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WEBINAR

BUILDING A MODERN BEHAVIOR CRISIS RESPONSE SYSTEM:
THE ROLE OF FEDERAL POLICY

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PARTICIPANTS:

Welcoming Remarks:

THE HONORABLE CATHERINE CORTEZ MASTO (D-NV)
Senator
United States Senate

Moderated Discussion:

RICHARD FRANK, Moderator
Senior Fellow and Director, USC-Brookings Schaeffer Initiative for Health Policy
The Brookings Institution

AYESHA DELANY-BRUMSEY
Director, Behavioral Health
Council of State Governments Justice Center

KANA ENOMOTO
Co-Director, Center for Societal Benefit Through Healthcare, McKinsey and Company
Former Acting Administrator, SAMHSA

EVELYN STRATTON
Retired Justice, Ohio Supreme Court
Project Director, Stepping Up

HEMI TEWARSON
Executive Director
National Academy for State Health Policy

VIKKI WACHINO
Principal
Viaduct Consulting, LLC

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P R O C E E D I N G S

MR. FRANK: Good afternoon to folks in the East and good morning to those in the West. My name is Richard Frank and I direct the Schaeffer Institute Initiative for Health Policy here at the Brookings Institution.

I'm pleased to welcome you to a discussion of how federal government policy could best support states and localities in the development of the continuum of behavioral health crisis response services.

Today's conversation is prompted by important advances in addressing crises involving mental illness and substance use disorders. Specifically, federal agencies, state governments, and a variety of private organizations and philanthropies are hard at work standing up the 988 crisis hot line that will service as a key point of entry for responding to behavioral health crises. It is slated to go live in July of this year. In addition, the American Rescue Plan Act created new authorities for Medicaid to support mobile crisis services in the states. And, finally, there is some new modest financial resources in the federal government set aside to support crisis responses in the states.

In our discussion today we'll focus on policy steps aimed at what happens after a call is made for help with a behavioral health crisis. This is important because historically emergencies that faced people with mental health and substance use issues have been responded to in a fragmented manner with default reliance on law enforcement, hospitals, and jails. Too often the responses to behavioral health crises have resulted in unfortunate outcomes, including unnecessary criminalization of people with mental illnesses and poor health outcomes, including death.

We'll be discussing policymaking necessary to support creation of the infrastructure and sustainable financing of the crisis continuum that the Substance Abuse and Mental Health Services Administration, or SAMHSA, identifies as having three key components. First, regional crisis call centers, second, mobile crisis response teams, and third, crisis receiving and stabilization facilities. We'll be emphasizing policy concerning the latter two elements.

The discussion today will have three parts. In the first part we are privileged to have

Senator Catherine Cortez Masto with us to offer opening remarks. The senator's remarks will be followed by a discussion with deeply knowledgeable and experienced panelists who span behavioral health, criminal justice, state policy, and Medicaid realms. Finally, we will have some time for questions and comments from you all.

It is now my pleasure to introduce Senator Catherine Cortez Masto. She represents the state of Nevada in the U.S. Senate and was first elected to the Senate in 2016. Prior to being elected to the senate she served as Nevada's attorney general. Senator Cortez Masto is a clear captain of women's health and mental health issues. To that end, she is the principle sponsor of a senate bill S1902, the Behavioral Health Crisis Services Expansion Act, that directly addresses the establishment and financing of the crisis continuum.

We're delighted to welcome Senator Cortez Masto to get us started this afternoon.

Senator.

SENATOR CORTEZ MASTO: Richard, thank you. I am so pleased to be able to join you. I also want to say thank you to the Brookings Institution and the incredible panel members who are going to be speaking. Look forward to the collaboration with all of you. This is such an important panel conversation. And so I want to thank you for this. Everyone on the call, thank you. You're working so hard to advocate on behalf of mental and behavioral health issues.

So now I know our focus today is about the mental health crisis facing our country, including in Nevada, and what we can do to get our communities the resources we need to address them. I just want to provide some perspective on the work that I've been doing, really informed by what I have seen and heard in Nevada, but it's not unique to Nevada. It's happening clearly across the country.

What I do know is this, as a lifelong Nevadan, unfortunately Nevada's mental health services have been underfunded for decades. About 30 years ago Nevada pulled money and resources out of mental health and the state really never really fully recovered from it or restored it. As a result, what we've seen are really dire outcomes and more people pushed to the brink. That's true in Nevada, but it's also true across the country.

In 2018 fewer than half of adults with mental illness nationwide receive some sort of

treatment for their condition. Many of you know this. And it's only gotten worse during the coronavirus pandemic. So today when I talk to anyone in Nevada about issues they're facing, mental health is always up on the list. Whether I'm on a call with local or state officials, with school superintendents, with law enforcement agencies, nonprofit groups, healthcare providers, everyone is seeing the same thing. And we know this. In 2019, before the pandemic, 11 percent of adults reported symptoms of anxiety and depression. By January 2021 that number was 41 percent. And the uncertainty and stress so many people have felt during the course of the coronavirus pandemic has especially severe impact for some in our state. That's what we — that I have seen. That includes communities of color, those who were laid off or furloughed, women, many of whom had to leave the workforce to care for their family, LGBTQ Americans, seniors facing serious health threats and isolation, and young people. And there's been a deeply concerning uptick in mental health problems, including self-harming behavior in our students. It was especially bad in my hometown of Las Vegas in 2020. With the pandemic raging and schools still closed, Las Vegas faced a state of student suicides that shook me and the community to our core. And that really was a reason why I started focusing on our schools and our students and what was — what they were dealing with during this pandemic. It was clear that our kids were not getting the support they needed and we had to find a way to get students better mental health support and get them back in the classroom. That was among my main priorities when we negotiated the American Rescue Plan. We needed to get the funding to our schools so that they could reopen and get kids back to the classrooms.

During that time I also called on the Biden administration to work with me to address the student mental health crisis because of what we experienced back home in Las Vegas. Fortunately they agree that using the Rescue Plan funding to integrate mental health services in schools is key to getting kids back on track. And I'm here to tell you I remain focused on getting our kids the help they need. I literally went to my elementary school that I went to — I went through the public school system in Las Vegas — had a conversation not only with the principals and the staff and looked at the staffing needs there, but brought in our county superintendent, our state superintendent to talk about how we address the needs of our children, particularly at a crisis mode and at a time when we have an opportunity through the American Rescue Plan and some of this funding to direct those resources.

So it's clear that what I saw in Nevada is happening across the country. It is also important for us to recognize it's not just our kids, right. It's a whole range of mental health issues that need addressing for so many people. And that means that we need to completely reshape our mental healthcare system. If it's one thing that I've seen — and I was the attorney general in Nevada for eight years — law enforcement, first responders, that is not a role for them. There is a role for us to partner with mental health — for law enforcement, first responders to partner with mental health to really address what I saw at the beginning stages of any mental health crisis, it's that crisis mode, those crises services at the beginning of this continuum of care are so important. Many people experiencing mental health crises have nowhere else to turn and we need to make sure they get the help that they need.

We need to respond to mental health emergencies just like we would physical emergencies. We have got to build a system that is equipped to help address a patient's mental health crisis and then we have to look down the line and make sure we have the services and supports in place that will keep them stable.

Now, from what I've seen is the real challenge is making sure people are getting the kind of treatment from the right providers at the right time. Now, at the moment, we don't have adequate nationwide standards for the kind of care people get when they're in the middle of a mental health crisis, nor do most communities have the capacity to deliver this care. Without these standards and systems in place too many people, as you all know, are facing mental or behavioral health emergencies and they don't get the care they need. Instead, when that first call is made in a crisis situation, and usually it's a 911 call, they encounter law enforcement or first responders or other emergency medical personnel who may not be trained to deal with behavioral health crises. We know this, we've seen it in too many instances, and there are devastating consequences as a result of it.

