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The Center for Law and Social Policy

YOUTH MOBILE RESPONSE SERVICES

AN INVESTMENT TO DECRIMINALIZE MENTAL HEALTH

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EXECUTIVE SUMMARY

The year 2020 forced many Americans to evaluate the role of law enforcement and mental health systems in the United States and their relationships to racial justice. After investigating and understanding the long-standing history of both systems, we recognize that each have caused harm to communities of color. These systems have been complicit in racism and discrimination, perpetuating negative narratives about Black Americans, specifically young Black people with mental health conditions.

In this report, we examine *mobile response*—an alternative to using law enforcement to respond to mental health and social crisis. Mobile response is one service in a continuum of crisis services for rapidly responding to youth and young adults who are experiencing a traumatic event, mental health symptoms, and/or crisis in their communities. While many states already have a mobile response system, they often lack the resources and structure to effectively and equitably engage communities of color. In this report for federal, state, and local government entities, we offer examples of states (Connecticut, Oklahoma, and Oregon) that have created good mobile response systems, principles for implementation, funding opportunities, and federal recommendations.

Mobile response as a first responder model is only as good for safety and healing as its implementation. We have created the following key principles for effective mobile response programs, which must:

1. **Invest in a police-free mental health response.** Mobile response should solely be handled by mental health professionals. Co-responder models with law enforcement are neither safe nor equitable.
2. **Create their own point of entry.** Mobile response systems should use a different phone number than existing emergency lines such as 9-1-1. Creating their own points of entry will make the services more inclusive to Black and brown communities.
3. **Train all staff involved in mobile response.** Everyone from the dispatch team to EMTs should be trained on how to acknowledge and engage someone who is experiencing a crisis. This will alleviate the issue of police presence from the onset.
4. **Not require mental health responders to have professional degrees.** Peer support specialists and community health workers are essential to the mental health system. Their knowledge and relatability cannot be replicated through a degree.
5. **For mobile response to be effective and equitable, services must be Medicaid reimbursable for all organizations and providers.** Medicaid provides sustainability to many services, including mobile response in some states. However, peer support specialists and peer-run organizations are often ineligible to obtain Medicaid support because of their non-traditional treatment options. For mobile response to be effective and equitable, t must be Medicaid reimbursable for all organizations and providers.
6. **Invest in a continuum of services to address the whole person.** Mobile response is only one way to ensure Black and brown people are safe and policymakers are financially supporting their communities. These communties also need jobs, quality education, access to more mental health supports, grocery stores, affordable housing, and so much more.

In addition to these key principles, mobile response services need additional funding support through Medicaid and the federal government. Currently, many states' mobile response systems are funded through multiple sources, including Medicaid 1915 (b) and (c) waivers, as well as 1115 demonstration waivers. These waivers have made it easier for states and localities to sustain their crisis services without relying on grants. But the federal government can do more by:

- **Effectively implementing the National Suicide Hotline Designation Act.** This law, which Congress passed in 2020, assigns 9-8-8 as the national suicide and mental health crisis hotline telephone number. Mobile response services should use 9-8-8 as dispatch to their mobile teams. This would help reduce costs for staff and additional infrastructure.
- **Passing the Crisis Assistance Helping Out On the Streets (CAHOOTS) Act.** This bill proposes an enhanced federal matching rate of 95 percent for mobile crises services. This would incentivize states to make their mobile response services Medicaid reimbursable.
- **Changing the priorities of the Substance Abuse and Mental Health Services Administration (SAMHSA).** Normally, SAMHSA's priorities are married to the agenda of the sitting president, which makes it hard under some administrations for states to seek guidance on services like mobile response. Because of the passing of 9-8-8, SAMHSA should create a permanent initiative to focus on technical assistance and best practice dissemination for crisis and mobile response services.

OVERVIEW

THE 2020 CORONAVIRUS PANDEMIC AND UPRISINGS FOR RACIAL JUSTICE HAVE FORCED A NATIONAL RECKONING WITH THE LONG U.S. HISTORY OF HEALTH INEQUITIES AND RACIAL INJUSTICE. This reckoning has included a long-overdue evaluation of investments in "helping" professions and systems, including law enforcement and mental health. Repeatedly, law enforcement and the criminal justice system have been the sole responders to mental health crises in marginalized communities leading to many people incarcerated or dead.

PEOPLE WITH AN UNTREATED MENTAL ILLNESS ARE 16 TIMES MORE LIKELY TO BE SHOT AND KILLED BY THE POLICE.[1] THEY ALSO ACCOUNT FOR ONE IN FOUR OF ALL INDIVIDUALS WHO ARE INCARCERATED IN JAILS AND PRISONS. [2]

However, Black people with a mental health diagnosis are more likely to be incarcerated than any other race.[3] The disproportionate incarceration of Black individuals with mental illness is a consequence of discriminatory policing, Black communities' lack of access to quality mental health care, as well as discriminatory practices by mental health systems.

These practices include providers' bias, prejudice, and the stereotyping of the Black community, which has led to frequent misdiagnosis of Black patients.[4] These pernicious practices and pervasive inequities by the mental health system have been a main contributor to and a consequence of the narrative that Black people are dangerous. Both systems have failed and actively discriminate against Black and brown people, deepening the pre-existing intergenerational trauma and mistrust in systems these communities already face.

Historical and generational trauma can lead to pervasive physical and mental health conditions, including cardiovascular problems, addiction, obesity, and diabetes that percolates down to the younger generations. More specifically, young people of color experience high rates of anxiety, depression, and suicidal thoughts and ideation partially due to racism and daily social inequities.[5] In the last year, more than 9 percent of young Black people reported having a major depressive symptom.[6] Moreover, between 1997 and 2017, the suicide attempt rate for Black youth increased by 73 percent, making it the second leading cause of death for this age group.[7]

While Black and brown youth face a range of mental health conditions, they often do not have access to mental health services in their schools or communities or lack insurance coverage to receive quality mental health care. Because of the lack of investment in mental health supports in their communities and schools, more often than not, **Black young people's first encounter with mental health services is through the justice system or in emergency rooms.** These are inappropriate and expensive points of entry that further stigmatize mental health conditions as dangerous and also perpetuate the racist notion that all Black people are criminals. Mistrust in both law enforcement and mental health systems explains why close to half of Black youth are not seeking treatment for their mental health symptoms.

