BEHAVIORAL HEALTH ASSESSMENT AND TRIAGE CENTER FEASIBILITY STUDY:

Current State Assessment

January 2019

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Executive Summary

The St. Louis region demonstrates a need for a Behavioral Health Assessment and Triage Center (BHATC) or another crisis-based solution.

1. **An Assessment and Triage Center or alternative model could alleviate emergency department (ED) crowding and provide a more therapeutic environment for addressing behavioral health crises, with shorter boarding times.**

   a. Behavioral health visits (~27,500) account for approximately 20% of total ED visits.

   b. Approximately 8,726 unique individuals in the region had more than one ED visit with a substance use disorder (SUD) or Severe Mental Illness (SMI) diagnosis between 2014 and 2016. SUD reoccurring users (individuals that visit the ED six or more times) represent 13–14% of total annual ED visits, and SMI reoccurring users represent 7–8% of total annual ED visits.

   c. Average ED boarding times are 7–8 hours for behavioral health patients needing inpatient beds, with patients having to wait 5–6 days in some instances (see *ED Access Report*).

2. **A Behavioral Health Assessment and Triage Center could also provide a more cost-effective and therapeutic environment than jails.** Customers report on the lack of adequate services and medications available in the current criminal justice system (see *Voice of the Customer Report*).

3. **Limited psychiatric alternatives to an Assessment and Triage Center exist in the St. Louis region**, with only six crisis beds and 839 psychiatric beds (see *Housing Access Analysis & Inpatient Psychiatric Bed Capacity Report*).

4. **Customers have reported the need for more crisis services**, including crisis prevention and crisis intervention resources, in St. Louis City and County (see *Voice of the Customer Report*).

In other communities, Behavioral Health Assessment and Triage Center models have been successful at reducing overall costs, diverting individuals with behavioral health needs from EDs and jails, and linking clients to social services.

After reviewing various models of Assessment and Triage Centers across the nation, the BHATC Planning Team chose three sites to visit in-person for a deeper analysis: Kansas City Assessment and Triage Center (KC-ATC) in Kansas City, MO; the Crisis Response Center (CRC) in Tucson, AZ; and the Center for Health Care Services (CHCS) in San Antonio, TX. **Not only do all three sites provide therapeutic interventions and link clients to social services, but they also save money by diverting individuals from the ED and criminal justice system** (see *Alternative Models Summary*).

1. **Kansas City Assessment and Triage Center**: Looking only at individuals referred to the KC-ATC by Kansas City police instead of the EDs, a cost-savings analysis showed a $2.3 million cost savings for 2,818 clients. Referral to the KC-ATC also decreased ED usage for individuals. Furthermore, in the program's first year, 70% of the clients visited the KC-ATC only once.

2. **Tucson Crisis Response Center:** Within one year of opening the CRC, the percentage of Pima County (Tucson) Jail inmates with serious mental illness decreased by half, and the number of behavioral health visits to the adjacent ED decreased from 750 per month to 150.

3. **San Antonio Center for Health Care Services:** Since its inception in 2003, the Center's Jail Diversion Program has diverted more than 100,000 people from jail or the ED; reduced overcrowding in the Bexar County (San Antonio) jail from over-capacity to 800 empty beds; and saved a total of $96,740,478 from direct cost avoidance (Bexar County Diversion Program).

Despite demonstrated need, St. Louis has a unique set of characteristics that could challenge the successful integration of a Behavioral Health Assessment and Triage Center into the region's behavioral health system.

1. **The geographical dispersion of need in St. Louis could pose a challenge in constructing a single, accessible crisis center to the entire region**, especially given the transportation challenges faced by low-income individuals. The two areas of highest need (North County and South City) are approximately 15 miles apart, equating to a 25-minute drive time or an hour commute (or longer) using public transportation (see *Geographical Analysis*).

2. **The large number of police** (60 police departments in St. Louis City/County) **and governmental jurisdictions** (89 St. Louis County municipalities and unincorporated areas) **will make coordination for a potential Assessment and Triage Center challenging** (see *Geographical Analysis*).

3. **Inadequate back-end supports may limit the ability of a potential Assessment and Triage Center to successfully triage to other behavioral health resources**, such as inpatient psychiatric beds, community mental health centers, crisis beds, and affordable, safe housing.

   a. **Any crisis-based solution, such as a Behavioral Health Assessment Triage Center, will not fully relieve the pressure on area EDs due to continued psychiatric bed capacity constraints in the region.** From 1990 to 2010, the St. Louis region lost 817 psychiatric beds, equating to a 42% decrease in bed capacity (see *Inpatient Psychiatric Bed Capacity Report*). Despite various hospitals' efforts to increase bed capacity, the Eastern region has seen an additional 3.3% decrease in the number of staffed psychiatric beds since 2009.

   b. Unless significant reforms are undertaken, **a St. Louis-based Assessment and Triage Center may not be able to triage many of its patients to long-term community behavioral health supports**, given the constraints of the current community-based "system" in St. Louis, such as:

      i. Community Mental Health Centers (CMHCs) in the St. Louis region provide significantly fewer services, per capita, to low-income individuals than their Eastern Region counterparts (Jefferson County and St. Charles, Lincoln, Warren, Franklin Counties) and fewer services per capita than Jackson County (Kansas City region).

ii. The limited provision of community mental health services is not solely a funding issue: CMHCs in St. Louis are not using $3–6 million in available state funding, exacerbating the lack of access to community-based services.

iii. While 4,680 next-day urgent appointments are available at CMHCs, Behavioral Health Response (BHR) referred 368 clients (less than 1% of their total encounters) to CMHCs for next-day appointments in 2017 (see *Community Mental Health Access Report*).

c. **The St. Louis region has limited and under-utilized crisis beds.** St. Louis City and County only have six available crisis/respite beds. BHR has authorization to utilize only one of the beds, but it remains under-utilized (utilization less than 5% of available days) due to restrictive exclusion/inclusion criteria (see *Housing Access Analysis*).

d. **St. Louis has limited transitional housing options as well as supported community living (SCL) and community housing options, which would pose a challenge for an Assessment and Triage Center to link clients to stable, safe housing.** The St. Louis region has 765 total supported community living (SCL) and community beds (or 1 bed per 2,769 residents) (see *Housing Access Analysis*).

4. **The St. Louis region lacks an obvious dedicated funding source to run operations for a Behavioral Health Assessment and Triage Center.** The closure of the Psychiatric Stabilization Center (PSC) highlights the need to secure a sustainable funding stream during the planning process for any crisis center. Without significant, ongoing financial commitment from a dedicated public source (local or State), and/or Medicaid expansion, an Assessment and Triage Center would likely face the same severe challenges to ongoing operations as the original PSC model. With pressure on both state and governmental budgets in Missouri and the St. Louis region, public funding for any new initiative is limited (see *Psychiatric Stabilization Center Lessons Learned*).

BEHAVIORAL HEALTH ASSESSMENT AND TRIAGE CENTER FEASIBILITY STUDY:

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Introduction

In St. Louis City and County, many individuals with serious mental illness (SMI) and substance use disorder (SUD) are not being adequately treated, resulting in an increased number of encounters in EDs and the criminal justice system. These systems may not be the appropriate settings for all individuals with SMI and SUD to receive support and treatment. Additionally, there is increasing pressure put on providers and first-responders due to recent trends in the rate of opioid use disorder. Leaders across the St. Louis region recognize that an intentional process is needed to connect individuals to resources that facilitate treatment, recovery, support services, and housing. Regional stakeholders are interested in exploring the feasibility of an Assessment and Triage Center that could provide more comprehensive care, improve community health, and result in system-wide cost-savings.

The St. Louis Metropolitan Hospital Council met in November 2017 and formally requested that the St. Louis Regional Health Commission (RHC) "serve as the coordinating entity…to support the community collaborative." The Commission approved RHC's lead role in the planning process. With financial support from the Missouri Foundation for Health, the RHC, in partnership with the Behavioral Health Network of Greater St. Louis (BHN), conducted a report to analyze the possibility of building an Assessment and Triage Center in the St. Louis region. The work was guided by the Assessment and Triage Center Planning Team (please see *Appendix A* for a full roster of Planning Team members).

This report serves as an assessment of the current state of the St. Louis behavioral health care system, with a particular focus on access to behavioral health services for the safety net population. Additionally, the report explores other Assessment and Triage Center models in the nation.

Alternative Models Analysis

Background

The BHATC Planning Team, a group of providers, advisors, and other stakeholders, studied various models of assessment and triage centers across the nation (see *Appendix A* for full roster). On June 8, 2018, the Planning Team chose three sites to visit in-person for a deeper analysis, based on the scope of services offered and connections to strategic community partners. These sites included the Kansas City Assessment and Triage Center (KC-ATC) in Kansas City, MO*, the Crisis Response Center (CRC) in Tucson, AZ, and the Center for Health Care Services (CHCS) in San Antonio, TX. All three sites focus on delivering effective behavioral health crisis management services while improving integration with social supports.

This report summarizes the organizational and operational structures of each of the three centers, based on clear design criteria developed by the Planning Team.

Site Visits

Travel teams, including members from the Planning Team, RHC staff, and BHN staff, conducted site visits in August and September 2018. A site visit checklist was developed to guide information gathering at each site. Additionally, a site visit feedback form was developed to help compare centers and evaluate the sites quantitatively and qualitatively.

The first half of the feedback form uses quantitative scoring (1–5) for 10 key areas, which were identified by the Planning Team as design criteria for a potential St. Louis model. Criteria include the following principles:

- Best practices/standardization
- Collaboration/coordination/integration
- Interpersonal communication
- Housing
- Linkage to services
- Navigation
- Reimbursement/funding
- Resource/knowledge/data-sharing
- System access
- System and provider capacity
- Participants were also asked to provide qualitative feedback in the following areas:
    - Advantages of the model
    - Disadvantages of the model
    - Concepts/components to apply to the St. Louis crisis system

Please see *Appendix B* for more information on BHATC Design Criteria.

*Stephanie Boyer, Program Manager of the KC-ATC, visited St. Louis in August 2018 to present to the BHATC Planning Team about the Kansas City Triage and Assessment Center. Additionally, many of the Planning Team members had already toured the center. Therefore, the travel team did not conduct an in-person site visit to the KC- ATC.

Summary

Based on the site visit question checklist and completed feedback forms, key observations from each site visit are summarized on the next page. ▶

SUMMARY OF QUANTITATIVE AVERAGE SCORES FOR SITE VISITS

Scores (1–5) are assigned based on the model's alignment with the initiative's themes.
(1 = MINIMAL alignment to our design criteria; 5 = COMPLETE alignment to our design criteria)

Design Criteria	Kansas City Assessment and Triage Center (MO)	Crisis Response Center (AZ)	Center for Health Care Services (TX)
Best practices/standardization	3.8	4.0	4
Collaboration/coordination/integration	4.3	4.7	5
Interpersonal communication	4.1	4.3	4.3
Housing	3.8	2.3	4
Linkage to services	3.9	3.7	4.7
Navigation	3.8	4.0	4.3
Reimbursement/funding	3.2	4.3	3.7
Resource/knowledge/data-sharing	3.6	4.3	4
System access	4.0	4.7	4.7
System an provider capacity	3.7	3.7	4.7
TOTAL SCORE	37.4 (n = 9)	39.7 (n = 3)	43.3 (n = 3)

Summary of Qualitative Feedback	Kansas City Assessment and Triage Center (MO)	Crisis Response Center (AZ)	Center For Health Care Services (TX)
ACCESS			
Open 24/7/365	✓	✓	✓
Walk-ins allowed		✓	✓
Exclusion criteria	✓		✓
INTEGRATION/COLLABORATION			
Co-located inpatient beds on campus or building		✓	✓
Co-located ED on campus		✓	
Collaboration with law enforcement	✓	✓	✓
THERAPEUTIC DESIGN			
Integrated teams	✓	✓	✓
Use of peers		✓	✓
Fish-bowl observation	✓	✓	✓
Segmentation based on acuity	✓	✓	✓
Group therapy sessions		✓	✓
Use of telemedicine			✓
FUNDING			
Medicaid expansion		✓	
SERVICES			
Sobering unit			✓
Stabilization beds	✓		✓

Alternative Model Report:

KANSAS CITY – KANSAS CITY ASSESSMENT AND TRIAGE CENTER (KC-ATC)

Background/History

After two years of planning with a broad range of stakeholders – including representatives from law enforcement, hospitals, courts, city government, mental health, and homeless shelters – the Kansas City Assessment and Triage Center (KC-ATC) was established in October 2016. With funding from St. Louis-based Ascension, the City of Kansas City, area hospitals, and the Missouri Department of Mental Health, the KC-ATC provides appropriate care to individuals with behavioral health issues who do not require inpatient treatment. The goal was to provide a more appropriate space for intervention during a behavioral health crisis than ED and jails.

