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Assessment #4

Addressing Substance Use in Behavioral Health Crisis Care: A Companion Resource to the SAMHSA Crisis Toolkit

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Alexandria, Virginia

Fourth in a Series of Ten Briefs Addressing—Beyond Beds: Crisis Services

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***Addressing Substance Use in Behavioral Health Crisis Care:
A Companion Resource to the SAMHSA Crisis Toolkit***

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Addressing Substance Use in Behavioral Health Crisis Care: A Companion Resource to the SAMHSA Crisis Toolkit

Introduction

A comprehensive crisis response system has an opportunity to direct the turning point of a behavioral health crisis for the better. In a webinar hosted by the National Association of State Mental Health and Program Directors (NASMHPD) on the recently published Substance Abuse and Mental Health Services Administration (SAMHSA) “National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit,”¹ the United States Assistant Secretary for Mental Health and Substance Use, Dr. Elinore McCance Katz, stated that “crisis services and systems play an integral role in the delivery of care ... provide acutely needed care and they also serve as a very important entry point for so many people in to the mental healthcare delivery system ... [and] serve as a means of immediate mental health intervention by trained professionals.” In essence, for individuals experiencing a behavioral health crisis, first impressions are important. As an illustrative point of reference, the American Psychological Association, Dictionary of Psychology includes in its definition of the word crisis: “a turning point for better or worse in the course of an illness.”² Especially for individuals with substance use disorders (SUD), crisis response may be the first and only chance to get it right, and impact not only the outcome of the crisis itself, but the entire recovery process.

The publication of SAMHSA’s Toolkit for Behavioral Health Crisis Care (hereafter referred to as the SAMHSA Crisis Toolkit) serves to coalesce a national effort to draw attention to the importance of crisis response for behavioral health. In 2005, the Technical Assistance Collaborative published “A Community-Based Comprehensive Psychiatric Response Service”,³ an informational and instructional monograph that laid the foundation for identification of essential service components in the crisis care

¹ Substance Abuse and Mental Health Services Administration (2020). National guidelines for behavioral health crisis care – a best practice toolkit. Rockville, MD: Substance Abuse and Mental Health Services Administration.

² VandenBos, G. R. (2015). APA dictionary of psychology (2007 ed.). Washington, DC: American Psychological Association.

³ Technical Assistance Collaborative, Inc. (2005). A community-based comprehensive psychiatric crisis response service. Boston, MA: Technical Assistance Collaborative. <http://www.tacinc.org/knowledge-resources/publications/manuals-guides/crisis-manual/>

continuum. In 2016, the National Action Alliance published the “Crisis Now”⁴ policy paper which identified exceptional practices desired in crisis services. NASMHPD has consistently voiced the need to prioritize crisis response for adequate funding, emphasizing community solutions to better address psychiatric needs outside of institutional based care in its 2017 paper “Beyond Beds.”⁵ And now the SAMHSA Crisis Toolkit serves to give the national voice of leadership in a call to action.

It is essential that the “Anyone” from “Anyone, Anywhere, Anytime” cited in SAMHSA Crisis Toolkit include substance use disorders meaningfully. Substance use disorders cannot be an afterthought in our approach to crisis care. Full integration of mental health and substance use disorders in treatment needs to be embraced across the continuum, which includes the crisis system. We know that 7.7 million adults have co-occurring mental and substance use disorders. Of the 20.3 million adults living with a substance use disorder, 37.9% also had a mental illness. Of 42.1 million adults living with a mental illness, 18.2% also had a substance use disorder. Only 9.1% of those with co-occurring conditions received both mental health care and substance use treatment.⁶ And the percentage of people that receive the simultaneous *recommended* care for both is even lower.⁷ An assessment of factors that prevent systems from embracing full integration of SUD must include screening for the presence of negative perceptions or attitudes related to SUD. Such perceptions can manifest in prejudicial attitudes about and discriminatory practices against people with substance use disorders. These and other forms of stigma at the organizational and individual levels pose major challenges to the integration of SUD into crisis response systems.

Of great significance in the SAMHSA Crisis Toolkit is the clear inclusion of substance use crisis within the behavioral health definition. It could be interpreted that previous descriptions of crisis care focused solely on mental illness, excluding substance use diagnoses. There is no doubt now that funding, policies, planning and operationalization of a community-based crisis system needs to incorporate the specific needs of individuals with co-occurring mental health (MH) and SUD as well as individuals with substance use only diagnoses and crisis needs related to substance use itself. This report highlights states and programs that are demonstrating success integrating substance use disorders in the three core services described in the SAMHSA Crisis Toolkit – crisis call centers, mobile crisis response services, and crisis stabilization services. This report also identifies the essential principles that are crucial for effective integration, as well as practices that are more specific to the SUD population not identified within the SAMHSA Crisis Toolkit but may be useful for consideration of implementation.

⁴ National Action Alliance for Suicide Prevention: Crisis Services Task Force (2016). Crisis now: Transforming services is within our reach. Washington, DC: Education Development Center, Inc.

<https://www.sprc.org/resources-programs/crisis-now-transforming-services-within-our-reach>

⁵ Pinals, D. & Fuller, D. (2017). Beyond beds: The vital role of a full continuum of psychiatric care. Arlington, VA: Treatment Advocacy Center and Alexandria, VA: National Association of State Mental Health Program Directors.

https://www.nasmhpd.org/sites/default/files/TAC.Paper_.1Beyond_Beds.pdf

⁶ Han, B., Compton, W. M., Blanco, C., & Colpe, L. J. (2017). Prevalence, treatment, and unmet treatment needs of US adults with mental health and substance use disorders. *Health Affairs*, 36(10), 1739-1747. doi:10.1377/hlthaff.2017.0584

⁷ Substance Abuse and Mental Health Services Administration (2017). Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health. (HHS Publication No. SMA 17-5044, NSDUH Series H-52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.

Person-Centered Care: Integrating Mental and Substance Use Disorders within the Crisis System

Crisis care cannot be diagnosis dependent, and the “no wrong door” approach is therefore critical, especially when there remains such a fragmentation of SUD and MH treatment delivery systems. Historically, the entire continuum of care for behavioral health from prevention to recovery, including crisis intervention, has segregated care for mental and substance use disorders. The SAMHSA Crisis Toolkit “Interview 6 with Nick Margiotta” illuminates this fragmentation.⁸ The interview provides his account of a frustrating effort to access help for an individual in crisis who was turned away from psychiatric care because they were actively using substances, only to be subsequently turned away from substance use disorder care because they were suicidal. This cycle of denying care due to active symptomology of co-occurring disorders is a clear demonstration of a poorly integrated system of care. As noted by NASMHPD in its 2019 Technical Paper “Integrated Systems and Services for People with Co-Occurring Mental Health and Substance Use Conditions: What’s Known, What’s New, and What’s Now?”, much work had been done beginning in the late 1980’s through early 2000s to support an organized implementation process for integrated services for mental illness and substance use disorders. Then as attention focused on costs and negative outcomes associated with comorbid physical and behavioral health conditions (specifically mental and substance use disorders), momentum shifted to integration within the physical health realm, as if mental health and substance use integration were completed.⁹ It was not.