This history demonstrates that Black people and other communities of color need more than reform and incremental change. Black communities need transformational change, bold and radical investments in systems that increase safety, healing opportunities, and programs that address the historical and intergenerational trauma caused by systemic racism in general and in our "helping" systems specifically.

Mobile response is a 24-hour rapid response service for youth and families that are experiencing crisis, a traumatizing event, or any other mental health symptoms. This program serves as one option to keep young people safe and treat their mental health needs. Mobile response is not a panacea for all police-related calls, but it is an investment that will make Black and brown communities safer. Furthermore, mobile response without police presence reduces further harm and trauma.

This report highlights why mobile response is one effective and "safer" alternative to law enforcement for youth experiencing mental health crisis. It aims to:

- Highlight critical principles for implementing a statewide youth mobile response system that works effectively.
- Feature/ spotlight different youth mobile response services across the nation.
- Outline federal opportunities that will support states in implementing mobile response services.

HISTORICAL CONTEXT

Since the beginning of the 20th century, law enforcement has increasingly responded to social crises, including non-threatening emergencies such as school discipline matters, domestic disputes, and mental health issues. In the mid 20th century, law enforcement was used to remove people with behavioral health conditions from their communities and place them in confined facilities or jail; many were released with little to no ongoing treatment.[8] Now, law enforcement and the criminal justice system as a whole have been the primary institution to handle mental health issues, especially for people of color. **Approximately 10 percent of all police contacts involve persons with serious mental illness.[9] Only 4 percent of the calls law enforcement responds to are considered violent.** The reliance on law enforcement and the criminal justice system to intervene in non-threatening crises, particularly in communities of color, is evidence of how behavioral health systems, school-based mental health supports, and community-based organizations are under resourced in low-income communities. This reliance on law enforcement and the justice system also underscores how racism toward communities of color leads to officers treating the symptoms of trauma exposure as dangerous and criminal.[10] This exacerbates the harmful and inaccurate stereotype and also perpetuates the stigma that people with mental health conditions are dangerous and violent.

Each year approximately two million people with mental health conditions are locked in jail. Police are more likely to shoot and kill a young Black person exhibiting mental illness than a young white man.[11] Additionally, nearly half of the individuals in state prison have a mental health condition.[12] **Of the two million youth arrested annually, 60-75 percent have at least one mental health diagnosis.**[13] These statistics show that the police and criminal justice systems are overly used for mental health services. Moreover, one in four of those youth has a severe mental illness, impairing their ability to function. The use of law enforcement as responders to mental health crises further criminalizes young people and exacerbates their mental health symptoms.

Law enforcement is not the appropriate profession to respond to mental health crises, even when they are trained to assist in a social (domestic violence, displinary action in schools, youth experiencing homelessness living on the street) or mental health crisis. For instance, officers typically receive only 4 to 12 hours of mental health training during police academy and 8 hours of crisis intervention training—yet they spend 58 hours in firearms training.[14] Overall, law enforcement should have no role in social crisis matters. We must make healing centered investments that recognize and atone for the historical and ongoing harms caused by law enforcement. Such investments can increase community capacity to support wellness and respond appropriately to mental health challenges. We must also stand up mobile response systems that do not include law enforcement.

WHAT IS MOBILE RESPONSE AND MOBILE CRISIS?

Mobile response is a 24/7 service that provides rapid response for individuals and families experiencing crises, traumatic events, or heightened emotional symptoms that have inhibited their ability to function or cope. Another term used interchangeably throughout the nation is *mobile crisis*. However, mobile crisis has primarily been used as a service that provides response to youth and young adults who have pre-established acute mental health diagnoses, meaning providers will not respond to the crisis unless the youth or young adult is actively experiencing significant and severe psychiatric symptoms. Mobile response allows the youth and young adult or their families to define the crisis for themselves. Mobile response is the preferred service to ensure police free mental health. Both mobile crisis and mobile response are part of a larger continuum of crisis services,[15] including:

- 23-hour crisis stabilization/observation beds,
- short-term crisis residential services and crisis stabilization,
- 24/7 crisis hotlines,
- warm lines,
- psychiatric advance directive statements, and
- peer crisis services.

Like many other services, child- and adult-serving systems often silo their crisis services, with separate crisis systems for children and adults. In many states, youth are eligible for youth-serving mobile crisis services up to the age of 21. However, some states have exceptions for serving youth up to 24 or 25. Most mobile crisis services are staffed by mental health professionals and/or trained teams skilled in

- crisis intervention,
- de-escalation,
- clinical assessment addressing severe mental health issues,
- developing crisis safety plans to address risks and behaviors associated with mental health and substance use issues, and
- coordinating short-term crisis placements for people.

Youth mobile crisis services across the nation have led to several positive outcomes. These include decreased emergency room (ER) visits and creating access to less restrictive treatment options, such as having someone available on demand, using more compassionate treatment protocols, and removing insurance as a barrier. Other mobile crisis programs have been linked to decreases in school arrest, improved school attendance, and a decline in police calls. Mobile response allows providers and clinicians to meet people where they are, physically and emotionally. It provides youth and young adults with services they may not usually have access to in their schools or communities. In many states, mobile crisis services were implemented in response to children and young people seeking mental health services in ERs. However, states with robust programs have seen the impact of the services infused into many other aspects of young peoples' lives, such as mental health supports in schools and a de-escalation tool in the community. Mobile crisis and response represent a healing investment that has positive outcomes for mental health and community safety.

A few states have taken mobile response a step further and have started to use it as an alternative to policing altogether. While many of these states use co-responder models that work in conjunction with the police, youth mobile response programs are most successful when they respond without law enforcement. Locations that have started to use mobile response instead of police for mental health related calls have seen significant positive outcomes, including a reduction in cost, as well as a decrease in hospitalization and confinement. The average cost per case was 23 percent less for persons served by the mobile response team.[16] As more states begin to adopt mobile response they must adhere to the following key principles to ensure positive outcomes for the communities they serve and to dismantle the harms experienced by Black and brown communities.