FUNDING

KC-ATC has the following funding sources, including both public and private partnerships:

Entity Amount	Amount
Ascension Health	$2 million annually for 10 years
City of Kansas City	$2.5 million – renovation (one time)
Area hospitals	$1 million annually/2 years
Missouri Department of Mental Health	$2 million for backdoor mental health services plus state-owned site for the urban core center

KC-ATC operates in a state with no Medicaid expansion. In 2017, more than three-fourths (77%) of the clients served were uninsured. 13% of the clients had Medicaid, while only 3% of clients had commercial insurance. The chart to the right breaks down all payment methods of clients.

Payment Source in 2017 (first three quarters; n=2,545)

Source	Percent of Clients
Commercial insurance	3%
Medicaid	13%
Medicare	1%
Private pay	6%
Uninsured	77%

The center has a total operating budget of $3.4 million.

MANAGEMENT

ReDiscover, a nonprofit community behavioral health agency, operates the center. Lauren Moyer, LSCSW, LCSW, vice president of clinical services for ReDiscover, stresses the organization's focus on system change and establishing authentic community links.

Operations

SERVICES

While open 24/7/365, the KC-ATC does not allow walk-ins; the facility is only open to Kansas City Police Department and approved EDs for transfers.

The KC-ATC, housed in a 14,000-square-foot building, has two units with 16 total available slots: eight sobering unit slots primarily for substance use response and eight stabilizing slots primarily used for mental health stabilization. Clients can stay up to 23 hours, due to licensing requirements for an outpatient facility. Clients must remain at the center voluntarily. The center developed exclusion criteria to ensure that only individuals not needing medical attention are referred to KC-ATC. These criteria include: under 18 years of age; blood pressure above 190; heart rate above 120 or below 45; blood glucose below 60 mg/ dL or above 250 mg/ dL; acute or traumatic medical needs such as bleeding, unconsciousness, seizures; combative and requiring restraint or field sedation; adaptive equipment (IV, catheter, oxygen tanks); and inability to self-transfer (the patient requires carrying).

The center is staffed by a multidisciplinary team that includes registered nurses, caseworkers, mental health technicians, licensed social workers, and advanced nurse practitioners, who collaborate with a psychiatrist.

Client Demographics

In 2017, 55% of individuals arrived at the center under the influence of alcohol or other substances. 68% were homeless and 65% were unemployed at the time of referral. 71% of individuals referred to the facility were male and 77% were between the ages of 25 and 54 years. As previously mentioned, 77% were uninsured at referral. The average length of stay for a client was 16 hours.

Follow-up Funds

The DMH budget allocates $2 million for KC-ATC follow-up funds, which can be used for core services or flex funds, including residential or outpatient treatment, detox, housing, respite, RCF, start-up funds, utility support, food, clothing, dentures, medications, hygiene items, transportation, labs, and dental and physical health. Additionally, these funds can cover Non-Medicaid services for those on Medicaid.

PROCESS

During the first year of operation, 4,192 patients were referred to the facility; 64% of whom came from area EDs, and 34% came from law enforcement. Law enforcement can complete the drop-off process in 7–10 minutes. ED will determine and arrange transportation for transfers. In 2017, most clients (91%) were transported from the EDs to KC-ATC via cab.

When ED staff or Kansas City law enforcement refer individuals to the KC-ATC, they are immediately triaged by a nurse and licensed team leader. Triage and assessment includes giving clients a comprehensive mental health assessment, shower, change of clothes, and meal. Clients can stabilize for up to 23 hours in an observation room, where they engage with a licensed social worker and case manager to create a discharge plan that includes medication management. If needed, they are then referred to behavioral health outpatient or residential services for ongoing treatment.

Case managers continue to follow clients for months after they leave the facility. This continued care helps ensure that clients are linked with appropriate services, are following through with appointments, and are progressing through the necessary outpatient levels of care.

COLLABORATION AND INTEGRATION

Participating hospitals all provide funding to become referral sources; they include the Research Medical Center, Research Psychiatric Center, St. Luke's Hospital – Plaza and East, Truman Medical Center Hospital Hill and Lakewood, North Kansas City Hospital, St. Joseph Medical Center, CenterPointe, Lee's Summit Medical Center, Research Belton, and Liberty Hospital.

Outcomes

According to Kevin O'Rourke, M.D., Director of Clinical Operations of the ED at Truman Medical Centers, the KC-ATC provides "the right care for the patient at the right location." Additionally, it saves the hospital system and the State money from diverting individuals from EDs and jail (O'Rourke 2018). Looking only at individuals referred to the KC-ATC by Kansas City police instead of the EDs, a cost-savings analysis showed a $2.3 million cost savings for 2,818 clients.

Decreased ED usage

Referral to the KC-ATC also decreased ED usage for individuals. The following data represent the change in client Truman ED usage from three months prior to the referral to the KC-ATC to three months after. The data are categorized based on the referral mechanism: Truman ED vs. EDs and Law Enforcement. As shown on the next page, the referral to KC-ATC had the following successful results: more than half of clients with decreased ED usage, a decrease in the mean number of ED visits, and a percent decrease in the total number of client ED visits.

Client Usage of Truman ED Three Months Before and After Referral to the KC-ATC

	Percent of Clients with Decreased Usage	Decrease in Mean ED Visits	Percent Decrease in Number of Visits
Clients referred by Truman ED	55% (98; n=178)	(-) 0.15 Visits (3.01 to 2.86)	(-) 5% (535 to 509)
Clients referred by EDs and law enforcement	57% (202; n=356)	(-) 0.44 Visits (3.25 to 2.81)	(-) 14% (1158 to 996)

Additionally, the five clients who used the Truman ED most frequently prior to referral decreased usage after referral.

Housing

Despite 68% of the clients being homeless upon referral, only 27% of clients left the KC-ATC without housing plans. More than a third (37%) of clients were referred to group living opportunities (i.e. transitional/sober living and shelters) and another third (36%) returned home or to their families.

Additionally, through case-management, of the 192 clients:

- 123 clients (64%) had their housing situations improve.
- 39 clients (20%) maintained housing situations from before case management and were already living with family/ friends, and in stable, supportive, or transitional housing.
- 29 clients (15%) remained homeless or their housing status was unknown.
- 1 client moved from a family setting to a shelter.

Other Case Management Outcomes

In 2017, case managers met 97% of client referral needs; on average, case managers met four referral needs per client (n=192).

In the program's first year, 1,588 unduplicated clients arrived at the KC-ATC, and 70% of the clients visited the KC-ATC only once.

Assessment

SITE-VISIT AVERAGE SCORES

Scores (1–5) are assigned based on the model's alignment with the initiative's themes.
(1 = MINIMAL alignment; 5 = COMPLETE alignment)

Theme	1	2	3	4	5	6	7	8	9	Average Score
Best-practices/standardization	4	-	3	3	4	4	5	3	4	**3.8**
Collaboration/coordination/integration	3	5	3	5	4	4.5	5	5	4	**4.3**
Interpersonal communication	4	-	4	4	5	4	5	4	3	**4.1**
Housing	3	5	2	4	4	3	3	5	5	**3.8**
Linkage to services	2	5	3	4	4	4	4	5	4	**3.9**
Navigation	3	5	3	3	4	4	3	5	4	**3.8**
Reimbursement/funding	3	3	2	3	4	3	5	3	3	**3.2**
Resource/knowledge/data sharing	2	-	2	3	4	5	5	5	3	**3.6**
System access	4	5	4	3	3	4	4	5	4	**4.0**
System/provider capacity	3	5	5	4	2	3	4	4	3	**3.7**
TOTAL SCORE	**32**	**-**	**31**	**36**	**38**	**38.5**	**43**	**44**	**37**	**37.4**

QUALITATIVE FEEDBACK

BHATC Planning Team Members reported on several major advantages of the KC-ATC model: its strong partnership with hospitals and law enforcement; collaboration with community organizations; short- term, follow-up case management, especially in regards to housing; provision of MAT (Medication-Assisted Treatment); and its recovery-based nature. Although the model generally impressed Planning Team members, several members commented on the difficulty of replicating this model in St. Louis as well as the unstable, limited funding sources the model currently relies on.

Alternative Model Report:

TUCSON – CRISIS RESPONSE CENTER (CRC)

Background/History

The Crisis Response Center (CRC) is a behavioral health facility in Tucson, Arizona, aiming "to provide high quality behavioral health care that is person-centered, evidence-based and culturally sensitive, that expects recovery from mental illness."

FUNDING

The CRC was built in 2011 with $50 million from Pima County bond funds. The bond aimed to provide urgent psychiatric care and reduce the number of persons with behavioral health needs in jail or boarding in hospital EDs. The Regional Behavioral Health Authority (RBHA) is the major source of funding supporting the operations of the CRC, which is managed by a single managed care company, Cenpatico (Centene). The CRC runs on approximately $58.5 million annually. More then 90% of the patients of the CRC have some form of insurance, largely due to Arizona's expansion of Medicaid in 2013. Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Medicaid agency that integrates physical and behavioral health services to increase access to health care services.

MANAGEMENT

Connections Health Solutions (CHS) is a physician-owned, for-profit organization that provides on-demand behavioral health care. CHS currently operates two crisis centers – one in metropolitan Phoenix, and the other in Tucson, Arizona. Both crisis facilities are licensed by the Arizona Department of Health Services and are accredited by the Joint Commission (TJC).

In April 2014, CHS assumed the management of the Crisis Response Center (CRC) in Tucson, which serves adults and children in Pima County. Under the leadership Dr. Margie Balfour, Chief of Quality & Clinical Innovation, the CRC's quality management program has been recognized by TJC as a best practice.

Operations

SERVICES

The CRC provides services to 12,000 adults and 2,200 children annually and provides the following three services:

1. Psychiatric Urgent Care (Walk-in) Clinic:

The urgent care clinic provides immediate access to psychiatric services. The clinic is staffed with financial eligibility specialists, crisis workers, behavioral health medical providers (MD, APN, PAs), and recovery support specialists.

2. 23-Hour Observation:

This program provides rapid assessment, early intervention, and proactive discharge planning and is staffed with an integrated team of medical providers, crisis workers, nurses, behavioral health technicians, and recovery support staff.

Approximately 45% of clients are brought to the center by law enforcement, and the remaining patients arrive via transfer from outside EDs,mobile crisis teams, or walk-ins.

Accessibility is prioritized with a "no wrong door" policy, especially for law enforcement. There are no behavioral health exclusionary criteria. The criteria for admission is similar to that of an inpatient psychiatric unit – danger to self/others, acutely psychotic, intoxicated, etc.

The program's maximum capacity is 34 adults and 10 children.

3. Short-Term Inpatient Unit:

The short-term inpatient unit provides continued treatment, recovery support, and discharge planning, with an average patient stay of approximately four days.

The unit's maximum capacity is 15 beds. ▶

PROCESS

- All patients must be assessed before being taken to the 23-hour observation unit or the inpatient unit, continuously segmenting the patients by risk and acuity.
- If the patient needs more than 23 hours to be stabilized, the inpatient unit provides short-term recovery services between three and five days.
- All patients are tracked through a system-wide EHR.

COLLABORATION AND INTEGRATION

The CRC is located on the Banner-University of Arizona Medical Center South Campus, which has received national recognition for both its architectural design and multi-agency collaborative clinical model. In addition to its urgent care clinic, 23-hour observational unit, and in-patient care unit, the CRC houses the crisis call center for southern Arizona, which controls "air traffic" by dispatching a dozen mobile crisis teams and managing the electronic regional bed placement board. Additionally, the CRC contains space for co-located community partners, such as behavioral health clinics that can immediately enroll patients, and a peer run program that provides post-crisis wrap-around services. The CRC also runs a center for MAT, due to the growing need in Tucson for these services. Furthermore, a covered breezeway connects the CRC to a Level II Trauma Center ED, a 66-bed inpatient psychiatric hospital, and the mental health court.