Low perceived need and barriers to care access for both disorders likely contribute to low treatment rates of co-occurring disorders.¹⁰ Individuals with substance use disorder often do not perceive the need for help, as the illness is often accompanied by a denial of its existence.¹¹ A moment of crisis may open the window of opportunity to break through and engage individuals to see the consequences of continued substance use more clearly and plant the seed of hope for recovery. Intervention at the time of crisis using evidence-based practices such as motivational interviewing combined with seamless connection to treatment and effective follow up may increase the rates of treatment initiation for a population typically hard to engage. Understanding the stages of change model prepares crisis responders to identify interventions that will have the greatest impact. This report offers specific examples of programs and States that have implemented person-centered approaches for individuals with substance use disorder through a crisis response system.

⁸ Substance Abuse and Mental Health Services Administration (2020). National guidelines for behavioral health crisis care – a best practice toolkit, pp. 73-55. Rockville, MD: Substance Abuse and Mental Health Services Administration.

⁹ Minkoff, K. & Covell, N. (2019). Integrated systems and services for people with co-occurring mental health and substance use conditions: What’s known, what’s new, and what’s now? pp. 4-5. Alexandria, VA: National Association of State Mental Health Program Directors.

¹⁰ Han, B., Compton, W. M., Blanco, C., & Colpe, L. J. (2017). Prevalence, treatment, and unmet treatment needs of US adults with mental health and substance use disorders. *Health Affairs*, 36(10), 1739-1747. doi:10.1377/hlthaff.2017.0584

¹¹ American Society of Addiction Medicine (2011). Public policy statement on relapse in healthcare and other licensed professionals. Chevy Chase, MD: American Society of Addiction Medicine.

https://www.asam.org/docs/default-source/public-policy-statements/111pip_relapse_4-11.pdf?sfvrsn=b274212a_0

As described further in this report, universal incorporation of Screening, Brief Intervention and Referral to Treatment (SBIRT) throughout the continuum of care can improve our identification of substance misuse and use disorders. It is critical that our crisis response system be fully prepared to address substance use disorders from triage to connection to care. Screening and assessment tools need to be inclusive of substance use and connections to care need to include referrals made to appropriate levels of care within the SUD treatment continuum, including medication-assisted treatment (MAT). As concluded by the National Academies of Science, Engineering, and Medicine, MAT prevents death, stabilizes patients, and should be available to all people – including people interacting with the crisis system.¹²

Core Services and Best Practices

The SAMHSA Crisis Toolkit identifies three essential elements of an effective behavioral health crisis response system incorporating a no wrong-door, integrated approach: crisis call centers; crisis mobile teams; and crisis stabilization facilities and services. This section identifies examples of states and/or programs that have effectively and meaningfully integrated substance use or co-occurring disorders into these core components of a crisis response system. It is important to note that SUD integration is most effective when integrated throughout the entire service delivery system. Some states, such as Georgia, have achieved integration across the three domains. Other states are evolving to become more inclusive of Co-occurring Disorders (COD) and SUD. For example, Delaware is in the process of re-procuring its crisis response system to comprehensively include SUD in all response services. Washington requires its central crisis administrator, the Behavioral Health Services Organization, to manage both SUD and MH crisis and has invested in cross-training its mobile crisis responders to develop and improve the competencies for addressing the needs of individuals with SUD experiencing crisis.

Regional Crisis Call Centers

People contact crisis lines for different reasons. Individuals who are feeling overwhelmed and unable to cope reach out in desperation seeking help and hope. Family members, teachers, friends, faith-based leaders, loved ones, and co-workers also call crisis lines seeking help for someone else and guidance on how to support the individual. A crisis call responder must provide a compassionate presence and quickly assess the needs of the caller as well as safety risks and concerns. Substance use is a risk factor for both fatal and nonfatal overdoses, suicide attempts, and death by suicide, accident, medical complications, and other causes. Compared with the general population, individuals with alcohol dependence and persons who use drugs have a 10–14 times greater risk of death by suicide, respectively, and approximately 22% of deaths by suicide have involved alcohol intoxication. Among the reported substances, alcohol and opioids are associated with the greatest risks of suicidal behavior.¹³ Additional risks associated with substance use disorders include non-suicidal accident, injury, victimization (including intimate partner violence) and trauma sometimes related to increased risk-taking behavior. Crisis lines must be equipped to take all calls; therefore, to adequately address needs of individuals using substances, with or without a co-occurring mental illness, training for call responders must include substance specific information. Crisis responders need to assess for risks specific to

¹² National Academies of Sciences, Engineering, and Medicine (2019). Medications for opioid use disorder save lives. Washington, DC: National Academies Press. <https://doi.org/10.17226/25310>.

¹³ Esang, M. & Ahmed, S. (2018). A closer look at substance abuse and suicide. *American Journal of Psychiatry*, 13(6): 6-8.

substance use, such as acute intoxication, withdrawal requiring medical monitoring or management, or overdose in order to adequately triage and determine appropriate response and referral options.

The SAMHSA Crisis Toolkit establishes minimum expectations for a regional crisis call services which include: 24/7 operation; a workforce of clinicians and trained team members overseeing triage; ability to answer all calls; ability to assess suicide and other danger risks; and ability to connect individuals to mobile crisis teams as well as facility based care. Examples of crisis call centers that meet these expectations as well as combining real-time service availability and scheduling capacity include New Mexico's NMCAL, Colorado's Crisis Services and Support Line, Georgia's GCAL, Behavioral Health Response in St. Louis, and the New York City NYC Well program.

For states and municipalities with crisis call services geared for mental health conditions, one option is to integrate SUD-specific capacities and competencies into the existing system. For example, Delaware has developed a comprehensive hotline workflow chart to incorporate SUD as well as social needs or emotional support. Retraining its crisis staff, Delaware is working to ensure individuals with SUD are connected to the right level of care using their real-time open beds platform, the Delaware Treatment Referral Network.

In addition, many states provide substance use-specific hotlines. A crisis for individuals with primary substance use may present differently than individuals with primary mental health or co-occurring disorders. Crisis response for these individuals often involves connections to a specialty addiction treatment system that may be hard to understand or navigate. The caller may present with a defined desire to discontinue their use of alcohol or other drugs. For this reason, substance use specific crisis lines have been developed in many states. For example, the Indiana Addiction Hotline is available 24/7 for individuals seeking addiction treatment services in Indiana. Referral to state-approved agencies is provided by master's degree counselors with bilingual capabilities. Hotline counselors can directly transfer calls to a treatment provider when available. While Tennessee has made significant investment in building a community-based behavioral healthcare system that is co-occurring capable, it also provides a SUD specific hotline. The Tennessee "red line" offers not only a warm handoff to treatment services; it also makes a real-time connection to "lifeliners" – individuals in recovery, employed by local behavioral healthcare providers.