I've had extensive conversations with healthcare professionals, with law enforcement officers in Nevada and civil rights leaders who agree that we can't rely on the same old system.

So here's what I've done to be a part of the solution. I've introduced bipartisan legislation, Behavioral Health Crisis Services Expansion Act, to build a continuum of crisis services and to make sure that they're available in every community across the country. Addressing our nation's mental

health challenges should not and cannot be a partisan issue. And that's why I was pleased that my colleague, Senator John Cornyn of Texas, joined me in introducing the bill to transform our nation's crisis response system.

Now, here's what the bill will do. It will create a framework for crisis call centers, more robust mobile crisis units, and crisis stabilization facilities. It would also integrate the 988 crisis hot line for behavioral health crisis cases. And the bill would require coverage of these services for patients, no matter where they get their health insurance.

Now, it just makes sense to get people the care that they actually need and to relieve that burden on law enforcement and other first responders who may not be trained or equipped to take on these complex cases. Now, this legislation is just a starting point for comprehensive reform in the area of mental and behavioral health. There's so much more that we can do.

For those of you who don't know, I sit on the senate finance committee, which deals with healthcare, and in August our committee launched a bipartisan effort to address barriers to mental health care. We are going to be looking at a number of issues, including integrating behavioral and physical health services, addressing the shortages among the mental health workforce, which I constantly hear back home, improving oversight and enforcement of the Mental Health Parity laws, and expanding access to telehealth services for behavioral health services. We are going to really be able to make meaningful bipartisan progress on these issues and do it in a comprehensive way. And there's so much that needs to be done.

You know, earlier in the year I was able to pass another piece of bipartisan legislation that focused on the mental health needs of our first responders and law enforcement. What I learned in Nevada from our local law enforcement is that peer to peer counseling programs really work when it comes to addressing the needs of law enforcement and first responders. So I took that best practice and I put it in a piece of legislation, and with bipartisan support was able to pass it. Not only does it create access to behavioral health services for federal law enforcement and first responders, it actually gives local state and federal law enforcement and first responders and local communities the opportunity to create their own peer to peer counseling programs and it puts the best practices in place, it identifies, it

requires at a federal level to identify those best practices and put it on a website so other communities can really focus on peer to peer counseling programs.

And the other part of it was making sure that not just law enforcement and the first responders, but we were opening the door for peer to peer counseling programs for those that also are in need. And because I sit on senate finance, I was able to make sure some of that funding goes through Medicare. So we have counselors that can work with our seniors in conjunction with a physician to help with their mental health needs as well.

So many of you know, this is to me such an important issue that we have to address. We really needed to address it before the pandemic, but the pandemic has really brought home why this is such an important issue. We have to get it right now and this requires our federal, state, and local communities working together. It is a top priority for me — it has been and will continue to be. And I know after talking with all of you I'm so pleased it's a priority for all of you. You really have an opportunity now to get this right. And it's one thing I stress back home, again, it comes down to this, no matter your needs, whether it's physical or mental health, you should be able to get services and be able to afford those services for your mental, just like you do your physical needs. And there should be no stigma associated with mental health care. That's the other thing that we have to address in this country.

So thank you. It's such an important issue. I wish I could stay for the panel discussion, but I — like I said, I look forward to working with all of you and hearing both great ideas and solutions that we can put in place together to address mental health needs and behavioral health needs across the country.

Thank you again.

MR. FRANK: Thank you, Senator Cortez Masto. You've really done a fabulous job setting out the agenda for what we have to do the rest of the time here and then beyond. So we're really grateful for the time you spent with us. Thanks.

I think I'll now turn to the panel discussion. I want to start by introducing our panelists. And before I do so, I want to remind those who want to submit a question that they can do so via Twitter at #CrisisServices or by emailing Brookings at Events@Brookings.edu.

Okay. We have a terrific panel to take on the challenges that were posed to us by the Senator. And let me start by introducing each one of them. Let's start with Ayesha Delany-Brumsey. She is a director of the behavioral health division at the Council of State Governments Justice Center. She oversees the division's portfolios which concern how parts of the criminal justice system intersect with mental health, substance abuse, and homelessness systems. She previously was a director of substance use and mental health programs at the Vera Institute for Justice. And she holds a Ph.D. in clinical psychology from UCLA.

Next we have Kana Enomoto, who is a senior expert at McKinsey where she leads a team supporting 988 implementation and crisis response. Kana spent 20 years in federal service at SAMHSA, serving as the acting administrator under President Obama.

Evelyn Stratton served as justice on the Ohio Supreme Court for 16 years and for 7 years before that as a trial judge. She's worked for decades on issues involving people with mental illnesses in the criminal justice system. She currently serves on Governor Mike DeWine's Recovery Ohio advisory council, which advises the governor on addiction and mental health policy issues.

Hemi Tewarson is the executive director of the National Academy of State Health Policy, or NASHP. She previously held leadership positions at the Margolis Center at Duke University and prior to that was a director of the health division at the National Governor's Association Center for Best Practices, overseeing a portfolio of projects including Medicaid transformation and coverage, payment system reform, opioids, and behavioral health.

And, finally, Vikki Wachino, who is my partner in organizing this event, which I am very grateful for. She's the principal of Viaduct Consulting. Vikki is a former deputy administrator at the Centers for Medicare and Medicaid services, which she oversaw all policy and operations for Medicaid and children's health insurance programs. Vikki also served as CEO of Community Oriented Correctional Health Services and has previously worked at the U.S. Office of Management and Budget, the Kaiser Family Foundation, and the Center on Budget and Policy Priorities.

Okay, so that's our panel. And let me start the questioning by making the observation that there are multiple approaches in how states and localities can and do build crisis continuums. And

so let me start by asking Kana, where are we nationally in moving towards building the crisis continuum?

MS. ENOMOTO: Thanks, Richard, and thank you to Vikki and you for inviting me here today.

You know, I think this is a question that we've all been kicking around in terms of where are we. I don't think there's one answer, right. As in so many things, you see one state, you see one state. We have some real pace car states like Arizona and Georgia who have been leaning in on crisis for some years and have made significant investments. We also have states that really aren't where they need to be at all and are playing catch up. So we have significant diversity across the country, but we know that people are leaning in at every level. So, you know, from the FCC, VA, HHS, we have a lot of action, a lot of movement. The most recent ARPA funding, you know, sending \$280 million to the crisis lines and to the states. Then also the SAMHSA recently transmitted its report to congress last month. And so we have a better sense of what the plan is nationally looking to not only strengthen the lifeline and the safety net capabilities of that number providing, you know, lifesaving services to people who contact 988, but also transforming — taking this opportunity to transform our country's behavioral health crisis care system because there is a significant portion of people calling 988. you know, they have a place to call, a place to — someone to come to them and somewhere to go. They won't need someone to come to them and somewhere to go. And so in order to make sure that 988 provides — you know, meets the promise of providing something very different from what we have now where people are calling 911 or going to the emergency department, we really need those behavioral health crisis care services in place. And that's where not only SAMHSA, but also partners at CMS, partners at the state level — you know, we have a handful of states that have passed legislation taking advantage of the authorized sort of mobile phone fees to pay for crisis services, other states not going quite as far, you know, enacting legislation without calling for fees, other that are creating commissions. Overall — and California has appropriated funds to shore up its hot line capacity statewide — but overall more than half of the states haven't made any progress at all. And this is worrying because if we want to deliver something different, if we really want to make a difference in the lives of people who are having mental health and substance use emergencies — this is what Assistant Secretary Delphin-Rittmon has made very clear that she sees

988 and the lifeline as something for people with both mental illnesses and substance use disorders who are experiencing such crises — we're going to have to make sure that we cannot only get the answer rate and the timeliness on the lifeline that people deserve and need, but also that when people have a further need that they can get connected to the care that's appropriate for them in the community.

