis and mental health services will benefit from adhering to the following core principles:

1. Multiperspective input and partnership is critical to a united crisis services strategy.
2. Leaders must strengthen and connect social services for crisis prevention and postvention.
3. Facilitating social connection is crucial to prevent mental illness and promote well-being.
4. Systems must be trauma-informed and accountable to all people served and the workforce members who serve them.
5. Access and engagement across all populations should go together, and they require more intention and research to improve outcomes.

Biden's Unity Agenda: Strengthening and Rebuilding Across the Lifespan

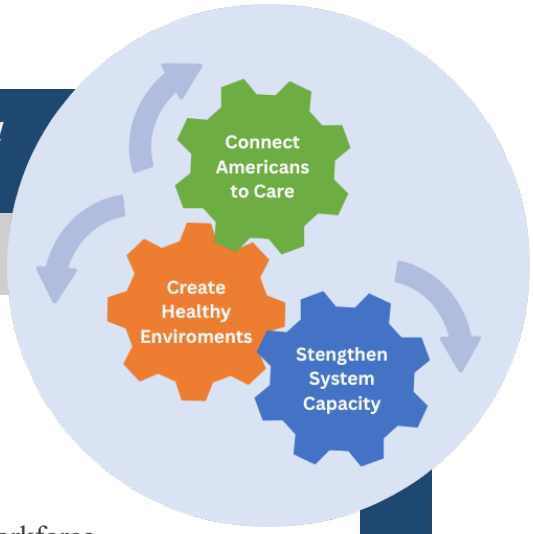
Across the globe, the innumerable impacts of the COVID-19 pandemic are still unfolding, even as it wanes. Many lives were lost, and disparities were unearthed yet again. Young, developing minds were caught in surreal changes to their routines, while older adults and persons with disabilities had unique challenges with isolation during lockdowns. The list goes on and on. As people now raise their heads and transition into recovery phases, pulling away from Zoom screens, traveling, and reengaging in in-person activities, it is difficult to reconcile all that has happened. Beyond the death rates, the emotional toll of the pandemic has been tremendous. One review of 16 studies examining 40,076 participants between 2019 and 2021 exposed how adolescents of varying backgrounds experienced higher rates of anxiety, stress, and depression during the pandemic, along with an increase in alcohol and cannabis use.[1] There are concerns that students may be five months behind in math and four months behind in reading compared to students before the pandemic, not to mention that about 33% of female students were reporting sadness or hopelessness.[2] One national survey reported that 90% of adults in the United States believe the country is experiencing a mental health crisis, with four in 10 adults reporting anxiety and depression in early 2021.[3]

The February 2020 release of the Substance Abuse and Mental Health Services Administration's (SAMHSA's) *National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit*[4] was quickly followed by news of the encroaching pandemic. It was not known at the time of writing the guidelines how critical they would soon be to assist in meeting the needs of an alarming number of Americans facing new pandemic-related mental and emotional distress. Yet given what the statistics about mental well-being are showing, in many ways, these guidelines and the subsequently galvanized effort to enhance mental health crisis services across the country could not have been better timed. The *National Guidelines for Behavioral Health Crisis Care* has become an instrumental document in the mental health services arena, catalyzing nationwide action to "meet Americans where they are" when they find themselves in a behavioral health crisis. The more recently released youth crisis guidelines and the companion article, "A Safe Place to Be," have also provided pivotal guidance.[5,6]

Beyond attention to the need to address crisis services, focus on mental health more broadly has been growing. In March 2022, President Biden laid out his Unity Agenda with a directive to attend to the national mental health crisis, putting the urgency of need for mental health resources at the forefront of the nation and providing a road map to address that need.[7] It highlighted many mental health challenges related to the fallout of the pandemic, including the large proportion of American adults reporting anxiety and depression; poor mental well-being and school achievement of youth; and disparities in access to mental health care, especially among Black and Brown communities.

The Unity Agenda includes three agenda items specifically relevant to mental health: Strengthen System Capacity, Connect Americans to Care, and Support Americans by Creating Healthy Environments. Within each of these, specific areas of focus are delineated, as described in **Figure 1.**

Figure 1: President Biden's Strategy to Address the National Mental Health Crisis as Part of the Unity Agenda



Strengthen System Capacity

- Invest in proven programs that bring providers into behavioral health
- Pilot new approaches to train a diverse group of para-professionals
- Increase the standardization of peer recovery specialists
- Promote the mental well-being of our frontline health workforce
- Implement the transition of the 988 Suicide & Crisis Line and strengthen community-based crisis response
- Expand the availability of evidence-based community mental health services
- Invest in research on new practice models

Connect Americans to Care

- Expand and strengthen parity
- Integrate mental health and substance use treatment into primary care settings
- Improve veterans' access to same-day mental health care
- Expand access to tele- and virtual mental health care options
- Expand access to mental health support in schools and colleges and universities
- Embed and co-locate mental health and substance use providers into community-based settings
- Increase behavioral health navigation resources

Continued

Figure 1: Continued

Support Americans by Creating Healthy Environments

- Strengthen children's privacy
- Institute stronger online protections for young people, including prioritizing safety by design standards and practices for online platforms, products, and services
- Stop discriminatory algorithmic decision-making that limits opportunities for young Americans
- Invest in research on social media's mental harms
- Expand early childhood and school-based intervention services and supports
- Set students up for success
- Increase mental health resources for justice-involved populations
- Train social and human services professionals in basic mental health skills

Fact Sheet: President Biden to Announce Strategy to Address Our National Mental Health Crisis, as Part of Unity Agenda in His First State of the Union. Washington, DC, The White House. March 1, 2023. https://www.whitehouse.gov/briefing-room/statements-releases/2022/03/01/fact-sheet-president-biden-to-announce-strategy-to-address-our-national-mental-health-crisis-as-part-of-unity-agenda-in-his-first-state-of-the-union/

The Unity Agenda strikes a chord that is widely embraced and has the potential to help millions of Americans of all backgrounds and ages with their mental health needs. To further drive needed progress in this area, in October 2022 the White House also announced the expansion of funding opportunities for Certified Community Behavioral Health Clinics (CCBHCs)[8] and outlined additional funding to strengthen the workforce, school-based mental health and telehealth supports for youth, 988, and other opportunities via the Bipartisan Safer Communities Act and the American Rescue Plan. In addition to funding, in February 2023, the White House put forth a research priority agenda related to mental health, as developed by the White House Office of Science & Technology Policy and the White House Domestic Policy Council.[9] This research agenda, outlined in **Figure 2,** was driven in part by the US Surgeon General's report on the concerns about youth mental health,[10] the aftermath of the pandemic, and recognition of the increasing prevalence of mental health challenges in light of structural marginalization of communites with particular vulnerabilities, increasing use of social media, barriers to affordable housing, increased exposure to violence, the opioid and suicide crises, and others.

Figure 2: White House Research on Mental Health Priority Areas

Cross-cutting research priorities
1. Advancing equity in promoting mental health and in understanding, preventing, identifying, and treating mental health conditions 2. Understanding and leveraging digital mental health interventions 3. Supporting and expanding the mental health workforce
Topical Research Priorities
4. Increasing the availability, quality, and impact of interventions for mental disorders in health care systems, communities, and justice settings 5. Integrating substance use and mental health research and treatment 6. Developing and improving treatments for serious mental illnesses 7. Preventing fatal and nonfatal suicide outcomes 8. Supporting youth mental health

White House Report on Mental Health Research Priorities. Washington, DC, The White House, February 2023. https://www.whitehouse.gov/wp-content/uploads/2023/02/White-House-Report-on-Mental-Health-Research-Priorities.pdf

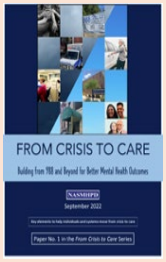
Through the Unity Agenda comes a road map for behavioral health directors, policymakers, and leaders across sectors to rally around and create needed change, at the same time Americans are shifting to a new order of business after the end of the public health emergency (PHE).

This technical assistance brief aims to catalyze a "connected and strong" behavioral health system of care, highlighting the Unity Agenda and detailing strategies to connect and strengthen mental health supports. In addition to highlighting the critical importance and timing of the Unity Agenda, this paper provides a summary of many of the issues and policy directions that are emerging as salient to the success of implementing the crisis continuum and beyond, in the context of needing to address current challenges. This paper represents the lead paper of a compendium of 10 total papers that bring together narratives aligning with the *Connected and Strong* theme. Each of the 10 papers covers a Unity Agenda priority area to help catalyze change and foster the ability of mental health services to meet the needs of people across the United States. To set the stage for the work ahead, it is important to understand the conceptual policy efforts to move "Beyond Beds." The topics of the 2024 *Connected and Strong* Technical Assistance Briefs are outlined in **Figure 3.**

Figure 3. Topics of the 2024 Connected and Strong Technical Assistance Briefs

The 2024 *Connected and Strong* Compendium	
1	Connected and Strong: Strategies for Accessible and Effective Crisis and Mental Health Services
Section I. Strengthen System Capacity	
2	Peer Support Services Across the Crisis Continuum
3	Growing and Strengthening the Behavioral Health Crisis Response Workforce
Section II. Connect Americans to Care	
4	Crisis Services: General Medical and Psychiatric Approaches to Care Delivery
5	Innovative Uses of Technology to Enhance Access to Services Within the Crisis Continuum
6	Crisis System Coordination and Collaboration: Leveraging Strengths and Opportunities of 988 and 911
7	Facilitating Rapid Access to Outpatient Mental Health and Substance Use Care
8	Increasing Equitable Access to Care for Co-Occurring Mental Health and Substance Use Disorders
9	Intersectionality: Faith, Mental Health, and Community Partnerships
Section III. Support Americans by Creating Healthy Environments	
10	Long COVID and High-risk Populations

Figure 4: The Beyond Beds Series

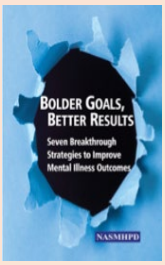


2022: From Crisis to Care: Building from 988 and Beyond for Better Mental Health Outcomes

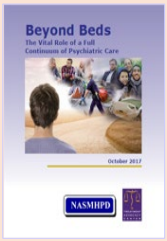
2021: Ready to Respond: Mental Health Beyond Crisis and COVID-19

2020: Crisis Services: Meeting Needs, Saving Lives

2019: Beyond the Borders: Lessons from the International Community to Improve Mental Health Outcomes



2018: Bolder Goals, Better Results: Seven Breakthrough Strategies to Improve Mental Illness Outcomes



2017: Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care

The Beyond Beds Series: Crisis Services Then and Now

In 2017, NASMHPD and SAMHSA articulated the concept of "Beyond Beds."[11] This was born out of the flawed narrative that more inpatient beds, especially state hospital beds, were a single solution to a fragmented and under resourced mental health system. Countless news reports suggested that the closure of state hospital beds was resulting in waitlists everywhere, including emergency departments (EDs) and jails. The Beyond Beds frame of reference alludes to the complexity of the behavioral health system across the United States and the critical need for a full continuum of care that has yet to be realized. From the time of the original Beyond Beds paper, every year, a new set of technical assistance briefs has been produced to articulate, for various sectors, what is needed to realize an accessible, equitable, complete, and high-quality continuum of psychiatric care. The 2017 Beyond Beds series provides relevant resources to this day (see **Figure 4**).

With the impact of COVID-19, the 2020 *National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit,* and the approval of 988 as an easy-to-remember three-digit number to access the National Suicide & Crisis Lifeline, the focus of the technical assistance Beyond Beds paper series has largely been on crisis services.[12] Crisis services, however, will work only if there is a linkage to a complete care continuum, including prevention and wellness promotion, outpatient care, and inpatient care, so that individuals can get the treatment they need, at the level they need, when they need it. With a more complete continuum of care, crises can be averted.