Mobile Crisis Team Services

Community-based mobile crisis services provide face to face interventions for individuals in crisis with trained clinical professionals and peers. These teams meet the person where they are, at the time of need, reaching the individual in the community in order to achieve the best outcome for that person. Historically, mobile crisis teams have been components of community mental health centers (CMHCs), serving a population with primary mental health diagnoses. Across the country, CMHCs have varying capabilities – and deficiencies – related to addressing co-occurring disorders and substance use primary diagnoses. However, there are several strong examples of states and programs that developed mobile crisis team services to meet the needs of individuals with SUD experiencing crisis.

For example, the Georgia crisis response system incorporates all three of the essential services described by the SAMHSA Crisis Toolkit and integrates substance use disorders throughout its services.

The Georgia Department of Behavioral Health & Developmental Disabilities (DBHDD) established a clear guide outlining the appropriate use of mobile crisis teams (MCT) in the community.¹⁴ MCTs are dispatched to respond to SUD crisis after determining this as the appropriate response as outlined below. The Georgia DBHDD acknowledges SUD as a core component of the mobile crisis system by articulating the intent of mobile crisis:

- De-escalate crisis situations;
- Relieve the immediate distress of individuals experiencing a crisis situation;
- Reduce the risk of individuals in a crisis situation doing harm to themselves or others; and
- Promote timely access to appropriate services for those who require ongoing mental health or co-occurring mental health and substance abuse services.

Prior to dispatch of an MCT, the call center makes an effort to engage the individual in crisis in order to create an alliance, involve the individual in care decisions, and assess safety concerns. Individuals are screened related to substance use which includes type of substance(s) used, amount, and presence of withdrawal symptoms. Based on acuity, a decision is made as to whether an MCT is appropriate or if an individual needs a more intensive response involving emergency medical services and/or law enforcement. For example, the MCT will be dispatched as long as the individual is not in active withdrawal from alcohol, benzodiazepines or barbiturates as the associated risks require medical intervention. Alternatively, opioid withdrawal may be appropriately responded to by MCTs that can provide the connection to the appropriate level of care with the ability to provide MAT induction.

In addition to determining clinical appropriateness for an MCT response, there are other community collaborators to facilitate MCT responses. For example, when MCT is the appropriate response, established guidelines help determine when to request varied levels of support from law enforcement, and when it is safe for MCTs to respond alone. This support ranges from asking law enforcement to accompany, follow behind, or be on standby for the team. MCTs are uniquely positioned to address SUD crises in the community when team members have received specific training in SUD risk assessment.

While not aligning with the best practices detailed in the SAMHSA Crisis Toolkit, **co-responder models** in which behavioral health specialists respond to crisis calls in collaboration with law enforcement exist in many states. There are generally two approaches to the co-responder model: an officer and behavioral health specialist ride together in the same vehicle for an entire shift; or the behavioral health specialist is called to the scene and the call is handled together. Aside from reducing costs, diversions of this sort are extraordinarily important for minimizing the criminalization of mental illness and substance use disorders and ensuring people are treated in the least restrictive environment possible. Also, identifying high volume time periods can help maximize this approach given the funding required to support the co-responders. In this way, co-responder models represent a promising tool to help achieve the goals of

¹⁴ Georgia Department of Behavioral Health and Developmental Disabilities (undated). Guide: Using mobile crisis services in lieu of an order to apprehend. https://dbhdd.georgia.gov/sites/dbhdd.georgia.gov/files/related_files/site_page/Guide%20to%20Mobile%20Crisis%20Services.pdf

the American with Disabilities Act as reflected in the *Olmstead* decision for individuals with mental health and substance use disorders.¹⁵

In response to the opioid crisis, many co-responder programs have been established in states, with a concerted focus on outreaching to the SUD population post-overdose. In Rhode Island, the Hope Initiative is a statewide collaboration between law enforcement and substance use professionals to help guide those in need toward recovery. These teams respond to individuals who have recently survived an overdose as well as responding to community referrals for outreach from friends and family members. If engaged individuals are interested in treatment, the team will provide transportation if needed. Treatment referrals and transportation include access to MAT. The outreach teams continue follow up with individuals who may not be interested in services at point of first contact to offer support and recovery resources. Teams will also provide support to family members impacted by the addiction. West Virginia has taken steps to expand the statewide capacity of similar co-responder models called Quick Response Teams. Quick Response Teams are composed of emergency response personnel, law enforcement officers and a substance use treatment or recovery provider who contact individuals within 24-72 hours of their overdose to offer and assist those individuals with recovery support including referrals to treatment options.¹⁶ And the Massachusetts Post Overdose Support Teams program involves teams of first responders, public health advocates and harm reduction specialists returning to the site of a non-fatal overdose to provide follow-up services to overdose victims and their families.

¹⁵ Martone, K., Arienti, F., & Lerch, S. (2019). *Olmstead* at 20: Using the vision of *Olmstead* to decriminalize mental illness. Access: *The TAC Blog*, September 2019. Boston, MA: Technical Assistance Collaborative. Retrieved from: <http://www.tacinc.org/blog/september-2019/september-2019-olmstead-at-20-using-the-vision-of-olmstead-to-decriminalize-mental-illness/>

¹⁶ <https://dhhr.wv.gov/News/2018/Pages/DHHR-Awards-Funding-for-Quick-Response-Teams.aspx>

Crisis Receiving and Stabilization Services

Behavioral health crisis centers serve as an alternative to emergency departments for an individual experiencing a mental health or SUD crisis. These centers are staffed 24/7 with a multidisciplinary team of behavioral health specialists, typically including access to peers, nurses and prescribers and they receive referrals, walk-ins and first responder drop-offs. Crisis centers are designed to address the behavioral health crisis, reducing acute symptoms in a safe, warm and supportive environment while observing for safety and assessing the needs of the individual. Over the last two decades, crisis centers have been expanding across the country, evolving to become more comprehensive, recovery-oriented, and welcoming to individuals receiving care as well as first responders and other referral sources.

Crisis stabilization centers vary in their approach to individuals presenting with co-occurring or primary substance use disorders. On one hand, some have established criteria that exclude individuals who may need withdrawal management services (detoxification), representing a clear opportunity for improving this pillar of the crisis response system to better meet the needs of individuals with SUD experiencing crisis. However, many crisis stabilization providers are connected to detoxification programs and can coordinate rapid admissions for crisis center patients who require that service. In areas where methamphetamine use is prevalent, such as California, Hawaii, and Georgia, crisis providers have become skilled in addressing methamphetamine induced psychosis, recognizing the need to treat the psychosis first and then connect individuals to the right level of care.