MR. FRANK: Thanks.

Hemi, you and your team at NASHP are following these developments in like several states. How are states preparing to respond to 988 calls when they start next July?

MS. TEWARSON: Thank you so much for having me. This is a really important topic and I'm so pleased to be on the panel with all of you.

I'll just say a couple of things in addition to — I mean Kana I think gave a very nice like snapshot of our states across the country. I'll just say a little bit more from our perspective actually working closely with states on some of this.

So when I was at NGA I will say we worked on crisis response. You know, this wasn't as part of 988, but this has been work that's been ongoing, longstanding at the state level and there has been I think some real interest and energy around trying to really build up the system. I think we now have an additional layer of this sort of national movement with 988 that states now have to prepare for, which I think, to Kana's point, is helpful in the sense of not every state is in the same place with this, and some states have made more investments and other states are catching up.

But I'll say a couple of things just in terms of what we're learning and how states are actually working on this at this moment in light of the July deadline and the national movement around it. So some of the things that they have to have in place are things that have been laid out by SAMHSA and they're working on that, right. They're making sure that they have seamless linkages to their law enforcement, EMS, crisis and behavioral health services and systems. And I do think that's a really important piece of this. There is going to be back and forth between the 911 and what's been happening right now and what sort of the new wave. And hopefully work will be — as everyone transitions to 988. So you need to really have those in place.

I'll say one other thing that's been interesting at some of the state level is a couple of

states have been pretty proactive in thinking about the stakeholder group to help build those linkages and who to bring in and how to bring them in and making sure that they have sort of those trusted relationships. And I will say, you know, there were states that we worked on this topic before 988, before the pandemic. Those states are still leaders. But there are other states that I think that are coming forward and really trying to build up those relationships, which I think are going to be of critical importance.

I think the other piece that we need to think about is who's the workforce? I think that is – you know, number one challenge I think that states we are working with have said it's the workforce. We really have to have the capacity. And particularly those areas that have frontier and rural areas, it's just — it just has to look a little bit different. And how do we think creatively about that. So the other thing that we've been talking about is it's a trauma informed, complexity dual diagnosis competent workforce, right. It's a particular type of workforce. And I think that is going to be an ongoing challenge. I cannot sit here and say by July states are going to have to solve for this. I think we're seeing across the country the challenges in really getting the right workforce in place. So that's going to have to be an ongoing effort I think not just at the state level, but also the federal government, thinking about how they can really do some work at that level to help states figure out how to address the workforce challenge.

I think no wrong door facilities. So some states are really working on okay, how do we effectively partner with those facilities that can work with law enforcement, they work with first responders, they're going to work with this new system, and really provide the right environments for individuals in need. And so I think that's an important piece of this. I think some of the work for the CCBHCs will be I think sort of on a long-term more sustainable basis. That can be an interesting additional element to all of this and how those entities can serve as a 24/7 place for care. But that's a sort of a longer-term investment.

I would say technology supported systems. I didn't want to leave that out. So we really do need to think about how we can leverage telehealth, EHRs, and data. Some say states are really thinking more creatively about what more can we do here, how can we be creative. We know we're not going to have enough folks, how do we build telehealth into some of our strategies and where can we

move forward.

And then I know we're going to talk about this in great length in a bit, but sustainable financing. So I'll probably not go into that right now, but I'll just say Kana mentioned the telecomm piece, but there's Medicaid, I think there's the block grants, there's more general ARPA flexible funding, there's some money for home and community based services, which some states are actually using that enhanced Medicaid match to help with some of the workforce here. So there's a lot of pieces I think to braid and blend that are going to be really important beyond sort of just the planning grants and the immediate funding that's coming into 988 now.

And then the last I'll just say and then I'll turn it back to you, Richard, is marketing communications. Some of the states I think have been a little but more proactive on this than others. Okay, we need to get the public to understand what's happening and yes there's sort of the national push of getting folks to understand, but states have to do work with sort of localities to make sure that the public understands the meaning of the new system and then where folks can go after they contact the new system, how it's all going to work. So I do think some resources and investment need to be made in that at the state level.

And then finally I'll say this is going to be an iterative process. Yes, we're going to go live in July, but there's going to be a lot of lessons learned I think. So states, they're not able to really completely think about this, but hopefully they'll get there, on sort of continued evaluation of, okay, what's missing, how do we fill the gaps, what are other states doing. I do think this is going to be an example of — and we all who work with states know, states love to learn from other states — but I do think this is going to be an example of where that's really going to be helpful, making sure we're holding up places where there is — you know, they've had some good ideas, they really have traction, and other states that may still be learning, where can they learn from them. So I think that's going to have to continue on even after we sort of go live in July.

So maybe with that I'll turn it back to you, Richard.

Thank you.

MS. ENOMOTO: Richard, can I just jump in and respond to one thing that Hemi said?

MR. FRANK: Sure.

MS. ENOMOTO: I think it's a great point about communications, that it's going to take communications coming from different directions and different parties to help people become aware and use the service. But I would also point out that probably — you know, July 2022 is not necessarily the magic moment that all people will become aware of the line and start calling in immediately. This is going to be a gradual ramp up. And it's really important to time the launching of communications sort of hand in glove with the state at it's considering the readiness of the lifeline network to — and of the services to absorb any increased volume.

And so I don't want people to think that, oh my god, we don't have a massive comms plan set for July 2022, we're way behind. We don't have to launch something at that time. The deadline is for the telecomm companies to be able to route calls from 988 to the lifeline. It is not the requirement of states to start advertising at that period.

So SAMHSA is working with a number of stakeholders to create readiness assessments so that maybe we can have a little bit more data informed way of helping states to understand what's the threshold point at which they are ready to launch that communications.

MR. FRANK: Yeah, I think both of you have made a very important point that July is truly the beginning. And it is the beginning of a process that's going to sort of build over time. And suddenly the world will not be different on the second day of the new creation.

So thanks for that.

Both of you also emphasized partnerships. And probably none is more central than the one with the justice system. And, Ayesha, I was hoping that you might jump in here to tell us sort of what has been going on in the justice side to sort of prepare for this, to kind of get sort of modern sort of justice policy approaches to play in this realm.

MS. DELANY-BRUMSEY: Yeah, absolutely. And first just of course thank you for having me here today. It's a great event and I'm excited to be able to speak.

And that's a great question because, you know, while we're focusing certainly on some of the recent changes that are brought by 988 and some of the other focus on crisis these last few years,

we've known for a long time in the justice system that people with behavioral health condition are vastly overrepresented. And you noted this in the blog that's associated with this event, rates of substance use disorder is 13 times higher, rates of serious mental health illness, 3 to 5 times higher when you're looking at people who are incarcerated. And it's not just the incarceration that's an issue in that over representation, we also know people have worse outcomes, more likely to engage in self harm or suicide or be subject to trauma. And we know that over representation and those poor outcomes happen at every point in the justice system. And you alluded to this a little earlier, but approximately 25 percent of fatal police shootings are of people with a mental health need.

So that's been — those are facts and information that we've known for a long time. And what I've been really encouraged to see is that communities are moving past the phase where they're kind of admiring and studying that problem and now are working towards fully implementing solutions. That didn't happen overnight. I want to emphasize this has been a long road. If you look more than 30 years ago and you look towards Joseph Dewayne Robinson, who was a 27 year old black man who was shot in Memphis, Tennessee in the midst of a psychiatric episode, and that really helped to birth crisis intervention training, which was one of the first what we call police mental health collaborations where behavioral health and law enforcement work together to try to improve responses to people with mental health conditions. And crisis intervention training is when officers are specially trained to respond to mental health needs. That was over 30 years ago.