As of the writing of *Connected and Strong,* many critical issues are dominant. Just over three years after the start of the pandemic, the PHE is declared over, and the unwind leaves a trail of needs. Diseases of despair, such as death by suicide and opioid overdoses, are rampant. Houselessness is a major concern, with county[13] and state leaders[14] declaring emergencies related to this phenomenon. Numbers of people with mental illness in jail continue to mount, and suicide rates within the confines of jails have increased[15] despite interventions to reduce them. Police departments are facing increased scrutiny for their treatment of people with behavioral health conditions.[16] Workforce shortages in the behavioral health field are overwhelming. The opioid epidemic has transitioned to a multi–drug use epidemic. Children's behavioral health systems are in desperate need of options given suicide risk, the youth mental health burdens, and systems fractures as countless youth board in their EDs and child welfare–involved youth are living in offices and hotels.[17] People with complex conditions of all ages are in settings out of state or not meant for their level of need when they should be closer to their natural environments and in integrated settings. In fact, people of all ages with complex conditions, such as co-occurring mental health and intellectual and other neurodevelopmental disorders, are increasingly recognized as requiring supports that current policy and system structures are not designed to provide.[18,19] Thus, information is needed to assist leaders to properly advocate for funds and policies that achieve better mental health outcomes through an array of more targeted and relevant services. In this way, this brief builds on themes to catalyze further progress.

The Current Crisis Services Landscape

There is a sea change occurring in the crisis services space. With the shift to 988 as the number to access the National Suicide & Crisis Lifeline in July 2022, there has been unprecedented bipartisan momentum to build out an array of crisis services. There are many elements to the crisis service array. As described in *Crisis Services: Meeting Needs, Saving Lives,*[20] there has been a long-standing approach to default crisis services, which has led all too often to overcrowded EDs or arrest of people with mental illness and co-occurring substance use disorders. It is an exciting time to be in this space, as an array of avenues for crisis support that meets a person's needs are increasingly becoming available.

The two-year anniversary of the rollout of 988 as the three-digit Suicide & Crisis Lifeline took place in July 2024. Although prior to the launch of 988 many states had been making great strides in expanding crisis services, this galvanizing, easy-to-remember number has created a major shift, bringing disparate voices together to determine how best to expand the reach of 988 and raise awareness among the American people. However, two-years after its launch, most Americans remain unaware of the 988 Suicide & Crisis Lifeline, according to population polls conducted by the National Alliance on Mental Illness and Ipsos.[21] Awareness will undoubtedly continue to grow, especially with plans for media campaigns to expand reach underway.

At the federal level, several forces are at play that are helping to move the needle on crisis services. First, 988 itself as a uniform number, and SAMHSA's work in creating a network of interconnected call, text and chat centers, is critical. This work is executed in coordination with the Lifeline administrator. On a quarterly basis, NASMHPD and Lifeline administrator leadership meet with state mental health authorities to review call center data and discuss any issues of concern in rolling out crisis services. Vibrant has established training and data collection to help policymakers track and learn from experience as it unfolds.

In addition, the Centers for Medicare and Medicaid Services (CMS) is investing a great deal in crisis services at all levels, from mobile crisis response to short-term crisis stabilization units, and more. The expansion of CCBHCs via partnership between SAMHSA and CMS demonstrates a commitment to crisis services, as CCBHCs are required to provide crisis services regardless of payor. In a 2021 report to Congress, the Medicaid and CHIP Payment and Access Commission advised the US Department of Health and Human Services (HHS) Secretary to direct CMS and SAMHSA to issue subregulatory guidance to address how Medicaid and State Children's Health Insurance Programs (CHIP) can be used to financially support crisis services, how those federal agencies should work together to provide an educational and technical assistance approach to enhance crisis services, and how they could together support state-level services in the crisis continuum.[22] The Medicaid and CHIP Payment and Access Commission's recommendations highlighted the need to make mental health services and coordination across federal agencies a priority.

In addition, the Department of Justice, through its Special Litigation Unit, has investigated the intersection of law enforcement and behavioral health to try to help shape services that promote a behavioral health response whenever possible.[23] This is important work, especially given concerns about excessive use of force by law enforcement disproportionately impacting persons with serious mental illness.[24] In January 2023, the Office of Justice Programs at the Bureau of Justice Assistance convened a gathering with SAMHSA leadership and others to promote the use of 988[25] and the year prior issued grants and promoted a briefing for law enforcement about 988.[26]

The Administration for Community Living also issued an award to the National Association of Directors of Developmental Disability Services (NASDDDS) to promote knowledge and services for people with Intellectual and other Developmental Disabilities with co-occurring mental health conditions, which will include a resource center called "The Link Center."[27] This work with several partner organizations will include a focus on crisis in partnership with SAMHSA.

The above examples are just a few of the actions taking place at the federal level to promote crisis services. At the state level, crisis services are rapidly evolving, guided by the pillars of someone to call, someone to respond, and a safe place for help.[28,29,30] Many states have passed or proposed legislation to expand and fund 988 and other crisis service access lines. A draft *Model Bill for Core State Behavioral Health Crisis Services Systems* helped promote an understanding

of the potential for state legislation to codify progress and funding of 988.[31] Meanwhile, according to a NASMHPD and Vibrant publication, *States' Experiences in Legislating 988 and Crisis Service Systems,* there has been fast-paced movement across states that pass 988 legislation and regulations to help make 988 come to fruition.[32] This legislation has included enacting fees to help fund 988, funding studies related to 988, and other strategies to help move 988 implementation forward.

Equally, at the local level, call centers, first responders, and municipalities are pursuing efforts to enhance crisis response, with mobile crisis teams expanding in a variety of forms and work related to coordination between dispatch and call centers getting underway. There is, of course, much more that needs to be done for the 911 and 988 systems to interoperate seamlessly. The sixth paper in this series, *Crisis System Coordination and Collaboration: Leveraging Strengths and Opportunities of 988 and 911,*[33] provides a careful landscape analysis of work in this area, with recommendations for the future.

The Impact of COVID-19: Lessons Learned for a Stronger America and Healthier Environments

The COVID-19 pandemic will be remembered, and many lessons can be drawn from it. The COVID-19 pandemic elevated the field of disaster preparedness and, in particular, has taken the focus on disaster behavioral health to a new level of importance.

The Administration for Strategic Preparedness and Response defines disaster behavioral health as "the provision of mental health, substance [use], and stress management services to disaster survivors and responders," noting that at the federal level, the work also involves addressing the behavioral health care infrastructure, individual and community resilience, and risk communication and messaging.[34] SAMHSA's Disaster Technical Assistance Center (DTAC) provides numerous resources, tool kits, and other guidance materials to help maximize preparedness from the behavioral health perspective (see **Figure 5**).[35] In addition, the Disaster Distress Helpline maintained by SAMHSA proved to be an important avenue of support, as was seen during the outset of the COVID-19 pandemic when by April of 2020, there was an 891% increase in call volume.[36]

While these resources are critical and were incredibly relevant as the COVID-19 pandemic was reaching the United States, many additional pivots needed to be made within behavioral health services.[37] In *Disaster Behavioral Health Through the Lens of COVID-19,* Pinals and Stephenson[38] noted gaps in epidemic/pandemic planning in the behavioral health space and

disparities in outcomes related to the virus. Studies have since shown that in addition to needing to manage the health impacts of viral infiltrations, determinants of mental health are requiring attention.[39] One comprehensive review of the emotional impacts of the COVID-19 pandemic offered clear information that mental conditions may appear in healthy individuals and in those with a predisposition or preexisting mental illness, and thus vigilance for emergence of symptoms is important. Factors that contributed to mental conditions included being female, younger, or older in age; social factors such as economic disadvantage; relationship factors of stress in relationships or social isolation; and preexisting mental conditions. On top of that, the researchers found that mental conditions were also impacted by threat of loss of life for oneself and loved ones, as well as the interruptions in the normal life functions and containment that occurred.[40] Others have pointed out the need to deliver psychological first aid or new models of crisis intervention during emergencies, including fostering the use of telepractices for disasters that make face-to-face encounters limited.[41]

Figure 5: SAMHSA's Behavioral Health DTAC Resources

DTAC resources for professionals in the disaster behavioral health field:

- SAMHSA Disaster Behavioral Health Information Series
- *The Dialogue* newsletter
- SAMHSA DTAC Bulletin
- SAMHSA DTAC Supplemental Research Bulletin
- DTAC Tip Sheets
- Disaster Response Template Toolkit
- DTAC Posters, Flyers, and Wallet Card
- DTAC Guides

As the PHE unwinds, there are still many unknowns related to its total impacts. During the height of the pandemic, disparities in outcomes for people of color[42] and people with disabilities[43] became more widely recognized. Take Long COVID,[44] for example, as well as all the other societal changes that have occurred—these are still being counted, catalogued, and studied. As more is learned, it will be important to continue to build services that can help people when their emotional needs surpass their ability to cope. The importance of creating healthy environments, promoting prevention through vaccination, and promoting health and wellness have all been heightened in recent years.

Current Challenges and Opportunities

Strengthening the Behavioral Health Workforce

Leaders of state behavioral health systems frequently point out that all of the best efforts to connect and strengthen behavioral health systems and services, including crisis care, cannot be successful without an adequate workforce, both in terms of quantity and quality. Unfortunately, the United States is in the midst of a behavioral health workforce crisis. According to the Kaiser Family Foundation (KFF), as of September 2022, 156,827,282 Americans lived in mental health professional shortage areas, meaning that only 27.7% of the need for mental health care in America was being met at that time.[45] KFF estimates that 7,871 mental health care practitioners would be required to meet 100% of the need for mental health care.[46] Youth behavioral health workforce shortages are particularly concerning and are tied directly to outcomes, with mental health workforce shortage area designation being associated with increased youth suicide rates.[47]

These shortages, in part, have led to an existing behavioral health workforce that is stretched thin and burnt out, including the crisis care workforce. A 2023 National Council for Mental Wellbeing survey found 93% of behavioral health workers have experienced burnout and 63% suffer from moderate or severe burnout.[48] This is a vicious cycle, with about half of the behavioral health workers stating that workforce shortages and subsequent burnout have caused them to consider other employment options.[49]

The impact of low wages on burnout cannot be ignored—many states implemented temporary hazard pay increases or permanent wage increases. The flexibility afforded by telehealth, flexible work schedules, and flexible work settings is increasingly expected by modern workers. Crisis work, however, often requires irregular hours and emotionally demanding tasks that will require their own unique attention.

Recruitment remains another major challenge for the behavioral health workforce, despite many efforts to find staff to fill vacancies. A 2023 survey found that 97% of mental health provider organizations were finding it difficult to recruit employees.[50] States are increasingly focused on building career pipelines for emerging professionals, starting as early as high school, and career ladders for staff at all levels of the crisis continuum to promote retention and realize the full potential of the existing workforce. Partnerships with colleges and universities, streamlining of credentialing and training processes, and outreach/education efforts are becoming more common. Many strategies to promote employee well-being are equally effective in attracting workers to roles in behavioral health.