For example, to improve the clinical capacity to address both MH and SUD, the Department of Public Health in Los Angeles County instituted incentives to promote workforce enhancements by providing increased rates for agencies with increased levels of licensed clinicians on staff. LA County inpatient detoxification programs can address mild symptoms of psychosis that are often a part of the treatment for methamphetamine. An adequately trained workforce is a key element in effectively addressing SUD in a crisis setting. Crisis centers often employ peers with lived experience with substance use disorders as well as peers with lived experience with mental illness. Training the crisis response workforce in evidence-based practice for SUD can improve outcomes. In early stages of interaction with a SUD population, incorporating the transtheoretical model of behavior change to assess stage of change and guide the use of evidence based practice such as motivational interviewing has demonstrated improvement of treatment engagement and retention rates. In Pima County, Arizona, leaders recognize that the number of individuals with behavioral health conditions in the correctional system represents a problem that cannot be addressed solely through legal means. The Tucson Police Department invested grant funding for comprehensive training in Motivational Interviewing and Trauma Informed Care. This training empowers officers to play a role in encouraging individuals to make recovery oriented decisions. In the provision of SUD crisis response, meeting the individual where they are is both a literal and figurative imperative.¹⁷

The “Rediscover Assessment and Triage Center” (ATC) is a regional crisis center located in Kansas City, Missouri that addresses both mental health and substance use disorder related crises. Originally established through collaboration with the criminal justice and hospital healthcare systems, the center has expanded to include walk-ins and referrals from community based providers. Case management and

¹⁷ Carroll, K., Ball, S., & Nich, C., Martino, S., Frankforter, T., Farentinos, C., Kunkel, L., et al. (2006). Motivational interviewing to improve treatment engagement and outcome in individuals seeking treatment for substance abuse: A multisite effectiveness study. *Drug and Alcohol Dependence*, 81(3). 301-312.

connection to peers are areas of significant focus at the triage center. As a regional service, peers come in from across all of the mental health agencies. The ATC dedicates equal attention and resources to both disorders. At the ATC, individuals with opioid use disorders (OUD) are offered induction on buprenorphine or methadone and connected to opioid treatment programs (opioid treatment programs are the sites legally allowed to offer methadone for OUD) in the community. Rapid access to MAT offered through onsite inductions can drastically increase the rates of follow-up and continuity of care and save lives. As ATC is a Certified Community Behavioral Health Center (CCBHC) and operates an opioid treatment program (OTP), their ability to provide continuity of service in the community is enhanced. The success of this program has led to plans for expansion in the state.

The Crisis Response Center (CRC) in Tucson, Arizona provides another example of a comprehensive crisis receiving and stabilization Center. Established in 2011, CRC has a longstanding history of providing services in coordination with community stakeholders through implementation of a no wrong door policy and has access to a comprehensive treatment system for SUD available 24/7. The CRC and Community Bridges provide 24/7 access to detoxification and 24/7 access to medication assisted treatment (e.g. Methadone and Buprenorphine induction) in outpatient settings through community partners. CRC provides access to MAT 24/7 for individuals with high acuity co-occurring mental health need. Individuals presenting at CRC receive assistance with accessing the appropriate level of care, including care coordination, transportation, and a warm handoff.

The SAMHSA Crisis Toolkit identifies short-term residential facilities as an additional element in the system of care. While not necessarily meeting the definition of a “crisis” facility required to take all referrals, these programs are often referred to as crisis stabilization units (CSU) and involve longer stays, usually between 4-7 days. In general, these programs serve individuals who need a longer period of time to return to the community but do not require a hospital-based level of care. Like receiving and stabilization centers, CSUs vary in their ability to address co-occurring or SUD primary patients. In West Virginia, CSUs are facilities with less than 17 beds that accept individuals with MH, SUD and co-occurring disorders. The CSUs provide psychiatric stabilization services, withdrawal management, and induction on buprenorphine for OUD. Individuals who are more appropriate for, or prefer methadone, are transported to the nearby OTP for methadone induction and then daily for continued dosing. While early in implementation, the state is already seeing positive outcomes related to MAT induction, including reductions in readmissions.¹⁸

Core Principles and Essential Partnerships

Beyond the three components constituting a comprehensive crisis response system as described in the SAMHSA Crisis Toolkit, there are core principles and essential partnerships necessary for effectively addressing co-occurring and SUDs before, during, and after crisis. These principles may be incorporated into services described above; however, for the SUD population, there are key nuances for consideration.

The SAMHSA Crisis Toolkit identifies six core principles that, when fully implemented, represent excellent crisis care systems that incorporate best practices:

- Addressing Recovery Needs;

¹⁸ Interview with West Virginia Bureau for Medical Services official. May 2020.

- Significant Role for Peers;
- Trauma-Informed Care;
- Zero Suicide/Suicide Safer Care;
- Safety/Security for Staff and People in Crisis; and
- Crisis Response Partnerships with Law Enforcement, Dispatch and Emergency Medical Services.

The identified principles of **Trauma Informed Care, Zero Suicide/Suicide Safer Care, and Safety/Security for Staff and People in Crisis** directly apply to individuals with SUD in crisis and are thoroughly addressed in the SAMHSA Crisis Toolkit. The remaining principles require additional exploration with respect to how they relate to SUD specifically.

Applying Core Principles to SUD: Addressing Recovery Needs

The principle of **Addressing Recovery Needs** deserves expanded consideration for a SUD population. *Recovery is possible.* This statement has such significance in the world of substance use disorders. It is easy to give up hope and hard to have compassion for one whose disorder is understood as a moral failing as opposed to a health care condition. For many years, and unfortunately to a significant extent to this day, society has viewed SUDs in this light. This belief is reflected in the oft-heard statement that a person with SUD does not want to change. This is an unfortunate variant of the “Stages of Change” construct in substance use treatment, which typically recognizes the enormous importance of motivational techniques to help people move from one stage of readiness for change to another.

A large percentage of those admitted to SUD treatment cite legal pressure as an important reason for seeking treatment. And some expert sources suggest that outcomes for those who have choices where participation might eliminate some legal consequence to enter treatment are as good as or better than those who were not. In addition to legal consequences, outside influences are also relevant- such as views of families, employers, significant others, desire to not compromise parenting, etc. Individuals with such outside influences, such as those who face some legal consequences if they are in the criminal justice system tend to have higher attendance rates and in remain in treatment for longer periods, which can have a positive impact on treatment outcomes.¹⁹ Implementation guidance suggesting pursuing a “no-force-first” approach is important in SUD crisis, but must not negate the important role that the criminal justice system has had for those facing criminal legal consequences on connecting individuals to care. This is especially the case when such legal “pressure” can itself be seen as a motivational force rather than an unwanted mandate. Indeed how the legal pressure is formulated as part of the treatment can be a crucial difference if presented as a motivational opportunity rather than something being imposed on one who is “not ready.” These types of conversations to aim toward engagement can be nuanced, and it is useful to have training in techniques like motivational interviewing, even to help individuals make decisions where there can be criminal justice consequences to a particular decision about treatment engagement.