PRINCIPLES FOR INVESTING IN MOBILE RESPONSE AND CRISIS SERVICES

Mobile response as a first responder model is only as good for safety and healing as its implementation. Mobile response services must be trauma informed, healing centered, culturally responsive, and developmentally appropriate.[17] They must also adhere to the following key principles:

1. **Law enforcement is not the appropriate response for individuals and communities in crisis. We must invest in a police-free mental health response that keeps our communities safe.** A co-responder model where police respond with mobile crisis teams perpetuates the criminalization of mental health and disparately impacts communities of color. As highlighted throughout this report, police are harmful, traumatic triggers for many people in communities of color. Including law enforcement in social crisis and mental health related emergencies is more dangerous than helpful.[18] Co-responder models prevent people from building trust in mobile response as an alternative to calling the police.
2. **Accessibility is a major component to an effective mobile response service and program, beginning with the phone number. Mobile response services must have their own point of entry.** Best practices call for using points of entry for mobile crisis response services that are independent of existing emergency numbers. Existing programs that use the non-emergency line for law enforcement or 9-1-1 directly should change this set up; otherwise, communities of color may not use their services because of the connection with the police line. Using a different line from emergency response makes mobile services more accessible to everyone.
3. **Training is an essential part of mobile response to ensure harm reduction, and positive outcomes. We must require all staff involved in mobile response delivery to be extensively trained.** When implementing mobile response, states must ensure that everyone involved is trained on many issues, including crisis intervention, de-escalation, culturally responsive services, trauma-informed care, and disability awareness. These skills will ensure that people's needs are being met at the onset of a call. It also allows the dispatch team to be able to differentiate between a crisis and an emergency. Additionally, while we strongly disagree with co-responder models and law enforcement responding to mental health calls in general, if a call gets directed to law enforcement, police officers should be trained in mental health first aid to understand what mental health crisis looks like and transfer the situation to a mobile crisis team.

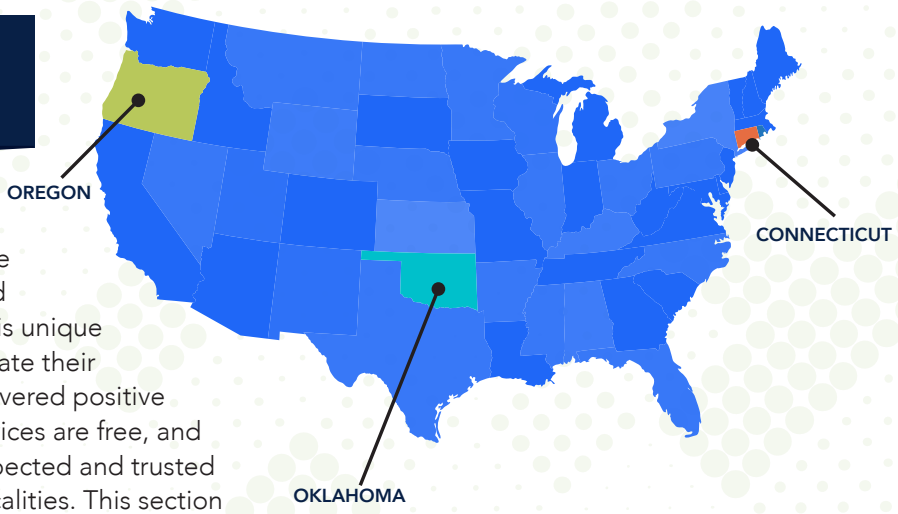
WHAT IS MENTAL HEALTH FIRST AID?

Mental Health First Aid is a skills-based interactive training course of at least eight hours that teaches participants about mental health and substance-use issues. During this course, participants are able to learn how to assess for risk of suicide or harm as well as identify if someone is experiencing a panic attack, acute psychosis, or a reaction to a recent trauma. Additionally, participants learn to assess the crisis to direct people experiencing a mental health crisis to the correct supports and resources. This training would be valuable for law enforcement officers in the event they mistakenly respond to a mental health call. Then, they are able to assess the situation, determine and summon the correct responders for the crisis, and leave the scene.[19]

4. **The involvement of people with lived experience is crucial to all mental health services and supports. We must ensure individuals are not required to have a professional degree to be mobile responders.** States and localities differ in size and population, meaning staff capacity for mobile crisis response must be proportionate to the population of the state to have high mobility rates (dispatched to crisis at high rates) and for the response to be effective, consistent, and reliable. For geographically smaller states, it may be easier to achieve high mobility rates. For bigger states and cities, this may not be the case, especially if the requirement is to have a professional degree, or if clinics don't appreciate the expertise of people with lived experience. Our nation has a shortage of mental health professionals, with only one mental health clinician for 529 people who have unmet mental health needs.[20] If policymakers waited to fill the quota for the number of mental health therapists we need, then the mobile response would never have sufficient capacity. Mobile response services must include positions for peer support specialists and community health workers. Both roles create trust in the community but also provide a level of knowledge that people with professional degrees and no lived experience simply cannot replicate.
5. **Medicaid is an essential part of ensuring mobile response is funded, well-staffed, and reimbursable for all providers, especially peer support specialists and community health workers. We must ensure mobile response is free for clients and reimbursable for the breadth of providers who provide mental health services and support.** Currently, many states' Medicaid programs do not reimburse peer support specialists or peer-run organizations for a number of reasons that include states' definition of medical necessity. Peer support specialists use non-traditional modes of treatment to help people with recovery and healing. However, peer support specialists are essential to the mental health system and provide a number of positive outcomes in mobile crisis programs. Still, more often than not, their services are not adequately reimbursed by Medicaid to sustainably fund their organizations. Where implemented, Medicaid funding for peer support specialists and peer-run organizations has increased organizational revenue, sustainability, and ability to reach more people in distress.[21] State Medicaid programs must understand the critical role that peer support can play in youth mobile response services and ensure that these services are reimbursed equitably.
6. **Mobile response is just one component to ensure safe communities and police-free mental health. We must also invest in a full continuum of services, and supports that address the whole person.** Sometimes a crisis falls beyond the parameters of a mental health provider and service. The crisis could be about a lack of resources and basic necessities, such as housing, food, employment, or money—things that are not easily accessible in some communities. Mobile response will not be funded to provide everyone with everything they need. In conjunction with mobile crisis, we must invest in Black and brown communities, creating a full continuum of services and other suppports, infusing the communities with employment opportunities, providing access to healthy foods and grocery stores, developing social programs and affordable housing, transforming the education system, and creating pathways for postsecondary education and careers.

