

Crisis Services for Behavioral Health Emergencies: Effectiveness, Cost-Effectiveness, and Funding Strategies
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Neva Kaye: Good afternoon and welcome everyone to our Webinar, Crisis Services for Behavioral Health Emergencies: Effectiveness, Cost-Effectiveness, and Funding Strategies.

I am very excited to share that we have over 1000 people registered for today's event representing all 50 states, the District of Columbia and Puerto Rico.

This Webinar is being produced through a collaboration among the Substance Abuse and Mental Health Services Administration or SAMHSA, Truven Health Analytics and the National Academy for State Health Policy or NASHP.

I'm Neva Kaye, Managing Director for Health System Performance at the National Academy for State Health Policy. I will be facilitating today's Webinar.

This Webinar stems from recent work by SAMHSA and Truven to produce a publication on crisis services, which are a continuum of services that are provided to individuals experiencing a psychiatric emergency.

Today, we'll discuss the business case for these services and strategies three states are using to provide them.

Before we get started, I wanted to focus on a few important housekeeping items.

First, Web-based interaction and phone lines support this Webinar. Many of you should be able to listen into the Webinar through your computers. Phone lines are also available and they will be muted for the duration of the Webinar.

At any point, you can ask a question by typing it into the chat box which is located at the bottom left of your screen. We will be responding to questions both through the chat box and during the question-and-answer portion of the Webinar. And don't hesitate to type in your questions as they occur to you. We will keep track of those and return to them during the appropriate time period.

We are recording the Webinar, so you can share it with other colleagues. The recording and slides will be available at NASHP.org and SAMHSA.gov.

We are also tweeting the Webinar and we encourage you to join us on Twitter as well at [NASHPhealth](https://twitter.com/NASHPhealth).

Please note that the views expressed on this Webinar do not necessarily reflect those of SAMHSA, Department of Health and Human Services or the US government.

Today's program will begin with a federal perspective on crisis services. We'll hear from Suzanne Fields, SAMHSA's senior advisor to the administration on health financing.

Next, we will hear about the business case for these services from Julie Seibert of Truven Health Analytics.

Then we'll hear how three states are delivering and financing a continuum of crisis services.

Today's panel includes individuals with deep experience in behavioral health: Joyce Allen in Wisconsin, Jane Beyer in Washington State and Mary Shelton in Tennessee.

Finally, we'll use the remainder of our time today to allow you to ask questions of today's presenters using the chat feature.

With that, I will turn to Suzanne Fields.

As I said, Suzanne is a senior advisor to the administrator on healthcare financing. She joined as senior advisor in August of 2012 and serves as SAMHSA's lead for health reform and works on other critical issues with other federal agencies on health financing and related activities.

Her work has been multiple settings including Medicaid, mental health and substance abuse, children services, child welfare and managed care.

Suzanne?

Suzanne Fields: Thank you very much, Neva.

At SAMHSA, we're very pleased to be able to partner with NASHP on sharing information about this important set of services.

Today we're going to be talking about crisis services. And by that, we're referencing a continuum of services that are provided to people experiencing a mental health or a substance use crisis situation. And we're also talking about services that meet the needs of individuals across the developmental spectrum: Children, youth, transition age, adults and older adults as well.

The primary goal of this continuum of services is to support and stabilize an individual and to engage them earlier in the process of a mental health or a substance use crisis to put important services in place.

Now historically, crisis systems have been geared towards hospital-based systems or emergency department-based interventions for people experiencing some type of psychiatric crisis.

Emergency room staff often lacked specialized training. They often don't have a cadre of resources available to them in an emergency department to effectively intervene for people experiencing a mental health or substance use crisis.

The national statistics and why the federal like SAMHSA wanted to bring this issue forward and highlight this important issue is the national statistics are quite unsettling.

In 2010, 2.2 million hospitalizations occurred related to some type of behavioral health condition and 5.3 million emergency department visits involved some type of behavioral health condition. We know that there is unmet need. We know that this is an important set of services that can assist in making sure that people get services earlier and that they get appropriate services in their community to assist them with their mental health or their substance use condition.

Now the nature of this comprehensive crisis set of services that we'll be talking about today covers a very complex range of programs, each of which has different financing opportunities and challenges inherent in it. As such, states, counties, provider systems often have to work across multiple payors and across different systems in order to develop a full continuum of crisis services to be available for people in their communities.

In today's presentation, we'll highlight both the clinical effectiveness as well as the cost effectiveness of a range of these crisis continuum services. And then, of course, we're going to be hearing from three different states and their efforts to improve their crisis behavioral health services.

With that, I would like to introduce Julie Seibert, who's going to be sharing information about both the clinical and cost effectiveness.

Julie Seibert has 20 years of experience in public mental health system including program and policy development and as a direct behavioral health provider.

She is currently with Truven Health and in that role has a variety of responsibilities related to quality management and implementation of programs for behavioral health.

And with that, I'd like to welcome Julie.

Julie Seibert: Thank you, Suzanne.

As she mentioned, today, what I'm going to talk about is the business case for crisis services. As we know, there's a substantial literature that shows that crisis services are clinically effective as well as cost effective. And in our research, we found that many states are implementing these services and are developing funding strategies to ensure their availability to the public.

As many of you who've tuned in today know, many states are wrestling with how to fund behavioral health services. Our latest available data show that the United States spent \$172 billion on mental health and substance abuse treatment in 2009.

The majority of these expenditures were supported by public funding. As a matter of fact, 60% of mental health expenditures were supported by public funding while 69% of substance abuse expenditures were supported by public funding. The remaining proportion were covered by private sources.

We don't have any data that really provides this information on the proportion of spending on crisis services, excuse me, specifically. But we do know that state and federal governments do provide a critical source of financing for crisis programs.

Suzanne talked a little bit about how we're defining crisis services today. And as she'd mentioned, we're defining them as services designed to stabilize and improve psychological symptoms of distress and to engage individuals in the most appropriate course of treatment.

And as Suzanne also mentioned, we're including individual substance abuse disorders and mental health disorders. And also we're speaking of crisis services across all age groups.

There are many services that can be considered to be a crisis service. However, for the purposes of our talk today, we're focusing on these specific services.

The core elements of these services are well documented in the behavioral health literature, so I'll briefly describe them to you right now.

So 23-hour crisis observation or stabilization is considered to be a facility-based service. It's a direct service that provides individuals in severe distress with up to 23 hours of supervised care to help deescalate the crisis and their need for urgent care.

There's been research that shows that 23-hour crisis stabilization results in lower inpatient hospital admissions.