While the CRC has relationships with community organizations and shelters in Pima County, the agency commented on the challenges of linking patients with stable housing after a crisis, specifically noting the lack of resources in the region.

Law Enforcement Collaboration

The CRC was designed with input from law enforcement. They have their own separate entrance into the facility and the Center ensures drop off of 10 minutes or less for adults and 20 minutes or less for children. Additionally, the CRC enforces a strict no-refusal policy for law enforcement, which creates a culture favorable to law enforcement.

Following a mass casualty in January 2011, the Tucson Mental Health Support Team (MHST) model was developed to prevent crises and associated threats to public safety. This model relies on close collaboration with the mental health system, the Tucson Police Department, and Pima County Sheriff's Office and utilizes dedicated law enforcement teams. The MHST model has achieved zero uses of force while serving civil commitment transport orders, a significant decrease in SWAT deployments to suicide-related calls, and case examples of averted threats to public safety.

All 900 law enforcement officers with the Tucson Police Department have been trained in Mental Health First Aid and 60% of officers elected to be trained in Crisis Intervention Team (CIT) to gain additional tools to respond to mental health crisis.

The dedicated MHST is made up of 10 full-time officers, two sergeants, and two detectives. The team is operating seven days a week from 7am–7pm. The team is currently applying for a SAMHSA grant to incorporate behavioral health co-responders. ▶

Outcomes

In 2012, a year after opening the CRC, the percentage of Pima County Jail inmates with serious mental illness decreased by half, and the number of behavioral health visits to the adjacent ED decreased from 750 per month to 150.

This table summarizes key measured outcomes[1] of the CRC.

Metric	Outcome	Relevance
Urgent care clinic: door-to-door **length of stay**	<2 h	Patients get their needs met quickly instead of going to an ED or allowing symptoms to worsen.
23-hour obs unit: **door-to-doctor time**	<90 min	Treatment is started early, which results in higher likelihood of stabilization and less likelihood of assaults, injuries or restraints.
23-hour obs unit: **community disposition rate**	60–70%	Most patients are able to be discharged to less restrictive and less costly community-based care instead of inpatient admission.
Law enforcement drop-off **police turnaround time**	<10 min	If jail diversion is a goal, then police are our customer too and we must be quicker and easier to access than jail.
Hours of **restraint use** per 1000 patient hours	<0.15	Despite receiving highly acute patients directly from the field, our restraint rates are 75% below the Joint Commission national average for inpatient psychiatric units, without the use of security personnel
Patient satisfaction: **likelihood to recommend**	>85%	Even though most patients are brought via law enforcement, most would recommend our services to friends or family.
Return visits within 72h of discharge from 23h obs	3%	People get their needs met and are connected to aftercare. A multi-agency collaboration addresses the subset of people with multiple return visits.[2]

[1] Balfour ME, Tanner K, Jurica PJ, Rhoads R, Carson CA. Crisis Reliability Indicators Supporting Emergency Services: A Framework for Developing Performance Measures for Behavioral Health Crisis and Psychiatric Emergency Programs. *Community Ment Health* J. 2016 Jan;52(1):1–9. http://dx.doi.org/10.1007/s10597-015-9954-5

[2] Balfour ME, Zinn T, Cason K, Fox J, Morales M, Berdeja C, Gray J; Provider-Payer Partnerships as an Engine for Continuous Quality Improvement; *Psychiatric Services*; 2018 Jun;69(6):623–625. http://dx.doi.org/10.1176/appi.ps.201700533

Assessment

SITE-VISIT AVERAGE SCORES

Scores (1–5) are assigned based on the model's alignment with the initiative's themes.
(1 = MINIMAL alignment; 5 = COMPLETE alignment)

Theme	Participant 1	Participant 2	Participant 3	Average Score
Best-practices/standardization	4	4	4	**4.0**
Collaboration/coordination/integration	5	5	4	**4.7**
Interpersonal communication	4	5	4	**4.3**
Housing	3	2	2	**2.3**
Linkage to services	4	4	3	**3.7**
Navigation	5	5	2	**4.0**
Reimbursement/funding	5	5	3	**4.3**
Resource/knowledge/data sharing	4	5	4	**4.3**
System access	5	5	4	**4.7**
System/provider capacity	4	4	2	**3.7**
TOTAL SCORE	**43**	**44**	**32**	**39.7**

QUALITATIVE FEEDBACK

Travel participants commented on the major advantages of the model, specifically mentioning its low barriers to entry; strong relationship with law enforcement; ability to segment patients by risk and needs; and its proximity to a hospital, ED, drug court, crisis call center, and other community resources. Despite the center's major advantages, replicating this model in St. Louis would be challenging. Arizona has a unique financial landscape, which enables the success of the facility. The state not only has Medicaid expansion, but it also has only one managed care company, which helps incentivize system-wide, value-based care. Furthermore, the $55 million facility was built with bond funds set aside specifically to improve the crisis behavioral health system. Without significant change to the entire St. Louis behavioral health and health care systems, raising and sustaining the necessary funding to build and run a facility like the Crisis Response Center would be nearly impossible.

SITE-VISIT PARTICIPANTS

1. Angela Brown, St. Louis Regional Health Commission, Acting Chief Executive Officer
2. Amanda Harris, St. Louis Regional Health Commission, Manager of Strategic Planning
3. Alison Kraus, Behavioral Health Network of Greater St. Louis, Program Manager of Evaluation and Communication
4. Dr. Bart Andrews, Behavioral Health Response, Vice President of Clinical Practices and Evaluation
5. Dr. Robert Poirier Jr., Washington University School of Medicine, Clinical Chief of Emergency Medicine and Director of ED Patient Safety, Quality, and Performance Improvement

Alternative Model Report:

SAN ANTONIO – THE CENTER FOR HEALTH CARE SERVICES (CHCS)

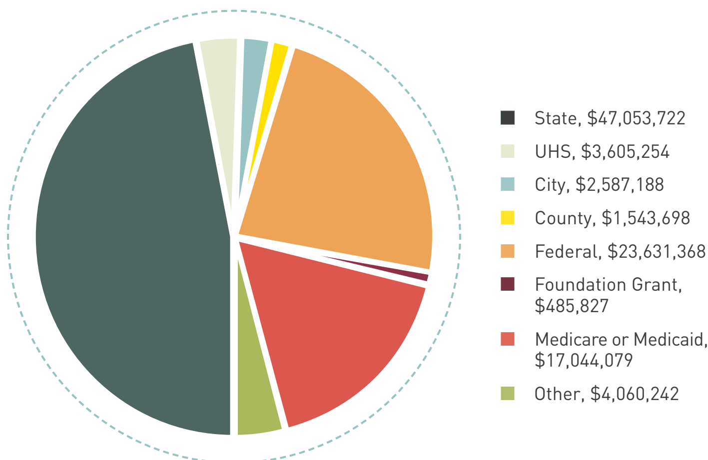
Background/History

Established in 1966, the Center for Health Care Services (CHCS) is the mental health authority for Bexar County, Texas (San Antonio Region).

FUNDING

In 2017, the final annual revenue for the CHCS was $97,015,674. The CHCS revenue came from 92 separate sources, including federal, state, county and city funds, as well as grants and philanthropic donations. The distribution of funding is represented below in the pie graph.

FUNDING BY SOURCE



As shown in the pie graph above, approximately 50% of the funding for the Center comes from the state. One reason for the state's large investment in the Center is the cost saving impact of diverting individuals from the county hospital and jail.

Texas has a unique health care landscape. The state does not have Medicaid expansion. Additionally, it organizes its health and human service systems on regional, geographic boundaries. The CHCS acquired its governance authority from a contract with the Texas Health and Human Services Commission (HHSC). HHSC is the "state authority" for behavioral health services and it grants "local authority" status to Local Mental Health Authorities (LMHAs) via the contract. Counties with large cities like San Antonio, are designated as Local Service Areas (LSAs) and are served by community centers like the CHCS.

Operations

SERVICES

In 2017, 977 full time employees provided services to 36,082 consumers. The CHCS operated 83 programs in 33 separate facilities, providing mental health, substance use, and intellectual and developmental disabilities services to adults and children. The Center also co-locates primary health with behavioral health services.

The Restoration and Transformational Services division of the CHCS operates most of the organization's crisis response and housing services. The Restoration Center is open 24/7 and provides an array of crisis services for all behavioral health challenges, including mental health crisis and substance use crisis. The CHCS offers crisis stabilization and medication assisted opioid addiction treatment, as well as houses a sobering unit, medical detox unit, mobile crisis response team, etc. The Restoration Center serves approximately 2,000 to 2,200 people monthly, who are both voluntary and involuntary. Several of the main programs offered through the Restoration Center are outlined below:

Sobering Unit

- Provides a safe place to sober, as well as basic necessities, such as a bed, bathroom, water and crackers
- Voluntary: 4–5 hour average stay
- 420 served per month
- Do not fill to capacity
- No Blood Alcohol Level exclusion; as long as an individual can ambulate, can stay
- No walk-ins; must be escorted by law enforcement
- Do not bill for services

Detox Unit

- Voluntary: 3–4 day average stay
- Capacity: 20 males, 8 females
- 56% completion rate (in line with national average)

Crisis Stabilization Unit

- Provides triage services and medical attention and observation
- Maximum stay of 48 hours
- Capacity: 15 beds
- Door-to-provider time below 12 hours
- Adults only, violent exclusion criteria because cannot physically restrain or seclude
- Officer drop off time ~32 minutes
- 24 patients served in medical unit
- 500 patients served in observation

Crisis Inpatient Unit

- Provides 30 inpatient beds
- 5–7 day stay

The Center identifies safe and affordable housing as one of the key social determinants of health for an individual, family, or community. The CHCS has a unit that exclusively works on securing safe, affordable living arrangements for individuals. This unit works with local housing advocates as well as city and county governmental programs that address housing issues. The Center uses HUD Section 8 resources as well as various private and religious resources. Haven for Hope, located across the street from the CHCS, is a significant partner in these housing efforts.

The Center is beginning to use a shared community health care electronic system to assess, track, and address overall physical and behavioral health concerns in its service population. The survey questionnaire addresses a wide variety of issues, including housing.

Treatment for Mental Illness and Substance Abuse

In addition to the crisis services, the Center has a wide range of programming to treat mental illness and abuse in the entire population. A few of the programs are outlined below:

- The Center's *Bexar Cares* program offers wraparound services to at-risk children struggling with emotional disturbance.
- The *Mommies* Programs, a partnership with University Health System, enables single mothers fighting substance use challenges to deliver and keep their babies.
- The Center's *Adult Behavioral Health Programs* empower adults experiencing symptoms of mental illness to make positive life changes.
- Other CHCS programs help veterans with mental illness, including Post-Traumatic Stress Disorder (PTSD), receive psychiatric treatment, linkages to safe housing, and employment assistance.
- *Prospects Courtyard* offers a safe place to sleep, a shower and a meal for homeless individuals. The facility has twin 80-bed dormitories (one for men and one for women). No demands are made on people seeking shelter: they are invited by experienced counselors and peer support specialists to begin a process of recovery, but it is not a requirement for admittance. Individuals can receive medical care, therapy, detoxification, and a thorough system of transformation and restoration care.

PROCESS

The Restoration Center provides services to anyone in crisis who comes to the center voluntarily or involuntarily. In Texas, law enforcement has the authority to take individuals into custody on an Emergency Detention (ED) if the officer believes they are immediate threats to themselves or

others. Law enforcement brings 150 to 170 people per month to the Restoration Center for treatment under the ED statute. The Sobering/Public Intoxication Unit at the Restoration Center admits approximately 500 individuals per month who are taken into custody by law enforcement for public intoxication. This is a jail diversion program that saves the city and county law enforcement time off the street, as well as approximately $5 to $7 million per year in diverted booking and incarceration. The Center assesses about 400 to 500 individual per month for crisis. These individuals would otherwise present at hospital EDs or other locations with less therapeutic outcomes and greater expense to the community.

COLLABORATION AND INTEGRATION

The Center partners with the greater health care community, public and private organizations, local and state government units, local law enforcement and the criminal justice systems and various regional entities.