These principles put Black and brown communities first, ensuring that they are invested in while diminishing harm and addressing inequities enacted by this country. These principles serve as a guide for individual mobile response teams, localities, and states on the implementation process to design the most effective programs. Yet, we also need federal investments to create sustainability and accountability for mobile crisis programs across the nation.

BEST PRACTICES



Connecticut, Oklahoma, and Oregon all have promising youth mobile response models that could be scaled up and used around the nation. Each of the locations is unique in their strengths and the ways they operate their mobile crisis services. Still, they have delivered positive outcomes for their communities, the services are free, and their mobile crisis systems are highly respected and trusted by the constituents in their states and localities. This section provides an synopsis of each state, including:

- an overview of the services offered by mobile crisis,
- a summary of how the system is funded,
- the outcomes they have achieved through mobile crisis services, and
- the key strengths of their systems.

CONNECTICUT

Overview

Connecticut has a statewide mobile crisis service. To meet residents' needs, the system was redesigned almost 12 years ago in conjunction with the Department of Children and Families Services and The Child Health and Development Institute (CHDI), which is a contractor.[22] Connecticut uses the 2-1-1 number as the point of entry for services. When someone under the age of 18 is in crisis, community members, parents, schools, case managers, or the youth or young adult themselves can dial 2-1-1 (open 24/7), and the crisis staff links them to the appropriate mobile crisis provider (a licensed or licensed-eligible clinician) for their town. Currently they are actively considering renaming their services from mobile crisis to mobile response.

> The system's motto is
> **THE CRISIS IS DEFINED BY THE CALLER.**

Funding

Connecticut funds mobile crisis services with multiple sources, including federal block grants, philanthropy, Medicaid, private insurance, and state allocated funding. The collaborative funding paves the way for the services to be free for clients and reimbursable for providers. Connecticut has six primary contractors across the state where the mobile crisis teams are located. Each contractor gets a grant from the state's Department of Children and Families (DCF). Plus, clinicians have a set fee-for-service (FFS) rate they use for billing Medicaid under specific mobile crisis codes. Providers have also negotiated the cost of mobile crisis services with private insurance companies.

CONNECTICUT'S MEDICAID REIMBURSEMENT RATES

Service Billing Codes	Billing	Rates per encounter
Crisis Assessments	S9485	$175.00
Crisis Team Assessments	S9485HT	$255.00
Crisis Follow-Ups	S9484	$85.00
Crisis Follow-Up Teams	S9484HT	$125.00

Outcomes

Since the redesign of its mobile services, Connecticut has seen 92-93 percent mobility rates, meaning providers were dispatched to a crisis over 90 percent of the time when called. They have achieved several positive outcomes, including reduced emergency department visits [23] and an improvement in youth functioning after receiving services. In 2019, a survey conducted among Connecticut parents using the Ohio Youth Function, Problem and Satisfaction Scale [24] (a set of four self-report questionnaires used to assess the improvement and outcomes of children and adolescents who have received mental health services) showed an average of 8.8 percent improvement in child functioning and 10.8 percent decline in child problem severity following mobile crisis involvement. Additionally, the state's mobile crisis units partnered with schools through a school-based diversion program to address the school-to-prison pipeline in schools with the highest arrest rates. Participating schools opted to call mobile crisis rather than law enforcement and saw a decrease in school arrests of 40-100 percent.[25]

Strengths

1. **High Mobility Rates.** Connecticut's mobile crisis providers are required to respond to 90 percent of their referrals in under 30 minutes (also called the mobility rate). The providers' current mobility rates are 92-93 percent. These high mobility rates have built trust in the community and led to more referrals. On average, the mobile crisis team responds to 15,000 episodes per year.
2. **Statewide System.** Connecticut's mobile crisis services are statewide, reaching every county. The Department of Children and Families contracts with six different clinics around the state and gives them grants to provide mobile crisis services. Additionally, Connecticut passed legislation (Public Act 13-178), which required schools and community-based organizations to collaborate with community mental health care centers, either through a memorandum of understanding or by developing procedures for mobile crisis referrals.
3. **Strong Data System.** Connecticut has a strong partnership with the Child Health and Development Institute (CHDI), which it contracts to run data analysis. Each year CHDI publishes an evaluation report [26] on Connecticut's mobile crisis interventions. With this data, Connecticut has been able to track the demographics of its clients and the impact across the state. Connecticut's robust data system has allowed administrators to adjust to the needs of the population but also make inferences on how to improve the system to reach populations that aren't represented in the data. The data holds the state as well as the providers accountable to the clients.

OKLAHOMA

Overview

Oklahoma's statewide children's mobile crisis response and stabilization system (CMRS) is similar to Connecticut's mobile crisis services in several ways. In the past five years, Oklahoma has redesigned its mobile response to address its constituents' needs. Before the redesign, the state offered mobile crisis services, which were only allowed to respond to acute mental health problems. Since the transition to mobile response and stabilization, providers can let the youth and families define crisis for themselves. This change allowed providers to assist and support more settings, such as schools and community-based organizations.

In Oklahoma, mobile crisis response and stabilization services are a part of Oklahoma Deparatment of Mental Health and Substance Abuse Services' Continuum of Care for children, youth, young adults, and their families. The CMRS system is designed to de-escalate the crisis; prevent possible inpatient hospitalization, detention, and homelessness; and restore youth to a pre-crisis level of stabilization. Then, immediate stabilization response is supplemented with a next day follow-up for non-hospitalized clients to continue support and provide assistance in following through with referrals and appointments. Providers tailor services to youth up to the age of 25 and their families and focus on family strengths, needs, and preferences.

