Behavioral Health Crisis Response Models

Discussion on Theory and Practice

Based on a 2022 literature review by Adam Sorensen, LPCC-S

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Learning Objectives

- Understand a Structural Functional approach to balancing community crisis behavioral health resources.
- Understand the potential for competing system priorities among crisis behavioral health stakeholders.
- Understand factors of success and barriers to implementation of behavioral health crisis response models.

First, define the target population.

Structural Functional Theory

- Criminalization of mental illness theory
  - Currently, in the United States, there are more people in jail with serious BH concerns than in psychiatric hospitals (Thordarson & Rector, 2020; Watson et al., 2021)
- Trans-institutionalization theory
  - Teplin (1984) observed that psychiatric hospitalization rates declined by sixty-six percent by 1980. Further restrictions of inpatient psychiatric care occurred with the Mental Health Systems Care Act of 1980 (Mukherjee & Saxon, 2019). Psychiatric hospitalization bed access declined by ninety-four percent by the year 2000 and by ninety-six percent by 2010 (Prins, 2011; Grecco & Chambers, 2019).

Structural Functional Theory

- The structure of society in SFT is understood as the ways in which the systems interact (Cornwell & Laumann, 2019).
- Okolo et al. (2019) add that dysfunctional structures force social problems on unprepared and less effective systems.
- SFT supports the theory that the lack of appropriate community BH resources results in the increased frequency of police encounters with the target population (Tyuse et al., 2017).
- Differences in population characteristics and available resources lead to diversity in how local systems function (Huey et al., 2021).
- Cornwell and Laumann (2019) add that SFT provides a comprehensive framework to conduct dynamic systems analysis which can facilitate a systems perspective among policymakers, align views on the performance of the system, and develop pathways to appropriate care for the target population
- As the system is studied, the values and ideologies that form the foundation of the status quo may emerge and provide an opportunity to align the system with health equity outcomes (Hiroki, 2021; Goulka et al., 2021).

Potentially Competing Priorities

- Collectively identify stakeholders in crisis behavioral health response.
- Do different systems have different goals with the shared population?
- What does “adequate resources mean?”
- What is our best outcome for the target population?
  - Remember Egon Bittner from 1967. Bittner (1967) concluded that police decisions in situations involving a mentally ill person were related to the craft of policing not patient outcomes, and “to settle for less than an adequate solution is apt to result in repeated calls and more work” (pg.288).

What doesn’t work for BH Crisis Response

According to LR review for MCRT, BH ED, Co-Responder, CIT, QRT.

- Stakeholders may have difficulties complying with HIPAA and 42CFR across provider networks and may use incompatible data systems (Beil et al., 2019). Health care provider shortages may lead to access and quality of care challenges (Beil et al., 2019; Shulz et al., 2021).
- The lack of funding is also a barrier to the implementation of home and community based BH services (Smith et al., 2020; Krider & Huerter, 2020; Bratina et al., 2021; Shulz et al., 2021; Efstathopoulou et al., 2022).
- The insufficient intensity of BH follow-up, the lack of a peer support component, and the reliance on the ED for BH crises are associated with a lack of access to quality BH care (Morabito et al., 2018; Gabet et al., 2020; Charlier & Reichert, 2020; Smith et al., 2020).
- Tension between patients’ needs and expectations and the services offered is associated with poor health outcomes (Walsh et al., 2022).
- A criminogenic risk approach to assess the target population, which fails to recognize the effectiveness of biomedical, trauma-informed, and person-centered approaches (Grecco & Chambers, 2019; Thordarson & Rector, 2020).
- The tough on crime and war on drugs policies have imposed a sense of hopelessness, lack of control, and exposure to institutional violence on the target population (Prins, 2011; Yang et al., 2018; Grecco & Chambers, 2019).
- Traditional criminal justice models operate in direct opposition of treatment science, which has resulted in increased barriers to care, increased overdoses, increased rates of bloodborne pathogens, and decreased access to stable housing (Grecco & Chambers, 2019; Thordarson & Rector, 2020).
- Criminal justice, public health, and BH sectors that do not collaborate around the shared population may experience fragmentation between service providers, long waiting times for BH care, and limited financial resources (Smith et al., 2020; Schulz et al., 2021; Bratina et al., 2021; Shulz et al., 2021; Efstathopoulou et al., 2022).
- Competing views among health care providers about the patient’s primary condition and misaligned goals among stakeholders who interact with the shared population may prevent the development of functional stakeholder relationships (Morabito et al., 2018; Gabet et al., 2020; Rochefort, 2020; White et al., 2021).

What does work

- A multi-disciplinary collaborative or integrated team of providers and stakeholders that uses a patient-centered and trauma informed approach is essential for successful program implementation (Kubiak et al., 2017; Yang et al., 2018; Schmidt et al., 2018; Shahzad et al., 2019; Osteen et al., 2020; Schulz et al., 2021; Seo et al., 2021; White et al., 2021).
- Stakeholder relationships should be based on a shared philosophy that centralizes patient health outcomes of the shared population and have respect for each other's differences in approaches toward this goal (Kubiak et al., 2017). A key feature of stakeholder collaboration is coordinated and patient-centered decision making that involves a comprehensive care plan and the ability to share information across provider and stakeholder systems (Beil et al., 2019; Wood, 2020; Bratina et al., 2020; White et al., 2021).
- BH crisis care models must be flexible for adaptation to the local system of care (Beil et al., 2019; Wood, 2020; Bratina et al., 2020; White et al., 2021). The makeup and role definitions of the collaborative group of stakeholders are unique to each community as are the specifics of care coordination mechanisms (Thordarson & Rector, 2020; Schulz et al., 2021). County-specific programs and efforts are necessary to strengthen interorganizational collaboration and address existing service gaps within the county (Marsden et al., 2019; Efstathopoulou et al., 2022).
- Patient-centered care in the BH crisis literature includes outreach to the patient, a focus on holistic health, engagement of family in the treatment process, and access to peer recovery coaches. The engagement process during the outreach phase has a higher likelihood of success if the person has no fear of arrest (Kopak & Gleicher, 2020). More frequent initial opportunities to participate in treatment are associated with long term treatment engagement (Smith et al., 2020; Champagne et al., 2020; Comartin et al., 2021).
- Flexible health care delivery and payment models are needed to achieve higher quality, integrated, and coordinated behavioral health care in the United States (Carlo et al, 2020). Value-based payment models are designed to provide more reliable access to necessary community-based services and avoid insurance loopholes (Beil, 2019; Rochefort, 2020). The value of services improves with this payment structure due to the integration of a patient-centered network of social, psychological, and bio-medical services (Grecco & Chambers, 2019; Rochefort, 2020). However, a common value-based payment structure for community-based crisis BH care does not exist in the US, and it takes a collective and local effort to implement this payment structure for services to the target population (Gong, 2019; Wang et al, 2021; Comartin et al, 2021).

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