Haven for Hope

The Restoration Center is located directly across the street from Haven for Hope, a comprehensive organization that offers a wide array of services to address issues of homelessness. The CHCS and Haven for Hope work collaboratively; for example, together, they operate an Integrated Treatment Program (ITP), which serves 140 adults with behavioral health issues. The ITP provides residential and supportive services for individuals with behavioral health concerns in a sober living situation for up to 120 days. The Center provides the behavioral health services, while Haven for Hope provides the housing coordination for this program.

Collaboration with Law Enforcement

The Center works closely with law enforcement and the justice system to identify and divert into treatment individuals with behavioral health issues. All law enforcement officers within the San Antonio Police Department (SAPD) and the Bexar County Sheriff's Office (BCSO) have received the 40-hour Crisis Intervention Training. Both SAPD and the BCSO have designated Mental Health (MH) Units that are specially trained officers or deputies who respond to behavioral health crises. The CHCS Mobile Crisis Outreach Team (MCOT) works closely with law enforcement officers to respond to crisis in the community. The CHCS MCOT unit has two clinicians embedded in the SAPD MH unit. The Center also has clinicians located at the Central Magistrate Division, where every person arrested in Bexar County is taken for processing by law enforcement. Law enforcement officers and deputies are trained to ask four questions to screen for any behavioral health issues. If a person in custody answers "yes" to any of the four questions, they are diverted to the CHCS clinicians who conduct a thorough behavioral health assessment. The clinician then works with the public defender and that Magistrate Judge to release the person on a Personal Recognizance Bond (PRB), as appropriate, and divert them into treatment at the CHCS Crisis Center rather than jail.

Outcomes

The Center's *Jail Diversion Program* has been adopted throughout Texas. The programs have saved taxpayers more than $50 million by enabling law enforcement to divert people from jail to crisis intervention and mental illness treatment. Since its inception in 2003, the Center's Jail Diversion Program has:

- Diverted more than 100,000 people from jail or emergency rooms.
- Trained 2,800 law enforcement officers in the 40-hour Crisis Intervention Team training model.
- Trained more than 250 school district police and administrators in the newly created Children's Crisis Intervention Training for Schools.
- Reduced overcrowding in the Bexar County jail from over-capacity to 800 empty beds.
- Saved a total of $96,740,478 from direct cost avoidance (Bexar County Diversion Program).

Assessment

SITE-VISIT AVERAGE SCORES

Scores (1–5) are assigned based on the model's alignment with the initiative's themes.
(1 = MINIMAL alignment; 5 = COMPLETE alignment)

Theme	Participant 1	Participant 2	Participant 3	Average Score
Best practices/standardization	4	4	4	**4**
Collaboration/coordination/integration	5	5	5	**5**
Interpersonal communication	4	5	4	**4.3**
Housing	5	2	5	**4**
Linkage to services	5	4	5	**4.7**
Navigation	5	5	3	**4.3**
Reimbursement/funding	3	5	3	**3.7**
Resource/knowledge/data-sharing	4	5	3	**4**
System access	4	5	5	**4.7**
System/provider capacity	5	4	5	**4.7**
TOTAL SCORE	**44**	**44**	**42**	**43.3**

QUALITATIVE FEEDBACK

Travel participants made note of several important advantages of this model: the center's strong relationship with law enforcement; use of a sobering unit; cohesive and diverse programming; collaboration with a non-profit focused on housing security; and its diverse funding sources. The center, however, would be difficult to implement in St. Louis because of differences in access to community partners and the funding landscape. The travel team commented on a few concepts that would be beneficial for the BHATC Planning Team to consider, specifically the region's use of an electronic navigation system for law enforcement dealing with a behavioral health case. Additionally, they commented on the advantages of renovating a pre-existing facility, rather than constructing a new building.

SITE-VISIT PARTICIPANTS

1. Angela Brown, St. Louis Regional Health Commission, Acting Chief Executive Officer
2. Amanda Harris, St. Louis Regional Health Commission, Manager of Strategic Planning
3. Alison Kraus, Behavioral Health Network of Greater St. Louis, Program Manager of Evaluation and Communication
4. Dr. Robert Poirier Jr. , Washington University School of Medicine, Clinical Chief of Emergency Medicine and Director of ED Patient Safety, Quality, and Performance Improvement
5. Karl Wilson, Department of Mental Health, Commissioner
6. Angela Tate, Behavioral Health Response, Clinical Supervisor

Geographical Analysis

Key Conclusions

- Based on *Maps 1–3*, residents of **North County and South City account for the highest utilization of emergency behavioral health services**, including mental health and substance use visits, at St. Louis City and County EDs. North City and South County also demonstrate a higher utilization of emergency behavioral health services than the rest of the region. West County has the lowest utilization of behavioral health services at EDs.

- As shown in *Map 1*, which overlays the locations of community behavioral health centers with utilization of emergency behavioral health services by zip code, the **primary care behavioral health services are not located in the areas of highest need.** This mismatch of high need and geographic accessibility to primary care behavioral health services could be a factor driving the high utilization of EDs by residents of North County and South City.

- The two areas of highest need (North County and South City) are approximately 15 miles apart, equating to a 25-minute drive time or an hour commute (or longer) using public transportation. "Old North", or Clayton, would be the midpoint between the two centers of highest need along a major highway, but the areas are still approximately a 10–15 minute commute (by car) to each center of need. **The geographical dispersion of need would pose a challenge in constructing a single, accessible crisis center to the entire region**, especially given the transportation challenges faced by low-income individuals, as documented in previous reports by the RHC and Generate Health.

- *Maps 4–5* show that **individuals from other counties, particularly St. Charles County and Jefferson County, are utilizing St. Louis City and County EDs** for behavioral health services, including mental health and substance use visits. Therefore, residents outside of the St. Louis region would likely utilize a St. Louis crisis center, as well.

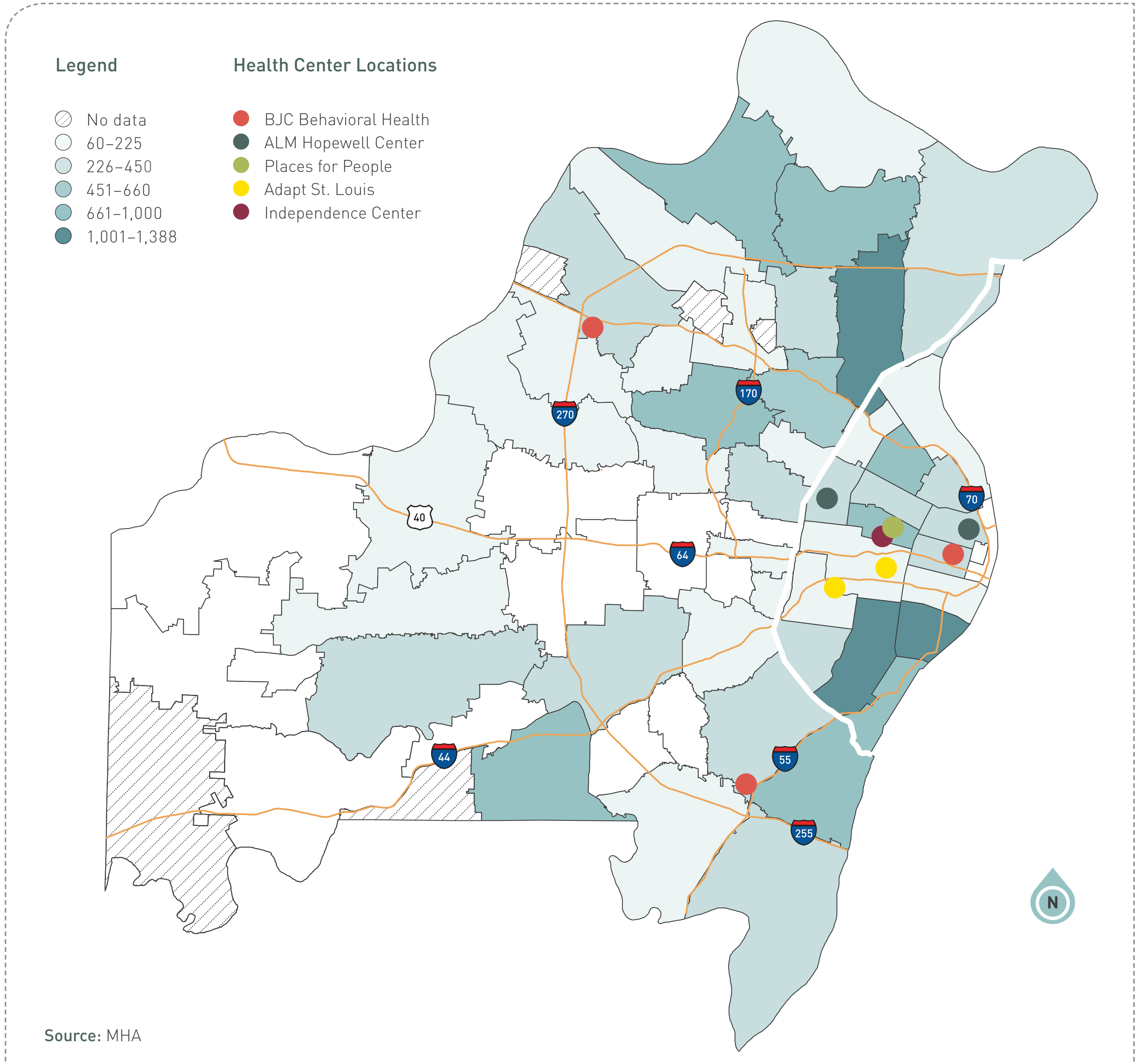
- The number of **mental health visits is approximately twice the number of substance use visits** at St. Louis City and County EDs. The data give an idea of what the breakdown (by type of visit) would be at a crisis center in the St. Louis region.

- The **large number of police** (60 police departments in St. Louis City/County) **and governmental jurisdictions** (89 St. Louis County municipalities and unincorporated areas), as shown in *Maps 6–7*, will make **coordination for a potential assessment and triage center challenging**.

Background

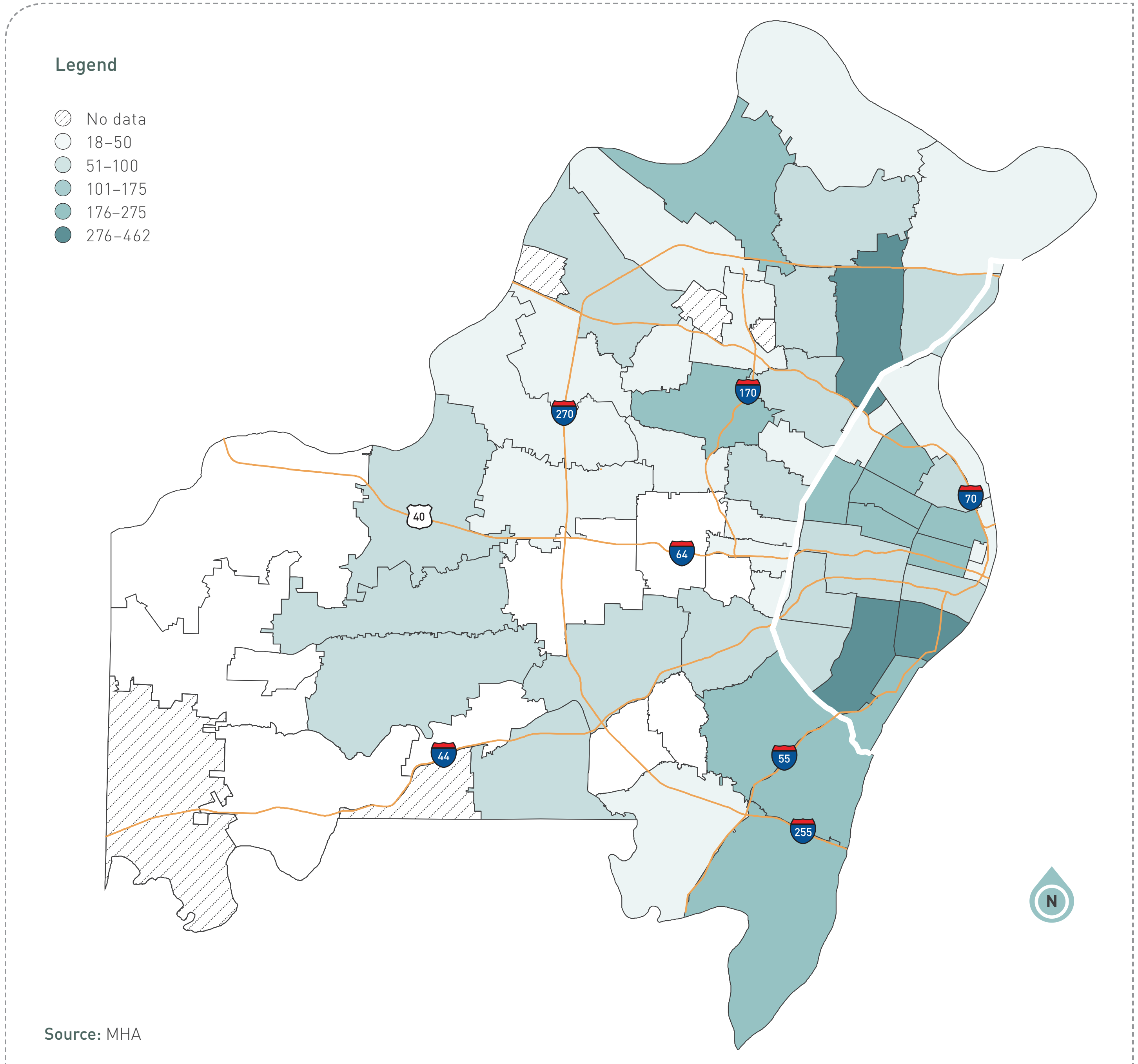
The first five maps are derived from ED utilization data from the Missouri Hospital Association (MHA) from 2017 for hospitals located in **St. Louis City and County**. The data are categorized by the type of visit – mental health visit (Serious Mental Illness) or substance use visit (Alcohol/Drug Use & Alcohol/Drug Induced Organic Mental Disorders) – and by the consumer's zip code of origin. *Maps 1–3* organize data based on zip code of origin, while *Maps 4–5* show aggregate data by county of origin. *Map 6* is from the St. Louis County Department of Planning (August 2010), and *Map 7* was made by Better Together, using data from the St. Louis County Office of Emergency Management (March 2015).