Mobile crisis response teams are comprised of peer support specialists, care coordinators, and licensed clinicians. The mobile crisis response is a 24-hour, 7-day-per-week service that assists in substance use and mental health crises through telephone or face-to-face assessments[27]. Upon receiving a call, call center staff gather relevant information that includes contact information, presenting concerns, suicide risk, current living situation, availability of supports, risk of harm to and/or from self or others, current medications and compliance, use of alcohol or drugs, and medical conditions. Crisis call center staff then facilitate a warm handoff or transfer of care to the community Mobile Response Team (MRT) while on the phone with the caller. This warm handoff is more impactful than a simple referral and ensures that callers and children, youth, young adults, and families are actively connected to service providers. Once a youth or family is connected, they can determine what type of response they need; if the need is immediate, the clinician will respond within the hour; if not, they can delay the reply and make an appointment for the clinician to come at a later time.

Funding

Oklahoma funds crisis services through state funding and Medicaid. In previous years, Oklahoma has used a Substance Abuse and Mental Health Service Administation's (SAMHSA's) Systems of Care Grant to create the infrastructure and sustainability plan for its mobile crisis services. Now that the state is no longer receiving the federal grant funding, crisis services are sustained and fully funded by state and Medicaid dollars. More specifically, Oklahoma's providers receive 60 percent of their funding from state funds. Providers are able to use this funding for training, technology, and mileage for on-call staff. The other 40 percent is reimbursed by Medicaid, which covers the mobile crisis response and stabilization service itself. Additionally, the state fully funds the call center and evaluation services for mobile crisis response. With mobile crisis response being fully funded through state funding and Medicaid, crisis services are free for clients and allows the providers to be reimbursed.

OKLAHOMA'S MEDICAID REIMBURSEMENT RATE

Service	Billing Code	Billing Rate/ Unit
Crisis Intervention, Agency-Based Individual (LBHP)*	H2011	$27.86/ 15 minute
Mobile Crisis Team (LBHP)	90839 (First Hour of Service)	$131.02/ 60 minute
Mobile Crisis Team (LBHP)	90840 (Additional 30 Minutes of Service)	$62.86/ Additional 30 minutes
Mobile Response (FSP)*	T1027 GT	$9.75/ 15 minute

*LBHP = Licensed Behavioral Health Professional
*FSP = Full Service Partnership

Outcomes

Through these services, Oklahoma has seen the following positive outcomes:

- a decreased number of suicide calls to the police,
- a high rate of students receiving services and returning to class,
- a reduction in Medicaid costs, and
- a positive change in youth behavior and functioning.

These measures are presented to the Oklahoma State Legislature every year and have been instrumental in the sustainability of statewide mobile crisis response.

Strengths

1. **Mobile Crisis Response and Stabilization vs. Mobile Crisis Services.** Oklahoma's mobile response and stabilization services are more comprehensive than just a mobile crisis service. They provide a continuum of crisis services in Oklahoma, ranging from crisis interventions and mobile de-escalation to mobile crisis and case management. They also provide respite placements, follow-up, and referrals to ensure that youth and young adults are receiving the care they need.
2. **Reimbursable through Medicaid.** Most of Oklahoma's funding for the crisis continuum is through state allocated funding and Medicaid. With the Medicaid dollars, providers can be reimbursed for crisis intervention, crisis diversion, and crisis de-escalation. These additional services allow providers to do more than treat symptoms, but they also connect with youth and teach them skills that would not be possible if their funding structure wasn't strong.
3. **Connections to the State Suicide Prevention Hotline.** Oklahoma mobile crisis response collaborates with the state suicide prevention hotline to dispatch providers across the state. This collaboration saves money on new infrastructure and creates the first line of intervention for people seeking services.
4. **Evaluation and Data-Driven Decision-Making.** Evaluation has been an integral part of Oklahoma Systems of Care. In support of its commitment to data-driven decision-making, Oklahoma System of Care has partnered with the E-TEAM at the University of Oklahoma to design and implement a statewide evaluation plan. The evaluation of Oklahoma's mobile crisis response allowed for dynamic decision-making for training, resource allocation, outcomes monitoring, and sustainability planning.

OREGON

Overview

Oregon's CAHOOTS (Crisis Assistance Helping Out On The Streets) has received national attention. While the Connecticut and Oklahoma mobile crisis services have many similarities, Oregon's program has some significant differences. The first is that the model is not statewide; CAHOOTS only provides 24/7 mobile crisis services in two localities: Eugene and Springfield.[28] CAHOOTS is dispatched through the Eugene police-fire-ambulance communications center and, within the Springfield urban growth boundary, through the Springfield non-emergency number. The CAHOOTS Team has access to police dispatch and can respond almost immediately. Each team consists of a medic (either a nurse or an EMT) and a crisis worker with at least several years' experience in the mental health field. CAHOOTS requires 500 hours of training for its civilian responders. But medics and the dispatch team also receive intense training on crisis response and de-escalation. Another difference is that CAHOOTS is not a youth-focused model—it serves all age ranges in these two locations. In fact, less than 10 percent of the people the program serves are youth and young adults between the ages of 16 and 25 in the community. However, in recent years, the CAHOOTS team has started going to high schools once a week to provide mental health services based on youth's request.

Funding

The third difference is the way the services are funded. Eugene's CAHOOTS service is entirely funded by the city, while Springfield uses state grants and city funds. CAHOOTS also receives donations, a small percentage of federal funds, and Medicaid funding to provide wraparound services. These specific funding streams make it possible for the CAHOOTS team to de-escalate and provide resources to the community and people experiencing homelessness.

Outcomes

Through the years, CAHOOTS has achieved several positive outcomes, including over $15 million a year in cost savings resulting from ER diversion—picking up calls that would otherwise have to be handled by law enforcement or EMS, which is a more expensive response—and placements of people experiencing

homelessness. Last year, out of roughly 24,000 CAHOOTS calls, police backup was requested only 350 times. Additionally, because service is so well received in the communities, CAHOOTS has expanded services to high schools, opened a new crisis center that offers walk-in services, and created a 24/7 crisis hotline.