Of course, the task at hand is not as simple as hiring 7,871 new behavioral health workers. Rather, leaders must ensure they are building a workforce that has the appropriate skills, experience, and demographic characteristics to best meet the needs of the individuals served. Racial, ethnic, social orientation, and gender identity diversity is currently lacking in the

behavioral health workforce, and progress in diversifying the workforce has been slow, even though we know that racially/ethnically discordant patient-physician dyads tend to have poorer patient experiences and are less likely to stay in treatment.[51,52,53] People of color and sexual orientation and gender identity minorities face disproportionate barriers to accessing mental health care, and compounding experiences of racial discrimination and mental illness stigma affect individuals of minoritized racial and ethnic groups with mental illness.[54,55] The United States is not only facing a workforce shortage—it is facing a shortage of workers who share identities and experiences with the individuals they serve, including race/ethnicity, sexual orientation, gender identification, and lived experience with mental illness and social systems. Behavioral health peer supporters are a critical part of this equation, as a friendly face that looks like yours can make all the difference when you are experiencing a crisis. Even setting up services for individuals with mental illness to join the workforce is important. Take, for example, the Advancing State Policy Integration for Recovery and Employment, or "ASPIRE" Initiative, which aims to support and expand competitive integrated employment opportunities for people with mental health conditions.[56] The Department of Labor's "Recovery Ready Workplace" guidance, which helps both employees and employers understand rights and needs of people in recovery trying to join or rejoin the workforce,[57] is another example of a mechanism to bring people with mental health conditions and substance use disorders into competitive employment, which could include behavioral health services outside of peer positions.

The workforce must be strengthened in terms of its ability to meet the needs of people with co-occurring and complex issues, such as co-occurring substance use, intellectual/developmental disability, physical disability, justice involvement, houselessness, unemployment, and other determinants that impact individuals' well-being and presentation in the crisis system. This is where training; sufficient pipelines; and bringing new partners, providers, and other expertise (such as faith-based organizations, schools, and physical health care) into the fold of behavioral health are important.

Possibly one of the most important strategies to improve and prevent burnout, inspire recruitment and retention, and create healthy workplaces is staff appreciation and employer focus on workplace mental health.[58] Staff want to feel heard by leadership, see their feedback acted upon, and receive genuine appreciation for the hard work they do to meet the needs of the populations they serve. Cultural shifts to promote employee well-being and promote social connection among employees and between employees are needed—offering an employee assistance program is not enough. Burnout and shortages are inextricably linked. Recognizing this, President Biden has specifically sought to address burnout among the health care workforce via his Unity Agenda.[59] The US Surgeon General has also released an Advisory on Addressing Health Worker Burnout and SAMHSA released a document specific to burnout within behavioral health organizations.[60, 61]

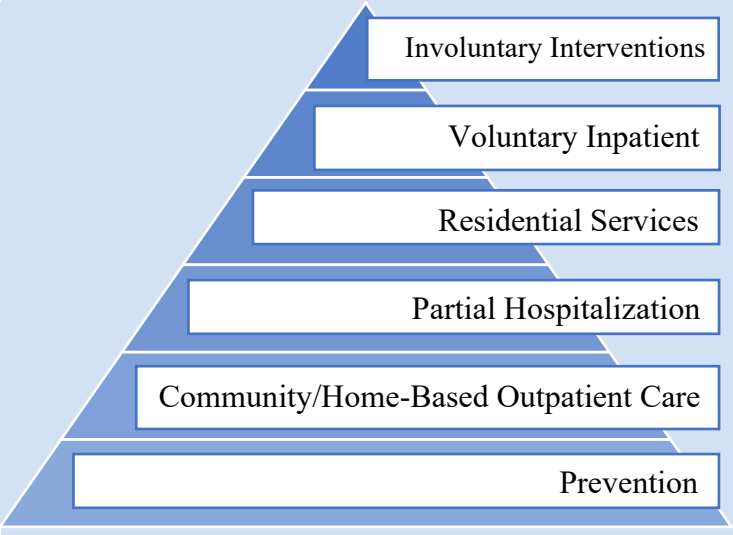
Connecting Individuals with the Right Level of Care at the Right Time

As of this writing, too many people continue to board in EDs, especially youth and those with complex conditions such as co-occurring mental illness and intellectual and other developmental disabilities. For crisis services to meet the needs of anyone at any time, the right level of care must be available once the need is identified. The determination of how best to help someone and the type of care that could be most beneficial at any given time also requires a comprehensive biopsychosocial approach across various systems, from primary care offices to community mental health centers.

CCBHCs are poised to meet many needs in behavioral health services and focus on biopsychosocial issues, such as timely access to services, crisis and jail diversion, and integrated medical and behavioral health care. Provisions of CCBHCs were described in the 2022 paper on the subject produced by NASMHPD.[62] Today, there are more than 500 CCBHCs in 46 states, the District of Columbia, Guam, and Puerto Rico, with even more being developed under new funding opportunities and authorizations. The CCBHC movement has the power to change the landscape of mental health care delivery.[63]

On the crisis care system continuum, to help link people to the right care at the right time, collaboration between 911 and 988 is critical.[64] Relationships between hospitals, EDs, and crisis stabilization units will be equally important.

Figure 6: General Levels of Psychiatric Care



As articulated by Browning and others in *Crisis Services: General Medical and Psychiatric Approaches to Care Delivery,* the need to ensure that individuals are getting the psychiatric and medical care they need is paramount at any crisis receiving center.[65] Additionally, there is a wide variety of service settings being built out in the care continuum, each of which has its own place in the continuum, from psychiatric residential treatment facilities, to peer respite programs, to crisis residential units, and others (see **Figure 6** depicting general levels of psychiatric care). Definitions of which types of services are available for whom, and what level of care is represented by these services, will continue to need to be refined, like the American Society of Addiction Medicine criteria that look at multiple dimensions of need[66] and the Level of Care

Utilization System and Child and Adolescent Level of Care Utilization System, which attempt to delineate levels of care that are appropriate for an individual at any given time.[67] These models help providers sort out needs for services, though they can also present challenges given that services may not be as black and white as what is described in writing. To that end, the National Council for Mental Wellbeing has produced guidance to help practitioners minimize the inappropriate denial of coverage for a certain level of care that may be needed.[68] To ensure that individuals get the right care they need when they need it, providers, practitioners, and others will benefit from ongoing research and information about these types of considerations.

Ensuring Continued Connection to Services with the Ending of the Public Health Emergency

On May 11, 2023, HHS Secretary Xavier Becerra issued a press release[69] announcing the end of the COVID-19 PHE. The Secretary said, "We have learned many lessons during the last two and a half years and have worked to strengthen our preparedness and response efforts by creating resiliency" in domestic supply chains, ensuring adequate stockpiles, and fostering innovations. He further noted, "HHS and the leadership across the Department remain focused on protecting the health and well-being of all Americans, particularly those at highest at [*sic*] risk." As part of the resiliency created and the aims to improve the well-being of those at risk, President Biden has continued to press and provide seminal directives to bring the country from division to unification on multiple levels, including the crucial domestic agenda to focus on the mental well-being of Americans.[70]

Yet with the ending of the PHE, it is also relevant to look at the many things that will require new transitions. The declaration of the PHE in 2020 called for pivoting dramatically and quickly in countless ways in the delivery of all health services. The behavioral health system adapted with shifts to telepractice, loosened regulations, and massive efforts to maintain a level of service delivery for underserved populations.[71]

With the PHE ending in May 2023, several historical access provisions and restrictions are newly being reconsidered. For example, the Drug Enforcement Administration and SAMHSA extended COVID-19 telemedicine flexibilities for the prescribing of controlled medications within established practitioner-patient relationships after receiving approximately 38,000 public comments expressing concerns about retightening regulations.[72] Pausing the retightening created more opportunities to sort through what the proposed rules might mean for people receiving these medications, such as a youth receiving a stimulant for attention deficit hyperactivity disorder or a person receiving medications for opioid use disorder (MOUD). With the delay, continuity of care can be maintained until there is greater planning for what rules might allow for legitimate treatments to continue while minimizing risks created by loosened regulations outside of the PHE. In a similar vein, Section 1262 of the Consolidated Appropriations Act of 2023 completely changes the potential access to buprenorphine for people with opioid use disorder by

eliminating the need for the special x-waiver (the specialized designation that had been required to prescribe buprenorphine for opioid use disorder), but also requiring a one-time, eight-hour training related to the treatment of opioid or other substance use disorders for practitioners seeking Drug Enforcement Administration registration (other than veterinarians) effective June 27, 2023.[73,74]

In another area of shifting from the PHE, there are many organizations sorting through whether to require workers to return to offices or to continue to operate through virtual meetings and contacts. Many office buildings are empty, and many state and government offices are working on protocols to allow for hybrid, remote, and in-person staff to all be able to work together. Many telehealth provisions have been made permanent by CMS, such as audio-only telehealth services for diagnosis, evaluation, and treatment of mental disorders and certain group psychotherapies allowing virtual contacts.[75] For clinical services requiring supervision, during the pandemic, CMS allowed for supervision to shift from direct and on-site to "general" supervision, so that supervisors and trainees could work through real-time audio or virtual telecommunication from different sites.[76] With the end of the PHE, this provision has been reconsidered, with CMS indicating a plan for enforcement discretion to allow audio/video real-time communications when billing the Physician Fee Schedule for Medicare Part B services that was slated to end in December 2023. CMS is continuing to examine this enforcement discretion going forward.[77] Given the concerns of an abrupt shift to require only in-person supervision, CMS has extended the virtual provision to December 31, 2024.[78]

The above examples are just some of the ways that the ending of the PHE in May 2023 has caused major shifts in how care may be delivered and to whom. To enhance strategies for improving services for youth with serious emotional disturbances, adults with serious mental illness, and many individuals with co-occurring other conditions, policymakers, practitioners, and others involved in behavioral health services will need to stay abreast of these evolving regulations and provisions while continuing to drive systems and services that can adapt to meet needs.

Funding Enhancements and the Need to Sustain Them

The historic and international underfunding of mental health services has been identified by some as a human rights issue.[79] Yet recent years have seen attention to the mental health needs of communities and put mental health in the national dialogue. Advocates have argued that just being aware of the critical importance of mental wellness and good mental health is necessary, but insufficient, as more funding is still critically needed to achieve better mental health across the country.[80] And with this awareness, the funding landscape for behavioral health services has changed dramatically over the past few years. Take, for example, crisis services, where appropriations seem to be staggeringly positive at the federal level, with the Biden-Harris Administration investing $3.8 billion through the American Rescue Plan Act and another $800 million through the Bipartisan Safer Communities Act to help improve access to mental health care and overdose prevention, which include expansion of crisis services.[81] School-based mental

health is another area of major growth fiscally, with the US Department of Education announcing $188 million from the Bipartisan Safer Communities Act to support student mental health and wellness.[82] In addition, many states are supporting the expansion of crisis response through call line, mobile crisis, and crisis stabilization services through state dollars.

Although there is tremendous forward momentum, there are looming concerns that the pandemic has exacerbated the demand for mental health services. Even the expansion of funding is not enough to meet the current need.[83] Thus, though more funding is coming to fruition, still more needs to be done.

The sustainability of funding is also a concern, as the American Rescue Plan Act (ARPA) 85% federal match for Medicaid-funded, community-based mobile crisis services is slated to last for only three years.[84] Bringing in private insurers to the payor mix will certainly help, as would enforcing mental health and addiction parity, but these are still solutions that have not been fully realized, even if they are moving in a positive direction.[85] The establishment of the 988 and Behavioral Health Crisis Coordinating Office within SAMHSA is another positive step that stemmed from the Consolidated Appropriations Act, 2023, and much is to be gained from that focused high-level approach that can stay abreast of developments and needs.[86] Additional attention to the work will require focused 988/911 coordination and collaboration, which may itself require intentional funding to develop the technology and infrastructure for that to be realized.[87] Keeping a focus on these areas of funding and sustainable advances will be critical to realize the full continuum of crisis care and beyond.