Map 1: Number of Combined Mental Health and Substance Use Visits to St. Louis City/County EDs per Zip Code



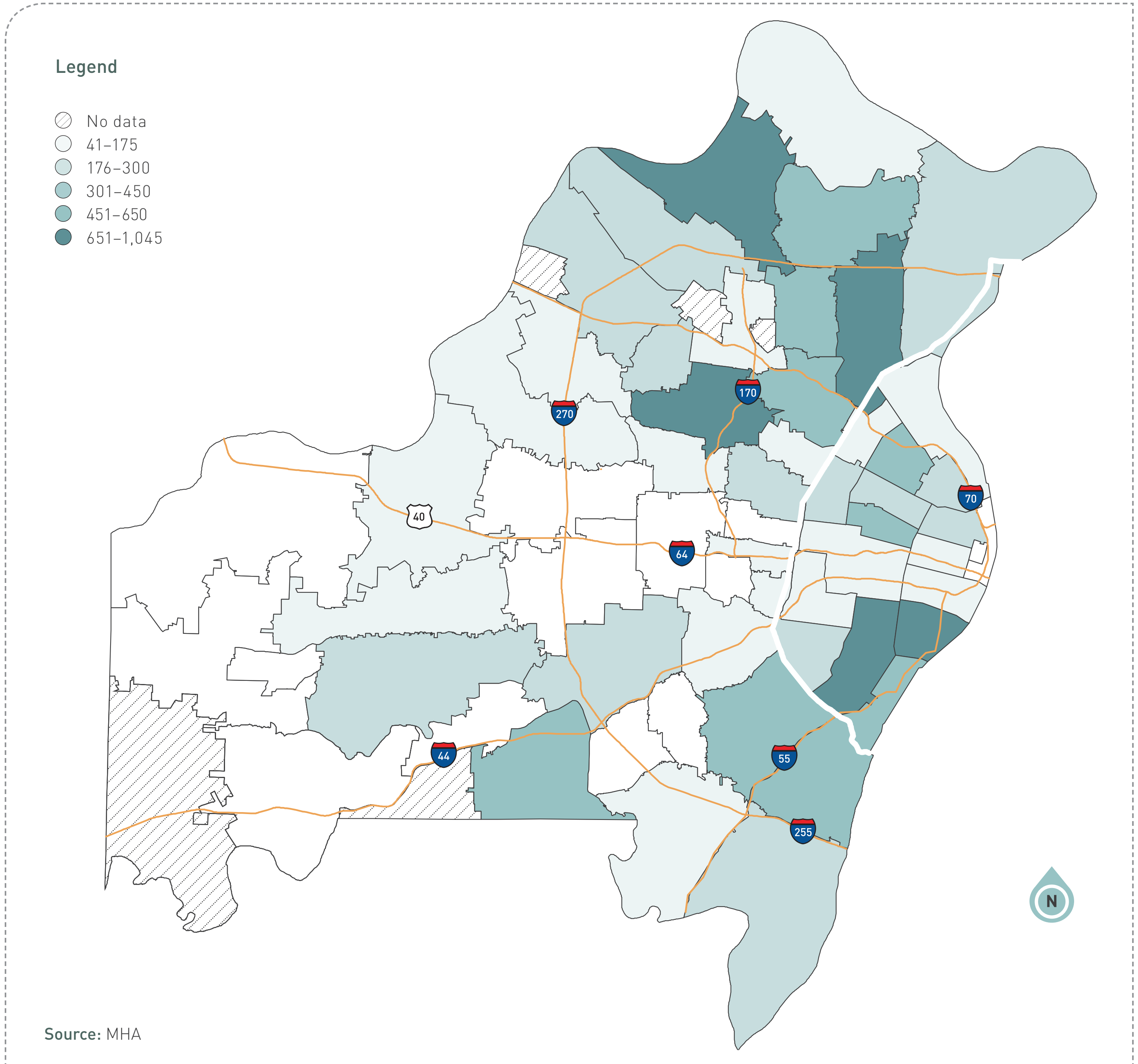
The three zip codes of highest ED utilization for **mental health/substance use** (*combined*) are 63136 (North County), 63118 (South City), and 63116 (South City). Seven of the nine community mental health center sites in St. Louis are clustered in mid-St. Louis City, and are not geographically accessible to key areas of high need in the region, especially in North County and South City.

Map 2: Number of Substance Use Visits to St. Louis City and County EDs per Zip Code



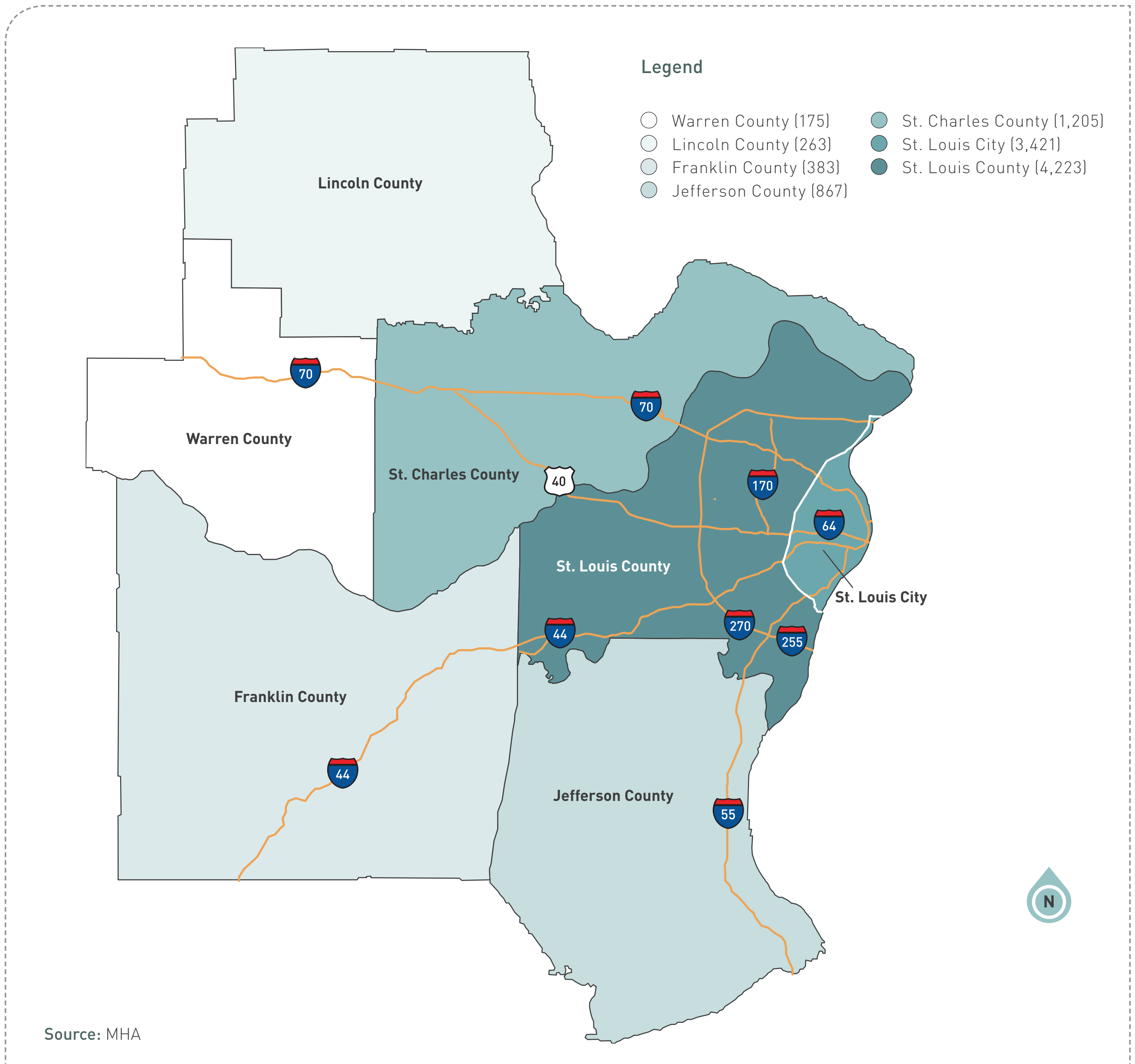
The three zip codes of highest ED utilization for **substance use** are 63118 (South City), 63116 (South City), and 63136 (North County).

Map 3: Number of Mental Health Visits to St. Louis City and County EDs per Zip Code



The three zip codes of highest ED utilization for **mental health** visits are 63136 (North County), 63116 (South City), 63118 (South City), 63114 (North County), and 63031 (North County).

