



NATIONAL ACADEMY
FOR STATE HEALTH POLICY

The Rural Behavioral Health Crisis Continuum: Considerations and Emerging State Strategies

Behavioral health crisis care consists of a range of interventions for people at risk for acute behavioral health issues, experiencing crisis, and engaged in recovery.

[Federal guidelines](#) for behavioral health crisis care provide specific guidance on core elements of care and considerations for the unique implementation challenges in rural and frontier areas. As state policymakers advance rural behavioral health crisis care, they are employing innovative approaches to overcome challenges of distance, limited resources, cultural differences, and workforce shortages.

This brief presents considerations and emerging state strategies for bolstering the rural behavioral health crisis care continuum at each level of care as defined by the Substance Abuse and Mental Health Services Administration. Some examples are drawn from advances in states that participated in NASHP's Policy Academy on Rural Mental Health Crisis Services. [Get additional information on this policy academy.](#)

Behavioral health crisis care interventions



Early Stages
of Crisis



Call
Centers



Mobile Crisis
Teams



Crisis Stabilization/
Receiving Facilities



Post-Crisis
Support



Early Stages of Crisis

In rural areas, intervening early to address behavioral health crises can be especially challenging due to [increased social isolation, stigma \(including self-stigma\), and less access to a full continuum of care and resources](#). Where behavioral health resources that are tailored to meet the unique needs of local communities exist, they are often scattered and difficult to scale.

Examples such as [Alaska's Behavioral Health Aide](#) (BHA) program and [Wyoming's statewide expansion of Mental Health First Aid](#) offer strategies to address workforce shortages, increase health literacy, and bring culturally-informed approaches to underserved communities.

Collectively, these approaches build capacity for intervening in early stages of crisis for people living in rural and frontier areas.

In **Alaska**, BHAs are a non-licensed provider type employed within the Alaska Tribal Health System, serving rural and remote communities populated mostly by Alaska Natives. They are certified by the [Community Health Aide Program Certification Board](#) and supervised by master or doctoral level clinicians. BHAs provide a wide range of culturally relevant, community-based mental health and wellness services, and connect people to higher levels of care when needed.

In **Wyoming**, the [state legislature appropriated](#) American Rescue Plan Act funding to the state's Department of Health to expand [Youth Mental Health First Aid](#) training to:

- Two trainers in each county
- One trainer in each school district
- One trainer in each community college district
- One trainer in the University of Wyoming

Youth Mental Health First Aid is an evidence-based course that trains participants to identify and understand serious behavioral health issues in young people. Youth Mental Health First Aid instructors help youth in crisis receive professional help, when needed, and host instructor training courses for communities that work with youth on an ongoing basis.



Call Centers

Launched in July 2022, the [988 Suicide & Crisis Lifeline](#) presents a unique opportunity for rural areas. Since [most crisis calls are resolved by phone](#), the 988 Lifeline and related behavioral health crisis hotlines serve as crisis interventions in and of themselves. Having such an accessible intervention (which includes phone, text, and chat options) is especially important in rural areas where mobile team response times may vary.

An example of a state call center that has managed high demand from rural areas is the [Georgia Crisis and Access Line](#) (GCAL). Operated by Behavioral Health Link, GCAL is available 24/7, 365 days a year and is accessible by calling an existing hotline number (1-800-715-4225). Those with Georgia area codes who call 988 are usually routed to GCAL. ([Georgia state officials recommend](#) that people in crisis call GCAL over 988 until at least July 2023 because GCAL routes directly to in-state providers, while 988 may route to a national hub not in the state.) The professionals at GCAL provide crisis intervention services by phone and, if needed, dispatch mobile crisis teams and link individuals to urgent services.

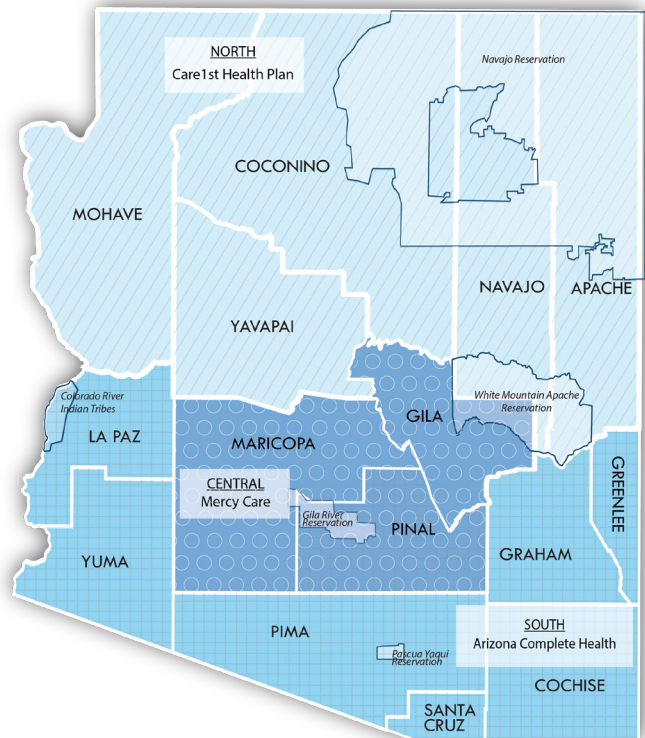
In addition to being able to call GCAL, Georgians can download the My GCAL app to access GCAL via text and chat 24/7 — a development that is particularly beneficial for youth. The state employs a strong data-driven approach, tracking and [sharing data](#) with the public regularly.