Opioids and Substance Use Disorders

The overdose epidemic continues to devastate American communities. Nearly 108,000 drug overdose deaths were reported in 2022, though rates remained stable from the year prior.[88] The rise in overdose deaths in recent years has disproportionately affected people of color.[89] Fentanyl overdose rates have exploded, increasing 279% between 2016 and 2021 and in 2021 affecting 21.6 Americans per 100,000.[90] Fentanyl is followed by methamphetamine, cocaine, heroin, and finally oxycodone in terms of deaths involving drug overdoses.[91] Alcohol, though often overlooked amidst the opioid crisis, remains a substance of major concern, with data showing increases in the use of alcohol during the COVID-19 pandemic as a stress-coping mechanism.[92] Alcohol-related deaths saw a significant increase in 2019 and 2020.[93]

There are bright spots, however, with respect to youth substance use: between 2019 and 2021, lifetime use of alcohol, marijuana, and cocaine and prescription opioid misuse decreased among youth, suggesting the field is on the right prevention path among youth. Still, the Centers for Disease Control and Prevention's Youth Risk Behavior Survey found that about one in 10 high school students binge drank in 2021 and 6% misused prescription opioids.[94]

For those with substance use disorders, hope can be found in the form of evidence-based treatments. Medications for addiction treatment, particularly MOUD and medications for alcohol

use disorder, can be an effective tool in sustaining recovery, and federal agencies are committed to making MOUD and other treatments available to those who would benefit from them while simultaneously prioritizing self-directed and noncoercive treatment philosophies.[95] President Biden's Unity Agenda seeks to drastically expand access to MOUD.[96] Naloxone is another invaluable and life-saving tool in the overdose fight. A large-scale national study showed that opioid overdose deaths decreased by 14% in states after they enacted naloxone access laws.[97] States have had success distributing naloxone through holding free pharmacy distribution days, placing vending machines in public areas, and using other strategies. Additionally, the Food and Drug Administration's approval of over-the-counter distribution of naloxone holds great promise to improve access.[98]

As state and federal behavioral health leaders seek to prevent and treat substance use disorders and crises, there is also important work looking across sectors to cross-pollinate and coordinate efforts across behavioral health and social service systems. There have historically been strong siloes between serious mental illness and substance use disorder service provision and workforce training systems, which is counterintuitive and inefficient in meeting the needs of individuals with co-occurring disorders (CODs). And disparities in care for some populations with CODs experiencing marginalization is a significant problem to be overcome.[99] Unifying approaches across service systems, as well as connecting treatment services with other services that address social determinants of health, such as fostering employment and stable housing, will be protective against current and future substance use disorder.[100]

Suicide and Suicidal Ideation

Perhaps no other issue illustrates the need to connect and strengthen our behavioral health crisis systems, mental health services, and communities than that of suicide. Suicide affects all segments of the population, though certain groups and populations are at higher risk of suicide and suicidal ideation than others.[101] Nearly half a million Americans lost their lives to suicide from 2010 to 2020, outnumbering deaths by motor vehicle accidents.[102] Suicide rates increased between 2010 and 2018, followed by a promising decrease in 2019 and 2020.[103] However, rates increased again in 2021 and 2022, the most recent year of data available.[104] It is also worth noting that suicide deaths may be undercounted due to possible misclassification as drug overdose deaths, as it is often difficult to determine intent in cases of overdose.[105] And sadly, deaths by suicide represent only a fraction of America's suicide problem. Research reveals that suicidal ideation is a significant concern. In 2023, an estimated 12.8 million American adults seriously contemplated suicide, 3.7 million planned a suicide attempt, and 1.5 million individuals attempted suicide.[106]

Specific risk determinants for suicide and suicidal thinking patterns exist within certain demographics. LGBTQI+ individuals, for instance, have higher rates of suicide attempts, with more than a quarter of high school students identifying as lesbian, gay, or bisexual reporting attempts in the prior 12 months—*five times higher* than that reported among heterosexual students.[107] Research also draws attention to the concerning rates of suicide and self-harm among all young people, with suicide being the third-leading cause of death among 14- to 18-year-olds and approximately 105,000 youth age 14 to 18 years visiting EDs for self-harm injuries in 2020.[108,109] Veterans also are a particularly high-risk group, with an adjusted suicide rate that is 57.3% higher than the nonveteran US adult population.[110] Perhaps most alarmingly, while overall suicide rates are declining, rates are rising significantly among people of color.[111] The suicide death rate is increasing faster among Black youth than any other racial/ethnic group, and suicide attempts rose by 73% between 1991 and 2017 for Black adolescents.[112]

Figure 7: 2024 National Strategy for Suicide Prevention

- **Strategic Direction 1.** Community-Based Suicide Prevention
- **Strategic Direction 2.** Treatment and Crisis Services
- **Strategic Direction 3.** Surveillance, Quality Improvement, and Research
- **Strategic Direction 4.** Health Equity in Suicide Prevention

2024 National Strategy for Suicide Prevention. US Health and Human Services. https://www.hhs.gov/programs/prevention-and-wellness/mental-health-substance-abuse/national-strategy-suicide-prevention/index.html

Firearm access cannot be disentangled from discussions about suicide. In 2022, more than half of all suicides were by firearms, and conversely, more than half of *all* deaths involving firearms were suicides. In 2022, we saw an increase in suicide deaths by firearms, as firearm homicide deaths decreased by 2%.[113] Lethal means access is an important piece of suicide prevention.

Broadly speaking, suicide and suicidal ideation are complex issues that require multisystemic solutions. In many ways, suicide and suicidal ideation can serve as proxy measures for the health of our behavioral health systems and our communities. Promoting and enhancing social connection and opportunities to contribute; addressing social determinants of health including economic supports; specifically targeting high-risk groups such as LGBTQI+ persons, youth, and veteran populations with more intensive suicide prevention programming; ensuring lethal means safety; improving the capacity of the workforce to deliver evidence-based suicide prevention care; and strengthening and connecting the components of our crisis care continuums are all key strategies outlined in the 2024 National Strategy for Suicide Prevention (**Figure 7**).[114]

The Interface Between Criminal, Juvenile Justice, and Civil Legal Systems and Behavioral Health

That there is a disproportionate number of people with mental illness and substance use disorders in criminal legal and juvenile justice settings is well known. Many of these individuals also have civil legal entanglements, such as housing evictions, fees and fines that are unpaid, child custody, and other issues. Some may also have faced civil commitment for mental illness. The risk of rearrest and re-incarceration after release from carceral facilities is high for people with such CODs.[115] In a study of 2,520 male juveniles confined on delinquency charges, adverse childhood experiences varied across race, ethnicity, and offending,[116] and backgrounds of trauma are replete among the justice-involved populations. The pathway from arrest to court to incarceration is complex, and efforts to divert individuals from the justice system are underway throughout the United States. These issues drive key policies across the country, but the data has still shown so many challenges that need to be addressed. In one study examining reentry of individuals with CODs being released from jails in rural areas, those who had more jail bookings and did not receive continuity of care had the highest recidivism.[117] People with CODs often face a number of challenges while in carceral settings, with one Canadian study documenting higher rates of transfer to segregation status within the institution and institutional charges (similar to charges of rule infractions) when people had both a substance use disorder and a mental illness.[118]

At the stage of arrest, the issues of negative outcomes for individuals with mental illness are getting increased attention. The Department of Justice has identified several areas of police misconduct based on violations of the Americans with Disabilities Act and race-related discrimination in several jurisdictions.[119] Studies continue to find that in police encounters, persons with serious mental illness, especially Black persons, are more likely to experience police use of force, injury, and even fatal shootings.[120,121] Separate from injury, arrest itself is more common for people with mental illness. In a large study of over 8,000 people released from a county jail, about 60% were rearrested within four years, yet among them, people with substance use disorders and severe mental illness had higher rearrest rates than those with serious mental illness alone or with no diagnosis.[122] Interestingly, drug-related arrests were not fully explanatory of the findings, pointing to the need for person-centered, individually tailored plans to address psychiatric and criminogenic issues.

At the criminal-legal interface, there are other facets of services that can point to potential areas for exploration and program development. For example, a lack of health insurance continues to be an issue, especially among individuals who are criminal involved with CODs, though data shows Medicaid expansion has increased access to Medicaid coverage and treatment for drug use and depression.[123] Another study of 8,763 males admitted to long-term juvenile justice residential placements showed higher diagnoses of conduct disorder among Black males and females, even after considering trauma and behavioral health factors,[124] pointing to the need to continue to understand the intersections of race and ethnicity on diagnostic bias and criminal

involvement. To that end, another concerning finding from that same study was that Black males were 32% less likely to receive psychiatric treatment than White males.[125]

Crisis services clearly present one opportunity, at Intercept 0 in the Sequential Intercept Model, to divert people into treatment and away from criminal involvement.[126] In *Lending Hands: Improving Partnerships and Coordinated Practices Between Behavioral Health, Police, and Other First Responders,* NASMHPD highlighted the ways in which these types of partnerships can help improve encounters that involve various first responders, which could ideally help redirect pathways of persons out of criminal processes, as envisioned by the Sequential Intercept Model.[127] Other avenues that have the potential to turn the tide to decrease the prevalence of people with mental illness and substance use disorders and youth with serious emotional disorders in criminal and legal systems are embedded in the Biden Unity Agenda and SAMHSA's 2023–2026 Strategic Plan priorities, including preventing substance use and overdose (another major concern for people leaving corrections); enhancing access to suicide prevention and mental health services; promoting resilience and emotional health for children, youth, and families; integrating behavioral and physical health care; and strengthening the behavioral health workforce.[128]

Social Determinants of Health and Social Systems

Services that address behavioral health needs in siloes, without considering the context of the individual, will be less than optimally effective. Mental and physical wellness are impacted by the environment and social context, and mental and physical states in turn impact our environment, those around us, and our ability to contribute to society. Particularly, unmet social and environmental needs, such as houselessness, unemployment, and lack of social and financial support, can be both contributors to mental illness and results of untreated mental illness. Neglecting to address these social determinants of health (see **Figure 8**) is a significant missed opportunity to prevent costly behavioral health crises. Biopsychosocial approaches, and coordination across service sectors, are critical.

Figure 8: Social Determinants of Health

Social Determinants of Health are the social and environmental factors that affect health status. These can include (among others):

- Economic Stability
- Education Access and Quality
- Health Care Access and Quality
- Neighborhood and Built Environment
- Social and Community Context

The relationship between houselessness, financial hardship, and mental illness is bidirectional and compounding. In a 2022 study, 16% of American adults said that they or a family member had experienced houselessness due to mental health problems.[129] Among Americans who said that their family had faced a mental health crisis, 22% said it had a major impact on their family's

finances.[130] Individuals with mental disorders are at a higher risk of houselessness, and a high proportion of individuals experiencing houselessness are also living with mental illness.[131] The relationship between youth mental illness and houselessness is of particular concern. In 2021, the Youth Risk Behavior Survey found students who are unstably housed were more likely to engage in substance use, suicidal ideation, and suicide attempts compared to their peers who have stable housing.[132] Supportive housing should be prioritized as a comprehensive strategy to address individuals' behavioral health concerns, and preventing houselessness as a whole will have a protective effect on the mental health of the population.

In the United States, health is strongly associated with employment, as most individuals have access to health insurance and health services through their employers.[133] It is well known that unemployment has a negative effect on mental health and that serious mental illness increases the likelihood of unemployment. Full-time employment is negatively associated with depression and distress, and it is suggested that full-time employees have greater access to resources and are less likely to participate in avoidant coping strategies, like turning to substance use.[134] Encouraging employment via models such as Individual Placement and Support can thereby improve existing mental health concerns, and preventing high rates of unemployment will have a protective effect on the mental health of the general population.