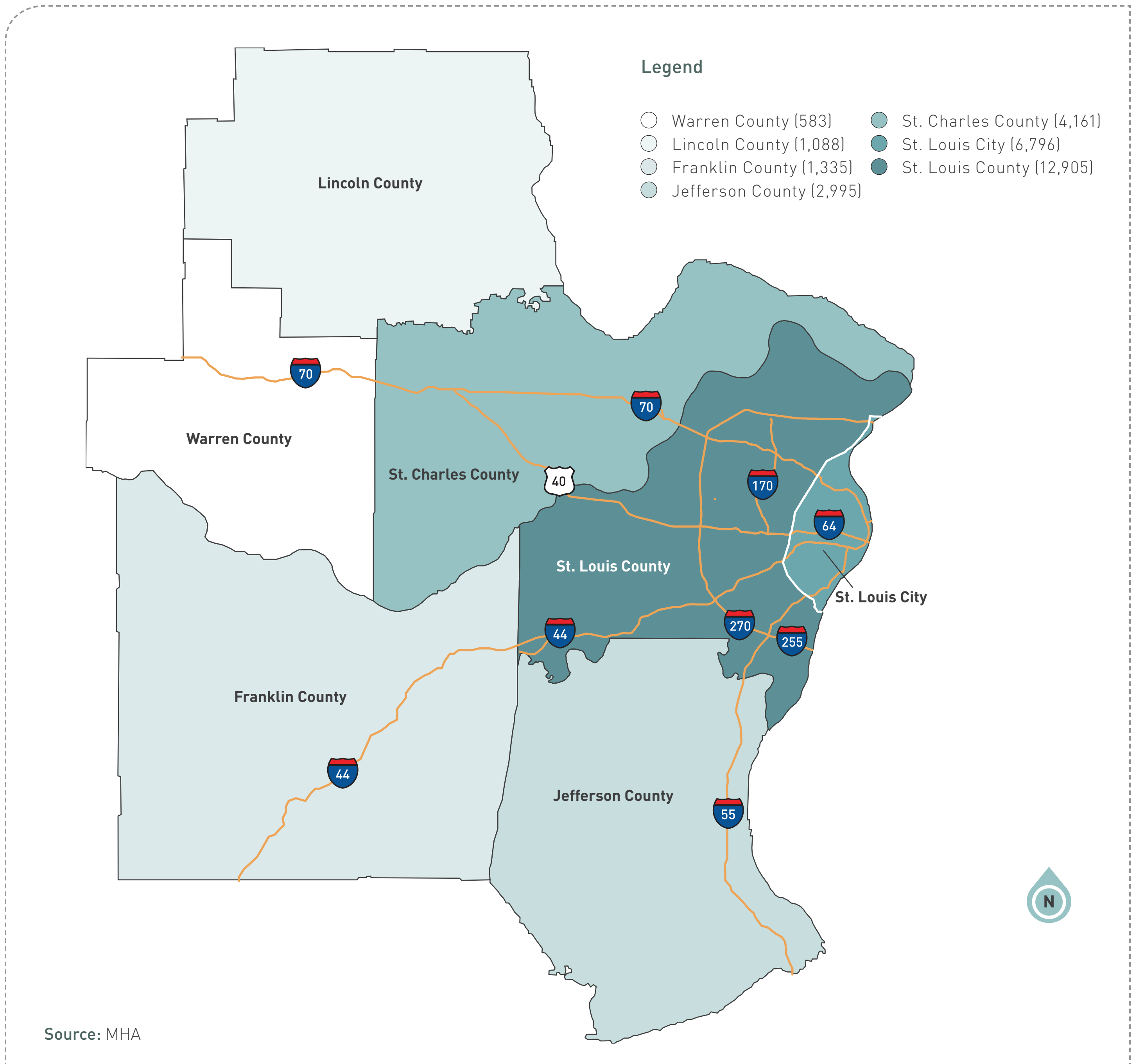
Map 4: Sum of Substance Use Visits to St. Louis City and County EDs per County



Source: MHA

St. Louis County residents use St. Louis City/County EDs most for substance use needs (40% of all visits), followed by St. Louis City residents (32%), St. Charles County residents (11%) and Jefferson County residents (8%).

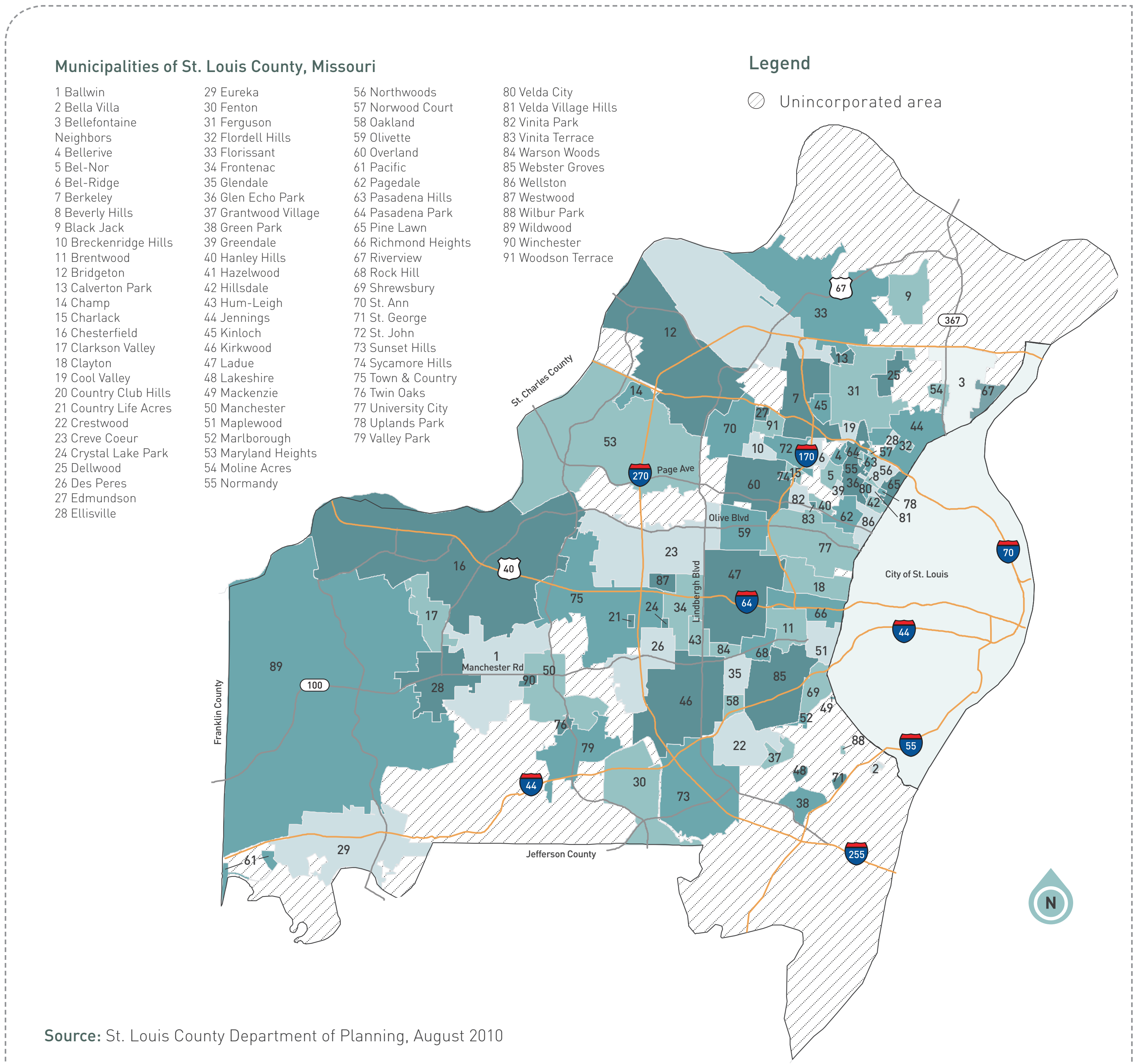
Map 5: Sum of Mental Health Visits to St. Louis City and County EDs per County



Source: MHA

St. Louis County residents use St. Louis City/County EDs most for mental health visits (43% of all visits), followed by St. Louis City residents (23%); however, St. Charles residents (14%) and Jefferson County residents (10%) also regularly visit St. Louis City/County EDs for mental health needs.

Map 6: Governmental Jurisdictions and Unincorporated Areas in St. Louis County

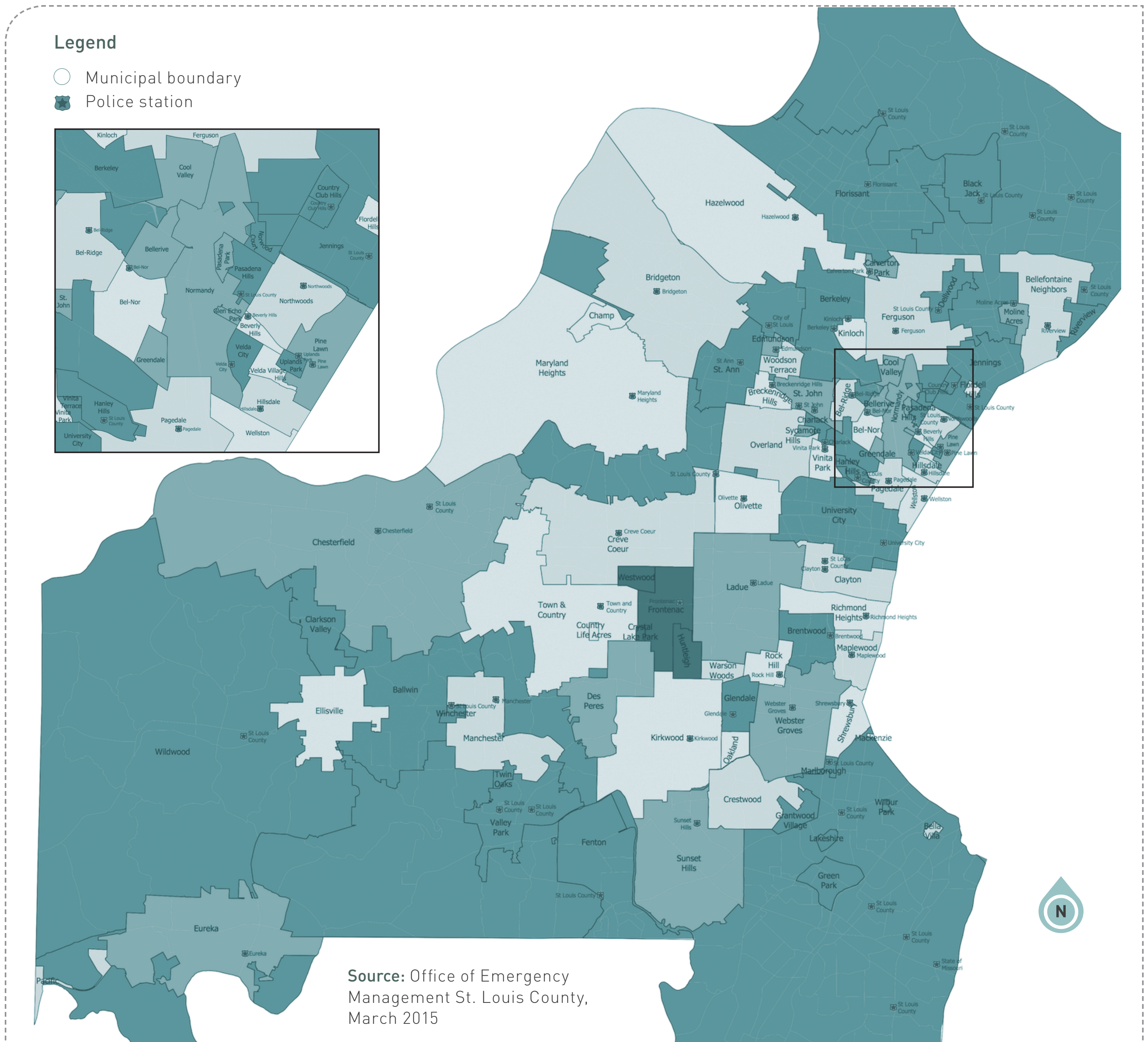


Source: St. Louis County Department of Planning, August 2010

Since the creation of this map in August 2010, which outlines 91 jurisdictions, the number of municipalities in St. Louis County has dropped to 89.

The large number of St. Louis County governmental jurisdictions, 89 municipalities as well as unincorporated areas, would pose a unique challenge for the St. Louis region to establish and manage an assessment and triage center.