In **Arizona**, the [Arizona Health Care Cost Containment System \(AHCCCS\)](#), provides Medicaid reimbursement for crisis services statewide via AHCCCS Complete Care Contractors with Regional Behavioral Health Agreements (ACC-RBHAs). Services are available to all Arizona residents regardless of health insurance coverage.

To operate the [state’s 24/7 crisis hotline](#) (1-844-534-HOPE), the ACC-RBHAs selected Solari Crisis & Human Services along with La Frontera Empact. Those who call 988 with an Arizona area code are routed to the statewide call vendor responsible for operating the ACC-RBHA crisis lines and can be easily transitioned into the local crisis system of care if a mobile team or facility-based service is needed for additional support.

Along with the ACC-RBHAs, AHCCCS has established intergovernmental agreements (IGAs) [with tribal nations](#) to provide them with funding for behavioral health crisis services via Tribal Regional Behavioral Health Authorities (TRBHAs) based on the needs and requests of each individual tribe. Arizona tribes, regardless of having an established an IGA directly with AHCCCS, are also able to connect with the ACC-RBHA serving their region for behavioral health crisis services as needed.

ACC-RBHA/TRBHA Map Effective October 1, 2022



Source: [AHCCCS](#)

Note: Zip codes 85542, 85192, 85550 representing San Carlos Tribal area are included in the South GSA.



Mobile Crisis Teams

In rural areas, mobile crisis teams' responses to behavioral health crisis calls [can be slowed](#) due to long travel distances and limited staffing. Some states have creatively addressed these challenges.

In **South Dakota** (a participating state in [NASHP's Policy Academy](#) on rural behavioral health crisis), the [Virtual Crisis Care](#) program provides law enforcement with 24/7 access to behavioral health professionals who can assist in responding to people experiencing a mental health crisis. It also ensures that those working in the criminal justice system have access to the resources they need to help people with mental illness, regardless of where they live. This service offers de-escalation, stabilization, safety assessments, and connections to local behavioral health resources for follow-up care.

[Arizona's mobile crisis teams](#) respond to a call in an average of 30–40 minutes anywhere in the state, including in rural areas. To achieve this, Arizona's mobile crisis teams are enabled with live GPS tracking and coordination so that the nearest available mobile crisis team is dispatched to a person in crisis across city and county lines.

In addition to being GPS enabled, mobile crisis teams in Arizona are often co-located in 911 centers, police departments, jails, and tribal health centers in areas that face a higher volume of crisis calls. These co-locations in areas with higher crisis utilization rates allow mobile crisis teams to respond in a timely manner. For example, in Mohave County (the fifth largest county in the contiguous United States), there are two co-locations at police departments that have yielded an average response time of 25 minutes from October 2022 to December 2022.

Arizona uses a braided funding approach, including Medicaid reimbursement, state appropriated funds, and federal grants to provide a “firehouse model.” This means teams are available for blocked periods of time during peak, off peak, and on call hours — ensuring that, despite volume fluctuations, there is always a team available.

In addition, this funding model ensures a response in which care is provided for all mental health emergencies regardless of a person's health coverage status (e.g., Medicaid, private insurance, no insurance) consistent with a true “no wrong door” model.



