# Behavioral Crisis System Regional Planning Recommendations

## Adaptations for Variations in Population Density

As more state systems are making progress following implementation o 988 call centers statewide, using SAMHSA's Behavioral Health Crisis Standards (2020), National Council/Group for the Advancement of Psychiatry's Roadmap to the Ideal Crisis System (2021)(www.crisisroadmap.com) and other materials to move toward implementation of a full continuum of BH crisis services for all communities, there is increasing recognition of the challenge of creating statewide standards for service availability that consider the significant variations in capacity and resources between counties (or – in many states – multicounty regions) of varying populations and geographies. The same challenge faces individual counties/regions: what is the right service continuum for our population that reflects the population and geographic realities of our communities?

As a starting place, there is emerging consensus on the essential components of an "ideal" continuum of community BH crisis services for adults and children with MH and/or SUD needs. This consensus list includes:

- 988 Call Center that can link handoffs to the local community.
- Mobile Crisis Team(s) serving adults and children.
- Behavioral Health Urgent Care Centers with afterhours capacity.
- Crisis Centers with 23 Hour Observation
- Residential Crisis Services for Adults with MH and/or SUD requests, and for Children.
- Intensive Crisis Intervention Follow-Up Services

There are also some emerging benchmarks for the expected volume of crisis services needed based on population size, as described in the Crisis Now Calculator as well as from some early analyses of real-world communities. These benchmarks provide some predictability about what level of capacity communities (counties and multicounty regions) should anticipate needing as they develop their services.

Finally, when communities and service recipients are asked to provide input about what service access is appropriate and desirable, the answer is consistent. Whether in large or small communities, people want their crisis response to be as close to home as possible, ideally within 30-60 minutes. However, just as with emergency medical services, people in more rural or frontier areas understand and expect that there may be greater distances to travel for all health services, including behavioral health. Nonetheless, there is generally a preference that behavioral health crisis services be as available and accessible as comparable emergency medical services.

From this information, it quickly becomes clear that counties/regions with low population density may not be able to generate sufficient service volume to support certain types of BH crisis services, just like there cannot be a Level 1 Trauma Center in every community. Communities frequently request guidance from state and national leaders about how to determine what services they can and should develop in their local region, and what types of services may require collaborative planning with a wider set of regional partners.

This document is intended to provide that guidance.

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# County and Regional Planning Recommendations

These recommendations are based on the expectation that all states commonly plan BH services in a way that is organized according to local or regional intermediary structures that reflect "functional geographies" within that state. These functional geographies commonly align with existing planning or resource allocation methodologies. Such intermediary structures may be individual counties, multi-county regions, delineated "catchment areas" or some combination of the above. States may have a variety of methods for coordinating regional planning, such as County BH departments, Local MH Authorities, Community Services Boards, or assigned CMHC Catchment Areas. Whatever the mechanism, these recommendations are designed to be adapted to the state structure and can be used for individual counties, multi-county regions, and larger "multi-region" planning.

To create this Regional Planning Guide checklist, three guides for population planning were used:

1) Crisis Now Calculator, which predicts 200 adults needing BH crisis response (beyond just a call center) in each month, per 100,000 population. Estimates for children may be as little as 10-15% of that number. However, some models indicate that the estimate may be as much as 50% of that number, since children in crisis present in much more diverse locations. We used 25% for this checklist.
2) Arizona system flow data indicating that 70-80% of crises are resolved "in the field" (through mobile or walk in services) and only 20-30% need a 23-hour crisis center or ED (and only a percentage of those need inpatient or residential services, but those who do need them for a longer period).
3) Estimates of crisis center capacity based on Arizona data,: 16 observation beds for adults per 500,000 population. There are no clear guidelines for how many residential crisis beds are needed. For this purpose, we assume 16 adult MH beds per 250,000, 16 adult SUD beds per 250,000, and 16 child MH beds per 250,000. (This is based on an analysis performed in a moderately large county in Michigan.)

The checklist is divided into the following categories:

- Small counties or regions (populations of 50,000- 150,000)
- Medium counties or regions (populations of 150,000 – 300,000)
- Larger counties or regions (populations of 300,000 or more)

The recommendations are based on the input from stakeholders cited earlier, which indicates that as many services should be close to home (inside a small county) as possible, but for those services where there was not sufficient volume to develop services there should be multi-county collaboration to plan a full array of services within approximately one hour drive from all parts of the multi-county "region".

# Small County or Region Planning Estimates and Checklist Population 50,000 – 150,000

Note: VERY small counties (less than 50,000), should plan in a multi-county partnership with sufficient population to support the BH crisis continuum that needs to be developed.

**Anticipated Total Crisis Episodes (beyond calls) based on Crisis Now Calculator:**

- Adults: 100- 300/Month: 3.5-10/day
- Children: 25-75 per month; 1-2.5/day

**Total episodes that can be managed with only mobile crisis or urgent care:**

- Adults: 75-225 per month: 2.5-7.5 per day
- Children: 18-54 per month: .5-2 per day.