While promoting meaningful employment can benefit the behavioral health of America's adult population, fostering positive school climates and school-based services can do the same for children. Data suggests that teachers and school-based mental health professionals are working hard to provide mental health support for youth but are significantly under-resourced. According to data from the 2021–2022 school year, an impressive 96% of public schools reported offering at least one type of mental health service to their students.[135] Among the most frequently provided services were individual-based interventions such as one-on-one counseling or therapy, case management or coordinating mental health services, and referrals for care outside of the school.[136] Since the onset of the COVID-19 pandemic, many schools have prioritized professional development for staff, aiming to improve their ability to identify and address growing mental health concerns among students. However, only one-third of schools currently provide outreach services, including universal behavioral health screenings for all students—a key best practice.[137] A significant lack of resources (both financial and with respect to the teaching and school personnel workforce), a lack of mental health providers, and a lack of buy-in from school administrators often hinder the implementation of screenings and service provision.[138] Enhancing school-based mental health services, including increasing the availability of outreach services and universal screenings as well as ensuring comprehensive training for school staff, is crucial in effectively meeting the mental health needs of children and youth in educational settings.

Along with the various social determinants of health, the social science community has long recognized the crucial role of isolation and loneliness as threats to mental well-being. In his *Advisory on the Healing Effects of Social Connection and Community,* US Surgeon General Dr.

Vivek Murthy emphasized that "social connection is a fundamental human need, as essential as food, water, and shelter. Throughout history, our survival has depended on our ability to rely on one another, and even in modern times, humans are biologically wired for social connection."[139] Recent surveys have revealed that approximately half of US adults report experiencing loneliness.[140] Poor social connection is associated with an increased risk of anxiety and depression, and social isolation is one of the strongest and most reliable predictors of suicidal ideation, suicide attempts, and lethal suicidal behavior across various demographics.[141,142] The COVID-19 pandemic and the subsequent measures of social isolation underscored the need for connectedness for the general public.[143] This need for connection remains a challenge as the impacts of the PHE unfold, and a sense of fractured connections remains a significant concern.

The Youth Mental Health Crisis

The current youth mental health crisis warrants its own, separate discussion. Much data has documented the youth mental health crisis in the wake of the COVID-19 pandemic.[144] Poor social connection and social media use are hypothesized to have had a negative effect on youth mental health, with the result being alarming rates of youth presenting in EDs in mental health crises. While the Centers for Disease Control and Prevention documented an overall decrease in ED mental health visits during the COVID-19 pandemic, due to general avoidance of health care and social settings, the proportion of mental health–related visits of overall ED visits increased by 25%.[145] This indicates that "children's mental health warranted sufficient concern to visit EDs during a time when nonemergent ED visits were discouraged."[146]

As previously mentioned, suicidal behavior and ideation among youth are reaching a fever pitch in the United States, with specific groups of youth being at particularly high risk. From 2019 to 2021, female students had an increased prevalence of seriously considering attempting suicide (from 24.1% to 30.0%), an increase in making a suicide plan (from 19.9% to 23.6%), and an increase in suicide attempts (from 11.0% to 13.3%).[147] In addition, from 2019 to 2021, Black or African American, Hispanic or Latino, and White female students had an increased prevalence of seriously considering attempting suicide.[148] In 2021, Black female students had an increased prevalence of suicide attempts and Hispanic female students had an increased prevalence of suicide attempts that required medical treatment compared with White female students.[149]

Sexual and gender minority youth are also particularly in need of support. One study found 54% of sexual and gender minority youth want mental health care but are unable to access it due to a lack of specialized understanding and focused care from providers, pointing to a need for workforce development in this area.[150] Limited rights and protections, along with interpersonal rejection, harassment, and internalized stigma, contribute to the stressors that negatively impact the health of LGBTQI+ youth.[151] For instance, studies have shown that school climate significantly influences the relationship between LGBTQI+ youth and suicidality and that higher levels of family acceptance are associated with increased self-esteem, social support, and overall health among LGBTQI+ youth.[152,153] Programs to foster accepting and affirming school,

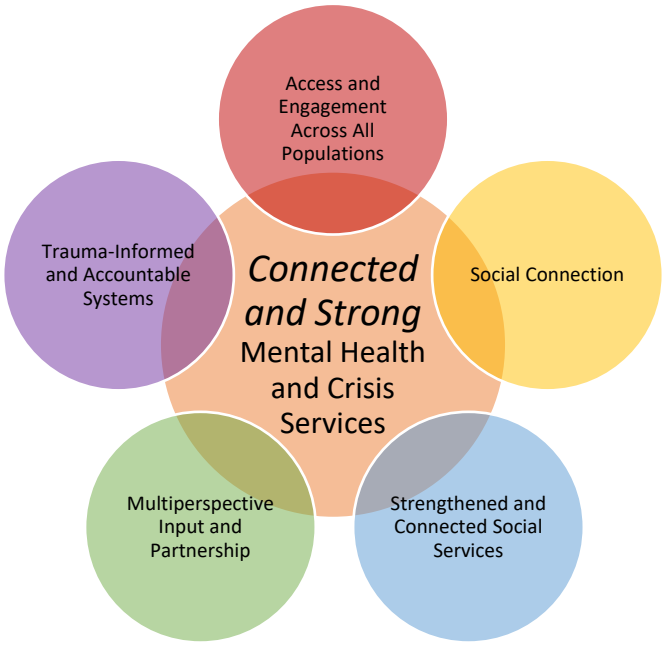
community, and family climates as well as connecting LGBTQI+ youth with social support are key strategies. To that end, the behavioral health field has mobilized to provide specialized services. For example, the 988 Suicide & Crisis Lifeline now offers specialized LGBTQI+-affirming counseling for youth via call, text, and chat to support youth without judgment.[154] SAMHSA has also launched an initiative to facilitate family counseling and support for LGBTQI+ youth and their families.[155]

President Biden's Unity agenda recognizes the critical need to address youth well-being and also focuses on social media's role in contributing to poor youth mental health. This was further emphasized by the US Surgeon General's recent advisory, *Social Media and Youth Mental Health.*[156] Up to 95% of adolescents between the ages of 13 and 17 are currently using social media platforms, and 40% of children between the ages of 8 and 12 are engaging with social media, despite the recommended minimum age's being 13.[157] Studies have shown a troubling association between the time spent on social media and deteriorating mental health among young people, with middle and high school students spending an average of 3.5 hours per day on these platforms.[158] Although social media has the potential to foster social connectedness and encourage help-seeking behaviors among youth, it is also significantly linked to poor mental health outcomes.[159] Disturbingly, one-third of adolescent girls report being "addicted" to social media.[160] These statistics highlight the alarming dangers posed by social media to the mental well-being of our youth, necessitating urgent action and support from policymakers and society as a whole.[161] The Biden Administration has funded the American Academy of Pediatrics to establish the Center of Excellence on Social Media and Youth Mental Health, which can serve as a resource for technical assistance in this area.[162]

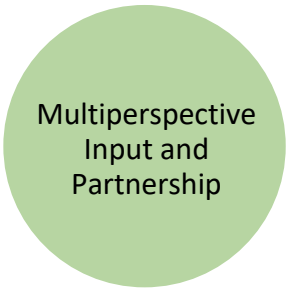
Unifying Principles to Achieve Accessible and Effective Crisis and Mental Health Services

The challenges outlined above point to the importance of the moment to consider the urgent priority of improving mental health services. The establishment of 988 has catalyzed focused efforts on crisis services. Yet an infrastructure for a complete continuum is needed if crisis services are going to succeed. This infrastructure should be designed to address the unique needs of people across the age span, from youth to older adults, and across diverse populations. Every item embedded in the Unity Agenda will require concretizing initiatives and taking ideas into action. For leaders, the tasks to achieve better mental health outcomes can be overwhelming. Taking steps forward, however, can benefit from intentional focus on overarching principles to guide the work (see **Figure 9**). Below are five principles, gleaned from the above review of the current challenges and opportunities across the United States. They are meant to serve as guideposts for behavioral health system leaders, along with other policymakers, legislators, court officials, peers, faith-based leaders, and other contributing communities to help steer them toward a path where better mental health outcomes can be realized.

Figure 9: Unifying Principles to Achieve Accessible and Effective Crisis and Mental Health Services



Principle 1: Multiperspective input and partnership are critical to a united crisis services strategy.



The idea of seeking partners outside of the behavioral health system was highlighted in the *Beyond Beds* key recommendations, and today that effort to reach out to new partners is as critical as ever.[163] Since not all the partners represent behavioral health disciplines, it is important to reference this work as prioritizing *multiperspective* input, rather than only *multidisciplinary* input. Specifically, behavioral health leaders must coordinate with public safety answering points and work with Computer Assisted Dispatch systems. Conversations with emergency medical

services and law enforcement are shifting as new models for mobile response are being developed. Faith-based leaders' playing a key role at several intercepts along the crisis continuum, tribal-state partnerships' working with pediatricians and other medical professionals with integrated care models, and school-based care are all examples of efforts that involve an array of partners. Peer involvement in crisis services and reentry from corrections is increasingly expected. Developmental disability services leaders are working more with behavioral health leaders and vice versa. Information technology personnel are helping behavioral health services navigate big data systems, information sharing, and local call routing. The list goes on and on. In this way, fostering dialogue that includes multiple perspectives is a key principle that can help build a better service system.

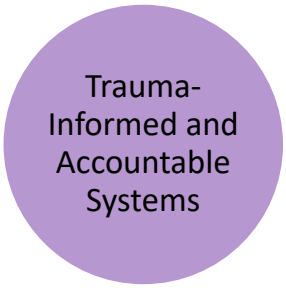
Principle 2: Leaders must strengthen and connect social services for crisis prevention and postvention.

Although the implementation of 988 has been a momentous step forward, the subsequent surge in demand, coupled with the planning efforts by states and localities to meet the needs of those who access care via the 988 Lifeline network, have laid bare the areas in which behavioral health systems are often lacking—namely, upstream crisis prevention, universal mental wellness promotion, and ongoing postcrisis care. Population mental health strategies to address the social determinants of health of American communities will be key to preventing behavioral health crises as 988 implementation rolls forward. Maslow's hierarchy of needs posits that a chronic lack of fulfillment of basic needs, such as physiological and safety needs, inhibits the ability to address social and emotional needs. Stated plainly, in the context of behavioral health, attempts to treat mental illness and substance use disorders without also attending to social, environmental, and financial needs will be less than optimally effective, and possibly futile. Strengthening social services and awareness of how this can be operationalized is thereby a critical strategy for behavioral health leaders implementing crisis systems. Moreover, facilitating *connection* between these service systems is crucial to avoid allowing individuals to fall through the cracks and into our default safety net settings: incarceration, institutionalization, or the streets.

Principle 3: Facilitating social connection is crucial to prevent mental illness and promote well-being.

Social connection can act as a powerful protective factor for self-harm, suicide, and depression, benefiting both individuals with serious underlying mental health challenges and those without.[164] State and federal behavioral health leaders should facilitate screening for loneliness and intervene to foster social connection, create policies that promote community engagement and connection, and cultivate cultures that promote connection in service settings and workplaces. Some considerations addressed in the *Connected and Strong* series[165] regarding building back the social fabric of our communities are the role of faith-based communities, which can play a significant role in promoting positive connections among their members; improved access to peer support to combat feelings of isolation by providing a source of shared experience; the double-edged sword of technology, to be harnessed as a source of connection for isolated individuals while it contributes significantly to feelings of loneliness for others; and promotion of social connection among the behavioral health workforce itself to promote retention and well-being. By prioritizing social connection and implementing these strategies, we can enhance mental wellness, prevent behavioral health crises, and create a more connected and resilient society.

Principle 4. Systems must be trauma-informed and accountable to all people served and the workforce members who serve them.