Our second service is also considered to be facility based. It's called short-term crisis residential stabilization services.

These are primarily housing services that are provided during a crisis that are short term and serve individuals or small groups of individuals and they are used to avoid hospitalization.

And our research shows that they are as effective as inpatient care and they result in high consumer satisfaction and also costs are much less than inpatient care.

The third service we're talking about today is mobile crisis services.

This is a community-based service which individuals go out to the community to meet the individual in crisis. Our research shows that mobile crisis services are very effective in diverting individuals from inpatient hospitalization and they're also very effective in linking consumers to outpatient services.

We'll also be looking at 24-hour crisis hotlines and warmlines. The difference between crisis hotlines and warmlines are basically individuals who man them. Warmlines are typically manned by individuals who are trained mental health consumers or peers and they're typically staffed by people who are also in recovery. We do have an evidence based or - around the effectiveness of 24-hour crisis hotlines. And research has shown that use of these hotlines can result in reported reduction in symptoms and also there's associated high satisfaction with the service.

We'll also talk a bit about psychiatric advance directive statements. And as you may know, these are documents that specify a person's future preference for treatment if they should lose their ability to make treatment decisions.

The research based for that is not as flesh out. More research is needed regarding psychiatric advance directive statements. However, we have discovered there's one study that's indicated lower cost and less service use.

Peer crisis services are services that are provided by peers in community-based settings. And as with psychiatric advance directive statements, more research is needed regarding the effectiveness of these services. However, the few studies that are available do indicate positive results and the need for more systematic study.

In addition to the clinical effectiveness, we've also reviewed the literature and the economic impact of crisis services. And multiple studies have shown that the implementation of crisis services can lead to cost savings through reduced inpatient hospitalization and diversion from emergency departments to more appropriate community-based services.

And right now I'm going to talk a bit more about the cost effectiveness of the different crisis services that we've outlined.

Twenty-three-hour crisis stabilization has been studied to show that the return on investment can be \$2.16 for every \$1 invested. And just to let you know, in a 2013 study by Wilder Research, the authors used claims data to calculate return on investment of the mental health crisis stabilization program in Minnesota. And as I said, they found that there was a return of over \$2 for each \$1 invested.

We should note that the ROI in the Minnesota area might be different than the same services implemented in the different geographic area.

Short-term residential crisis services have also been known to be very cost effective. There are several studies that show that respite care compared to standard hospitalization can be 44% to 65% less costly than a psychiatric hospitalization.

And studies also showed that clinical outcomes were also similar.

Mobile crisis services has been very well studied for clinical effectiveness as well as cost effectiveness. One study in 2000 analyzed the effectiveness and efficiency of a mobile crisis program by comparing it to police intervention. And what this study showed that mobile crisis services are 23% lower average cost per case as compared to police intervention.

There are additional studies that show that mobile crisis services can reduce inpatient cost by 79% in a six-month follow-up period. So individuals that do receive these specialized services over time have reduced inpatient cost.

Peer crisis services are also considered to be very cost effective. The cost per treatment is - in one study was shown to be \$211 per day for the peer service as compared to \$665 per day for hospitalization. So there's a dramatic savings when you compare peer crisis services to psychiatric hospitalization.

Truven receives some funding from SAMHSA to do some crisis services interviews with several states. And we were able to interview eight states regarding the crisis services continuum funding mechanisms and challenges in funding. We're able to interview Maine, Massachusetts, Minnesota, Missouri, Tennessee, Texas, Wisconsin and Illinois. In addition, we also conducted an

environmental scan of 50 states and the District of Columbia to gain a better understanding of the Medicaid funding for crisis services.

And from this study, we saw that states are engaging in several different strategies for crisis services.

One study that several states engage in were grouping different crisis services in one particular area. These services typically serve adults and children and they're based in facilities that cover a specific geographic region. Massachusetts, Illinois, Tennessee and Missouri all use this strategy to provide crisis services.

Other states, such as Wisconsin, rely on state policy to ensure crisis services continuum. And we also found several states are involving peers in operation of crisis services. Peers are typically included in a variety of roles including certified peer specialists who are included on mobile crisis teams in Tennessee and peers who staff the central crisis call line along with mental health professionals in Maine.

Several states use law enforcement as adjunct to crisis services. Several states use crisis intervention teams or CIT. We also have several states who use crisis hotlines or warmlines. Actually some form of crisis hotline or warmlines was provided by all states that we interviewed.

And also we saw that one state, particularly Wisconsin, has mobile crisis teams and respite for children and adolescence.

A review of the state showed that states are using many different mechanisms to fund crisis services. All 50 states and the District of Columbia use Medicaid to fund crisis services. And several states use other federal funds such as

veterans administration funds, Department of Defense, SAMHSA Block Grant funds, HRSA and also other funds that are available from CMS.

Many states also use state funds, county and local funds, private insurance and grants as well as special taxation.

Many states use state funding to fill in the service gaps. Several states use state funding to finance services for which there's no other billable source, for example, crisis hotlines or mobile crisis in states that don't bill Medicaid and also to pay for services for the uninsured and for individuals who are Medicare eligible.

Many states use state funding to pay for infrastructure for crisis services. For example, in Massachusetts, 4 of the 21 crisis services programs are operated by state personnel and they're primarily funded through state funding, although Medicaid-eligible services are provided by the programs are billed to Medicaid.

Many states also use Medicaid to pay for crisis services. We found that that was a very significant resource for crisis services among the states we interviewed and also from the environmental scan.

Medicaid managed care states we found the combined the state and Medicaid funds for crisis services programs. And we also saw that Michigan was able to leverage Medicaid funds and the way they were able to do that is they establish an electronic system to immediately determine if individuals was covered - were covered by Medicaid once they entered the Michigan system.

Other funding strategies or funding sources used by states include private insurance, taxes and grant funding.

We found with interviewing the states that the ability to bill for providers using private insurance is very mixed. However, Michigan has contractual agreements with private insurance to bill for services.

One state, California, has a special tax levy called Proposition 63. And what this does is it imposes a 1% income tax on personal income in excess of \$1 million. And they've been able to use that to generate millions of dollars each year to pay for mental health services including crisis services.

States are also supplementing crisis services through grant funding by funding evidence-based practices and also providing technical assistance to providers.

Several states talked about providing crisis services to the uninsured and states reported variability in the number of uninsured who access their crisis services. Some states reported that between 60% to 70% of individuals who access crisis services were uninsured.

State and local funds, as well as grants, also are used as funding sources for the uninsured. And we have some states, such as Massachusetts, that earmark state funds specifically for crisis services for the uninsured.