Map 7: Police Jurisdictions in St. Louis County



Source: Office of Emergency Management St. Louis County, March 2015

The St. Louis region has 60 police departments, ranging from small municipal departments with only five officers to large, full-service agencies. The St. Louis Metropolitan Police Department and the St. Louis County Police Department are the two largest departments, while St. Louis County's 58 municipal police departments have smaller teams and jurisdictions, which are outlined above in Map 7 (PERF Report, 2015). The large number of jurisdictions would make coordination for a potential assessment and triage center challenging. *See next page for full list of departments.* ▶

Map 7: Police Jurisdictions in St. Louis County *(cont.)*

Department	Municipality	Department	Municipality	Department	Municipality
1 St. Louis County	Unincorporated	**16 Country Club Hills**	Country Club Hills	**39 Northwoods**	Northwoods
St. Louis County	Black Jack	**17 Crestwood**	Crestwood	**40 Olivette**	Olivette
St. Louis County	Clarkson Valley	**18 Creve Coeur**	Creve Coeur	**41 Overland**	Overland
St. Louis County	Dellwood	**19 Des Peres**	Des Peres	**42 Pacific**	Pacific
St. Louis County	Fenton	**20 Edmundson**	Edmundson	**43 Pagedale**	Pagedale
St. Louis County	Grantwood Village	**21 Ellisville**	Ellisville	**44 Pine Lawn**	Pine Lawn
St. Louis County	Green Park	**22 Eureka**	Eureka	**45 Richmond Heights**	Richmond Heights
St. Louis County	Hanley Hills	**23 Ferguson**	Ferguson	**46 Riverview**	Riverview
St. Louis County	Jennings	**24 Flordell Hills**	Flordell Hills	**47 Rock Hill**	Rock Hill
St. Louis County	Marlborough	**25 Florissant**	Florissant	**48 Shrewsbury**	Shrewsbury
St. Louis County	Norwood Court	**26 Frontenac**	Frontenac	**Shrewsbury**	Mackenzie
St. Louis County	Pasadena Hills	**Frontenac**	Crystal Lake Park	**49 St. Ann**	St. Ann
St. Louis County	Twin Oaks	**Frontenac**	Huntleigh	**50 St. John**	St. John
St. Louis County	Uplands Park	**Frontenac**	Westwood	**St. John**	Sycamore Hills
St. Louis County	Valley Park	**27 Glendale**	Glendale	**51 Sunset Hills**	Sunset Hills
St. Louis County	Wildwood	**28 Hazelwood**	Hazelwood	**52 Town & County**	Town & County
St. Louis County	Winchester	**29 Hillsdale**	Hillsdale	**Town & County**	Country Life Acres
2 Ballwin	Ballwin	**30 Kinloch**	Kinloch	**53 University City**	University City
3 Bel-Nor	Bel-Nor	**31 Kirkwood**	Kirkwood	**54 Velda City**	Velda City
4 Bel-Ridge	Bel-Ridge	**Kirkwood**	Oakland	**55 Vinita Park**	Vinita Park
5 Bella Villa	Bella Villa	**32 Ladue**	Ladue	**56 Warson Woods**	Warson Woods
6 Bellefontaine Neighbors	Bellefontaine Neighbors	**33 Lakeshire**	Lakeshire	**57 Webster Groves**	Webster Groves
7 Berkeley	Berkeley	**34 Manchester**	Manchester	**58 Wellston**	Wellston
8 Beverly Hills	Beverly Hills	**35 Maplewood**	Maplewood	**59 Woodson Terrace**	Woodson Terrace
Beverly Hills	Velda Village Hills	**36 Maryland Heights**	Maryland Heights		
9 Breckenridge Hills	Breckenridge Hills	**Maryland Heights**	Champ		
10 Brentwood	Brentwood	**37 Moline Acres**	Moline Acres		
11 Bridgeton	Bridgeton	**38 Normandy**	Normandy		
12 Calverton Park	Calverton Park	**Normandy**	Bellerive		
13 Charlack	Charlack	**Normandy**	Cool Valley		
14 Chesterfield	Chesterfield	**Normandy**	Glen Echo Park		
15 Clayton	Clayton	**Normandy**	Greendale		
		Normandy	Pasadena Park		

Housing Access Analysis

Key Conclusions:

- Additional transitional housing options are needed in the St. Louis region to support individuals until safe, affordable, permanent options can be identified.
- Crisis/Respite beds in the St. Louis region are limited and underutilized.
- The clustered and intensive residential treatment options in the St. Louis region are comparative to Kansas City. The St. Louis City service providers have limited ability to expand these options when allocations are being utilized due to a capped system.
- Gateway Housing First is a resource in our region that could be leveraged to bring in additional housing options.

Overview of Planning Efforts on Housing

Key stakeholders in the planning process have noted that safe and affordable housing is a critical part of the recovery process for individuals with a behavioral health illness. In response to the need of having permanent, affordable, supported housing for individuals with a wide range of disabilities and life situations, the BHN is leading a Regional Housing Collaborative. The Housing Collaborative's vision is for people with behavioral health needs to have access to an array of safe, decent and affordable permanent housing options through the region. Expansion of safe affordable housing and supportive service options for persons with behavioral health issues is a regional strategic priority. A key partner is this work is Gateway Housing First (GHF).

GATEWAY HOUSING FIRST OVERVIEW

Guided by the values and outcomes achieved by Housing First and Harm Reduction programs, GHF's immediate focus is on increasing housing stock for the hardest to house, eliminating "housing readiness" barriers and increasing long-term housing success. GHF is the only organization in the region whose sole mission is to create supportive housing for people with special needs.

GHF will begin to relieve the burdens experienced by public and private systems serving those most in need in the region by making access to healthcare, community-based treatment and affordable housing more cost effective and impactful.

Below is a summary of the data collected through the feasibility study of an access and triage center for the St. Louis Region. Comparisons with the Kansas City region (Jackson County) have been provided, where data is available.

TRANSITIONAL HOUSING OPTIONS FOR CRISIS SERVICES

Attached to the Kansas City Access and Triage Center (KC-ATC) is a 24/7 crisis respite residential facility that provider crisis stabilization and transitional living for adults suffering with substance use and mental health illnesses. The goal of the facility is to address immediate crisis needs and transition back to stable and safe housing, as well as connection to outpatient care and follow-up. The average length of stay is approximately 10 days. The crisis respite center has a special governor approved rate to support operations.

In addition, ReDiscover, in Kansas City, receives approximately $2 million of follow-up funding that can be used to cover housing needs until permanent housing options are available. Due to the media coverage regarding the work of the access and triage center, they have developed relationships with developers and landlords to provide short-term housing options. The average length of stay in the transitional housing is 90 days.

The St. Louis region has six crisis/respite beds, three at Hopewell and three at Places for People.

BHR has authorization to utilize one of the beds located at Hopewell. The current process calls for CMHCs to contact BHR to authorize use of the crisis bed. Crisis beds are underutilized because the setting requires high level of functioning and exclusion and inclusion criteria are quite restrictive. Yearly utilization of available days is under 5%.

PERMANENT SUPPORTED HOUSING OPTIONS

Combined Supported Community Living (SCL) and Community Housing Options:

The geographic area of the Western Region (1,541,736) is smaller than the size of the Eastern Region (2,118,552). According the data provided by the Missouri Department of Mental Health, the two regions have comparatively similar total supported community living (SCL) and community beds. **The East has 765 beds (or 1 per 2,769 residents)**, and the West has 590 beds (or 1 per 2,613 residents). A breakdown of the available beds by type have been provided on the next page in *Table 1*.

Table 2 shows the intensive residential options billed in 2017. These options include:

- Clustered Apartment Setting: individual apartments clustered in one or more apartment complexes with staff available on a full or part-time basis;
- Intensive Residential Treatment Setting (IRTS): congregate living environment with 5 to 16 beds and staff available on a full-time or part-time basis; and
- Psychiatric Individualized Supported Living Environment: private home with 2 to 4 bedrooms with full-time staff.

The Eastern Region has significantly more Psychiatric Individualized Supported Living Environment beds (23 beds in the Eastern Region vs. 2 in the Western Region). The beds available in the Clustered Apartment Setting and the Intensive Residential Treatment Setting are comparable.

ST. LOUIS CITY AND COUNTY CONTINUUM OF CARE

In 2005, St. Louis City and County partnered to develop a 10-year plan to end chronic homelessness. In 2010, a five-year update to the 10-year plan was released (refer to *www.stlouis-mo.gov*). This report provides an analysis of the homeless population and the number of beds, for permanent supportive and transitional housing, available in the region. Despite the progress referenced in the report, stakeholders still report a gap in meeting the needs of the homeless population in the St. Louis region. The data collected in 2010 represents the most recent housing data available for the St. Louis region. ▶

Table 1. Regional Comparison of SCL and Community Beds[3]

Combined SCL Office and Community Eastern Region	Skilled Nursing Facility	Residential Care Facility II	Residential Care Facility I	Psychiatric Group Home	Apartment	Child & Youth Facility	Semi- Independent	Treatment Family Home	Total	Male	Female
COMTREA (Jefferson County)	3	2	7	0	26	7	0	1	46	21	25
Crider/Compass (Franklin, Lincoln, St. Charles, Warren)	0	23	9	0	65	1	0	0	98	49	49
BJC (St. Louis County)	1	5	44	0	86	7	0	4	147	73	74
BJC (St. Louis City)	0	31	3	0	79	3	0	1	117	66	51
Hopewell (St. Louis City)	9	11	12	0	43	1	0	0	76	39	37
Adapt (St. Louis City & County)	0	5	4	0	53	0	0	0	62	25	37
Independence Center (St. Louis City & County)	0	3	8	0	44	0	0	0	55	33	22
Places For People (St. Louis City & County)	0	1	2	0	161	0	0	0	164	96	68
TOTAL	**13**	**81**	**89**	**0**	**557**	**19**	**0**	**6**	**765**	**402**	**363**
Gender % Housing										52.55%	47.45%
STL CITY & COUNTY	**10**	**56**	**73**	**0**	**466**	**11**	**0**	**5**	**621**	**332**	**289**

[3]Data provided by Department of Mental Health (CIMOR system).

Table 1. Regional Comparison of SCL and Community Beds[3] *(cont.)*

Combined SCL Office and Community Western Region	Intermediate Care Facility non	MHRCF II RA	Residential Care Facility II	Residential Care Facility I	Trans ComPlac RT	Apartment	Child & Youth Facility	Semi-Independent	Treatment Family Home	Total	Male	Female
Compass/Crider (Clinton)	0	0	0	2	0	18	0	0	0	20	9	11
Comprehensive CMHC (Jackson County)	0	0	12	0	0	47	0	0	0	59	40	19
Family Guidance (Andrew, Atchison, Buchanan, Clinton, Dekalb, Gentry, Holt, Nodaway, & Worth Counties)	0	30	0	24	27	56	2	0	0	139	90	49
North Central (Caldwell, Daviess, Grundy, Harrison, Linn, Livingston, Mercer, Putnam, & Sullivan Counties)	0	0	0	0	0	31	0	0	0	31	12	14
ReDiscover (Jackson County)	10	0	1	10	0	5	0	0	0	26	39	36
Swope (Jackson County)	10	0	22	4	0	39	0	0	0	75	39	42
Tri-County (Clay, Platte, & Ray Counties)	0	0	13	0	0	65	0	0	0	81	108	51
Truman (Jackson County)	5	0	30	8	0	86	0	0	0	159	108	51
TOTAL	**25**	**30**	**78**	**48**	**27**	**347**	**2**	**0**	**0**	**590**	**353**	**237**
Gender % Housing											59.83%	40.17%
STL CITY & COUNTY	**25**	**0**	**65**	**22**	**177**	**177**	**0**	**0**	**0**	**319**	**226**	**148**

[3]Data provided by Department of Mental Health (CIMOR system).

Table 2. Regional Comparison of Intensive Residential Options[4]

Adding Intensive Residential program served in June 2017 last month all billed on intensive codes prior to CCBHC.

Eastern Region	Clustered	Intensive Residential Treatment Setting	Psychiatric Individual Supported Living	Total	Male	Female
COMTREA		12		12	9	3
Crider/Compass		16	12	28	21	7
BJC County		10		10	9	1
BJC City	10	6		16	12	4
Hopewell	15	7	3	25	17	8
Adapt				0		
Independence Center	30			30	23	7
Places For People	43	24	8	75	54	21
INTENSIVE TOTAL	**98**	**75**	**23**	**196**	**145**	**51**
Intensive Gender %					74%	26%
SCL Office, Community and Intensive Total Unduplicated						
				933	524	409*
Gender %					56%	44%

Western Region	Clustered	Intensive Residential Treatment Setting	Psychiatric Individual Supported Living	Total	Male	Female
Crider/Compass	0	0	0	0	0	0
Comprehensive CMHC	0	13	0	13	8	5
Family Guidance	0	0	0	0	0	0
North Central	0	0	0	0	2	0
ReDiscover	2	56	2	60	42	16
Swope	29	14	0	43	31	12
Tri-County	14	0	0	14	6	8
Truman	36	0	0	36	23	13
INTENSIVE TOTAL	**81**	**83**	**2**	**166**	**112**	**54**
Intensive Gender %					64%	36%
SCL Office, Community and Intensive Total Unduplicated						
				715	436	279**
Gender %					61%	39%

[4]Data provided by Department of Mental Health (CIMOR System)

*There were 28 clients in intensive who also had housing expense (24 Male and 4 Female) they were deducted from category totals to get unduplicated served in total.

**3 clients were found with services at SCL and the Community in housing. Those clients' data remains in the category (29 Males and 12 Females.)