Since then we've seen a real push at local levels, but also supported by the state and importantly supported by the federal government to expand those police mental health collaborations. And I would say these last two years that focus has really doubled down as states are preparing for 988, as we've seen these alarming increases in anxiety and substance use due to the Covid 19 pandemic and as communities are really still facing and working towards answering the calls for racial justice after George Floyd's killing.

So what we're seeing really is all of these factors are coming together to drive more effort towards public health and public safety systems, working together to both divert people away from the criminal justice system and into community based supports. And we're seeing them build out a real

continuum from those kind of jointly held police-mental health collaboration models, as well as models that are what I sometimes term "health first", where you're sending behavioral health professionals to some of these crisis calls, whether through 911 and hopefully in the future also through 988. And just as one kind of example of how that looks at the local level, you can look to a place like Austin, Texas where for years they've been partnering with their police department and their sheriff's department — integral pair of their health system — has built a relationship that's allowed them to build out a kind of continuum of supports. From having a 24/7 crisis line to having a code response model and more recently embedding clinicians in their 911 to triage those calls for behavioral health service and be able to send there what we call community responder programs or mobile crisis teams that go to 911 calls for service to field behavioral health needs. And they are to my knowledge the first place in the country where when you call 911 you're calling you get someone that answers the phone they say are you calling for police, fire, EMS, or mental health services. And through that they've had really important and positive outcomes, including being able to divert 99 percent of the calls that they responded to away from arrest.

So that's just one example, but that kind of partnership that builds on itself over time and helps to create a kind of continuum of responses at that intersection of law enforcement and criminal justice is what we've been seeing over the years from communities across the country.

And just one final point about that, what I would say is what I think the next frontier of work and reform for many of these communities is determining how these interventions and these new initiatives they're doing in their crisis system are promoting health equity and addressing these calls for racial justice. And that is going to be another place where we're starting to see communities build out their capacity, where I hope that we are going to see communities build out their focus.

MR. FRANK: Great. Thank you.

Evelyn, you've been involved deeply in Ohio's efforts to build a crisis system for a while and I was hoping you could sort of now reflect on the lessons that you think are sort of must have as the rest of the country perhaps looks to Ohio as a place to — one of the places on the forefront of all this.

MS. STRATTON: Thank you very much. And so it's a great honor to be included with this panel and be able to talk about the work we've done.

Just a little background to put in perspective where I come from. I was born and raised a missionary kid in Thailand. I lived there for 18 years before I came to America. I never saw mental health issues as a missionary kid, never saw it in college, although now I know it's very prevalent, never saw it until I was elected a trial judge and boy it smacked me front and center because I had so many people in my court that had mental health issues and there was no collaboration or coordination. And that kind of started me on my journey. And then when I got to the Supreme Court I served there for 16 years and I realized that I had a very valuable tool. I have a big title and people come to my meetings. And so I used that to start working on a lot of projects, both here and nationally.

And so when I started working on CIT we had 100 officers trained. We now over 14,000. When started doing our sequential intercept mapping, which is where you look at how you people get into the system and out of the system, we map the community resources, the deficits, we rank them. Everyone came up with crisis as the top need. Not treatment, crisis was first and housing was almost always second. And we are sort of a victim of our own success because we had all these police officers now and they didn't have any place to take most of the people that they would try to divert. Our crisis system was just very poor, as it was in most states.

So about five years ago, as a result of working on Stepping Up — council state governments, thank you very much — we started looking at crisis work, visited five different states looking at their systems. We put together a statewide conference, brought some outside leaders in to talk about crisis work, we did a series of crisis academies over the next couple of years, all across the state, putting partners together, and then partnering with the State of Ohio, the State of Ohio put together a statewide crisis committee. We have over 50 partners on that committee, very inclusive.

And a couple of lessons there is, one, you can identify a need, then you've got to go out and look at models, places who might have done something that might work, and then you bring partners together. It's got to be inclusive. It's got to have law enforcement, hospitals, consumers, mental health boards, schools — you name it. You've got to be inclusive.

Now that working committee last year has split into six committees. We have a 988 one, rapid response, we have one focusing on crisis centers, one on data, one on funding. All those just have

experts that are really experts in those fields that are working on that.

But another important thing is that we partnered with Peg's Foundation. Peg's Foundation is a private corporation— or a private nonprofit formed by a father and mother who had a son with schizophrenia. NAMI was very instrumental in helping them. And they put this foundation together and they fund the majority of the Stepping Up work in Ohio. And they became very passionate about this and really were the ones that drove it in the early days. And then partnering with the State of Ohio, they formed a program called Clear Pathways. It's sort of an online learning community. So as we develop all these lessons in all these 88 counties that we have in Ohio, they can join this collaborative learning online community. And then we've picked five sites — because the State of Ohio doesn't have the resources to go into the counties with the funding to dig down deep — so we picked five counties, from a very large county to a very small rural county, so we have a wide spectrum of different counties, to really try to put the whole system in place in those five counties. What lessons are we going to learn from doing that? Where are the deficits, where are the issues, where are the needs? And 988 is just one of those tools in that continuum. Because the State of Ohio continuum we have four buckets. We have connect, respond, stabilize, and thrive. Connect is the call lines, the warm lines, the care line, the crisis text lines, a statewide directory. The respond are the mobile crisis teams, CI teams, crisis response units, critical incident stress management teams. The stabilize stage is getting the crisis centers, short-term residential treatment, step down, which is an Adam-Amanda. We call that a rehab center for mental health, which you have for all sorts of other illnesses but not for mental health. And then thrive is to try to break that cycle — housing, treatment, connections to community support, transportation, schools, employment, drop in centers. That prevents the recycling.

So we're trying to focus on the whole continuum, not just the crisis piece. How do we then keep it from coming back? And so the funding is — one of the crisis centers in Lorain, which is a very fairly small county, are setting up one of the first crisis centers and they have a mix of funding from state, federal, hospitals, private foundations. There's lots of different ways. Every county has different resources and different funding. And I'm a big proponent of the rehab centers because we have so many hospitals that are only allowed to keep them so many days and we were finding the hospitals would

release them to the community with no connections. So we really need the hospitals to look at building out a community treatment center that you can stay 30-60-90 days to get stabilized on mental health treatment and then we step you down into supportive housing in the community, or wherever we can send you to keep you from cycling back.

So that's a quick summary of a whole lot of work over a whole lot of time, but we feel really good about the progress we're making in Ohio. We have wonderful partners between the state, the local, and the private sectors and the hospitals. And we feel very excited about the progress we made. And SUD is part of all of it. I mean it's co-occurring. The crisis centers will deal with drug and treatment just as much as they'll deal with mental health because so many of them are co-occurring and sometimes you can't really tell they have a mental health issue until you detox them and find the underlying mental health issue. So it's part and parcel of every step along the way.

MR. FRANK: Thank you so much.

Now, as I said, Hemi and Kana have sort of pointed to some gaps and you just told us about this incredibly complicated array of strategies that Ohio has used to sort of start to fill them. Vikki, you're kind of around talking to a lot of Medicaid directors and other state officials, what are you seeing as sort of front and center for them in starting to approach that problem?

MS. WACHINO: First, Richard, thank you for the partnership in developing this event. And thanks, Kana, Ayesha, Hemi, and Evelyn. It's just such a pleasure to be with you here today.

As I talk to Medicaid leaders I think they see a very clear marriage between the moment of time we're in and some of the tools and capacities of Medicaid that are available. They see mental health rates that are skyrocketing and rates of substance use disorder and addiction that are shattering all records and they are looking, as are so many of us, for how to address these conditions. Medicaid is a very natural tool to turn to. It covers nearly one in five Americans but plays an even bigger role for people with mental health challenges, substance use issues, and for people of color. So as we think about how to address national crises and how to advance racial equity, Medicaid is really a key foundational element of their approaches. And there are new tools available through the America Rescue Plan, in particular for states to use to build crisis continuums using Medicaid and using other sources, block grant funds and

other forms of grant funds.