¹⁹ National Institute on Drug Abuse (last updated April 2014). Principles of drug abuse treatment for criminal justice populations — a research-based guide. Retrieved on 3/27/20 from <https://www.drugabuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations-research-based-guide>

Applying Core Principles to SUD: Significant Role for Peers

The **Significant Role of Peers** in crisis response for individuals with SUD can differ from roles of peers in the traditional MH system. Despite the prevalence of co-occurring disorders previously noted, there continues to be some division amongst peers defined as having MH or SUD lived experience.

The nascent yet growing recovery movement has been game-changing for individuals affected by substance use disorder, and the power of peers with lived SUD experience sharing their experiences, hope, and resilience has had significant impact not only on affected individuals but also on the system of care as a whole. Despite a foundation of addict helping addict through traditional 12 step programs, the SUD delivery system was slow to engage the power of peers throughout the continuum. With the launch of the SAMHSA Access to Recovery (ATR) discretionary grant program in 2004, peers with SUD experience were increasingly considered to be essential members of the overall system of care. The Connecticut Community for Addiction Recovery (CCAR) led the nation in the development of training, standards, and the activation of peer experience to influence care.²⁰ In addition, Georgia has a rich history of peer involvement in the continuum of care for mental health. However, even there, the number of peers working throughout the continuum with SUD lived experience is significantly less than those with MH lived experience. As is the case with virtually every state, Georgia seeks to increase the number of SUD peers in their crisis system, as they do not yet have enough who are trained and certified to meet the need.

The opioid crisis has prompted states to consider new ways to leverage and employ the SUD recovery community to share hope and resilience with individuals who are hard to engage and at risk.

Pre-crisis programs like AnchorMore in Rhode Island deploy Peer Recovery Specialist to overdose hotspots to engage high-risk individuals.²¹ Weekly team calls identify areas where overdoses have been most prevalent and may convene more often if there is a marked increase in an area not previously identified. Teams of peers are sent to these areas and dispense Narcan kits as well as fentanyl test strips. During these interactions, peers are establishing connections with active users and will provide referral to treatment and recovery services when individuals are interested. This program has demonstrated a high rate of engagement for services with an at-risk population.

Peers have also been deployed to respond to crises, including overdoses, in EDs. While preferable to address crisis in community-based settings, the nature of SUDs may necessitate the use of ED in crisis, and it is important to have SUD-focused supports across settings in the crisis continuum to effectuate the “no wrong door” approach. Individuals who have overdosed or those whose substance use has resulted in serious injury must receive appropriate medical care first. In the wake of the opioid crisis, EDs have become an important component of the crisis system in addressing SUD. Many states have incorporated peer response to overdose survivors and other individuals with SUD presenting in EDs and have seen this crisis point as a successful point of intervention and engagement for care. For example, Kentucky implemented the Bridge Program which not only provides peer support post overdose, but also involves hospitals providing induction on MAT. Pennsylvania integrates peers in community based

²⁰ Connecticut Community for Addiction Recovery (2010). CCAR history (2000-2010). Retrieved on 5/27/20 from: <http://ccar.us/about-ccar/history/ccar-2000-2010/>

²¹ Waye, K. M., Goyer, J., Dettor, D., Mahoney, L., Samuels, E. A., Yedinak, J. L., & Marshall, B. D. (2019). Implementing peer recovery services for overdose prevention in Rhode Island: An examination of two outreach-based approaches. *Addictive Behavior* 89, 85-91. doi:10.1016/j.addbeh.2018.09.027

care management teams that reach out to clients in EDs post overdose, but also extends outreach to correctional facilities, primary care settings and other community-based settings. The aim of the outreach is to engage individuals in their successful Center of Excellence program, expanding access to MAT, providing case management to address other social determinants of health, and encouraging continued involvement with health and mental health treatment.

Crisis receiving stabilization centers, such as The Restoration Center in San Antonio, Texas employ peers, identified as recovery support specialists to provide follow up care for individuals discharged from the crisis centers. These peers provide services to individuals up to 45 days post crisis which include assistance in obtaining housing, accessing medications, transportation to appointments, peer support, follow up phone calls and welfare checks.

Applying Core Principles to SUD: Crisis Response Partnerships

Effective response to SUD throughout the crisis care continuum entails developing **Crisis Response Partnerships** with partners and in settings above and beyond those described in the SAMHSA Crisis Toolkit. As noted previously, EDs can provide a place of engagement for individuals with SUD. Intervention efforts can extend beyond connecting individuals with SUDs to peers. Forty percent of ED visits are due to trauma, and of these, between 40% and 50% are alcohol related. Implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT) in ED settings allows an opportunity for identification, engagement and intervention. Massachusetts' Project Assert uses health promotion advocates (HPAs) to perform SBIRT as part of routine emergency department care. These encounters with HPAs provide patients with the opportunity to explore change through non-judgmental conversations combined with access to health and treatment services. EDs can also be an effective site for treatment initiation.²² A study published in 2015 demonstrated the impact of MAT induction within an ED setting for individuals presenting with Opioid Use Disorder (OUD). This study concluded that ED-initiated buprenorphine, "compared with brief intervention and referral, significantly increased engagement in formal addiction treatment, reduced self-reported illicit opioid use, and decreased use of inpatient addiction treatment services."²³ In California, the Bridge Program supports hospitals to provide buprenorphine and embeds Recovery Support Navigator staff in EDs with the goal of meeting individuals with SUD where they are and improving connections to care following an SUD-related ED visit.²⁴ The Bridge Program shows comparatively high rates of completed follow-up visits to community-based providers among patients who received buprenorphine and Recovery Support Navigator services in the ED.²⁵

Forming partnerships with first responders also have the potential to achieve significant impact on assisting individuals experiencing SUD crisis in areas of crisis prevention, response and post crisis outreach. For example, the Safe Stations program initiated in Manchester, New Hampshire has now been replicated in cities across the country. The Safe Station program provides fire stations as open doors for individuals seeking help for substance use disorders, 24/7. Fire Department personnel

²² Massachusetts ED SBIRT Initiative: <https://www.bu.edu/bniart/sbirt-experience/sbirt-programs/sbirt-hospital-emergency-department/>

²³ D'Onofrio, G., O'Connor, P. G., Pantalon, M. V., Chawarski, M. C., Busch, S. H., Owens, P. H., Bernstein, S. L., & Fiellin, D. A. (2015). Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: A randomized clinical trial. *JAMA*, 313(16), 1636–1644. <https://doi.org/10.1001/jama.2015.3474>