Crisis Stabilization/Receiving Facilities

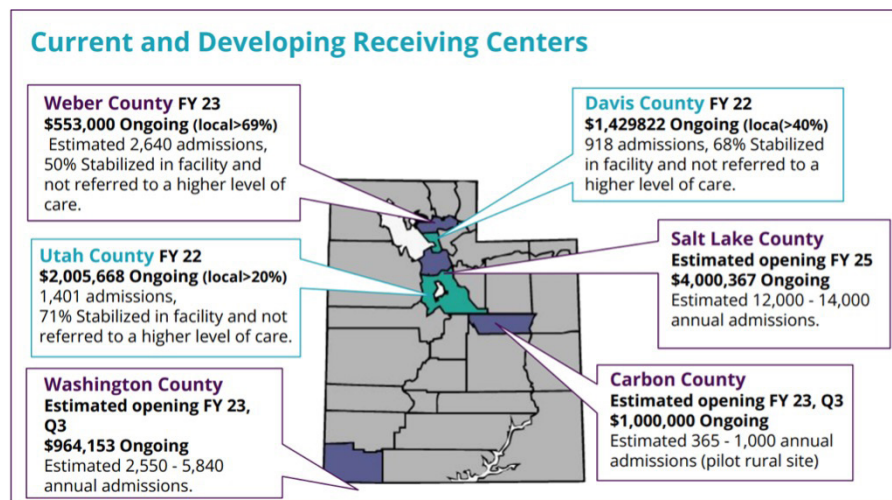
State behavioral health officials observe that the few crisis stabilization/receiving facilities (CSUs) that exist in rural areas often operate with limited resources and staffing challenges, including the potential for high rates of burnout and turnover. These facilities offer diversion from jails and emergency rooms as well as engagement, observation, and stabilization of people experiencing more acute behavioral health crises, thereby increasing opportunities for less restrictive care settings. Below are some state approaches to address the various barriers to running and linking to CSUs.

In **Utah**, policymakers have bolstered the workforce in CSUs and across the continuum through the creation of a free [crisis worker certification](#). This certification allows both licensed and non-licensed providers with varying levels of crisis response training and experience to learn the same basic crisis care skillset. Licensed behavioral health providers, those with bachelor’s degrees in social services, certified peer support specialists, certified case managers, and certified family resource facilitators are among those eligible to apply for the Crisis Worker Certification.

In addition, [since the passage of HB32 in Utah](#) in 2020, the state has sought to develop four additional community-based, zero-refusal CSUs (leading to a total of six centers overall). Funding for these centers is braided with state general funds, county/provider contributions, and Medicaid reimbursement.

For Utah’s rural receiving center projects, policymakers are considering the following approaches:

- Adjusted administrative rule with adapted minimum standards and expectations (such as staffing requirements)
- Adjusted Medicaid reimbursement rates for rural adaptations
- Coordinating and subcontracting with urban psychiatric providers via telehealth in rural settings



Source: Nichole Cunha, UT

Oklahoma is expanding access to community-based services, including crisis services, in rural areas by expanding Certified Community Behavioral Health Clinics (CCBHCs) throughout the state. Oklahoma started as a [CCBHC demonstration state](#) with certifying three of its Community Mental Health Centers (CMHCs) as CCBHCs. Due to the success of the demonstration, Oklahoma policymakers expanded the opportunity for CCBHCs statewide through a Medicaid state plan amendment. Since this opportunity, all of Oklahoma's 13 CMHCs have become CCBHCs.

One of the required core services for all Oklahoma CCBHCs is providing crisis stabilization services directly or via designated collaborating organizations that already exist within the state's crisis response continuum. In Oklahoma, crisis stabilization is provided through a continuum of care that includes:

- Telephone and telehealth-based responses ([in partnership with 988](#))
- Statewide mobile crisis teams for both children and adults
- Psychiatric urgent recovery centers
- Crisis centers
- Psychiatric hospitals

Each service along the continuum provides engagement with staff from multiple disciplines including certified peer recovery support specialists, case managers, licensed clinicians, and more.

[Oklahoma's CCBHC model](#) has allowed for short-term investments of state and federal dollars to operate as seed funding to create new programs and services, which then become self-sustaining through an expanding client base. This has allowed for state appropriated funds for new psychiatric urgent care and crisis centers to support operation of many more facilities than prior to CCBHC implementation.

In addition, integrated technology is included as a covered cost in the CCBHC model. To support care coordination for people in rural areas, Oklahoma has leveraged [integrated technology funding](#) by giving tablets to patients leaving crisis stabilization facilities. The telehealth devices link the client to a CCBHC care team available to them 24/7. Connectivity is provided through connection with a first responder cellular network that operates in all areas of the state, including rural and frontier regions. Oklahoma's data demonstrate that patients who have received these telehealth devices have a dramatically decreased chance of returning to a crisis stabilization unit or inpatient facility.



Post-Crisis Support

Coordinating connection to ongoing care to avoid or support recovery after a behavioral health crisis is an [essential component of crisis care](#). However, in rural areas, it can be especially challenging for individuals to be linked with regular post-crisis support.

Tennessee's [Project Rural Recovery](#) offers a potential strategy for delivering post-crisis support in resource-limited rural areas. Since March 2020, Tennessee has leveraged a five-year federal grant to provide free, integrated behavioral and physical health services to 10 rural counties in the state.

Currently, Project Rural Recovery consists of two mobile health clinics that offer mental health counseling, behavioral health screenings, and outpatient substance abuse services along with primary health care. These mobile clinics are available once a week in each of the 10 rural counties served. Due to the success of the program, state policymakers have [awarded \\$6.3 million](#) of American Rescue Plan Act funding to add two mobile health units and double the number of counties served starting in spring 2023.

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