Strengths

1. **Extensive Training for Everyone.** CAHOOTS responders begin the program with 30-40 hours of class time on topics including crisis Intervention, de-escalation, harm reduction, and street medicine. This class time includes skills labs with Eugene-Springfield Fire/EMS responders' assistance in proctoring. In a subsequent "gradually elevated training in the field" over the course of up to 6 months, responders engage in an average of 500 training hours, though most complete this within 3-4 months. Additionally, the program trains dispatchers to differentiate between non-emergency and emergency calls. This training includes a ride along with CAHOOTS team members.
2. **Build Strong Partnerships Between Mental Health Experts and EMTs.** All CAHOOTS Teams dispatched include a crisis worker and a medic. However, both the crisis workers and medics have the option to be cross-trained to fulfill the clients' needs. Additionally, a handful of staff are able to receive reimbursement for their enrollment in an EMT-B course and then receiving a truncated CAHOOTS Medic training.
3. **Not All Mobile Responders Have a Clinical Degree.** Before CAHOOTS became a funded service in these two localities, White Bird Clinic provided training to volunteers interested in helping with crisis service. The program's significant benefits caused the local government to fund it, and many of the volunteers became staff on the mobile crisis team. Additionally, the service actively recruits people in the community who have lived experience with mental health issues, recognizing that they are an invaluable resource to the CAHOOTS team.

Best Practice Recap

While Connecticut, Oklahoma, and Oregon are not a full list of all the nation's youth mobile crisis and response services, they are three of the most comprehensive. Each of them has its own set of strengths that gives them the capability to offer vital services to their clients. When looking at youth mobile crisis services to replicate and use as national models, legislators should consider these three states.

CHALLENGES

Representatives from all three programs describe challenges, including staff capacity, external partnerships, data collection, and community stigma about mental illness.

Connecticut and CAHOOTS both stated that their staff capacity had been one of their biggest challenges with mobile response. Connecticut responds to 15,000 calls per year, and officials there expect that number will increase in the future. However, the state does not have the staff capacity to take on many more cases. Similarly, CAHOOTS has been seen as an effective program that the Governor of Oregon would like to scale to a statewide model, but as it functions now there isn't enough funding to support the staff capacity for a transition to a statewide model.

Connecticut, Oklahoma, and CAHOOTS mentioned other challenges in building external partnerships in the community, such as with schools, law enforcement, hospitals, and state agencies. The challenges they encounter come from having systems that still rely heavily on police to respond to mental health calls, rather than calling mobile crisis. Each of these mobile crisis teams would like to be the first responder for people experiencing mental health crises.

In addition to the other challenges, Oklahoma specifically pointed out the difficulty of collecting data. Currently, the state only has two data sets: Medicaid cost for services and the Ohio Youth Function, Problem Satisfaction Scale assessment. Providers have had difficulty administering the full assessment during crises because of the young person's and parent's mental capacity at the time. This has resulted in Oklahoma being unable to get consistent data on clients' demographics, reasons for crisis services, or outcomes and functioning after receiving services. Overall, Oklahoma has had challenges with tracking long-term outcomes of clients.

Each of the locations also noted stigma as a challenge. Oklahoma noted that many people believe youth who have mental illness should not be in the community. This is harmful thinking and perpetuates discrimination, trauma, mass incarceration, and further distrust in the mental health system. Additionally, it hinders efforts to create a space for healing in Black and brown communities.

With the assistance and support of the federal government and more funding through Medicaid, representatives from Connecticut, Oklahoma, and CAHOOTS believe some of their challenges could be resolved. Additionally, with federal support, mobile crisis programs across the nation can change how Black and brown communities experience safety and healing.

MEDICAID FINANCING MODELS FOR MOBILE RESPONSE SERVICES

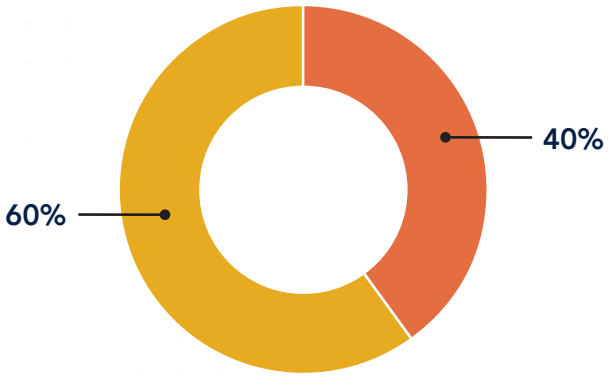
EACH OF THE MOBILE RESPONSE SERVICES OPERATES DIFFERENTLY, BUT THEY ALL HAVE ONE THING IN COMMON: MULTIPLE FUNDING SOURCES, ALSO KNOWN AS COLLABORATIVE FUNDING.

Collaborative funding is access to and coordination of multiple financing sources to enhance the provision of crisis services. Collaborative funding ensures that the continuum of crisis care is sustainable and accessible to anyone who presents for services, regardless of insurance status. A component of sustainable collaborative funding for some mobile crisis response services is Medicaid. States have used Medicaid's 1115 Waivers, state plan amendments, and 1915 waivers to fund mobile response systems.