And finally, regarding the results of the study, I just wanted to review a couple of the limitations. We did interview a convenient sample of states. The states very readily agreed to be interviewed and we really appreciate that.

We also - another limitation is that there's some limited availability of public documents on the Internet. And a final limitation is that information obtained on the Internet for states might have been a bit outdated. But I believe we're able to get a rich resource from states of the different strategies they are using to pay for crisis services.

Neva Kaye: Thank you, Julie.

Now we'll move into the discussion with state panelists. We have three presenters joining us to tell us about exciting work they are doing to ensure individuals in crisis have access to a continuum of services.

Joyce Allen is the director of Bureau of Prevention, Treatment and Recovery in the Division of Mental Health and Substance Abuse Services in the Wisconsin Department of Health Services.

The bureau serves as a single state agency for substance abuse and state mental health authority in Wisconsin. In that role, Ms. Allen oversees policy in community mental health and substance abuse programs in the state.

Jane Beyer joins us from Washington where she currently serves as the assistant secretary for Aging and Disability Services, Behavioral Health and Services Integration in the administration of - at the Washington State Department of Social and Health Services.

From 1988 through 1994 and since January 1999, Jane Beyer has been senior council with the Washington State House of Representatives Democratic Caucus. In that position, she has handled a variety of healthcare issues including Medicaid, access to healthcare for uninsured people, individual and group health insurance reform, federal healthcare reform and state purchasing of healthcare.

The final state speaker today will be Mary Shelton, who has worked for the state of Tennessee for 18 years at the Department of Mental Health. She worked at Mental - Tennessee Mental Health Institute Central Office and in the Managed Care Division. In the private sector, she works for the First Health managing PASARR contracts for Medicaid-eligible nursing facility

members. She transferred to the Bureau of TennCare, the state's Medicaid agency, in 2008 to manage the behavioral health activities of the integrated contract and was promoted to director of behavioral health operations in 2012.

I'd like to begin today's discussion with a broad question to set the stage. I'd like to ask all three panelists to describe what is the extent of crisis services in your states. And I'd like to start with Wisconsin.

Joyce?

Joyce Allen: Thank you.

Wisconsin crisis services are embedded in the Wisconsin's mental health and substance abuse service system. And our state law establishes counties as a single point of responsibility for both mental health and substance abuse, especially for those individuals who have no other resource to pay for those services.

Counties, according to that law, must provide emergency services and emergency services include providing for the needs of people who might be at danger to themselves or others, who may need an emergency detention or hospitalization.

But it also includes providing those individuals that do not have that level of need with their crisis service intervention.

Counties also in our state must approve emergency detention placement in hospitals. And this allows those local county crisis programs to have an opportunity to intervene and also community alternatives through those crisis services which include crisis stabilization as well as others.

Our state establishes standards for crisis services for those providers through the county program. And those standards are enforced through our administrative rule system. And the standards provide for a whole range of services that the county can develop in a way that really meets their individual county and community needs.

Next slide, please.

So in order to be eligible for Medicaid financing for crisis services, counties must provide a continuum of crisis services. And this includes having available telephone services for individuals to call 24 hours, 7 days a week.

It also includes mobile crisis response team, so that they can respond to a situation in a home or another community location.

It also requires that there - among the staff, there needs to be a qualified mental health professional and that all services beyond our crisis assessment or response must be authorized by a psychiatrist or a psychologist.

However, the range of staff that do provide services include people that do not have that qualified mental health status such as peer specialists who are often involved in various components of these services.

It also requires that they provide walk-in services, so if someone wants to pick those services in person, they can do so.

They also must assess and respond to the individuals. And we call that crisis assessment and response.

Of course then, once they assess and respond, they also need to link the individual or coordinate the services that the individual needs after the initial crisis has been resolved.

And finally, many counties provide a range of stabilization services. This might be anything from an in-home stabilization where staff of the crisis program actually go into the individual's home and provide the stabilization services there or it may include a specialized residential facility.

Neva Kaye: Thank you, Mary. I mean, thank you, Joyce.

Mary, would you please provide an overview of Tennessee's program?

Mary Shelton: Yes. The state of Tennessee gets the direction to develop and implement crisis services from Title 33, which is the Tennessee State Mental Health Law. The commissioner of the Tennessee Department of Mental Health and Substance Abuse Services has the statutory authority to set the service areas and designate the crisis providers.

So a little bit about our system. Tennessee has 12 crisis service areas for adults served by 12 different providers. Some areas range from one county to three to five counties, all the way up to 15 to 20 counties.

The counties for our two largest metro areas, Nashville and Memphis, are each served by a single crisis provider. The children in these crisis services has been served by a statewide crisis provider for the past 12 years. This was just rebid by the Department of Mental Health on a regional basis and was awarded to four separate providers, one being the provider who has the contract for the past 12 years.

In Tennessee, all Medicaid members are enrolled in a managed care organization, which is fully integrated to cover medical, behavioral, including SED and SPMI and long-term care benefits. This includes mental health and substance abuse services.

The Medicaid program in Tennessee is called TennCare. TennCare's contract, known as the contractor risk agreement, with each of our three MCOs requires each managed care organization to contract with all of the crisis teams designated by the Department of Mental Health commissioner.

The management in oversight of crisis services comes from both the Department of Mental Health and Substance Abuse Services and the managed care organization.

The Department of Mental Health operates a crisis services division and goes on site to agencies for monitoring and collect data elements through monthly and quarterly reports from the agencies. The MCOs do the same.

We have collaborated -- and this includes TennCare, the Department of Mental Health and the managed care organizations -- on identifying the data elements that are captured, so the reports the agency submits are all the same. Okay?

As far as requirements, this language is found in the TennCare contractor risk agreement. The Department of Mental Health and Substance Abuse Services also has a scope of services with similar language in their contract with the crisis services agency.

Now each agency has their own crisis line. There is also a Tennessee statewide crisis line funded by the Department of Mental Health and is answered by the crisis team located in Nashville. This number is publicized

across the state. And when that team receives the call, the national agency then transfers the call to the crisis team that serves the geographic area where the caller is located.

Also, the second bullet, they provide telephone and face-to-face crisis intervention services, follow-up telephone or face-to-face assessment to ensure safety of the member until treatment begins and/or the crises are alleviated and/or the person is stabilized.

I've added information on the mandatory prescreening agent to give an idea about the authority the crisis service providers have on the screening for emergency and voluntary admissions in Tennessee. The minimum qualification for a mandatory prescreening agent is a licensed master's level mental health clinician who has received the Department of Mental Health's training and then designation by the commissioner.