Trauma exposure, especially in developmental years, has long been recognized as a major contributing variable to negative social, health, and mental health outcomes. When crisis and other mental health service systems adopt an approach that recognizes the vulnerabilities of persons served related to their past traumas and establish environments—both in physical surroundings and in welcoming places and person-centered care plans—individuals with trauma histories may be more likely to feel safe, nurtured, and in the driver's seat of their own care. There is evidence that for youth, positive childhood experiences can offset the negative impacts of adverse childhood experiences,[166] and as such, environments and mobile responders and others who provide behavioral health support for youth should be cognizant of this literature and foster expanded positive youth supports. Minoritized populations face additional barriers to care, unhealthy environments, and the stress and other impacts of discrimination inside and outside of the health care system every day. They require increased access to culturally competent providers and crisis responders. Moreover, these providers must recognize the high prevalence of trauma and its presentations to help individuals cope and also support other systems (faith, child welfare,

schools, etc.) to prevent and mitigate the aftermath of trauma. Without continuing to drive behavioral health services and supports to become trauma informed, the risk of perpetuating the overwhelming harms and costs that can come from the unfortunate alternative of further traumatization remains too high.

Principle 5. Access and engagement across all populations should go together, and they require more intention and research to improve outcomes.

Treatment access is one of the driving goals of many programs. Too many people with serious emotional disturbances or mental illness are waiting for services, and the time to have access to care is when the care is needed. Yet even in programs where access is made a reality, if individuals do not stay in care, then the access efforts will have been for naught. This is one of the reasons coordinated specialty care for first-episode psychosis, critical time intervention, assertive community treatment, and high-fidelity wraparound supports for youth, to name a few, are such exciting models as they aim to help people receive supports and have meaningful connections to care. Yet there is more research needed to understand barriers to treatment retention and opportunities to overcome them. In the world of traditional therapy, a therapeutic alliance is a necessary component to building a relationship that can help individuals engage with their conditions and shift toward recovery. Too many people are disconnected from ongoing care at times of transition: when leaving an inpatient setting, when leaving a carceral setting, when transitioning from houselessness to shelter, and even when making a geographic personal move across county lines. And too many people discontinue care because the care delivery system is too complex to navigate, or because the services are not person centered to meet individual needs, or because it is just a hard road to find recovery in one's personal journey. For these reasons and more, access and engagement translated into treatment retention should be a united driving principle to achieve better mental illness and substance use disorder outcomes for all.

Conclusion

There is a sea change occurring with the unparalleled momentum of a shared agenda to build a more complete, accessible, and effective psychiatric continuum of care. With 988 now operational, and the overwhelming need for mental health and substance use services in the aftermath of the COVID-19 pandemic, there is tremendous energy and enthusiasm for building better crisis response and mental health services across a continuum of psychiatric care. Behavioral health leaders across local, county, state, and federal entities are working to meet the needs of individuals of all backgrounds who live in all types of communities, ranging from the most remote and rural to the most densely populated urban areas. The task of strengthening the

mental health services infrastructure in the midst of a workforce crisis and after a global pandemic can be daunting. And the policies, regulations, and funding needed to facilitate an interconnected and interoperable system across all levels of care and between various systems will take ongoing and sustained effort. This vision is achievable with the collaboration of many multisector partners and with the input of peers and individuals with lived experience who are daily facing their own mental health and substance use challenges, along with the voices of their families and the backing of an entire community and country that is connected and strong. Working in lockstep to uphold the principles outlined herein can serve as an important strategy to help realize the promise of accessible and effective crisis and mental health services.

Authors:

Debra A. Pinals, MD
Senior Medical and Forensic Advisor and Editor-in-Chief, and Chair, Medical Directors Division, National Association of State Mental Health Program Directors
Adjunct Clinical Professor of Psychiatry, Director, Program in Psychiatry, Law and Ethics, University of Michigan
Medical Director, Behavioral Health and Forensic Programs, Michigan Department of Health and Human Services

Genna Schofield, MPH
Senior Technical Assistance and Communications Specialist, National Association of State Mental Health Program Directors

---

References

[1]Jones EAK, Mitra AK, Bhuiyan AR: Impact of COVID-19 on mental health in adolescents: A systematic review. Int J Environ Res Public Health 2021; 18:2470

[2]Fact Sheet: President Biden to Announce Strategy to Address Our National Mental Health Crisis, as Part of Unity Agenda in His First State of the Union. Washington, DC, The White House, 2022. https://www.whitehouse.gov/briefing-room/statements-releases/2022/03/01/fact-sheet-president-biden-to-announce-strategy-to-address-our-national-mental-health-crisis-as-part-of-unity-agenda-in-his-first-state-of-the-union/

[3]The Implications of COVID-19 for Mental Health and Substance Use. San Francisco, CA, Kaiser Family Foundation, 2023. https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

[4]National Guidelines for Behavioral Health Crisis Care—A Best Practice Toolkit. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2020

[5]National Guidelines for Child and Youth Behavioral Health Crisis Care. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2022

[6]Schober M, Harburger DS, Sulzbach D, et al: A Safe Place to Be: Crisis Stabilization Services and Other Supports for Children and Youth. Technical Assistance Collaborative Paper No. 4. Alexandria, VA, National Association of State Mental Health Program Directors, 2022

[7]Fact Sheet: President Biden to Announce Strategy to Address Our National Mental Health Crisis, as Part of Unity Agenda in His First State of the Union. Washington, DC, The White House, 2022. https://www.whitehouse.gov/briefing-room/statements-releases/2022/03/01/fact-sheet-president-biden-to-announce-strategy-to-address-our-national-mental-health-crisis-as-part-of-unity-agenda-in-his-first-state-of-the-union/

[8]Statement by President Joe Biden on New Mental Health Funding. Washington, DC, The White House, 2022. https://www.whitehouse.gov/briefing-room/statements-releases/2022/10/18/statement-by-president-joe-biden-on-new-mental-health-funding/

[9]White House Report on Mental Health Research Priorities. Washington, DC, The White House, 2023

[10]Protecting Youth Mental Health. Washington, DC, Office of the Surgeon General, 2021

[11]Pinals DA, Fuller DA: Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care. Alexandria, VA, National Association of State Mental Health Program Directors, 2017

[12]National Guidelines for Behavioral Health Crisis Care—A Best Practice Toolkit. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2020

[13]LA County Declares State of Emergency on Homelessness. Los Angeles, CA, County of Los Angeles Homeless Initiative, 2023. https://homeless.lacounty.gov/news/la-county-declares-state-of-emergency-on-homelessness/

[14]Shumway J: Oregon Gov. Kotek declares homelessness state of emergency, signs housing executive orders: the governor will also ask for $130 million early for homelessness early in the legislative session. Oregon Capital Chronicle, 2023

[15]Carson EA: Mortality in Local Jails, 2000–2018—Statistical Tables. Bureau of Justice Statistics 2023; 1–43.

[16]Justice Department Finds Civil Rights Violations by the Minneapolis Police Department and the City of Minneapolis. Washington, DC, Office of Public Affairs 2023. https://www.justice.gov/opa/pr/justice-department-finds-civil-rights-violations-minneapolis-police-department-and-city

[17]Whitehead S: High-Needs Foster Kids Sometimes Have to Sleep in Hotels or Offices. The Pandemic Made the Problem Worse. Public Broadcasting Service, 2023. https://www.pbs.org/newshour/nation/high-needs-foster-kids-sometimes-have-to-sleep-in-hotels-or-offices-the-pandemic-made-the-problem-worse

[18]Pinals DA, Edwards ML: Crisis Services: Addressing Unique Needs of Diverse Populations. Alexandria, VA, National Association of State Mental Health Program Directors, 2020

[19]Pinals DA, Hovermale L, Mauch D, et al: The Vital Role of Specialized Approaches: Persons With Intellectual and Developmental Disabilities in the Mental Health System. Alexandria, VA, National Association of State Mental Health Program Directors, 2017.

[20]Pinals DA: Crisis Services: Meeting Needs, Saving Lives. Alexandria, VA, National Association of State Mental Health Program Directors, 2020

[21]National Alliance on Mental Illness. (2024). Poll of Public Perceptions on 988 & Crisis Response. https://www.nami.org/support-education/publications-reports/survey-reports/poll-of-public-perspectives-on-988-crisis-response-2024/

[22]Report to Congress on Medicaid and CHIP. Washington, DC, Medicaid and CHIP Payment and Access Commission, 2021

[23]Justice Department Finds Civil Rights Violations by the Louisville Metro Police Department and Louisville/Jefferson County Metro Government. Washington, DC, Office of Public Affairs, 2023

[24]Kesic D, Thomas SD, Ogloff JR: Estimated rates of mental disorders in, and situational characteristics of, incidents of nonfatal use of force by police. Soc Psychiatry Psychiatr Epidemiol 2013; 48:225–232.

[25]Readout of Office of Justice Programs Meeting With Criminal Justice and Behavioral Health Leaders to Promote the 988 Suicide & Crisis Lifeline. Washington, DC, Office of Public Affairs, 2023

[26]How to Use 988 to Respond to Behavioral Health Crisis Calls. Washington, DC, Bureau of Justice Assistance, National Alliance on Mental Illness, Council of State Governments, 2021

[27]ACL Selects NASDDDS & Partners for DD TA Center. Alexandria, VA, National Association of State Directors of Developmental Disabilities Services, n.d.

[28]National Guidelines for Behavioral Health Crisis Care—A Best Practice Toolkit. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2020

[29]National Guidelines for Child and Youth Behavioral Health Crisis Care. Pub ID PEP22-01-02-001. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2022

[30]Schober MA, Harburger DS, Sulzbach D, et al: A Safe Place to Be: Crisis Stabilization Services and Other Supports for Children and Youth. Alexandria, VA, National Association of State Mental Health Program Directors, 2022

[31]Model Bill for Core State Behavioral Health Crisis Services Systems. Alexandria, VA, National Association of State Mental Health Program Directors, 2021

[32]Stephenson AH: States' Experiences in Legislating 988 and Crisis Services Systems. Alexandria, VA, National Association of State Mental Health Program Directors, 2022. https://www.nasmhpd.org/sites/default/files/2022_nasmhpd_StatesLegislating988_022922_1753.pdf

[33]Stephenson AH, Naturale A, Miller A, et al: Crisis System Coordination and Collaboration: Leveraging Strengths and Opportunities of 988 and 911. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2024

[34]Disaster Behavioral Health. Washington, DC, Administration for Strategic Preparedness & Response. https://aspr.hhs.gov/behavioral-health/Pages/default.aspx. Accessed Sept 12, 2023

[35]Disaster Technical Assistance Center (DTAC). Rockville, MD, Substance Abuse and Mental Health Services Administration, 2023. https://www.samhsa.gov/dtac

[36]Jackson A: A crisis mental-health hotline has seen an 891% spike in calls. Cable News Network, 2020. https://www.cnn.com/2020/04/10/us/disaster-hotline-call-increase-wellness-trnd/

[37]Pinals DA, Hepburn B, Parks J, et al: The behavioral health system and its response to COVID-19: a snapshot perspective. Psychiatr Serv 2020; 71:1070–1074

[38]Pinals DA, Stephenson AH: Disaster Behavioral Health Through the Lens of COVID-19. Alexandria, VA, National Association of State Mental Health Program Directors, 2021

[39]Lindert J, Jakubauskiene M, Bilsen J: The COVID-19 disaster and mental health-assessing, responding and recovering. Eur J Public Health 2021; 31:iv31–iv35

[40]Ibid.

[41]Talevi D, Socci V, Carai M, et al: Mental health outcomes of the COVID-19 pandemic. Riv Psichiatr 2020; 55:137–144

[42]Magesh S, John D, Li WT, et al: Disparities in COVID-19 outcomes by race, ethnicity, and socioeconomic status: a systematic review and meta-analysis. JAMA Netw Open 2021; 4:e2134147–e2134147

[43]Johnston KJ, Pollack HA: COVID-19 reveals longstanding health inequities and discrimination against Americans with disabilities. Medical Care 2023; 61:55–57. https://doi.org/10.1097/MLR.0000000000001810

[44]Ogbu-Nwobodo L, Hwong A, Murphy K, et al: Long COVID and High-risk Populations. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2024

[45]Mental Health Care Health Professional Shortage Areas (HPSAs). San Francisco, CA, Kaiser Family Foundation, 2022. https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/

[46]Ibid.