Now, as Kana noted earlier, a lot of this work is not new. There have been states that have built crisis continuums over time and have very strong approaches. However, there's also a lot of variation and still very significant gaps in the crisis continuum. So I think one question that Medicaid leaders are dealing with is how to really leverage a lot of these new resources to fill in the gaps as well as how to align with 988 implementation and other parts of the crisis continuum that reside outside of a Medicaid director's responsibility. And as they do that, a key constraint is staffing capacity because we're all still dealing with the pandemic and many Medicaid agencies have ongoing responsibilities for the public health emergency. And as Hemi noted earlier, there are very significant behavioral health workforce challenges that need to be overcome.

The last thing I'll say is I think that while Medicaid leaders are extremely committed to tackling these issues, they also don't want to go it alone and are looking to Medicare and commercial insurance to play a bigger role with regard to building a crisis continuum. So as they sit down at the build a crisis continuum table they're saving seats for their Medicare and commercial partners.

MR. FRANK: Well put. Certainly Senator Cortez Masto's bill sort of lays the groundwork for that. I mean that to me is like a primary challenge.

Now, I'd like to continue to pull this thread that you raised, Vikki, which is establishing mobile crisis teams and receiving facilities in particular to kind of stabilize and treat people is complicated and really costly. You know, for example, I'm just thinking of Pima County by itself, which built a receiving facility. They put in a bond issue for about \$18 million just for that facility and the State of Arizona sort of in a larger way uses its Medicaid program, pays out about \$163 million a year to support its crisis programs. And that's just on the Medicaid side.

And so when we think about this there are 326 cities in this country that have over 100,000 people and there is about another 70 with over 300,000. So I think as Kana said at the beginning, many places have not started to make these investments and some states haven't started to really put the financing plans into place.

So I was hoping that you might kind of continue down that road, Vikki, and say well, what

are these sort of hidden authorities that you think folks might really try to pursue in order to kind of push this agenda forward?

MS. WACHINO: Sure. I mean I think when it comes to Medicaid there is a lot of ability for states to cover a full continuum of crisis services. Crisis stabilization, assessments, case management, peer support — the full array of services that you really need to respond to someone in crisis and ideally prevent the onset of a crisis to begin with is there at the disposal of states and has been for a long time, although there are gaps. What's different now are a few new opportunities that states have that I just wanted to highlight.

First is through the American Rescue Plan there is an ability for states to cover mobile crisis services that are led by a behavioral health professional and supported by a multi-disciplinary team to help someone who is experience a mental health and substance use crisis. That brings a very favorable matching rate for states and is generating a lot of interest. Half of all states are planning to build these new programs this year.

There's also the ability for states to build a broader set of crisis services with an enhanced match rate through some of the home and community based services options that were established in the American Rescue Plan. So that can be used to support rehabilitative services, peers, a very broad variety of services.

And last, and more specific to crisis call response, there's also an ability for states to support some of the administrative and information technology spending on call response and dispatch as they pertain to helping Medicaid beneficiaries. And CMS just clarified that ability and guidance on the mobile crisis response that they issued just before New Year's.

So those are some of the new levers that I think are available to states as we all try to build a stronger crisis continuum.

MR. FRANK: Hemi, could you jump in here and talk a little bit about sort of in a sense building on sort of some of Evelyn's insights about how are you seeing states thinking about mixing and matching sort some of the things that Vikki has raised with these various other sources ranging from state only funds to philanthropy, et cetera?

MS. TEWARSON: And I just wanted to — happy to do that — I also wanted to just follow up on Vikki's point about sort of the new Medicaid authorities and also kind of where we are in this pandemic. You know, I think mental health as a topic is really coming to the forefront in a different way than where we were probably in 2019 and 2018 when there were a couple of states really coming forward. You know, much like when I was at NJ and we talked about the opioid crisis, right. There was so much attention at the leadership level on opioids and that lent itself to talk more broadly about substance use disorder.

I think the same thing just in my view is really coming true for mental health because of what's happened during this pandemic, and really frankly what constituents are bringing back to their governors and their legislative staff. So I hope, fingers crossed, that that will really lend itself to sort of broader thinking on how do we really build this new behavioral health system in a way that's going to work for the need that we have. So I'll just say that.

But with respect to the specific funding sources, so all of what Vikki listed, yes, yes, yes, we've heard from a number of states that are really thinking about okay, how do we really get this enhanced match and how do we really leverage our home and community based services, you know, 10 percent bump, which is actually quite sizable, right, for many, many states. There are the planning grants for 988 specifically, which I think helps to sort of — for this piece of it, for the program. And I think there's a couple of other areas. One is the SAMHSA block grants that were available through ARPA. You know, \$1.5 billion for substance use and community mental health. We certainly have talked to some states that have been thinking about, okay, so how do we be creative in thinking about as we build sort of the broader continuum, blending those funds along with sort of these other funds that are more specific to 988 and we really can build a more robust crisis system. There's also some money going to CCBHCs, which I mentioned earlier, which I think some states are curious about. You know, can we help support those facilities, especially as we think about who are going to be the 24/7 recovery facilities.

But think one of the points that Vikki made that I just wanted to double down on is where I think more work needs to be done is really looking at other insurers, Medicare and private. Just up until this point in time it really has been about, okay, SAMHSA funding, Medicaid, how do we braid and blend,

some local funding. Just from the states that we've been working with, there's an interest but not yet a plan on how to really engage the commercial market as well as Medicare. And so I think we really need to collectively across all the different groups that we touch in our work think about how we can help make those connections a little but more robust and really, as Vikki put it, bring them to the table in a very real way with new ideas and ability to braid and blend funding. Because I really do think this is ripe for the public-private partnership.

We were looking at data, you know, who accesses crisis lines and a lot of those people aren't on Medicaid, right. Lots of folks access those crisis lines. Medicaid shouldn't have to shoulder sort of the burden of like building this entire system. I think we'll have more sustainability if we bring other sort of folks into the mix. And I will say employers, talking to employers, because we're doing some multi payer work outside of sort of this issue, they are raising behavioral health as one of their number one issues. How can we get more involved and like where can we bring sort of our power to the table? And this is one area where if we really want to build up a robust crisis system we really need to leverage and bring them over.

MR. FRANK: So on that point, on your last point there, I want to give everybody a minute to think, so I won't ask anybody this question, but I'd like the panel to think about well, you know, ARPA and the CARES Act were all about mental health parity enforcement. They all had provisions about that. And this must fit in there somewhere. And I know that we haven't really talked about that in terms of the crisis response. So if you all could think about that while I ask you the question that I was planning to ask and then we'll come back to that.

My next question was for Ayesha to really say what are the complementary resources that justice brings to this that sort of dovetails with the things that Vikki and Hemi have just been sort of talking about?

MS. DELANY-BRUMSEY: Yeah, absolutely. And I just want to validate that all the resources that Vikki and Hemi have talked about are certainly some of the core resources that we're seeing jurisdictions use to build out their crisis systems. But I also want to elevate the fact that there's funding through the Department of Justice that many communities are using to help them build out crisis

system responses, particularly funding that really privileges and reinforces the idea that there does need to be partnership between the criminal justice and behavioral health systems to build out effective crisis services that will divert people away from the justice system and that those services should be tracking outcomes and should be implementing as much as possible sort of system wide reforms. And so even though we see many jurisdictions really making progress on this, we do still see a lot of jurisdictions struggling to build those real partnerships between their behavioral health and law enforcement, courts, jails. And too often those communities still don't have accurate data on who's in the criminal justice system with a mental health or substance use need, which is a real challenge because you can't solve a problem that you can't measure or see or track.