The crisis services agencies employ mandatory prescreening agents and dispatch them when a screening is needed.

Neva Kaye: Thank you, Mary.

Jane, please tell us about Washington.

Jane Beyer: Okay. Washington State, like Tennessee and Wisconsin by statute, designates our state department of social and health services to ensure provision of statewide 24/7 crisis services through our - largely through our Involuntary Treatment Act.

And Washington State delegates or contracts for administration of mental health services through entities that are called regional support networks in all but one of our RSNs. These are county - administered county-run entities.

And we contract with the regional support networks both with Medicaid funding and state general fund contracts.

Much like we've heard before, RSN crisis services are available to all people within the geographic boundaries of the regional support network including tribal members on tribal land without regard to the individual's insurance status or any source of funding. The state licenses and certifies facility-based services as well as community mental health agencies.

So the crisis, especially the - as I indicate, the residential-based crisis triage, crisis stabilization services all have state licensing and certification requirements.

On the next slide, I just included a map of how our state divides up into the 11 regional service areas that we currently have. And given that we've had this regional support network system - so we can go to the next slide. Given that we have our regional network system, we define in our contracts with the RSNs minimum requirements that must be in place on a 24/7 basis.

So these include a crisis line, face-to-face crisis intervention services, involuntary commitment investigations, crisis stabilization services and capacity for voluntary and involuntary hospitalization.

We have seen amongst some of our regional networks activities to add, in addition to the required services, crisis respite beds, crisis triage beds, which are the 23-hour settings, crisis diversion services, mobile crisis response teams and in order to meet the need for evaluation of individuals who have been committed under our Involuntary Treatment Act, freestanding evaluation and treatment centers in addition to using hospital services for evaluation and treatment.

I think what I can say is that when we look across the state at the capacity that we have, more would be better. There are investments in new services both evaluation and treatment services for people who's involuntarily committed and crisis diversion services through substantial amount of funding over \$50 million that was provided by our legislature in both 2013 and 2014.

I would note that Washington State is one of the states that's very active in using peers in our crisis diversion and crisis response service system.

Washington State has a system for peer certification. It's a 40-hour program with a written and oral examination that follows and then our regional support networks in the community mental health agencies that they contract with frequently more and more are hiring peers who are supervised by mental health professionals who play really critical roles in hospital emergency rooms and in freestanding crisis stabilization and diversion programs.

Neva Kaye: Thank you, Jane.

Each of the states we are featuring today, Wisconsin, Tennessee and Washington, cover an impressive array of crisis services.

Next, we wish to turn to the financing of those services. Would each of you please tell you how crisis services are financed in your state?

And let's begin once again with Wisconsin.

Joyce?

Joyce Allen: In our state, since counties are the responsible entity for providing crisis services, they also have the responsibility to blend funding from multiple sources.

So, you know, as every other state, Medicaid does pay for crisis services for their members. So if a county serves an individual that is Medicaid-eligible, they are reimbursed on a fee-for-service basis with those clients.

Our Wisconsin law and insurance regulations also include that health insurance plans must cover what they call transitional mental health and substance abuse benefits if they offer mental health benefits.

And under those regulations, crisis services or crisis intervention services are included as one of those transitional benefits.

So sometimes they also receive funding through those project sources. In addition, the state provides counties with a basic community aid funding which is made up state general purpose revenue. They can use that basic funding to fund a range of health and human services which include emergency and crisis services.

In addition, our division provides counties with an allocation of Community Mental Health Block Grant fund. And one of the allowable uses of the Block Grant is for crisis services. And this is for those individuals, again, that are not covered through their insurance or through Medicaid coverage.

And then finally, because counties really are the backstop for crisis services, counties use their own tax levy to fund the crisis services. And in general, in Wisconsin, counties do provide a large share of their own tax levy for services.

And finally, some individuals would also self-pay for services.

Neva Kaye: Thank you, Joyce.

Let's now turn to Mary to tell us about Tennessee's financing strategy.

Mary Shelton: In Tennessee, funding for the statewide crisis comes from both Medicaid dollars through TennCare and state dollars from the Department of Mental Health and Substance Abuse Services.

Medicaid payments are made through the MCOs and is paid on a per member per month or PMPM to the crisis services team.

The rates were set by our actuaries and it's based upon utilization. The PMPM is also calculated using the TennCare membership as the crisis service area. These payments cover the staff for the crisis services agency, the call center and the face-to-face responses.

Some of the crisis providers, the additional needs in their community, and they use the PMPM and the Tennessee Department of Mental Health's grant fund to open and operate walk-in centers, offer telehealth services and laptop technologies and offer other supports to help those in crisis. Okay?

Tennessee has other crisis services available to TennCare members and in many cases also the uninsured. Reimbursement for TennCare members comes from - through the MCOs based on submitted claims. Reimbursement for the uninsured comes from the Tennessee Department of Mental Health and Substance Abuse Services either through grants or claims for their Safety Net members.

So three of the most frequently utilized services are crisis respite, crisis stabilization and medically monitored crisis detox.

Crisis respite may be located at a community mental health center, housing operated by the community mental health center or a foster family. This service is usually just overnight and most of the time no more than 24 hours.

Crisis stabilization services are located at one of the eight CSUs or crisis stabilization units. The crisis stabilization units are in the major urban areas across the state and have less than 16 beds and therefore are not considered an institution for mental diseases. Admission to the CSU is voluntary and the staying is no more than four days. The CSU serves 18 and older.

Now the MMCD, the medically monitored crisis detox centers, there are seven agencies providing MMCD services in Tennessee. These are agencies that provide substance abuse detoxification services delivered by medical and nursing professionals that provide 24-hour - sorry, medically-supervised evaluation and withdrawal management.

These services occur in residential treatment facilities with inpatient and residential bed.

These services have proven helpful with hospital and emergency room diversions. We see this data in the crisis report provided by the crisis services agency.

Neva Kaye: Thank you, Mary.

I'd now like to turn to Jane to wrap up this question on the financing of crisis services.

Jane Beyer: Very much like the other states that we heard from, Washington State's financing strategy is clearly one of rating funding.

The majority of our mental health funding is through our Medicaid capitation or per person per month payments that we make through our regional support networks.

Alongside the Medicaid contracts with the RSNs, we also have what we call state-only contracts, which are state general fund dollars. And these state-only funds are used for two primary purposes.