²⁴ <http://www.californiamat.org/matproject/california-bridge-program/>

²⁵ California Bridge Program. *Barriers, Gaps, and Opportunities*. Treatment Starts Here convening. January 2020.

conduct a brief medical assessment before connecting these individuals to treatment and recovery resources. Similarly, partnerships with law enforcement also represent a promising opportunity for responding to the needs of individuals with SUD experiencing crisis. The Police Assisted Addiction & Recovery Institute is a national network of police departments spanning 32 states that offer simple, stigma-free, non-arrest pathways to treatment and recovery based on the Angel Program established by the Gloucester Police Department in Massachusetts in 2015.²⁶

Financing Strategies

There are several federal funding authorities that states can leverage to finance crisis care systems, including those that deliver services for individuals with co-occurring and SUD-only diagnoses experiencing crisis. States can use traditional federal funding sources available for mental health-oriented crisis response services to achieve progress towards a more fully integrated crisis care system. Given the patchwork nature of mental health and SUD crisis service funding highlighted in the SAMHSA Crisis Toolkit, states can develop a braided funding approach to finance system improvements and pay for service provision.²⁷ In a braided funding approach, policymakers coordinate the use of multiple, discrete funding authorities to support a single strategy while retaining the identity and expenditure data specific to each authority.²⁸ SAMHSA has identified strong examples of states that braid funding sources to develop crisis service systems and provide crisis care, including with state general funds, federal grants, and various Medicaid authorities.²⁹

Discretionary SAMHSA grant funding opportunities can be used to pay for certain costs of crisis care systems not covered by payments from health care plans, such as infrastructure and “startup” costs associated with developing crisis care system capacities, crisis response care for uninsured individuals, and components of crisis response care that are not included in individual plan coverage. States can use the annual Community Mental Health Services Block Grant and Substance Abuse Prevention and Treatment Block Grant programs to develop and enhance crisis response systems with SUD-specific capacities.³⁰ In addition, states (and often providers) can apply for other SAMHSA grant funding opportunities to implement crisis response efforts with SUD-specific capacities. States are leveraging the State Opioid Response (SOR) grant funding opportunity to implement some of the best practices described in this report. For example, California and West Virginia are allocating SOR funding to scale up the Bridge Program and Quick Response Team SUD crisis interventions described above to meet

²⁶ The Police-Assisted Addiction and Recovery Initiative: <https://paariusa.org/about-us/>

²⁷ Page 36

²⁸ AGA Work Group on Blended and Braided Funding, operating under the auspices of AGA’s Intergovernmental Partnership (2014). Blended and braided funding: A guide for policy makers and practitioners. Alexandria, VA: Association of Government Accountants.

<https://www.agacfm.org/AGA/Intergovernmental/documents/BlendedandBraidedFunding.pdf>

²⁹ Substance Abuse and Mental Health Services Administration (2014). Crisis services: Effectiveness, cost effectiveness, and funding strategies. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration. <https://store.samhsa.gov/product/Crisis-Services-Effectiveness-Cost-Effectiveness-and-Funding-Strategies/sma14-4848>

³⁰ FFY 2020-2020 Block Grant Application (Community Mental Health Services Block Grant Plan & Report and Substance Abuse Prevention & Treatment Block Grant): https://www.samhsa.gov/sites/default/files/grants/fy2020-2021_blockgrantapplicationandplan_091718_508.pdf

individuals with SUD literally where they are and improve connections to care following an SUD-related crisis event.³¹

States can also design their Medicaid program to maximize federal matching funds and secure a sustainable source of funding for crisis response services in ways that account for local circumstances. There are longstanding federal policy and regulatory options at states' disposal to cover crisis response services for Medicaid beneficiaries with SUD, including the core components described in the SAMHSA Crisis Toolkit. For example, components of crisis call center, mobile crisis response, and crisis stabilization services can be covered under Medicaid:

- in the state plan through the rehabilitation, other licensed practitioner, and clinic services at Section 1905(a);
- in the state plan through the home and community-based services option at Section 1915(i);
- in the home and community-based services waiver programs at Section 1915(c); and
- as administrative costs, especially for crisis call centers.³²

In addition, states have additional flexibilities to receive federal Medicaid funding for crisis stabilization services provided in facilities that meet the definition of an institution of mental disease (IMD) and would otherwise be excluded for federal Medicaid reimbursement. Specifically, in states delivering crisis services through risk-based managed care, federal Medicaid funds are available for capitation payments to managed care plans whose enrollees receive psychiatric and SUD crisis residential services provided in IMDs as an "in lieu of" service so long as the length of stay is less than 15 days.³³ In addition, states can apply for the Section 1115 demonstration opportunity announced in 2018 that offers federal Medicaid funding flexibilities for mental health services provided in IMDs, including crisis stabilization services.³⁴ Notably, the 2018 guidance identifies improved availability of crisis response services, including crisis call centers, mobile crisis response, and crisis stabilization services, as a milestone that states must meet over the course of the demonstration.

Impact and Lessons Learned from COVID-19

The COVID-19 pandemic has created a new set of challenges for policy makers and providers serving individuals with SUD, including those who may experience a crisis episode. Yet amid these challenges are key opportunities to leverage for developing comprehensive crisis response systems designed to meet the needs of individuals with SUD experiencing a crisis, and mitigate disparities in public health and crisis care that are being brought to the forefront during this pandemic.

³¹ California MAT Extension Project: California Bridge Program (updated April 2019). Retrieved on 5/28/20 from: <http://www.californiamat.org/matproject/california-bridge-program/>

³² U.S. Department of Health and Human Services Center for Medicare and Medicaid Services (2018). State Medicaid Director 18-011: <https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18011.pdf>

³³ 42 CFR 438.6(e)

³⁴ U.S. Department of Health and Human Services Center for Medicare and Medicaid Services (2018). State Medicaid Director 18-011: <https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/smd18011.pdf>

For one, individuals receiving MAT are at increased risk for morbidity and mortality caused by interruptions in their pharmacotherapy as discontinuing MAT often leads to relapse and overdose.³⁵ Despite federal agencies such as SAMHSA and DEA issuing guidance offering states and providers considerable flexibility for maintaining access to medications, access to certain SUD treatment services has nevertheless been jeopardized during COVID-19. Intensive levels of care provided in congregate care settings such as inpatient and residential treatment programs have been especially impacted by COVID. For example, a survey of behavioral health providers reveals that 91 percent have reduced operations, with two-thirds closing at least one of their programs.³⁶ It is essential that the crisis response system be aware of these capacity limitations and develop strategies to maintain engagement with individuals if they must wait for admission.