[47]Hoffmann JA, Attridge MM, Carroll MS, et al: Association of youth suicides and county-level mental health professional shortage areas in the US. JAMA Pediatr 2023; 177:71–80

[48]New Study: Behavioral Health Workforce Shortage Will Negatively Impact Society. Washington, DC, National Council for Mental Well-Being, 2023. https://www.thenationalcouncil.org/news/help-wanted/

[49]Ibid.

[50]Behavioral Health Workforce Is a National Crisis: Immediate Policy Actions for States. Washington, DC, Health Management Association, National Council for Mental Well-Being, 2022

[51]Santiago CD, Miranda J: Progress in improving mental health services for racial-ethnic minority groups: a ten-year perspective. Psychiatric Services 2014; 65:180–185

[52]Satcher D: Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General. Washington, DC, US Department of Health and Human Services, 2001

[53]Takeshita J, Wang S, Loren AW, et al: Association of racial/ethnic and gender concordance between patients and physicians with patient experience ratings. JAMA Netw Open 2020; 3: e2024583

[54]Santiago CD, Miranda J: Progress in improving mental health services for racial-ethnic minority groups: a ten-year perspective. Psychiatric Services 2014: 65:180–185

[55]Gabbidon J, Farrelly S, Hatch SL, et al: Discrimination attributed to mental illness or race-ethnicity by users of community psychiatric services. Psychiatric Services 2014; 65:1360–1366

[56]The ASPIRE Initiative. Washington, DC, Advancing State Policy Integration for Recovery and Employment. https://www.stateaspire.org/

[57]What Is a Recovery-Ready Workplace? Washington, DC, US Department of Labor, n.d. https://www.dol.gov/agencies/eta/RRW-hub/Recovery-ready-workplace

[58]Workplace Well-Being. Washington, DC, Office of the Surgeon General, 2022. https://www.hhs.gov/surgeongeneral/priorities/workplace-well-being/index.html

[59]Fact Sheet: President Biden to Announce Strategy to Address Our National Mental Health Crisis, as Part of Unity Agenda in His First State of the Union. Washington, DC, The White House, 2022. https://www.whitehouse.gov/briefing-room/statements-releases/2022/03/01/fact-sheet-president-biden-to-announce-strategy-to-address-our-national-mental-health-crisis-as-part-of-unity-agenda-in-his-first-state-of-the-union/

[60]Addressing Health Worker Burnout: The US Surgeon General's Advisory on Building a Thriving Health Workforce. Washington, DC, Office of the Surgeon General, U.S. Department of Health & Human Services, 2022. https://www.hhs.gov/surgeongeneral/priorities/health-worker-burnout/index.html

[61]Addressing Burnout in the Behavioral Health Workforce Through Organizational Strategies. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2022. https://www.samhsa.gov/resource/ebp/addressing-burnout-behavioral-health-workforce-organizational-strategies

[62]Schuffman D, Parks J, Rose S, et al: Responding to and Preventing Crisis CCBHCs, Urgent Care and an Example of One Health System in Maryland and Its Approach to Crisis Services Within an Accessible Psychiatric Care Continuum. Alexandria, VA, National Association of State Mental Health Program Directors, 2022

[63]HHS Announces Over $120 Million In Funding Opportunity for Certified Community Behavioral Health Clinics Providing Mental Health and Substance Use Disorder Care Across the Country. Washington, DC, US Department of Health and Human Services, 2023. https://www.hhs.gov/about/news/2023/03/24/hhs-announces-over-120-million-funding-opportunity-certified-community-behavioral-health-clinics-providing-mental-health-substance-use-disorder-care-across-country.html#:~:text=The%20U.S.%20Department%20of%20Health%20and%20Human%20Services%20(HHS)%2C

[64]Stephenson AH, Naturale A, Miller A, et al: Crisis System Coordination and Collaboration: Leveraging Strengths and Opportunities of 988 and 911. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2024

[65]Browning C, Cotes R, St. George L, Riddle M, Pinals DA: Crisis Services: General Medical and Psychiatric Approaches to Care Delivery. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2024

[66]About the ASAM Criteria. Rockville, MD, American Society of Addiction Medicine. https://www.asam.org/asam-criteria/about-the-asam-criteria

[67]Sowers W, Pumariega A, Huffine C, et al: Best practices: level-of-care decision making in behavioral health services: the LOCUS and the CALOCUS. Psychiatric Services 2003; 54:1461–1463

[68]A Compelling Argument for Facilitating the Equitable Use of Generally Accepted Standards of Care: Strategies for Mental Health and Substance Use Disorders Providers. Washington, DC, National Council for Mental Well-Being, 2020

[69]HHS Secretary Xavier Becerra Statement on End of the COVID-19 Public Health Emergency. Washington, DC, US Department of Health and Human Services, 2023. https://www.hhs.gov/about/news/2023/05/11/hhs-secretary-xavier-becerra-statement-on-end-of-the-covid-19-public-health-emergency.html

[70]Fact Sheet: President Biden to Announce Strategy to Address Our National Mental Health Crisis, as Part of Unity Agenda in His First State of the Union. Washington, DC, The White House, 2022. https://www.whitehouse.gov/briefing-room/statements-releases/2022/03/01/fact-sheet-president-biden-to-announce-strategy-to-address-our-national-mental-health-crisis-as-part-of-unity-agenda-in-his-first-state-of-the-union/

[71]Pinals DA, Hepburn B, Parks J, et al: The behavioral health system and its response to COVID-19: a snapshot perspective. Psychiatric Services 2020; 71:1070–1074

[72]DEA, SAMHSA Extend COVID-19 Telemedicine Flexibilities for Prescribing Controlled Medications for Six Months While Considering Comments From the Public. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2023. https://www.samhsa.gov/newsroom/press-announcements/20230509/dea-extend-covid19-telemedicine-flexibilities-prescribing-controlled-medications

[73]Waiver Elimination (MAT Act). Rockville, MD, Substance Abuse and Mental Health Services Administration, 2023. https://www.samhsa.gov/medications-substance-use-disorders/waiver-elimination-mat-act

[74]Substance Use Disorders and Addiction Education to Meet New DEA Requirements. Chicago, American Medical Association. https://edhub.ama-assn.org/course/302

[75]LaRosa J: Avoiding the Cliff: Medicare Coverage of Telemental Health and the End of the PHE. New York, Commonwealth Fund, 2022

[76]Hospital Outpatient Physician "Supervision": CMS's Latest Rule Offers Greater Operational Flexibility but Still Exemplifies the Issue's Complexity. Katten, 2019. https://katten.com/hospital-outpatient-physician-supervision-cmss-latest-rule-offers-greater-operational-flexibility-but-still-exemplifies-the-issues-complexity

[77]Teaching Hospitals, Teaching Physicians and Medical Residents: CMS Flexibilities to Fight COVID-19. Baltimore, Centers for Medicare and Medicaid, 2023

[78]Calendar Year (CY) 2024 Medicare Physician Fee Schedule Final Rule. Baltimore, MD, Centers for Medicare and Medicaid Services, 2023. https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule

[79]Mahomed F: Addressing the Problem of Severe Underinvestment in Mental Health and Well-Being From a Human Rights Perspective. Health and Human Rights 2020; 22:35–49

[80]Cohen J: Mental Health Awareness Isn't Enough: More Funding Is Needed. Forbes, 2023. https://www.forbes.com/sites/joshuacohen/2022/10/15/mental-health-awareness-isnt-enough-more-funding-is-needed/?sh=41e701a226a1

[81]HHS Awards Funding to Build Out the Biden-Harris Administration's Crisis Care 988 Lifeline. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2023. https://www.samhsa.gov/newsroom/press-announcements/20230525/hhs-awards-funding-build-out-biden-harris-crisis-care-988-lifeline

[82]U.S. Department of Education Announces More Than $188 Million From the Bipartisan Safer Communities Act to Support Mental Health and Student Wellness. Washington, DC, US Department of Education, 2023. https://www.ed.gov/news/press-releases/us-department-education-announces-more-188-million-bipartisan-safer-communities-act-support-mental-health-and-student-wellness

[83]Denean A: Pandemic Exacerbates Lack of Mental Health Resources in US. New York, National Broadcasting Company, 2022. https://news3lv.com/amp/news/nation-world/pandemic-exacerbates-lack-of-mental-health-resources-in-us-childrens-mental-health-crisis-depression-anxiety-psychiatrist-psychologist-covid19

[84]LaRosa J: Avoiding the Cliff: Medicare Coverage of Telemental Health and the End of the PHE. New York, Commonwealth Fund, 2022

[85]Stephensen SA, Hudock WJ: A Behavioral Health Parity Playbook: Strengthening State Laws and Partnerships. Alexandria, VA, National Association of State Mental Health Program Directors, 2023.

[86]Saunders H, Guth M, Panchal N: Behavioral Health Crisis Response: Findings From a Survey of State Medicaid Programs. San Francisco, CA Kaiser Family Foundation, 2023. https://www.kff.org/medicaid/issue-brief/behavioral-health-crisis-response-findings-from-a-survey-of-state-medicaid-programs/

[87]Stephenson AH, Naturale A, Miller A, et al: Crisis System Coordination and Collaboration: Leveraging Strengths and Opportunities of 988 and 911. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2024

[88] Spencer, M, Garnett, MF, Minino, AM: Drug Overdose Deaths in the United States, 2002-2022. NCHS Data Briefs, 2023. https://stacks.cdc.gov/view/cdc/135849

[89]Panchal N, Garfield R, Cox C, et al: Substance Use Issues Are Worsening Alongside Access to Care. San Francisco, CA, Kaiser Family Foundation, 2021. https://www.kff.org/policy-watch/substance-use-issues-are-worsening-alongside-access-to-care/

[90]Spencer MR, Warner M, Cisewski JA, et al: Estimates of Drug Overdose Deaths Involving Fentanyl, Methamphetamine, Cocaine, Heroin, and Oxycodone: United States, 2021. Report No. 27. Atlanta, GA, Centers for Disease Control and Prevention, 2023

[91]Ibid.

[92]Grossman ER, Benjamin-Neelon SE, Sonnenschein S: Alcohol Consumption During the COVID-19 Pandemic: A Cross-Sectional Survey of US Adults. Int J Environ Res Public Health 2020; 17:9189.

[93]Alcohol-Induced Death Rates in the United States, 2019–2020. Atlanta, GA, Centers for Disease Control and Prevention, 2022. https://www.cdc.gov/nchs/products/databriefs/db448.htm

[94]Hoots BE, Li J, Hertz MF, et al: Alcohol and Other Substance Use Before and During the COVID-19 Pandemic Among High School Students—Youth Risk Behavior Survey, United States, 2021. MMWR Suppl 2023; 72:84–92

[95]DEA's Commitment to Expanding Access to Medication-Assisted Treatment. Springfield, VA, US Drug Enforcement Administration, 2022. https://www.dea.gov/press-releases/2022/03/23/deas-commitment-expanding-access-medication-assisted-treatment

[96]Fact Sheet: President Biden to Announce Strategy to Address Our National Mental Health Crisis, as Part of Unity Agenda in His First State of the Union. Washington, DC, The White House, 2022. https://www.whitehouse.gov/briefing-room/statements-releases/2022/03/01/fact-sheet-president-biden-to-announce-strategy-to-address-our-national-mental-health-crisis-as-part-of-unity-agenda-in-his-first-state-of-the-union/

[97]McClellan C, Lambdin BH, Ali MM, et al: Opioid-overdose laws association with opioid use and overdose mortality. Addictive Behaviors 2018; 86:90–95

[98]FDA Approves First Over-the-Counter Naloxone Nasal Spray. Silver Spring, MD, US Food and Drug Administration, 2023. https://www.fda.gov/news-events/press-announcements/fda-approves-first-over-counter-naloxone-nasal-spray

[99]Gaba A, Wangari Walter A, Pinals DA: Increasing Equitable Access to Care for Co-Occurring Mental Health and Substance Use Disorders. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2024

[100]Henkel D: Unemployment and substance use: a review of the literature (1990–2010). Curr Drug Abuse Rev 2011; 4:4–27.