One, the provision of crisis services and Involuntary Treatment Act investigations and evaluation and treatment facility services to people who are not Medicaid eligible, and secondly, Involuntary Treatment Act and evaluation and treatment facility services that are provided in an institution for mental diseases and IMD to individuals who are Medicaid eligible.

We are, as we expand capacity for evaluation and treatment, crisis stabilization and crisis triage, focusing our funding on facilities of 16 or fewer beds, so that we're able to claim Medicaid's federal matching funds for the services provided in those facilities, which is especially important for us here in Washington State as we're one of the - it's either 25 or 26 states that opted for the Medicaid expansion under the Affordable Care Act.

In addition, we have an option under state law that allows counties to enact 1/10 of 1% local sales tax revenue option, which can be used for chemical dependency, substance abuse or mental health services and a number of counties have chosen to use their local revenues to enhance crisis services.

We also distribute the bulk of our Federal Mental Health Block Grant funds through the regional support networks, some of whom have used those funds to augment their crisis programs for non-Medicaid consumers or non-Medicaid services.

And finally, although not noted on this slide, where possible, we use private health insurance funds. Washington State has had a state mental health parity statute that has - that was phased in over the course of a period from 2006 to about 2010. And then we also have the enactment of the federal parity law and its application to small group and individual and ultimately Medicaid programs through the Affordable Care Act.

We are - a question that has come up here in Washington State and we're awaiting clarifying regulations from our insurance commissioner's office relates to mental health parity and its application to the coverage of crisis services and facilities like crisis stabilization and crisis triage and evaluation and treatment facilities.

So we do not have absolutely clear policy on that issue largely because of the complications related to finding analogous services on the medical surgical side of coverage when we're looking at parity issues.

Neva Kaye: Thank you.

I'd now like to dig a little more deeply into some specific issues within each state.

For Mary in Tennessee, how does your financing model help promote innovation in service delivery?

Mary Shelton: Tennessee's crisis system had been in place for a number of years. However, starting in 2010, TennCare, along with Tennessee Department of Mental Health and Substance Abuse Services, our three contracted managed care organizations, all the crisis providers and other stakeholders, took a new look at the system, namely the purpose of the crisis system.

Questions addressed included which community agencies were calling the crisis line such as jails, nursing facilities, substance abuse providers, and when is that appropriate to stabilize and repurchase services over the phone and also to address when is it appropriate to respond face to face.

During the look at the system, TennCare decided that we needed the crisis system as it was set up for two main reasons. The first bullet, many of our TennCare members access the behavioral health system via crisis services; and the second bullet, having a crisis system to divert more members from the emergency department and direct members to the treatment more quickly.

In order to accomplish this for the TennCare members and have crisis services available 24/7, we needed to maintain the firehouse model. Meaning, spending the service at a level that staff and the call center can operate 24/7. Also, we had to have a reliable spending source which is from the PMPM. This gives a guaranteed funding level to ensure the service. The funding, however, does vary based on the TennCare/Medicaid population of the service area.

So back to the TennCare contractor risk agreement, the first bullet, here it states that the crisis line and services are for any individual in the general population.

The intent of this we didn't want the MCOs to have to develop a private TennCare crisis system. We felt that that would lead to confusion as to which number someone should call.

The Department of Mental Health states and resources published on their Web site that crisis services are available 24/7 to anyone in the state when there is a perception of a crisis.

I'd also like to direct those who would like to learn more about Tennessee's crisis system to the Crisis Services page of the Tennessee Department of Mental Health and Substance Abuse Services Web site. They have manuals, which are products of collaborative workgroups and a map of the available crisis services in Tennessee.

So this slide really outlines our philosophy and approach in Tennessee around crisis services. They are available to anyone in Tennessee.

As I hope has been clear throughout answering these questions, crisis services in Tennessee is a true partnership and collaboration with the Department of Mental Health. We are both bending the service, providing input into the design and the scope of the services and providing oversight and monitoring of the providers.

Thank you.

Neva Kaye: So, Joyce in Wisconsin, what is the importance of Wisconsin's state law to put some responsibility on county systems?

Joyce Allen: Similar to what Mary said, Wisconsin model is a model that some may call a public safety model, a public health model or, as she noted, a firehouse model. That means that the individual has the crisis service available to them no matter where they live in those states.

Our system is also decentralized and that it puts the services in the communities where people live. And I think this is important because counties, as the focal point, then can work with their local law enforcement and their local providers to develop the most appropriate response for the community.

This means that the counties who get to know their local law enforcement agencies can develop specific protocols that work best for their community.

A couple of examples of the diversity of our services include, first of all, in Milwaukee, it's a large community. And in that community, they have developed a specialized mobile outreach team serving youth. Wraparound Milwaukee is pretty well known for the services that they provide and they have expanded those services that they provide in the mobile outreach not only to their enrolled members and their managed care organization but they've expanded their services to provide mobile outreach to the various schools across Milwaukee.

Another example is that in our state, there are some very rural areas. And in those rural areas, the population may not be based - may not be there that has a real comprehensive crisis program fully staffed 24/7 but the way our situation works in those states counties can come together and do multicounty crisis program if that works best for them.

In some instances, counties may share a common provider who they designate as the crisis intervention team for that area.

It also, in our system, allows for an identified organization to county to be responsible for providing training to local law enforcement because we know that's very important.

And finally, in Wisconsin, we believe that aligning fiscal incentives is important also. Counties are responsible to pay for both the emergency detentions in a hospital setting as well as the community emergency and crisis services if there is no other insurance coverage.

For us, that means the individuals can receive the most appropriate treatment in the environment that best meets their needs and there's no incentive to use the more intensive service if that is not needed for them.

In the end, people receive good quality services where it is most appropriate.

Neva Kaye: Jane in Washington, what are the key aspects of your program that you feel really make it work for clients?

Jane Beyer: So much like some of Joyce's comments, in Washington State, because our regional support networks are largely county-governed entities, there clearly is a value in localities defining their needs and having some flexibility to design services that the folks in their community need.

And we try to balance that with the overall statewide mandate that the provision of crisis services is a mandated service with the range of services based upon an individual's need without regard to funding.

In our system, if there is a perceived crisis, our system response whether the - if the person is in crisis, whether it's due to mental illness or chemical dependency, once stabilized, an individual is referred to other services as needed. An issue or an area that has been getting some attention is with legislation that recently passed our legislature directing us to bring chemical dependency into our managed care system for mental health so that we have fully integrated mental health and chemical dependency services is whether we should also integrate our chemical dependency in mental health crisis systems.