Another important consideration for the crisis response system is the increase of substance use in general. A survey of patients, families, and individuals in recovery revealed that 20 percent of respondents have increased their substance use since the start of the pandemic, and 14 percent were unable to access needed services due to COVID-19.³⁷ Individuals in recovery may be challenged by increased stressors resulting from COVID-19, such as loss of a job and income, lack of child care, and increased isolation. Some data indicates increase in alcohol sales up to 32% compared to a same point in time one year prior, and several states show an increase in per capita alcohol sales in April 2020 compared to the prior 3-year April average.³⁸ Excessive alcohol use can increase not only susceptibility to COVID-19 but also severity. Alcohol use is also indicated in increased Intimate Partner Violence. The United Nations Secretary General called for measures to address the “horrifying surge” in domestic violence associated with government lockdowns and stay at home orders.³⁹ Increased use of alcohol and other substances during COVID-19 heightens the need for crisis responders to be fully aware of assessing and addressing SUD during intervention.

The associations between certain SUDs and COVID-19 risks are not fully known. However, there are several areas worth noting as data is still emerging. For instance, individuals who smoke or vape as a route of administration may be more susceptible to infection and face poorer prognoses due to respiratory health issues, which might include higher case-fatality rates. Conversely, COVID-19 positive individuals who develop compromised lung function could be at heightened risk of hypoxia associated with opioid and/or methamphetamine use given the potential for pulmonary damage associated with

³⁵ National Academies of Sciences, Engineering, and Medicine 2019. *Medications for Opioid Use Disorder Save Lives*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25310>.

³⁶National Council for Behavioral Health. (April 6, 2020). “COVID-19 Economic Impact on Behavioral Health Organizations”. National Council for Behavioral Health. Retrieved from https://www.thenationalcouncil.org/wp-content/uploads/2020/04/NCBH_COVID19_Survey_Findings_04152020.pdf?daf=375ateTbd56.

³⁷ Hulsey, J., Mellis, A., & B. K. (June 8, 2020). “COVID-19 Pandemic Impact on Patients, Families & Individuals in Recovery from a SUD.” Addiction Policy Forum. Retrieved from <https://www.addictionpolicy.org/post/covid-19-pandemic-impact-on-patients-families-individuals-in-recovery-fromsubstance-use-disorder>; Meadows Mental Health Policy Institute. (April 28, 2020).

³⁸ Macmillan, Carrie (June 4, 2020). “Drinking More Than Usual During the COVID-19 Pandemic?” Yale Medicine. Retrieved from <https://www.yalemedicine.org/stories/alcohol-covid/>; National Institute on Alcohol Abuse and Alcoholism. “Alcohol Sales During the COVID-19 Pandemic”. Retrieved from <https://pubs.niaaa.nih.gov/publications/surveillance-covid-19/COVSALES.htm>.

³⁹ United Nations (April 6, 2020). “UN chief calls for domestic violence ‘ceasefire’ amid ‘horrifying global surge’”. UN News. Retrieved from <https://news.un.org/en/story/2020/04/1061052>.

each of these conditions under various circumstances.⁴⁰ Harm reduction strategies such as “never use alone” and ensuring naloxone is available may not be effective or possible when individuals are socially distancing and sheltering-in-place consistent with public health guidelines.

As data is starting to come to light, some of the worst fears about the connection of the pandemic to the SUD population may be coming true. Suspected overdoses have increased by 191% in January-April 2020 compared to January-April 2019, according to the Overdose Detection Mapping Application Program, an initiative developed by a federal Office of National Drug Control Policy grantee.⁴¹ The COVID-19 pandemic is reinforcing the value of crisis response strategies especially tailored for individuals with SUD. During the pandemic, it will be critical to ensure overdose response teams as described earlier in this paper have sufficient personal protective equipment and funding to perform these vital engagement, follow-up and referral services to overdose survivors and their families.

Crisis Services for Substance Use Disorders Examined with a Racial Equity Lens

The COVID-19 pandemic is also reinforcing the need to address disparities inherent in the public health emergency and in the systems designed to address crises and SUDs. Research shows that racial and ethnic minority groups are disproportionately affected by the coronavirus and the resulting economic crisis.⁴² In addition, data that parses out the impact of various substances and access to services among racial and ethnic minority groups is shedding light on disparities in outcomes. Disparities in health care may actually have attenuated the impact of the “first wave” of the opioid epidemic associated with prescription opioids in the Black/African American community, as Black/African American patients are 29 percent less likely to be prescribed opioids for pain than white patients.⁴³ However, as part of the “third wave” of the opioid epidemic associated with skyrocketing rates of overdose deaths involving fentanyl, between 2011 and 2016 the Black/African American population experienced the highest increase in fatal overdose rates of deaths involving fentanyl.⁴⁴ Between 2015 and 2016, the rate of increase in overdose deaths was highest for the Black/African American population among all racial and ethnic groups. In addition, Black/African American individuals with OUD experience disparities in access

⁴⁰ Volkow, Nora (July 2020). “Collision of the COVID-19 and Addiction Epidemic.” *Annals of Internal Medicine*, Vol. 173(1).

⁴¹ Alter, A., Yeager, C (May 13, 2020). “The Consequences of COVID-19 on the Overdose Epidemic: Overdoses are Increasing.” Overdose Detection Mapping Application Program. Retrieved from <http://www.odmap.org/Content/docs/news/2020/ODMAP-Report-May-2020.pdf>.

⁴² Centers for Disease Control and Prevention. COVID-19 in racial and ethnic minority groups. Retrieved on July 16, 2020 from <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html>; Brown, S. (2020). The COVID-19 crisis continues to have uneven economic impact by race and ethnicity. *Urban Wire*, blog of the Urban Institute. Retrieved on July 16, 2020 from <https://www.urban.org/urban-wire/covid-19-crisis-continues-have-uneven-economic-impact-race-and-ethnicity>;

⁴³ Centers for Disease Control and Prevention. “Understanding the Epidemic”. Retrieved from <https://www.cdc.gov/drugoverdose/epidemic/index.html>; Pletcher MJ, Kertesz SG, Kohn MA, Gonzales R. Trends in opioid prescribing by race/ethnicity for patients seeking care in US emergency departments. *JAMA* [Internet]. 2008 Jan 2 [cited 2019 Dec12];299(1):70-8.