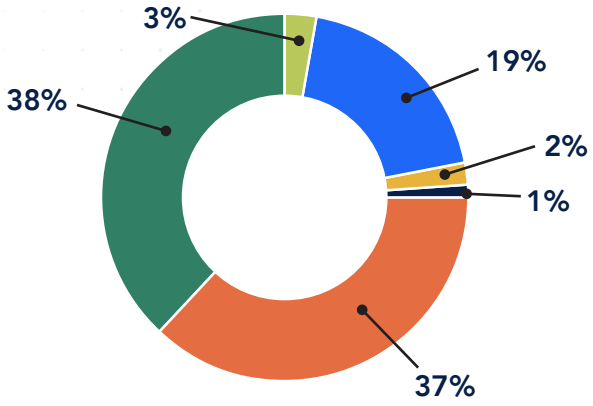
TOTAL COST OF MOBILE CRISIS AND RESPONSE SERVICES

Connecticut	CAHOOTS	Oklahoma
$14,862,122	$2,224,530	$ 4,000,000

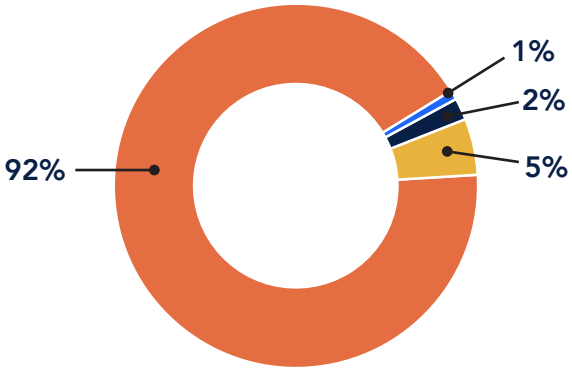
Oklahoma Funding Sources



CAHOOTS Funding Sources



Connecticut Funding Sources



Connecticut receives funding from both private insurance and Medicaid. In its budget, both are calculated together. However, the majority of funds come from Medicaid.

- Federal Funds
- State Funds
- City Funds
- Medicaid/Insurance
- Philanthropy
- Earned Income

Medicaid Option 1: 1115 Demonstration Waiver

The 1115 demonstration waiver is a section in the Social Security Act that permits states to provide services that aren't typically covered by Medicaid.[29] With the 1115 waiver, states can pilot projects that align with the objectives of Medicaid and Children's Health Insurance Programs (CHIP) during a five-year period. The waiver can also expand eligibility to individuals who are not already covered by Medicaid or CHIP. For instance, Massachusetts uses a 1115 demonstration waiver[30] to operate its crisis programs and services, including mobile crisis.

Medicaid Option 2: 1915 (b) and (c) waivers

1915(b) waivers, often referred to as "freedom of choice waivers,"[31] provide states with the flexibility to modify their delivery systems to incorporate managed care by allowing the Centers for Medicare and Medicaid Services (CMS) to waive requirements for comparability, providing services on a statewide basis, and freedom of choice. 1915(c) waivers, also known as home- and community-based services (HCBS) waivers[32], allow states to expand coverage for community-based services for populations that would not otherwise be Medicaid eligible. States have used both 1915 (b) and (c) waivers to make mobile crisis and stabilization Medicaid reimbursable. For instance, Michigan uses both the 1915 (b) and (c) waivers to cover its crisis services. The state specifically use the 1915 (b) waiver to provide crisis residential, emergency or crisis services including substance abuse services through Medicaid managed care.[33]

Medicaid Option 3: State Plan Amendment

A State Plan Amendment (SPA) allows a state to change the services covered under its Medicaid State Plan.[34] SPAs make permanent changes to the Medicaid service array that is available to everyone eligible for Medicaid coverage. An SPA could support states and localities that currently do not have their mobile response services covered by Medicaid in getting coverage. For example:

- New Jersey amended its state plan to make Mobile Response and Stabilization Services (MRSS) for youth up to age 21 reimbursable under Medicaid's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit. The Medicaid Rehabilitation option offers states unique flexibility in delivery settings, provider options, and service array.[35] This option allows for services to be provided in a person's home or work environment; permits services to be provided by a broader range of professionals than other options including community paraprofessionals; and covers services that support individuals to acquire skills that improve everyday functioning. The option can also authorize peer/family specialists to be reimbursed for delivering services. The Medicaid rehabilitation option has become a sweeping opportunity for many states to include mental health services in their Medicaid programs. Connecticut and New Jersey have amended their state plans to include the Medicaid rehabilitation option to support funding for mobile crisis.

MOBILE CRISIS AND RESPONSE WITH MEDICAID FUNDING

	1115 Waiver	1915 (b) Waiver	1915 (c) Waiver	State Plan Amendment (SPA)
Type	Demonstration Waiver	Freedom of Choice Waiver	Home and Community-Based Services Waiver	Legislative Change
States Using it	Massachusetts, Tennessee, Texas	Michigan, Texas	Michigan, Texas	New Jersey, Connecticut, Oklahoma

Each of these options provide states with different ways to make their mobile response services Medicaid reimbursable. States can combine Medicaid options or choose one of the waiver options and combine it with other funding sources they already have in their state, including state general dollars, private insurance, and philanthropic dollars. Because states have unique needs and populations, there is no one-size-fits-all model or combination of Medicaid options. The braided funding plus the Medicaid options will make the mobile response services available to all. Aside from states creating robust financial structures to sustain mobile response, states must have federal investments to create accountability.