The - as we noted earlier with respect to local flexibility, the regional support networks have some flexibility to figure out how they want to design crisis diversion services, for example, what do they want to do in terms of facility-

based services like crisis triage or crisis stabilization versus investing in outreach services such as mobile crisis outreach.

And in addition, under our state law, one of the strengths is that local law enforcement, if they have probable cause to believe that a person has committed a nonviolent misdemeanor, do have the opportunity to divert people from the criminal justice system completely and move them into the mental health system where they can be more appropriately served.

And I do - one of the other issues in terms of the linkage and the local flexibility is the clear relationship that we see between - and the clear partnerships that we can have between law enforcement and community mental health systems around appropriately diverting people from the criminal justice system into the treatment that they need.

In terms of the challenges that we have, we are - to maintain the flexibility of the crisis system and to try to keep it from turning into an emergency room-based system, which does seem to be a trend that we're seeing more of - in other words, individuals being brought by ambulances to the emergency room with the evaluation being done in the emergency room, we are funding a number - an increased number of mobile crisis outreach teams to try to get those services and those evaluations happening back in the community rather than in the emergency room.

Here in Washington State, I don't know exactly what the case is in Wisconsin or Tennessee, we still have concerns about inpatient capacity for evaluation and treatment, crisis triage and crisis stabilization needing to be strengthened because like much of the rest of the nation, we do still have situation -- too many situations -- where individuals are boarding in emergency rooms while they're waiting an appropriate short-term placement.

And as noted earlier, another challenge is to more - I think not so much more effectively but to more extensively take advantages of opportunities to divert mentally ill individuals from the criminal justice system.

And then finally, I would note as both a challenge and an opportunity, as I noted earlier, is looking at the impact of federal and state mental health parity provisions. The federal regulations note the reference to intermediate levels of services, and again the issue is in an effort to increase private insurance financing of crisis response services, being able to clarify issues related to what kinds of crisis response services must be covered by private health insurance plans. So that would be both a challenge and an opportunity.

Neva Kaye: So I'd like to thank all of our speakers for providing such a thoughtful overview of your work today.

And now I'd like to turn our attention to the questions and answers that have come from the audience.

Remember, please ask your questions using the chat feature. We already have quite a few that have come in. And there have been a couple along the theme of the population served by the crisis programs, in particular whether the crisis programs in the states serve both adults and children. And I wonder if each of the states would wish to respond to that.

And, you know, since, Jane, you've been responding last to all of the questions so far, why don't we ask you to respond first to this one?

Does your program cover both adults and children?

Jane Beyer: Yes, it does. We have specialty use evaluation and treatment facilities in several areas of the state. And our mobile crisis response teams and our

designated mental health professionals, individuals that go out to evaluate whether an involuntary treatment is appropriate serve both adults and youth.

Neva Kaye: Thank you. And Mary from Tennessee?

Mary Shelton: Yes. Our crisis services cover both adults and children. We have 12 adult teams covering it statewide and then regional crisis teams for the children and youth statewide.

Neva Kaye: Okay. And Joyce in Wisconsin?

Joyce Allen: Sure. It's the same as the other states. It covers both adults and youth. I did note that we do have a specialized team for youth in Milwaukee. But in general, most of the services around the rest of the part of the state just serve both adults and youth through the same program and also do serve substance abuse issues as well.

Neva Kaye: Okay. Thank you.

Neva Kaye: And Jane we had a question come in to ask you to describe the collaboration with tribal jurisdictions and reservation based mental health and substance abuse care in Washington.

Jane Beyer: We are - that's a very interesting question. We have direct contracts with tribal mental health providers to provide services with respect to crisis response services we work very closely to try to build relationships between the tribes and the local regional support networks to ensure that tribal members have access to crisis response services on an equitable basis with non-tribal members.

And many of our tribes are in very rural areas and so the same issues that rural counties who are part of a regional support network have related to getting services to folks in frontier and rural areas come into play with respect to tribal services as well.

Neva Kaye: Thank you, I had a question that came in for the state presenting but I'm actually wondering if Julie you looked at this in your review. Do you have a sense or can you talk about the role that Medicaid waivers play in these programs and in (unintelligible) crises services?

Julie Seibert: Yes some states especially Tennessee did report that they had a waiver and they did report that they experienced a bit more flexibility with Medicaid waivers.

They were able to combine funding with state funding, it was easier to build the firehouse model with Medicaid waiver funding and that was mostly what they reported.

Neva Kaye: Okay and do any of the three presenters want to add anything about the role of waivers in financing and delivering these services.

Jane Beyer: So Washington States mental health program our regional support network program is actually a 1915B managed care waiver through Medicaid.

Neva Kaye: Okay anyone else?

Joyce Allen: In Wisconsin the (unintelligible) Milwaukee program has a special designation I believe it's a 1915A. So it has some special provisions in it but as I noted they do provide services not just for the enrolled populations but also for other use in the community.

Neva Kaye: Thank you and there's a question about the short-term residential crisis stabilization facilities, which I believe is mostly addressed in the Tennessee presentation.

They just wanted more, know more about how do you define short-term and if any of those residential facilities have more than 16 beds?

Mary Shelton: No they do not have more than 16 beds. So they are not considered an IMD or Institution for Mental Diseases. And the average length of stay is around three days. The rules do allow for an extra 24 hours for planning for disposition.

Jane Beyer: And in Washington State in - we've got our crisis triage facilities, which are usually up to 24 hours and then crisis stabilization beds. And what we've done with that is link it up or synch it up with our involuntary treatment act, which has an initial detention period of 72 hours and then a subsequent detention of 14 days.

So an individual can be in a crisis stabilization or an evaluation and treatment bed on an involuntary basis for up to 14 days. The crisis stabilization facilities that are voluntary facilities I don't know that we have an absolute limit on the number of days but it is I think in the shorter range of less than a week in order to try to get folks stabilized and referred onto other services and in our state we have a mix of IMD and non-IMD facilities.

Joyce Allen: And in Wisconsin I don't believe there is a specific time limit on crisis stabilization facilities. They are all small facilities they are not IMD.

Neva Kaye: Okay thank you and we have a question on the mobile crisis response teams. The question is about the personnel that staff those would you please talk a little bit about how staffs those and how closely those teams work with

available EMS and I think well, which of the states would like to address that first? Jane.

Jane Beyer: I can - okay I can jump in. Our mobile crisis response teams are a combination they're not exactly the same I think from regional support network to regional support network.

But many involve peers, a mental health professional and some use RN's and then with psychiatric support, psychiatric consult rapport or support.