[101]Saunders H, Panchal N: A Look at the Latest Suicide Data and Change Over the Last Decade. San Francisco, Kaiser Family Foundation, 2023. https://www.kff.org/other/issue-brief/a-look-at-the-latest-suicide-data-and-change-over-the-last-decade/

[102]Ibid.

[103]Ibid.

[104] Curtin, S. C., Garnett, M. F., & Ahmad, F. B. (2023). Provisional estimates of suicide by demographic characteristics: United States, 2022. Vital Statistics Rapid Release; no 34. DOI: https://doi.org/10.15620/cdc:133702.

[105]Ibid.

[106]2023 NSDUH Annual National Report. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2024. https://www.samhsa.gov/data/sites/default/files/reports/rpt47096/2023-nsduh-companion-report.pdf

[107] Jones SE, Ethier KA, Hertz M, et al: Mental health, suicidality, and connectedness among high school students during the COVID-19 pandemic—Adolescent Behaviors and Experiences Survey, United States, January–June 2021. MMWR Suppl 2022; 71:16–21

[108]Multiple Cause of Death, 2018–2021, Single Race. Atlanta, GA, Centers for Disease Control and Prevention. https://wonder.cdc.gov/mcd-icd10-expanded.html

[109]Injury Prevention & Control: WISQARS—Web-Based Injury Statistics Query and Reporting System. Atlanta, GA, Centers for Disease Control and Prevention, 2020. https://www.cdc.gov/injury/wisqars/

[110]Veteran Suicide Data and Reporting. Washington, DC, US Department of Veteran Affairs. https://www.mentalhealth.va.gov/suicide_prevention/data.asp

[111]Panchal N, Saunders H, Ndugga N: Five Key Findings on Mental Health and Substance Use Disorders by Race/Ethnicity. San Francisco, CA, Kaiser Family Foundation, 2022. https://www.kff.org/racial-equity-and-health-policy/issue-brief/five-key-findings-on-mental-health-and-substance-use-disorders-by-race-ethnicity/

[112]Ring the Alarm: The Crisis of Black Youth Suicide in America. Congressional Black Caucus Emergency Taskforce on Black Youth Suicide and Mental Health. https://watsoncoleman.house.gov/imo/media/doc/full_taskforce_report.pdf

[113]Injury Prevention & Control: WISQARS—Web-Based Injury Statistics Query and Reporting System. Atlanta, GA, Centers for Disease Control and Prevention, 2022. https://www.cdc.gov/injury/wisqars/

[114]U.S. Department of Health and Human Services. 2024 National Strategy for Suicide Prevention, 2024. https://www.hhs.gov/programs/prevention-and-wellness/mental-health-substance-abuse/national-strategy-suicide-prevention/index.html

[115]Wilton G, Stewart LA: Outcomes of Offenders With Co-Occurring Substance Use Disorders and Mental Disorders. Psychiatr Serv 2017; 68:704–709

[116]DeLisi M, Alcala J, Kusow A, et al: Adverse Childhood Experiences, Commitment Offense, and Race/Ethnicity: Are the Effects Crime-, Race-, and Ethnicity-Specific? Int J Environ Res Public Health 2017; 14:331

[117]Victor GA, Comartin E, Willis T, et al: Factors of recidivism among individuals with co-occurring conditions in rural mental health jail interventions. Int J Offender Ther Comp Criminol 2022; 66:758–773

[118]Wilton G, Stewart LA: Outcomes of offenders with co-occurring substance use disorders and mental disorders. Psychiatr Serv 2017; 68:704–709

[119]Justice Department Finds Civil Rights Violations by the Minneapolis Police Department and the City of Minneapolis. Washington, DC, Office of Public Affairs, 2023. https://www.justice.gov/opa/pr/justice-department-finds-civil-rights-violations-minneapolis-police-department-and-city

[120]Laniyonu A, Goff PA: Measuring disparities in police use of force and injury among persons with serious mental illness. BMC Psychiatry 2021; 21:500

[121]Saleh AZ, Appelbaum PS, Liu X, et al: Deaths of people with mental illness during interactions with law enforcement. Int J Law Psychiatry 2018; 58:110–116

[122]Schramm-Sapyta NL, Ralph M, Huynh L, et al: Relationships between substance use disorders, "severe mental illness" and re-arrest in a county detention facility: a 4-year follow-up cohort study. Crim Behav Ment Health 2023; 33:185–195

[123]Winkelman TN, Kieffer EC, Goold SD, et al: Health insurance trends and access to behavioral healthcare among justice-involved individuals—United States, 2008–2014. J Gen Intern Med 2016; 31:1523–1529

[124]Baglivio MT, Wolff KT, Piquero AR, et al: Racial/ethnic disproportionality in psychiatric diagnoses and treatment in a sample of serious juvenile offenders. J Youth Adolesc 2017; 46:1424–1451

[125]Ibid.

[126]Abreu D, Parker TW, Noether CD, et al: Revising the paradigm for jail diversion for people with mental and substance use disorders: intercept 0. Behav Sci Law 2017; 35:380–395

[127]Pinals DA: Lending Hands: Improving Partnerships and Coordinated Practices Between Behavioral Health, Police, and Other First Responders. Alexandria, VA, National Association of State Mental Health Program Directors, 2022

[128]SAMHSA's 2023–2026 Strategic Plan. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2023. https://www.samhsa.gov/about-us/strategic-plan

[129]New KFF/CNN Survey on Mental Health Finds Young Adults in Crisis; More Than a Third Say Their Mental Health Keeps Them From Doing Normal Activities: Half of Adults Say Their Families Have Experienced a Severe Mental Health Crisis, Including One in Four Who Say a Family Member Engaged in Cutting or Other Self-Harming Behaviors. San Francisco, CA, Kaiser Family Foundation, 2022. https://www.kff.org/other/press-release/new-kff-cnn-survey-on-mental-health-finds-young-adults-in-crisis-more-than-a-third-say-their-mental-health-keeps-them-from-doing-normal-activities/

[130]Ibid.

[131]Fazel S, Khosla V, Doll H, et al: The prevalence of mental disorders among the homeless in western countries: systematic review and meta-regression analysis. PLoS Med 2008; 5: e225

[132]McKinnon II, Krause KH, Robin L, et al: Experiences of unstable housing among high school students—Youth Risk Behavior Survey, United States, 2021. MMWR Suppl 2023; 72:29–36

[133]Keisler-Starkey K, Bunch LN: Health Insurance Coverage in the United States, 2021. Report Number P60-278. Suitland–Silver Hill, MD, US Census Bureau, 2022. https://www.census.gov/library/publications/2022/demo/p60-278.html

[134]Perreault M, Touré EH, Perreault N, et al: Employment status and mental health: mediating roles of social support and coping strategies. Psychiatric Quarterly 2017; 88:501–514.

[135]Panchal N, Cox C, Rudowitz R: The Landscape of School-Based Mental Health Services. San Francisco, Kaiser Family Foundation, 2022. https://www.kff.org/other/issue-brief/the-landscape-of-school-based-mental-health-services/

[136]Ibid.

[137]Ibid.

[138]Ibid.

[139]Murthy VH: Our Epidemic of Loneliness and Isolation: The US Surgeon General's Advisory on the Healing Effects of Social Connection and Community. Washington, DC, Office of the Surgeon General, 2023, 9

[140]Bruce LD, Wu JS, Lustig SL, et al: Loneliness in the United States: a 2018 national panel survey of demographic, structural, cognitive, and behavioral characteristics. Am J Health Promot 2019; 33:1123–1133. https://doi.org/10.1177/0890117119856551

[141]Mann F, Wang J, Pearce E, et al: Loneliness and the onset of new mental health problems in the general population. Soc Psychiatry Psychiatr Epidemiol 2022; 57:2161–2178. https://doi.org/10.1007/s00127-022-02261-7

[142]Van Orden KA, Witte TK, Cukrowicz KC, et al: The interpersonal theory of suicide. Psychol Review 2010; 117:575–600. https://doi.org/10.1037/a0018697

[143]How Does Social Connectedness Affect Health? Atlanta, GA, Centers for Disease Control and Prevention, 2023.

[144]Hoffmann H, Jäckel D, Glauser S, et al: Long-term effectiveness of supported employment: 5-year follow-up of a randomized controlled trial. Am J Psychiatry 2014; 171:1183–1190

[145]Leeb RT, Bitsko RH, Radhakrishnan L, et al: Mental health–related emergency department visits among children aged <18 years during the COVID-19 pandemic—United States, January 1–October 17, 2020. MMWR Morb Mortal Wkly Rep 2020; 69:1675–1680

[146]Leeb RT, Bitsko RH, Radhakrishnan L, et al: Mental health–related emergency department visits among children aged <18 years during the COVID-19 pandemic—United States, January 1–October 17, 2020. MMWR Morb Mortal Wkly Rep 2020; 69:1675–1680; 1679

[147]Gaylor EM, Krause KH, Welder LE, et al: Suicidal thoughts and behaviors among high school students—Youth Risk Behavior Survey, United States, 2021. MMWR Suppl 2023; 72:45–54

[148]Ibid.

[149]Ibid.

[150]Choi KR, Wisk LE, Zima BT: Availability of LGBTQ mental health services for US youth, 2014 to 2020. JAMA Pediatr 2023; 177:865–867

[151]Fish JN: Future directions in understanding and addressing mental health among LGBTQ youth. J Clin Child Adolesc Psychol 2020; 49:943–956

[152]Ibid.

[153]Ryan C, Russell ST, Huebner D, et al: Family acceptance in adolescence and the health of LGBT young adults. J Child Adolesc Psychiatr Nurs 2010; 23:205–213

[154]LGBTQ+. 988 Suicide and Crisis Lifeline. https://988lifeline.org/help-yourself/lgbtq/

[155] Family Counseling and Support for Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Intersex+ Youth and their Families. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2023. https://www.samhsa.gov/grants/grant-announcements/fg-23-004

[156]Murthy VH: Social Media and Youth Mental Health: The U.S. Surgeon General's Advisory. Washington, DC, Office of the Surgeon General, 2023

[157]Ibid.

[158]Ibid.

[159]Ibid.

[160]Ibid.

[161]Ibid.

[162]Center of Excellence on Social Media and Youth Mental Health. Itasca, IL, American Academy of Pediatrics. https://www.aap.org/en/patient-care/media-and-children/center-of-excellence-on-social-media-and-youth-mental-health/

[163]Pinals DA, Fuller DA: Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care. Alexandria, VA, National Association of State Mental Health Program Directors, 2017

[164]Choi KW, Stein MB, Nishimi KM, et al: An exposure-wide and Mendelian randomization approach to identifying modifiable factors for the prevention of depression. Am J Psychiatry 2020; 177:944–954

[165]Pinals DA, Schofield G (Eds.): Connected and Strong: Strategies for Accessible and Effective Crisis and Mental Health Services. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2024

[166]Creating Positive Childhood Experiences. Atlanta, GA, Centers for Disease Control and Prevention, 2022.