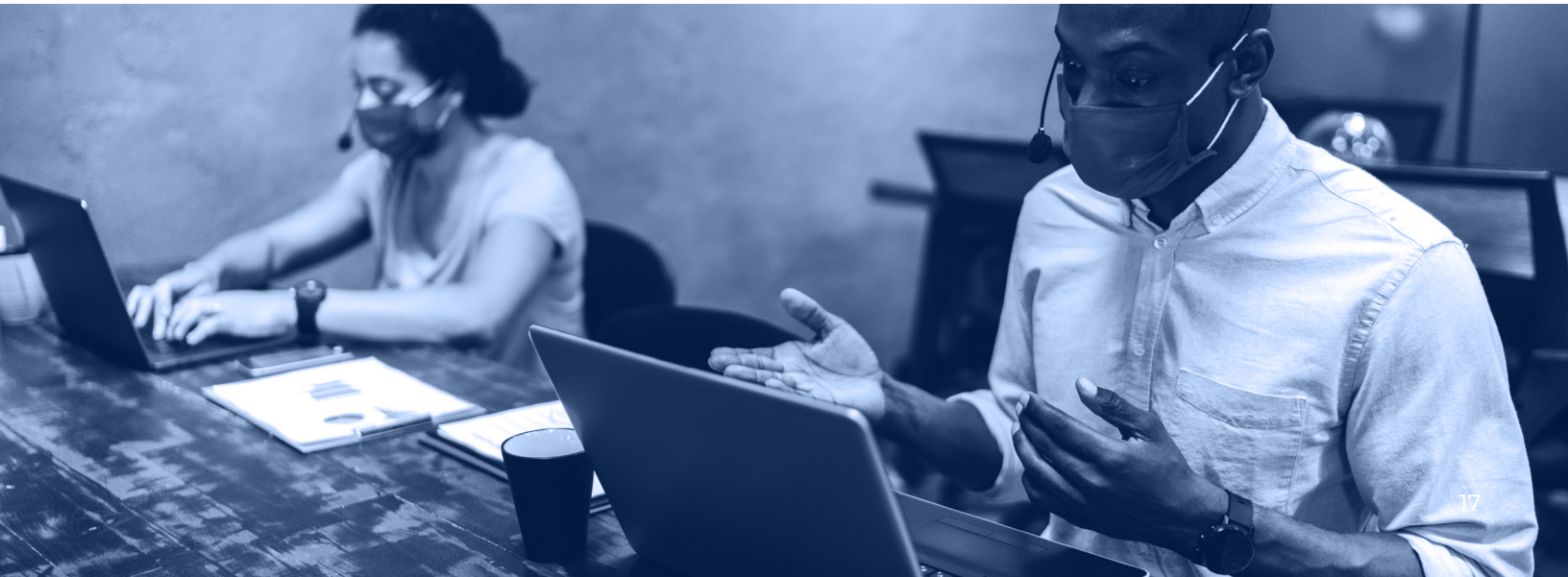
FEDERAL OPPORTUNITIES IN MOBILE RESPONSE

The federal government can support the scaling of mobile response services nationally through additional funding, data collection and accountability, and technical assistance. The majority of the funding for mobile crisis response services is provided through state allocation, which isn't enough to develop robust programs and services. Federal funding through grants, legislation, and other avenues would provide the support mobile response services need to collect data, provide extensive training to providers, and provide a continuum of services., all of which the services have had challenges in funding.

Members of Congress have proposed several bills to support the implementation of mobile response and to scale up existing programs. Recent legislation to support mobile crisis models include:

- **National Suicide Hotline Designation Act.** The National Suicide Hotline Designation Act (P.L. 116-172) assigns 9-8-8 as the national suicide and mental health crisis hotline telephone number. This universal number will make resources more accessible for young people who are in crisis. Moreover, it requires cell phone companies to pay a fee set by the state to support the implementation and enhancement of 9-8-8 services. States can also choose to implement fees for broadband companies earlier and invest in building out provider networks to support successful implementation. This legislation was signed into law on October 19,2020, but the implementation deadline is July 16, 2022. With implementation, states should use this national hotline as dispatch to mobile response, like the Oklahoma model. In Oklahoma, the mobile response and stabilization services are connected to and are dispatched through the statewide suicide and crisis hotline. With this model, Oklahoma has saved money on infrastructure and staff.

- **Crisis Helping Out on the Streets Act (CAHOOTS ACT).** Another federal bill—the CAHOOTS ACT—was first introduced in the House Energy and Commerce Committee on August 7, 2020 in the 116th Congress. This bill amends the Medicaid section of the Social Security Act to support qualified community-based mobile crisis services. It proposes an enhanced federal matching rate for mobile crises services of 95 percent. The CAHOOTS Act creates an incentive for states to make their mobile crisis services Medicaid



reimbursable, which will result in the services being sustainable over time. The American Rescue Plan reconciliation bill includes an enhanced federal Medicaid match for crisis services of 85% and some planning grant funding for states to develop crisis response infrastructure. However, the match rate provided in the legislation is less than what is outlined in the CAHOOTSAct. Passing the CAHOOTS act will expand this higher federal match rate and provide much needed additional planning grants to help states develop needed infrastructure.

Policymakers can also support mental health services by making changes to federal agencies, for instance by:

- **Changing the priorities of the Substance Abuse and Mental Health Services Administration (SAMHSA).** SAMHSA was founded by Congress to make information about mental health and substance use easily accessible. However, SAMHSA research is mostly dependent on the agenda of the current administration. This hinders its ability to effectively and consistently support states in implementing different mental health services, including mobile crisis. As states begin to scale and develop comprehensive mobile response services, they will need support on best practices, fundamental service delivery techniques, and other resources. SAMHSAs FY21 budget included a 5% set aside in its Mental Health Block Grant for mobile crisis. To help support with the implementation process of the national "9-8-8" number and mobile response in states across the nation, SAMHSA should create a permanent initiative to focus on technical assistance and best practice dissemination for crisis and mobile response services.

Many states' mobile crisis and response services receive some funding through Medicaid, whether 1115 demonstration waivers, 1915 (b) or (c) waivers, or state plan amendments. However, many of these plans are on a time limit that requires states to apply for a renewal once the limit is up – and approval is not guaranteed. If not approved, this could leave many states' mobile services low on funding. Medicaid, plus additional federal funding, could resolve this issue through both the CAHOOTS Act and the National Suicide Hotline Designation Act. States should include all crisis services, including mobile response, in their service array for Medicaid. This change would allow providers to be reimbursed for providing services and clients to receive those services for free. States could use other funding for mobile response to provide wraparound services and follow-up. Moreover, this would allow more people to receive services and essentially create more equitable services.

CONCLUSION

An investment in youth mobile crisis is an investment in healing Black and brown communities. History shows us the harmful impacts of law enforcement in communities of color. It has also shown us how the United States has divested from health and mental health in these communities through a lack of services, supports, and resources. Law enforcement is not suitable for assisting in social crises, whether related to mental health, school disciplinary actions, or welfare checks. Young people of color must have services that provide them with the care they need, teach them ways to cope, and offer them referrals to more supports. They also need a system that can meet them where they are physically and mentally. Mobile response does just that. Investing in mobile response services as a nationwide response to mental health and social crisis is the first step for this country to demonstrate its commitment to Black and brown healing while also decriminalizing, destigmatizing, and reframing mental health.[36]

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