And so one of the important investments that the Department of Justice has made is the Justice Mental Health Collaboration Program, or JMHCP, which the CSG Justice Center has provided technical assistance for since its launch. That program is a grant program that communities can access and really helps them implement innovative solutions at the intersection of the justice system and the health system. And there's a requirement for the partnership between criminal justice and health systems, which means that anyone that gets that grant is already working towards or building on these existing — their partnerships.

And so there's a significant focus on crisis systems within that and really making sure that people are being diverted away from crisis systems.

So I just wanted to give kind of one example of how jurisdictions use that. The really nice thing about this funding is it's very flexible. Communities can use it in a lot of different ways. But what we are seeing is that communities don't take just one grant sometimes, they might take one grant, braid it with other types of funding to sustain those services and then over time might get another JMHCP grant to build additional innovations. So just as one example, for looking at a place like Douglas County, Kansas, they were able to leverage multiple JMHCP grants as well as sources of state and local funding to build a comprehensive crisis system, which includes crisis call center, code response, and mobile crisis teams, a respite center and supportive housing to support people in the aftermath of a crisis. And they're currently working on their 23 hour stabilization center.

And because there is a big focus on looking at outcomes within JMHCP, they're also able to let us know that over the course of a four year period these types of initiatives and others helped reduce jail bookings for people with serious mental illnesses by 56 percent.

So that kind of funding has helped communities over time build these systems that aim to reduce incarceration and arrest for this population, but I would say that the grant funding in and of itself is important. What's also important is that JMHCP provides guidance to communities about how to do this. So that guidance goes directly to grantees, but it also goes to people who are not grantees. And that guidance is meant to be particularly very practical. So it happens in the form of webinars or briefs, but even more important it happens in the form of peer to peer learning, where if there is a community who has stood up a crisis receiving center and you're another community that's looking to stand that up, the JMHCP program can help broker that connection so that communities are really seeing how this work happens on the ground.

And so that's just one way in which some of the DOJ resources are being used to support communities to build these out. And then I would say that they often will look towards Medicaid, philanthropy, and other sources of funding to really sustain that work.

MR. FRANK: Evelyn, I know you wanted to jump in here. So why don't you do that because I was going to ask you the question anyhow. You're probably going to preempt me.

You're on mute.

MS. STRATTON: I want to stress the importance of leadership, getting a leader to really take the reigns.

When I started in this area my first committee I had 10 people, 20-some years, 30 years ago almost. And I looked up and I said I have no staff, no budget, no training, no background, no idea what I'm doing, but I have something pretty big. I have a big title and everybody comes to my meeting. How many of you have not gone to a meeting where a judge has asked you or a justice has asked you? And out of that came my justice committee, the Supreme Court Committee on Mental Health and Criminal Justice. And I worked with counsel for state governments and the GAINS Center and we did funding to get 11 of those established in other states. Many of them are still very active. And then the AG asked me

to join him, who is now Governor DeWine. And I did eight years. I merged my committee into his, which gave me even more clout because he and I were co-chairs. And then I continued to do that after I left the bench and then he became governor and put the Recovery Ohio Council on and now I'm doing it with Attorney General Yost and we have over 500 members with 15 active committees. But the benefit of pulling in leaders, pulling your judges — you talk about you can't maybe get your community together, you get your judge to call a meeting, I guarantee almost everybody in that county will come. You get a justice to call a meeting, you'll get the state partners to come. I mean our Stepping Up committee has 45 associations. Almost all the state agencies, the sheriff's association, county commissioner's association, you name it. All I have to do is call them and ask them to join. That's the power of leadership with the judiciary because they have a lot of clout. And if they're good leaders they pull people together and then let the experts take over and make things happen. But a lot of times that power gets overlooked and I would really want to stress that you can use that to start these collaborations and then people who are so dedicated and committed that work on this will run with the action part of it. I'm not an expert by any means. I'm a convener and a collaborator. That's my role. I let the experts then figure out the solutions. But you've got to take advantage of that and I don't see enough states doing that.

MR. FRANK: Well, I was going to ask you about leadership in Ohio and there you go.

Once again, I've been made a sideshow. But let me kind of circle back to Kana on kind of two issues. One, I'd like you to say something about the parity point if you can. But then also to talk a little bit about, if you could, what SAMHSA and the administration could do to sort of encourage states to make use of these new resources, both on the CCBHC side and on the block grant side, to sort of make the infrastructure investments that we've been talking about.

MS. ENOMOTO: Yeah, the parity question is one of my favorites. As many people may know, I'm not only a big policy one, but I'm also a mom of a kid with some serious emotional disturbance challenges. And we have wonderful private insurance and yet I have spent night after night in hospital emergency rooms, I have been told when I said — when I called a warm line, she doesn't need to go to inpatient, but she is having a crisis, where can she go. They said well you could go here and then they're going to send you to the ED, or we could send a mobile crisis team to your home and then they'll take her

to the ED, right, and where the 75 percent chance is that she will be admitted. And so parity interestingly is — it's the reverse issue from what most people think and people have noted already, that private payers are being subsidized by Medicaid in this case, or people with commercial insurance are being subsidized by the states that do have crisis systems that are covered by Medicaid because private payers don't have a way to pay for a lot of these crisis services.

And I know there are folks that are working on new codes or identifying codes that commercial payers could be using, but I think that's essential and I think it is part of parity enforcement because it's not only saving money but it's actually delivering the right level of care for the level of need that the person is experiencing. And so when we look at Wit v. United and other cases where payers are using idiosyncratic or non-evidence based guidelines to make determinations. I think this falls under those considerations. Why are payers not covering the continuum of care that is established in the national guideline. I think that's a critical issue and I hope we can address that.

My issues personally are past, but for all the other families I think and individuals that experience a system that isn't set up to meet their needs, but we know what to do, and we are doing it in the public sector, there's just not really an excuse for that.

In terms of what the federal government can do, I mean there are a lot of really exciting new opportunities, but I would remind people that the set aside for crisis services in the mental health block grant is not permanently authorized. So with the flick of a pen, that could change. And so that's something — I mean there are some real basics that we need to think about. That permanent set aside crisis in the SAMHSA's authorizing language, we could authorize funding for mental health crisis response pilots. I think, Richard, one reason why it's hard for states to take advantage for some of these funding opportunities is because they haven't done the program in the first place. And so you're kind of going from 0 to 60. And that's exactly the kind of seed funding that SAMHSA is actually very good at doing, right. Like here's a grant, three to five years, test it out, get your data, get your workforce in place, get your certifications in place, and then you can scale it because you know how it works. And for those programs, I would say it is NCTs — normal crisis teams — those are important, but also the peer and provider navigation teams, also in home crisis stabilization. You know, it doesn't have to be build a

facility, it doesn't have to be something that is as elaborate but can be smaller or lower key solutions as well across that continuum.

And if we could authorize — if we wonder why is this such a heavy lift, I was just waxing nostalgic the other day and looked back through some old budget docs and the budget for the lifeline in 2018 was less than \$10 million. So I know in your paper, Richard, you said like the 280 is 10X. But in 2018 we were at \$7 million. So this is a pretty rapid shift in four years, four to five years. And we have obviously under invested in the system and we have never authorized direct funding to the regional and local contact centers that comprise the lifeline network.

So if we're struggling now to professionalize it, we have no one but ourselves to blame for that. But that I think is something that could — investing in that technology, the training, the operations, not only for the states but for the centers themselves, for Vibrant, who operates the lifeline, I think all of those are important aspects. I think we could extend capital development grants to crisis receiving stabilization facilities and crisis contact centers. As you noted, those are massive investments. But why can't there be a federal-state partnership in enhancing them and accelerating that build? And obviously, I think it's been said once if not a dozen times, but the workforce. When we have a workforce shortage across the board already, but now we also have a workforce shortage for our crisis call centers, our NCTs, and our receiving and stabilization programs. So we need that full spectrum from licensed independent practitioners, we need the docs, the psychiatrists, the counselors. But we also need the peers, we need the coaches, we need the other types of supportive professionals to help build out that whole crisis system. And I think it will be through workforce investments at the federal level as well as the state level.