⁴⁴ Substance Abuse and Mental Health Services Administration: The Opioid Crisis and the Black/African American Population: An Urgent Issue. Publication No. PEP20-05-02-001. Office of Behavioral Health Equity. Substance Abuse and Mental Health Services Administration, 2020.; Centers for Disease Control and Prevention. “Understanding the Epidemic”. Retrieved from <https://www.cdc.gov/drugoverdose/epidemic/index.html>.

to evidence-based treatment for OUD, with studies showing that buprenorphine-based treatment is less accessible and delivered less frequently to Black/African American patients than white patients.⁴⁵

American Indians and Alaska Natives (AI/AN) also experience disparities in both the COVID-19 pandemic and opioid epidemic. The AI/AN population is hospitalized for COVID-19 at five times the rate as the white population.⁴⁶ In addition, Tribal governments and communities are facing relatively greater economic devastation than many states during this severe fiscal environment. Because Tribes do not have tax bases similar to local and state governments, casino and other enterprise represent Tribes' main revenue stream. As these industries have been put on hold as a public health measure, Tribes are grappling with even greater budget shortfalls than states; COVID-19 threatens to "completely reverse" the progress that Tribes have made in community economic development.⁴⁷ With respect to SUD, relevant data for American Indian and Alaska Native populations are often compromised by racial misclassifications in surveillance and vital statistics systems. The racial misclassifications – whereby AI/AN individuals are reported as belonging to racial/ethnic groups other than AI/AN – result in undercounting the true prevalence of health conditions among AI/AN communities. For example, a recent study matched drug and opioid-involved overdose-related death records from the Washington State Center for Health Statistics with the Northwest Tribal Registry, a database of AI/AN patients seen in Indian Health Service, tribal, and Urban Indian health clinics in Washington state. The Washington death records were corrected for AI/AN classification using the Northwest Tribal Registry data, and the corrected death records were then compared with federal CDC data. The comparison suggests that CDC data underestimate drug overdose mortality counts and rates among AI/AN by approximately 40%.⁴⁸ Underestimation notwithstanding, AI/AN individuals still experience above-average rates of drug overdose deaths.⁴⁹

Disparities in public health and overdose deaths represent an opportunity for states to develop innovative, community-specific outreach and engagement strategies, especially for individuals with SUD experiencing a crisis. For example, Black/African American individuals were found to be three times more likely to die during a police encounter than white individuals, even though they were more likely to be unarmed.⁵⁰ Given the recognition of police violence as a public health risk by organizations such as the American Medical Association and American Public Health Association, states are more poised than ever to reallocate resources and responsibilities for crisis care services away from law enforcement and

⁴⁵ Ibid.

⁴⁶ Centers for Disease Control and Prevention. COVID-19 in racial and ethnic minority groups. Retrieved from <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html>.

⁴⁷ Akee, R (April 10, 2020). "Re: allocation of COVID-19 Response Funds to American Indian Nations." Harvard Kennedy School ASH Center for Democratic Governance and Innovation. Retrieved from: https://ash.harvard.edu/files/ash/files/hpaied_covid_letter_to_treasury_04-10-20_vsIGNEDvfinv02.pdf.

⁴⁸ Seven Directions: A Center for Indigenous Public Health (September 2019). "An Environmental Scan of Tribal Opioid Overdose Prevention Responses: Community-Based Strategies and Public Health Data Infrastructure". University of Washington. Retrieved from <https://www.nihb.org/docs/04092020/Environmental%20Scan%20of%20Tribal%20Opioid%20Response%20Booklet.pdf>.

⁴⁹ Centers for Disease Control and Prevention. "Injury Prevention in American Indian and Alaska Native Communities." Retrieved from <https://www.cdc.gov/injury/fundedprograms/tribal.html>.

⁵⁰ DeGue, S. "Deaths Due to Lethal Force by Law Enforcement." *Am J Prev Med.* 2016 Nov; 51(5 Suppl 3): S173–S187.

towards appropriate crisis response systems such as those described in the SAMHSA Crisis Toolkit and this brief.⁵¹

SUD crisis care during COVID-19 is revealing a confluence of disparities. Yet from crisis comes opportunity: this moment in time presents an excellent opportunity for policy makers to catalyze on public sentiment and political will to ensure crisis response systems are adequately funded and positioned to respond to behavioral health crises. The momentum provided by a heightened national and state interest in transferring public and social service functions from law enforcement entities to human service agencies also offers states a platform to continue evolving their crisis systems to adequately address the needs of individuals with SUD experiencing a crisis event.

Conclusions

Behavioral health parity requires some insurers that provide coverage for mental health and substance use conditions to ensure those benefits are subject to limitations that are not more stringent than similar benefits physical health conditions.⁵² The healthcare system can no longer tolerate services that are disparate for individuals with substance use disorders. SAMHSA's specific inclusion of SUDs in its Crisis Toolkit should serve as notice that service parity needs to exist in all behavioral health crisis response systems. The "Anyone" in the "Anyone, Anywhere, Anytime" from the SAMHSA Crisis Toolkit must include individuals with co-occurring SUDs or sole SUD diagnoses. The degree to which states' crisis response systems encompass SUD varies and states are continuously evolving these systems to meet needs.

A comprehensive system of crisis response can positively impact the entire continuum of care for individuals with SUD from prevention through recovery. Incorporating SUD meaningfully into a crisis response system requires training of staff at levels, implementation of evidence-based screening and assessment tools, employment of peers with lived SUD experience, access to services that can support withdrawal management and medications to treat conditions such as OUD, and monitoring fidelity to evidence based practices as well as outcomes. Crisis providers should be able to demonstrate success of interventions with SUD and implement processes for continuous quality improvement with this population. Providers should also routinely assess staff for presence of negative perceptions or attitudes related to SUD, as stigma poses a challenge to strategic planning and implementation efforts to better meet the needs of individuals with SUD.

Effective partnerships are crucial for positive outcomes in crisis response. Partnerships ensure appropriate resources for preventing crisis, responding to crisis, and providing effective warm handoffs for care and continued recovery support. Including SUD in a behavioral health crisis response may require the system to expand these partnerships to include community based organizations and providers outside the historical networks. Law enforcement, EMS, health care providers, hospital

⁵¹ Strazewski, L (June 8, 2020). "Why police brutality is a matter of public health." American Medical Association. Retrieved from <https://www.ama-assn.org/delivering-care/health-equity/why-police-brutality-matter-public-health>; American Public Health Association (November 13, 2018). "Addressing Law Enforcement as a Public Health Issue." Policy Number 201811. Retrieved from <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2019/01/29/law-enforcement-violence>.

⁵² Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight. The Mental Health Parity and Addiction Equity Act. Retrieved on 5/28/20 from: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet

systems, peer-based recovery organization and substance use specific treatment providers all have a critical role in SUD throughout the continuum. This call to action also requires SUD providers to come out from the shadows to be front and center as partners in responding to the emerging needs of individuals in crisis with SUD. It is no longer sufficient for the SUD treatment world to stand back and wait for individuals to show up at the door. The absence of SUD specific providers as active partners in the crisis system only perpetuates the potential for discrimination toward individuals with SUDs.

There is clear opportunity for all states to use and incorporate the SAMHSA Crisis Toolkit to improve, enhance and expand their crisis response systems to be more inclusive of individuals with SUDs. The potential for positive impact throughout the behavioral healthcare system, and most importantly for the individuals in need of care, their families, and their communities cannot be overstated.

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