**Total "chairs" needed for crisis center with observation (based on 16 beds for 500,000)**

- Adults: 1.6-5; Children: 0.4-1.25

**Table 1. Small County or Region Services Checklist**

| Service | Need |
|---|---|
| **Call center (988 or non-988) – linkage to receive handoffs from a 988 center** | YES |
| **Mobile Crisis Team (adults and children combined)** | YES – Note: in a region with multiple small counties, there may need to be a team in each county. |
| **Behavioral Health Urgent Care capacity (both business hours and after hours)** | YES – Note: In a region with multiple small counties, there should be walk in BHUC in each County, which can be built into and onto other services (Medical Urgent Care; CMHC). |
| **Crisis Center with Observation** | NO – Volume too small* |
| **Residential Crisis Services for Adults (MH and SUD) and Children (MH)** | NO - Not enough volume to sustain a freestanding program for each. ** |
| **Intensive Crisis Intervention Follow-Up** | YES - This should be developed for both adults and children so it can happen on a case-by-case basis when needed. Multiple options, including building it into mobile crisis for home visits, whether for adults or children/families |

*** Modification recommended:** *Build organized capacity into the local ED, so that there is ability for mobile crisis to work with the hospital for intervention and disposition. Ideally a safe, welcoming location within the ED. Availability of consultation regularly from a 24/7 crisis center in a neighboring region. Can transport to the neighboring crisis center (should be within 1 hour by ambulance) if needed.*

** **Modifications to consider:** *Combining crisis and non-crisis residential into a single program; combining SUD and MH in a single location; working with a neighboring program in a larger county. Minimum for MH: using local apartment or other available site for adults on a case-by-case basis, with wraparound staff for overnight supervision as needed, with follow up the next day. Minimum for SUD – detox in hospital setting with wraparound consultation.*

# Medium County or Region Planning Estimates and Checklist
# Population: 150,000-300,000

NOTE: For multi-county regions, there may be a combination of planning county specific services using the small county checklist, plus some "regional" services that cover all the counties in the region.

**Total Crisis Episodes (beyond calls) based on Crisis Now:**

- Adults: 300- 600/MONTH: 10-20/day.
- Children: 75-150 per month; 2.5-5/day

**Total episodes that can be managed with only mobile crisis or urgent care:**

- Adults: 225-450 per month: 7.5-15 per day
- Children: 54-108 per month: 2-3.5 per day.

**Total "chairs" needed for crisis center with observation (based on 16 beds for 500,000)**

- Adults: 5-10; Children: 1.25-2.5

**Table 2. Medium County or Region Services Checklist**

| Service | Need |
|---|---|
| **Call center (988 or non-988) – linkage to receive handoffs from a 988 center** | YES |
| **Mobile Crisis Team (multiple teams needed, some may be child specific)** | YES – Note: in a region with multiple small counties, there may need to be a team in each county. |
| **Behavioral Health Urgent Care capacity (both business hours and after hours)** | YES – Note: In a region with multiple small counties, there should be walk in BHUC in each County that can be built into and onto other services (Medical Urgent Care; CMHC). |
| **Crisis Center with Observation** | MAYBE – The projected need for 5-10 chairs is on the cusp of feasibility for a non-hospital-based crisis center. Some communities may be able to implement; others may have the ability to create a hospital-based crisis center. For others, partnering with other regions may be needed. |
| **Residential Crisis Services for Adults (MH and SUD) and Children (MH)** | YES - The need for these services will usually support one of each type of program. Even for populations of 150,000, smaller size programs may be feasible, or the modifications suggested in the Small County/Region checklist can be considered. Some regions may elect to partner with neighboring regions if a suitable location for residential crisis services that is accessible in a timely fashion to both regions is available. |
| **Intensive Crisis Intervention Follow-Up** | YES - This should be developed for both adults and children so it can happen on a case-by-case basis when needed. Multiple options, including building it into mobile crisis for home visits for children and adults. In multi-county regions, there should be provision for intensive crisis intervention in each county. |

# Large County or Region Planning Estimates and Checklist Population over 300,000

**Total Crisis Episodes (beyond calls) based on Crisis Now:**

- Adults: 600-2000/Month: 20-65/day.
- Children: 150-500 per month: 5-17/day

**Total episodes that can be managed with only mobile crisis or urgent care:**

- Adults: 450-1500 per month: 15-50 per day
- Children: 108-375 per month: 3.5-12.5 per day.

**Total "chairs" needed for crisis center with observation (based on 16 beds for 500,000)**

- Adults: 10-32; Children: 2.5-8

**Table 3. Large County or Region Services Checklist**

| Service | Need |
|---|---|
| **Call center (988 or non-988) – linkage to receive handoffs from a 988 center** | YES |
| **Mobile Crisis Team (multiple teams needed, some may be child specific)** | YES – Note: in a region with multiple small counties, there may need to be a team in each county. Further, in a large county, there may need to be teams focused on different geographic regions within the county. |
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| **Behavioral Health Urgent Care capacity (both business hours and after hours)** | YES – For larger population centers, can be free standing, but also can be built into other services (Medical Urgent Care; CMHC). In a region with multiple small counties, there should be walk in BHUC in each County. Large counties will need multiple BHUCs serving different geographies. |
| **Crisis Center with Observation** | YES – Even the "smallest" large counties have feasibility for a non-hospital crisis center, that can also support surrounding smaller counties. The largest counties will need multiple crisis centers (2-3) to serve different geographies and may have both hospital and non-hospital crisis centers. |
| **Residential Crisis Services for Adults (MH and SUD) and Children (MH)** | YES - Should have at least one of each type of program. The largest counties (500K - 1 million) will need two-four of each type of program. |
| **Intensive Crisis Intervention Follow-Up** | YES - - This should be developed for both adults and children so it can be provided whenever needed. Multiple options, including building it into mobile crisis for home visits for adults or children. In multi-county regions, there should be provision for intensive crisis intervention in each county. In the largest counties, there will need to be intensive crisis intervention programs for different regions in the county. |