Joyce Allen: This is Joyce from Wisconsin it's very similar the makeup of the teams will vary based on the local community but always a licensed mental health professional needs to be available by - at least by telephone if not in person.

Mary Shelton: This is Mary in Tennessee and our - the same as the other two, most of the crisis services workers will have a bachelor level and many are masters level unlicensed but they do have to have a licensed mental health provider that is designated as a mandatory pre-screening agent available at all times.

Neva Kaye: Thank you Joyce you really spoke to the strength of having counties as responsible entities for crises services. What challenge does this de-centralized create and how has Wisconsin worked to overcome those challenges?

Joyce Allen: Well any time you have a de-centralized system that means that each locality develops their own unique way to deliver the service. So it is difficult then to really understand the quality of the services or at least the breadth of the services in each of those communities.

We do through our vision of quality assurance assure that there is a minimum level of quality for those who are certified at the highest level of care to this or highest level.

But in general there is variability and so that's always a plus and sometimes it's a detriment when the same standard isn't met by every county.

Neva Kaye: Julie we did have a question come in about the surfaces that you were looking at in measuring mobile crises versus police intervention. Can you please elaborate a little bit about those services?

Julie Seibert: Sure, in the studies we looked at they really talked more about the cost per case as opposed to the personnel that were involved but I could provide that. We did look at a study that talked about mobile crisis programs were much less expensive than our police intervention.

And for mobile crisis program surfaces the average cost per case was \$1520, which was \$455 for mobile crisis cost and \$1065 per psychiatric hospitalization and that could be compared to an individual that had a police intervention.

And the cost for the police intervention was \$73 while the cost for the psychiatric hospitalization was \$1890. So basically you can see even though mobile crises is a bit more expensive to implement as compared to police services the cost for the hospitalization is on average is much lower. I hope that answered the question.

Neva Kaye: Yes and I do have a question for Suzanne. You had mentioned grant funding for provision of evidence based practices and there's a question about are the opportunities - are there opportunities for counties to apply for that grant funding, Suzanne?

Suzanne Fields: All right hello, yes there are numerous opportunities for various types of funding that can assist with both crisis service provision as well as implementation support.

Currently the ACA has several different provisions for funding. And so what that means is there are several different federal agencies that local authorities and state authorities may be able to pursue funding for these types of services.

I would encourage people to watch SAMHSA's Web site for our announcements about funding opportunities. I would also encourage you to be on the list serve to watch at CMS particularly for their innovation center called CMMI for those funding opportunities as well.

And of course HRSA related to various workforce and other opportunities around health integration FQHC activities to be also watching for HRSA and CDC for those funding opportunities.

Neva Kaye: Thank you, we have a number of questions about asking more detail on specific services and I'll just pick from some of them. To all the states do each of you have a psychiatrist available 24/7 for consultation among your crises services?

And Jane since I asked you to go first last time why don't we start with Mary from Tennessee?

Mary Shelton: Yes each agency has a psychiatrist that's available 24/7 for telephone consultation.

Neva Kaye: Joyce in Wisconsin.

Joyce Allen: It is not required that that 24/7 individual be a psychiatrist but all counties do have a psychiatric consultation available within their system and but it is not available 24/7 as a part of the team.

The individual needs to be a licensed professional, the psychiatrist or the psychologist does need to order more intensive services so they would - they have to have a way to reach a psychiatrist if needed.

Neva Kaye: Okay and Jane.

Jane Beyer: I am not sure about the answer to that question I would have to get back to folks in terms of the details in our contract.

Neva Kaye: Okay, well let's try another service specific question. Do you provide detox services in your mental health crisis stabilization program?

Jane Beyer: We provide detox services actually separately as I indicated when I spoke earlier. The legislature just this past session directed us to integrate mental health and chemical dependency services into our managed care system.

So we contract separately on a fee for service basis for medical and non-medical detox services in distinct facilities.

Neva Kaye: And in Tennessee Mary.

Mary Shelton: It's not required that the CSU's the Crisis Stabilization Unit provide detox services, I believe one or two of them provide non-medical detox. We do however have the medically monitored crisis detox unit and there are seven of those across the state who provide detox services.

Neva Kaye: Okay and Joyce.

Joyce Allen: Again it isn't required within the crisis rule but they provide the medically monitored detox. So how counties provide that really does vary. Many counties do provide that type of service but it is not kind of embedded in the requirements of the crisis program.

So it's going to vary all across the state as to how those services would be provided and where they would be provided.

Neva Kaye: And Mary I have a question about your crisis respite and crisis stabilization unit. One of our participants is asking you to expand a little on the difference between the two and who determines which service is appropriate for the consumer.

Mary Shelton: Right so crisis respite it's usually up to the crisis provider to determine who goes into crisis respite. And that is located at the community mental health center or housing operated by the community mental health center and it's a short-term it is generally no longer than 24 hours.

The crisis stabilization unit often receive referrals from the crisis service providers but then there's an evaluation at the walk in center of the crisis stabilization unit to determine if that person needs to be admitted, meets the criteria for admission for that particular crisis stabilization unit.

And since the CSU is paid on - paid by the MCO's, our managed care organization, they do have the ability to require prior authorization for admission to the crisis stabilization unit and since our MCO's are at full risk they're - they can choose to do that.

And one of our MCO's has elected to require prior authorization prior to admission.

Neva Kaye: Thank you and one of our participants is asking each of you or perhaps Julie from your broader vantage point, do any of the crises services support disaster response and if not what capacity do you think these crises services could offer in a disaster?

Julie Seibert: This is Julie.

((Crosstalk))

Julie Seibert: Yes and actually I was going to say no we did not look at that when we were doing the research for this study. So I would probably turn to the states to see if they have a response for that.

Jane Beyer: So I'm sorry this is Jane we just unfortunately had our disaster when we had the Oso mud slide, which folks probably heard about northeast of Seattle. And the regional support network for that county, for Snohomish County was very, very actively involved in the disaster response.

And interestingly enough though in terms of the on site access to services because one thing that we have to think about is that in a disaster people might be physically isolated.

So for example the evaluation and treatment facilities or the crisis triage and crisis response facilities in Snohomish County are more along the I5 corridor and the landslide took place in a community that literally blocked access to I5 to the people who are to the East of the community.

And so we relied most heavily during the Oso landslide on the Red Cross disaster volunteers who are specifically trained to deal with immediate trauma

and we - our department of social home health services actually set up a mobile community services office on site.

And it was really a uniquely mobilized disaster response system that was there in the immediate aftermath. We also received funding through FEMA for crisis counseling services who are individuals that will literally go out into the community and will try to find individuals who are experiencing PTSD or experiencing trauma and need access to counseling services and will link those individuals up with the services that are offered through our regional support network.