MR. FRANK: So on that note, sort of continuing down that road, I wanted to ask both Hemi and Ayesha in a sense when you sort of looked out there into kind of the states and the communities that you work with, some places have been very successful figuring out how to do this on their own. And to some extent the opportunities are short lived typically. So as Kana just pointed out, there's been a big infusion. It may not be there tomorrow. And even the one that we're most interested in making permanent is a small portion of what we need.

And so at the end of the day, what are the strategies that you've seen be successful in the states, both Hemi and Ayesha, is sort of promoting this kind of thing so that, as you say, states can learn from other states?

MS. TEWARSON: Ayesha, I'm happy to go first and you follow up with your thoughts.

So there's a couple of states that came to mind when you asked that question, Richard, and I think this is an evolving topic. And I think the workforce shortage in particular is also evolving. That's going to impacts all of these aspects of what maybe states had success in the past, they're going to continue to be challenged on workforce. So I'll just stay that.

I double down on Kana's comments about really investing in the workforce and thinking about that holistically. But Arizona is an interesting state. We worked with them when I was back at NGA and what I like about their model is really it considers all aspect of the crisis continuum. They connect crisis lines, they have mobile mental health teams, they really have the partnership with the justice system, which I think is so important. You know, responders can drop individuals off at crisis dedicated centers, law enforcement drop offs are expedited and clinicians can provide assessments and interventions in the first 24 hours. And I really think as a result of that they have seen — and this is at a statewide level, right, which is hard to do — and that was really I think — there was a leadership push, I think back to Evelyn's point, at the Medicaid level and then on the justice side as well, and frankly at the gubernatorial level of we need to do something and let's all work together. So think some of that led to kind of where they are today.

I think Georgia is another interesting state. They have used a number of policy levers to build their crisis system and they could be a national model as well. They've used Medicaid effectively with their administrative claiming and they've worked with a cost allocation plan that considers the Medicaid penetration rate for the services. They also — to Vikki's point, there are all these Medicaid options that existed beforehand where you can really take advantage of. They used the Medicaid rehab option through state plan amendment and they also fund the infrastructure needs for call center, mobile responsive facility based care. So I do think they're an interesting model in terms of how to build a more sustainable financing strategy around this. Although I do think we need to bring in other payers as well.

I think I'll just say a couple more and then I want to turn to Ayesha. Colorado I think is really interesting. They had some leadership that was very focused on suicide frankly a number of years ago and they've really built a crisis continuum that has warm and hot line crisis care, as well as I think just a crisis service unit. And I think they've been really good at leveraging their community stakeholders in areas like bringing transport of individuals in crisis to facilities, which has really been a constant challenge. And then so they don't have to just rely on local law enforcement, they've actually used in rural areas, like grant to community organizations who have then helped to provide transport, which I think is also a model to think about in other parts of the country.

And then one that I just have to share that's really interesting is Alaska. Just because they are so different with their challenges with respect to their population as well as their geographic vastness. I mean they are the largest state by geographic lines. And they actually have an innovative Medicaid waiver where they consider the roles of various members of the crisis response workforce from EMTs to peers. And we've been talking a little bit about peers in this conversation. And they really leverage unlicensed workers. Like sort of by peer as in volunteers. And they've also been working with several municipalities to provide Medicaid bill the services through local fire and EMS. I think that's an interesting model of how do we really get creative around who can work in the system.

I think what's also really interesting to Ayesha's point earlier about sort of equity and thinking about how do you meet the needs of the community in a more effective way, there the state's Indian Health Service — which they have a very close partnership with their Indian Health Service. I think probably one of the closest I've seen across the states. They've engaged native Alaskan communities to develop new workforce categories, like behavioral health aides, to respond to behavioral needs in frontier areas. And I think that has been really critical and really being able to connect with the community and having sort of community actually reflect how the workers are reaching out to them.

And I'll say, finally, last but not least — Ayesha, I hope to save some thunder for you — is New Jersey. I think they've been really interesting in leading the children's mobile crisis services through their mobile response stabilization and intervention where behavioral health workers are available to any family anywhere in the State of New Jersey anytime. So I just think their outreach to families and

children, I think to Kana's point, of really understanding where to go has been I think particularly impactful with respect to kids.

So, Ayesha, you probably have some more to add on.

MS. DELANY-BRUMSEY: Thank you. I mean all those were great.

And I think when I was also thinking about your question, Richard, I was also really interested in sort of the local level and what's happening. What we're seeing happen at the local level because particularly when you're talking about intersection with the justice system, the justice system is very local and you're thinking about how people get into contact with law enforcement and jail. So many of the places that I was thinking about actually are within some of the states that you elevated, Hemi. I think having that statewide structure allows for local jurisdictions to build out innovative responses.

So, for example, when we're looking to Arizona, many people talk about Pima. They have a fantastic system. But there are other jurisdictions in Arizona that have done really fantastic work and one of them I wanted to elevate was Yavapai County, Arizona, which is really rural. And so to the point that many people made on the call, building crisis systems in rural communities is a particular challenge. You have enhanced workforce challenge, there's less transportation, so people with lower incomes have a harder time getting to services, and many other challenges that are specific to rural communities. But Yavapai County, which covers about 8,000 square miles, which for people who are kind of directionally challenged as I am, that's about the size of Massachusetts, and has about 240,000 people over that area. Because Yavapai County has had a couple of things in place in addition to what's going on at the state level in Arizona, I think what's been really helpful to them to build out crisis systems to the points that Justice Stratton made, as well as others, they've had real leadership within both their law enforcement and sheriff's offices and their local behavioral system to say that addressing the needs of people with substance use and mental health conditions within the justice system is a priority for us. And so they've had that leadership to come together and actually built a joint initiative that was focused on implementing supports at every single point from crisis system to reentry with the goal of reducing incarceration and criminal justice system contact for that population. And with that, they did a number of initiatives. We talked about training officers, 24/7 crisis stabilization unit. They also, to the point about

transportation, provide transportation to people to service when they are leaving the jail to make sure that people who don't have access do have good outcomes and are able to access services. They have a very interesting model where they're able to provide mobile crisis responses over the size of a place as large as Massachusetts in 30 minutes or less. And they do that by utilizing staff members who are at home and can use their own vehicles to get to those crises.

So they've really tackled some of the challenges that we're seeing in rural communities and they are also one of those — as I mentioned earlier through JMHCP, they're actually one of those communities that serves as kind of a peer to peer learning site and provides guidance to other jurisdictions who look like them or who look similar who might want to build out those services.

You know that kind of leadership, data informed practice, and then building over time a series of interventions to reduce systematic contact for this population is something that we're also seeing in places like Houston, Texas. So I remember — it couldn't have been terribly long ago, maybe five or six years ago, when I heard about their crisis call diversion program where they were on the — I think the first place in the country to put a person with a — a behavioral health professional in their 911 center to divert and triage calls. That blew my mind. I had not ever at that point, five or six years ago, considered that as one of the ways that you would infuse a behavioral health response as early as possible into your public safety system. And so because of the leadership of Houston's public safety, law enforcement, as well as their behavioral health system, they've been able to use that as well as their mobile — the ability to provide crisis counseling on the phone and also to deploy mobile crisis teams and to provide follow up to really improve outcomes for people in crisis. And they have a number of other sort of — a number of other initiatives as well within — that include training for officers, as well as places where — a homeless outreach team, and initiatives that focus specifically on people with frequent contact to try to reduce that frequent contact that have been very successful.

So I would say just overall the elements that we see that make this successful from a kind of programmatic policy perspective is the leadership, the partnership, the commitment that this work is important and that you're going to use data to track your outcomes and that you're not going to stop with just one initiative, you're going to build out an entire sort of vital continuum of support.

And so I think those are just two of the examples that I wanted to elevate there.

MR. FRANK: Great. Great. Thank you.

Evelyn, I wanted to sort of stay with the leadership point here. Probably the thing that's most informative to at least many of the people who are listening here, is how does one really engage the judges, the justices, the sheriffs? Because as you pointed out, those are incredibly important leverage points in the system.

MS. STRATTON: Well, I find that a lot of times it starts with somebody who's not in leadership going to the leadership. Like when I started working on CIT we didn't start with the sheriffs, we had — I just gave speeches. Every time we have a campaign, you give hundreds of speeches, and I spoke about it every speech, every campaign I had. And I would have a deputy or some line staff officer go to their chief and say I heard about this program. It sounds like it really makes a lot of sense. And that is how it got going. Or we would have a probation officer go to a judge and say, hey, we've heard about this specialized docket and we think that would be a great thing. Because every judge that does a specialized docket becomes a community organizer and community leader.

And so sometimes it takes someone who goes up to a person of leadership and says, why don't you do this. With Mike DeWine, when he was AG, several people went to him and said we need to do a statewide committee. I was already doing one and he approached me and asked me to merge with his. But his staff was the one that went to him. Somebody from NAMI. NAMI's been very influential in Ohio in getting leadership involved and our head over at NAMI, Terry Russell, has a close relationship with the governor and he's not afraid to use his bully pulpit. So you don't always stop with the top, you start with people — any on this call — going to somebody in leadership and saying this will get done a lot faster if you're willing to step forward. And we'll help you do the work, we'll help you get the staffing, or whatever you can offer to lend support. But it doesn't have to start with that top person having that image or vision or whatever. It often starts below and works its way up.

MR. FRANK: Thanks.

This discussion has been super rich. I want to sort of shift gears a little bit here and get to a couple of the questions that have come in our last few minutes.

And the first one I'll start with Vikki, but Hemi might want to jump in on it as well, which is how are states preparing to deal with the 24/7 requirements for getting the enhanced match on the mobile crisis provisions from ARPA?

MS. WACHINO: Great question, Richard. Thank you.

The new Medicaid mobile crisis incentive includes a number of policies that states need to operationalize in order to qualify for the increased Medicaid matching rate. And one of them is that services need to be available 24/7. And I imagine that congress created this requirement because it wanted services available to people around the clock. People are in crisis around the clock and they can't wait for services. That would produce bad outcomes. And yet I think in a number of places across the country the operations behind building to 24/7 are challenging. And it's not necessarily a service that's been available 24/7 historically.

So what I've heard from states — and in this work I am informed by a project that — and a report that will be out in the next week to 10 days with the technical assistance collaborative looking at how 5 states have implemented mobile crisis response. And we learned is that particularly in states where there are significant rural or frontier areas, 24/7 services are going to be very challenging. I was very happy to hear Ayesha's example in Arizona. It sounds like there's something we could all learn from there. But in places of the country where we have not had access to behavioral health services, it's going to be a challenge to build out 24/7 response. And I think states are feeling that now as they try to stand up these new services.

There are a couple of potential mitigations in CMS's mobile crisis guidance. They clearly recognize the role of telehealth in helping to achieve access to services and that Medicaid would pay for services provided over telehealth. So that can help fill some of this gap. I would also encourage states and CMS to think about payment rates to providers. Providers have to be paid enough to recruit people to perform the services and to provide access to services. So I think that there is an ability for states to encourage provider participation and get to 24/7.

And then the last tool that's available to states right now are ARPA grant funds. Both the block grant funds and some of the more general ARP grant funds for Covid response that have gone to

both state and local governments can be used to build some of the infrastructure behind these new programs.

So I think there are things that states and local governments can do to get to 24/7, but in some parts of the country it could be a stretch and take a little bit more time.

MR. FRANK: Hemi, do you want to add anything or are you —

MS. TEWARSON: Well, Vikki had a fantastic answer. So the only thing I'll add on is NASHP is currently working with five states on mobile crisis response. And I think all of the issues she just raised are what we're hearing from them directly. These are states with some big frontier areas.

Two of the things, just to add on, that I just wanted to emphasize, was some of the states are thinking about how do we ease barriers to certification and roles for teams for non-licensed staff. So as you think about who can provide the services, thinking more creatively about how to fill those roles. I just did want to raise that. I'd also say I completely agree with the hybrid responder telehealth delivery model. I think that's going to be a necessity for some parts of the country. And thinking about how to pay for that I think is continuing to sort of challenge some states. You know, how to think about oversight and payment on sort of a longer-term basis, not just in the context of the pandemic, but what follows the pandemic.

And then the third piece I'll just say is the role of call centers and how to use call centers effectively in conjunction with then the local service of making that connection very clear. And I think that's where some work — you know, I think some states have made some progress on that and others I think there is a way to go. But I think all of this like — I guess the theme is like workforce, creativity about the workforce. I will just keep saying that because I think we all need to offer really interesting ideas.

And one thing I just want to say before we end this, Kana's point earlier about the federal government's role on workforce and how to help with these specific models, I really would ask for how do we get guidance, more guidance from the federal government about how to think about some of these pieces. Not necessarily requirements, but guidance and models. I think I'm feeling this in the context of the pandemic and in the context of sort of building a crisis response. States just need ideas and more concrete how to's. And I know there's a lot of effort going on for that, but I do want to emphasize that

point. There's so much going on in the context of trying to recover from this pandemic. The more that we can give them, the more they'll have to be able to build off of.

MR. FRANK: Yeah, the last word I had was — or question was actually one that's come in from several forums, which I would say goes to Kana because what you just said, which is in a sense you can't — given the diversity that's out there, where we are and what the approaches are, a single platform isn't right. But then the question gets to what can the federal government do to sort of set something like a platform that all the states can build on to sort of solve some of these problems.

MS. ENOMOTO: I mean I give — we may not all be aware, but I give SAMHSA and its partner federal agencies a lot of credit for the work they are doing. This week they are meeting with (inaudible) and CMS and NAMD to think about how do we have more sustainability leveraging Medicaid for crisis services. I think they are working with a set of planning partners to create readiness assessments, playbooks, and a road map. So the idea isn't one size fits all, but I think you need to spend the time, and SAMHSA is spending the time, trying to understand what is out there, where is everybody. We're a little bit behind, but I think in short order they will have a better sense of where the different states are. Vibrant put out its state planning grants. I think through that process you can probably derive archetypes or quartiles or learning communities where we can group folks into — that are prioritizing like issues or experiencing like challenges where some other rural frontier states can learn from others who are doing things that are really cool in terms of how do we make our services work remotely or those who have developed really strong training programs can work with one another or lend their expertise to others. I think it's fostering the ability of states to learn from each other and then creating those collaborative opportunities where they have similar interests and issues and delivering that kind of targeted technical assistance and facilitation.

MR. FRANK: Thanks.

MS. ENOMOTO: And they're on their way.

MR. FRANK: Thanks, Kana. I really appreciate that.

We're just about out of time and so I wanted to personally thank all of you. This has been an incredibly rich conversation and hopefully it's the first of more to come. And I also wanted to thank the

folks at Brookings who supported this — in particular Megan Waring and Kate Hannick. And again thank the audience for their participation. I hope we got a bunch of your questions answered and that you will continue to put effort and thought into all of this good work. And finally, I think we should all be grateful to the Senator for having gotten us off to such a good start.

So thank you very much and we'll see you soon.

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