So it is very, very much a partnership but when you have a disaster like that the key thing is to have the services where the individuals are and remember that the people who do mobile crisis response generally their training is to look at an individual who is having an exacerbation or a mental health crisis related to a mental illness or related to substance abuse.

And that's different than going into a disaster and having the skills that you need to help somebody address trauma. It's a different skill set, which is why we relied so heavily upon the Red Cross disaster volunteer - mental health volunteers who are specifically trained to provide that service.

Neva Kaye: Okay thank you, Mary or Joyce do you have anything you wish to add to that response?

Mary Shelton: This is Mary in Tennessee, Tennessee does have a disaster mental health response guide that was put together by the Department of Health, the Tennessee Department of Health, the Tennessee Department of Mental Health and then the Nashville Public Health Department.

We fortunately haven't had a disaster here recently but this guide really helps all the agencies know how to contact each other between the community mental health centers, the Department of Mental Health, the county emergency management agencies and then also the Tennessee Emergency Management Agency.

So it's a nice little handbook to help guide us through an emergency or a disaster.

Neva Kaye: Joyce.

Joyce Allen: In Wisconsin it really depends on the scale of the disaster. In general we have local emergency management agencies that assume the initial responsibility. Since they are local they are often connected to our local Department of Human Services or our mental health agencies and our crisis services.

In as an example when we had some flooding in Wisconsin in one of our communities the crisis teams did have to respond to individuals that they found initially but then we were able to get also a FEMA grant to do more outreach and case management to find the people that weren't actively presenting but still had issues.

So it's really - it depends on the scale of the event and it depends upon what is needed at that time.

Neva Kaye: Suzanne I believe you have something to add.

Suzanne Fields: Yes this is Suzanne from SAMHSA, there is some additional information on SAMHSA's Web site related to a range of topics on this question about disasters and disaster response.

So I would refer people to additional examples from other states and from other counties as well as other information at the samhsa.gov Web site.

Neva Kaye: And we have a number of states or participants who are very interested about the room and board in particular around crises residents for adults. Essentially do you have crises residents for adults and if you do how are they paid for? And I'm not sure who wants to start but I will pick Joyce.

Joyce Allen: Well I think the Medicaid does not pay for room and board so that's just something you need to know. As I said, the counties do need to blend the resources and depending on the funding source they will fill in the gaps if you will.

And they will use their local funding, they might use our state GTR funding that they receive. So there is a range of resources they can call upon to pay for those - that room and board.

Neva Kaye: So this is one of those areas where I think where that braiding and blending of funding is just incredibly important to create that continuum?

Joyce Allen: That is correct.

Neva Kaye: Okay, Jane or Mary do you want to weigh in on this question?

Mary Shelton: This is Mary from Tennessee, I would say basically the same. As far as crisis respite it depends on, you know, the contract that the crisis provider has with the managed care organization, you know, that is reimbursing for the crisis respite service.

But then there's also the grant dollars from the Department of Mental Health that can cover other needs.

Neva Kaye: Okay, I have a - well it will probably be the final question that I would like to ask of each of the state presenters. And what I'd like to know is what do each of you see as your top priority in order to ensure the long-term sustainability of crises services in your state and Jane why don't we start with you again?

Jane Beyer: Gosh, I would say that the top priority for us is to have a robust set in order - in addition to we have our - I'm trying to be articulate but not doing a very good job.

We have our State Involuntary Treatment Act and we know that we have timeframes and we have services related to 72-hour detentions, 14-day detentions and longer term commitments to our safe psychiatric hospitals that we need to meet.

In terms of priorities our priority is to sustain and grow our system of voluntary crisis services. Mobile crisis outreach, crisis triage, crisis stabilization so that we have meaning - and access to the therapies on an outpatient basis in the community.

So that we take every opportunity that we can to divert individuals with mental illness or substance abuse from either an involuntary commitment proceeding, which has it's - which has a whole (sequelae) of impacts on that individual in the community and or from the criminal justice system.

Where it clearly is the individuals mental illness or substance abuse that might be leading - that might result in a misdemeanor charge, which would be much better responded to by having that individual in an effective treatment crisis response and then treatment environment rather than being put into the criminal justice system and into the forensic mental health system.

Neva Kaye: Thank you, and Mary how about for Tennessee?

Mary Shelton: Right and I think for Tennessee especially within the (teen) care program working with our managed care organizations and their contracts with the crisis service providers we're all interested in increasing the number of peer support or peer recovery services providers within the crisis system.

Either operating warm lines like was mentioned by another state or pairing up with the mobile crisis response unit to respond to calls in the community or at the emergency department.

And having a peer available for the crisis respite services or even at the crisis stabilization unit we've heard a lot great things about how peers are used in other states and we get this information from our managed care organizations and also from other national conventions and workshops.

So we're very interested in increasing the number of peer services within our crisis services.

Neva Kaye: Thank you, and Joyce, Wisconsin's priority.

Joyce Allen: Well I think for us it is a combination of things. I think that what we're learning is training for law enforcement needs to be ongoing that the individuals involved in law enforcement there are often changes that people come and go.

And there are in some counties multiple municipalities with a variety of different organizations providing those law enforcement services. So training is an ongoing need because we need to connect our crisis programs with law enforcement to make really an effective program of diversion into the most appropriate setting.

But we also need to make sure that our crisis programs don't become emergency rulings, which I think someone mentioned. We need to have those alternative services available in the community so that people can be diverted to those services and not have to wait for services, which may in turn create another situation in another crisis response.

So in Wisconsin we are beefing up our local support for those alternative programs and our psychosocial rehab programs. We are very lucky that the Governor proposed and the legislature approved the expansion and we see that as a real key to reducing even our crisis service use.

And finally I do agree with the others that peer run respite is an alternative that we're also developing and it's a very, very exciting alternative so that people receive the respite they need before a crisis actually ensues.

Neva Kaye: Thank you and I want to thank all of you for joining us today. I know that a number of you did not get your questions answered we had many of them and we will make sure to pass those on to presenters.

We do thank you all for joining us, the slides will be posted tomorrow on NASHP and SAMHSA's Web sites and we encourage you to take a look at the new publication produced by SAMHSA entitled Crises Services Effectiveness, Cost Effectiveness and Funding Strategies.

When this Webinar concludes your browser will be directed to an evaluation form. Please take a moment to share your feedback on this Webinar and have a great afternoon, thank you for joining us.

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