Psychiatric Stabilization Center Lessons Learned

Background/History (2010–Present)

In April 2010, the State of Missouri Department of Mental Health (DMH) announced its intent to close the ED and a phased closure of 50 inpatient psychiatric beds at the St. Louis Metropolitan Psychiatric Center (MPC), the only public acute mental health hospital in the Eastern Region of Missouri, located in the City of St. Louis on Delmar Blvd. near Union. The July 15 closure resulted in long wait times for psychiatric patients in the region's other hospital EDs, medical environments that are not therapeutically designed to provide emergency psychiatric care. In May 2010, the State made a formal request of the St. Louis Regional Health Commission (RHC) to create a local plan to address issues created by the closure.

In response to the State's request, the RHC convened a Regional Planning Group and a Short-Term Crisis Management Team the following month. These groups assessed the scope and scale of the closure and its impact on the community, then identified and addressed the key issues the closure created.

http://www.stlrhc.org/work/establishing-st-louis-psychiatric-stabilization-center/

As a result of this collaborative effort, the St. Louis Regional Psychiatric Stabilization Center (PSC) opened its doors one year later in 2011, as an independent non-profit organization, with ongoing financial support from the Missouri Department of Mental Health ($1 million annually), BJC HealthCare ($500,000 annually), SSM Health ($500,000 annually), and $1.5 million in one-time start-up funding from the RHC. PSC initially opened with the maximum of 16 beds allowed for a freestanding psychiatric hospital under Medicaid's Institute for Mental Diseases rule, and expanded to 25 beds under the three-year Medicaid Emergency Psychiatric Demonstration (MEPD) project of the Affordable Care Act. Prior to closure, MPC had operated 50 beds, resulting in a net loss of 25 inpatient psychiatric beds for the region post-closure.

Also, ED services were not offered at the new PSC, as 24-hour physician coverage was deemed not feasible.

Once opened in 2011, the PSC cared for a higher-than-budgeted volume of uninsured patients, with up to 40% of patients unable to pay for services, chiefly as a result of Missouri's failure to expand Medicaid as originally anticipated during the planning phase. Also, the Federal MEPD project was slated to be discontinued in July 2015, which would have reduced PSC to 16 beds. These conditions, together with a concurrent decline in Medicaid reimbursement, caused PSC's financial model to be unsustainable.

Current Operations of the PSC

In April 2015, BJC HealthCare assumed operations and ownership of the PSC, expanding to 50 beds and consolidating psychiatric units formally operated at Christian Hospital to the Delmar location. The PSC operating license was transferred at this time to Barnes-Jewish Hospital, in order to maximize potential Medicaid revenue opportunities for the region, as well as due to geographic proximity. Barnes-Jewish Hospital currently operates the facility, with medical staffing largely provided by the Department of Psychiatry at Washington University School of Medicine. The facility's current name is the Barnes-Jewish Hospital Psychiatric Support Center. The majority of patients/consumers are admitted to the PSC after a medical screening examination in the Barnes-Jewish Hospital ED, and the facility currently does not accept clients brought by law enforcement or EMS personnel since it does not operate an ED at the Delmar site.

Despite the sustained commitment of BJC to continue psychiatric operations at the Delmar location since 2015, the solutions developed after the closure of services at MPC in 2010 have not fully addressed the

gaps left in the wake of the loss of the acute psychiatric services that MPC provided, most notably its ED. In the meantime, demand for such services has only intensified, especially with the well-documented rise in acute substance use disorder cases in the region over the past five years.

Key "Lessons Learned" from the PSC experience

In 2018, RHC staff interviewed former staff, board members, and key stakeholders of the PSC. The following five key themes emerged as "critical success factors," in large part missing from the original PSC planning and/or implementation from 2011–2015, to consider prior to developing a new "Behavioral Health Assessment and Triage Center" (BHATC):

1. Identify sustainable funding streams during the planning process
2. Strengthen community supports, such as housing and community mental health services, across the St. Louis region, prior to implementation
3. Consider the geographic demand patterns in St. Louis prior to locating the site(s) for new services
4. Plan for meeting the needs of first responders during the design process
5. Take significant measures to secure the necessary workforce to staff any new model

1. IDENTIFY SUSTAINABLE FUNDING STREAMS DURING THE PLANNING PROCESS

All stakeholders interviewed agreed that the most significant critical success factor was the identification of sustainable funding. Approximately 40% of the PSC's clients were uninsured adults in or near poverty, without sufficient resources to pay for services rendered. Initial financial planning for the PSC assumed Medicaid expansion coverage for those earning 138% of the Federal Poverty Level (FPL) or below, which would likely have provided enough revenue to sustain operations. However, without Medicaid expansion in Missouri, significant financial support was needed to cover the annual financial losses of the PSC, which was initially provided by DMH, SSM, and BJC. When the State of Missouri and SSM Health declined to continue subsidizing losses after three years of operations, the PSC was no longer able to operate as originally designed.

Without significant, ongoing financial commitment from a dedicated public source (local or State), and/or Medicaid expansion, any new effort will likely face the same severe challenges to ongoing operations as the original PSC model.

2. STRENGTHEN COMMUNITY SUPPORTS, SUCH AS HOUSING AND COMMUNITY MENTAL HEALTH SERVICES

Even in its original design from 2011–2015, stakeholders mentioned that the PSC was not able to fully execute its function as a triage center for the acutely mentally ill. A significant lack of access to community mental health services and key community supports, such as housing, was cited as a key barrier to the PSC's success. Recent Access to Care data from the RHC identified significantly lower access to community mental health centers per capita in St. Louis City and County than other areas of the State, and mental health advocates and consumers report significant wait times of at least 2–3 months to access community-based mental health services and/or substance use disorder treatment once a patient is initially assessed.

In addition, the St. Louis region is reported to lack significant permanent supportive housing needed for this population. Please note that a complete discussion of this data can be found in the *Housing Access Analysis*, beginning on page 30.

Without these key supports, a service such as the PSC or a potential BHATC is not able to effectively triage patients to needed community services due to a lack of access and thus, serves the same patients multiple times per month without

hope for long-term recovery. Until the St. Louis mental health community moves to a recovery-based model, with significant increases in access to housing and community mental health supports, interviewees feel that a PSC/BHATC model may not reduce the pressure on the criminal justice system or regional EDs, as hoped.

3. CONSIDER THE GEOGRAPHIC DEMAND PATTERNS IN ST. LOUIS PRIOR TO LOCATING THE SITE(S) FOR NEW SERVICES

Data suggests that multiple areas of the St. Louis region have significant need for behavioral health assessment and triage services. However, the PSC operated at one site, near the intersection of Delmar and Union, which is 11 miles (20 min drive) to Christian Hospital; 13 miles (20 min drive) to both Missouri Baptist Medical Center and Mercy St. Louis; 15 miles (30 min drive) to SSM DePaul Hospital; and 18 miles (30 min drive) to Mercy South (*formerly St. Anthony's*). While PSC admitted many patients from these hospitals, given these distances, the PSC did not divert a significant number of acute mental health/substance use cases from most EDs in the region. This diminished its effectiveness and may have reduced the amount of support from key stakeholders, which was needed to advocate for sustainability. Interviewees cautioned that the BHATC planning effort will have to determine how to serve more of the greater St. Louis region than the PSC did, if the model is to be successful and sustainable in the long-term.

4. PLAN FOR MEETING THE NEEDS OF FIRST RESPONDERS DURING THE DESIGN PROCESS

Interviewees indicated that one of the significant challenges of the PSC was that it was not open to all first responders for direct admission. While EMS could conduct a required medical screening exam, law enforcement officers would have to take clients/patients to a regional ED for medical screening prior to transfer to the PSC. Thus, area EDs did not see a substantial decrease in acute mental health/substance use volumes as originally projected from the implementation of the PSC model. It should be noted that PSC routinely received approximately 20% of admissions from walk-in and EMS. Interviewees suggested that any new models consider the implications of the chosen admissions criteria prior to implementation.

5. TAKE SIGNIFICANT MEASURES TO SECURE THE NECESSARY WORKFORCE TO STAFF ANY NEW MODEL

The shortage of mental health workforce is well-documented nationally. Although the region is rich in academic programs, this shortage is exacerbated in the St. Louis region due to a lack of focus by area universities on training practicing psychiatrists, psychologists, advanced practice psychiatric nurses, and licensed clinical social workers.

A 2016 Missouri Hospital Association workforce report highlights a concrete example of what this shortage means, with turnover rates for behavioral health nurses at 29.2% and vacancy rates of 12%, which is near the top of the 36 occupations assessed.

Any new models, such as the BHATC, will face challenges in recruitment. Short-term efforts to recruit and retain workers to a potential BHATC, as well as community-wide long-term solutions to the behavioral health workforce shortage in the region, will be essential to the success of any new model.

Voice of the Customer Report

Key Conclusions

- Stakeholders report that opportunity exists to increase the capacity of current initiatives (e.g. peer supports and the BHN's Hospital Community Linkages (HCL) project, Bridges to Care and Recovery, Engaging Patients in Care Coordination, etc.) to better meet the needs of individuals in crisis and improve care transitions and navigation.
- Stakeholders hope that addressing social determinants and environmental "supports", such as housing, employment, and transportation, will lead to increased engagement in services and will foster long-term recovery.
- Recent feedback on the current behavioral health "system" in St. Louis City/County resembles the feedback received from stakeholders in 2006, namely:
    - significant system fragmentation;
    - inadequate access and long wait times, especially for new users and individuals in crisis;
    - and stigma/prejudice toward the mentally ill.

Background

In an effort to understand the access and barriers to effective SMI/SU crisis and stabilization treatment by consumers and providers, the BHN, in partnership with the St. Louis Regional Health Commission (RHC), recently conducted focus groups and stakeholder interviews with consumers and providers to capture the "voice of the customer."In addition, the RHC held extensive focus group sessions to support its 2006 comprehensive behavioral health assessment (reports can be found at *www.stlrhc.org*).

The "Voice of the Customer" report is a summary of the focus reports developed by the BHN in August 2018. Feedback was received from more than 100 individuals, including providers, front line staff, behavioral health consumers, caregivers, and lay community members.

All those interviewed were asked to comment on their perceptions of:

- What works well within the crisis behavioral health system
- Where barriers, gaps, and needs exist
- What potential solutions they would offer to improve services and supports for consumers

On September 5, 2018, the RHC and BHN hosted a public session to confirm the key conclusions of the BHN 2018 and RHC 2006 focus group sessions. Stakeholders confirmed that the key conclusions from these reports fairly represented the current state of the behavioral health system in St. Louis in 2018, and added additional support comments that have been synthesized with the other feedback obtained previously.

Opportunities to Improve St. Louis Region Crisis System

The inadequacy of the current crisis system in St. Louis was presented as a key challenge for adults with behavioral health needs in all feedback sessions. Many stakeholders expressed concern that behavioral health needs are often not addressed until they reach crisis levels, and hospitals and law enforcement need to be engaged. Supported care transition post-crisis, respite services, and 24/7 safe spaces were identified as essential components for stability. Feedback from stakeholders has been summarized in the themes below:

1. BUILD UPON OR EXPAND CURRENT SYSTEM RESOURCES AND ASSETS

In all of the feedback sessions, participants noted services that work well within the behavioral health system. Day programming, clubhouse services, and opioid use services were noted to be strong in the St. Louis region. Additionally, stakeholders noted the growing range of settings in which behavioral health services are delivered. A key example was the integration of services within other settings, such as behavioral health coaches and

Medication-Assisted Treatment (MAT) within primary care settings. The regional strength of enhanced outreach and transitions of care efforts (e.g. Engaging Patients in Care Coordination (EPICC), Emergency Room Enhancement (ERE) project, etc.) were also noted as key community assets.

"Newer services for opioids – more funding through the Missouri Opioid State Targeted Response"

"Good that services are increased, but still does not meet overall demand"

"Better transition from ED to community provider – enhance ERE and peers and add behavioral health staff in ED"

"Expand partnerships with BHN's Hospital Community Linkage (HLC) project – connect patients directly to CMHC – especially new patients"

"Expansion of all of our roles – police/ED staff/community provider – must reduce barriers"

2. ADDRESS BROAD RECOVERY NEEDS/TREAT THE "WHOLE PERSON"

In addition to appropriate treatment services, recovery requires attention to basic needs and connection with others who struggle with mental illness. Many consumers noted that addressing social determinants and environmental stressors, such as housing, employment, and transportation leads to increased engagement in services and fosters long-term recovery.

"More support services (esp. housing) needed to make any new crisis system work"

"People in crisis/repeaters need social assistance – but none are available…people don't know how to follow-up"

"Consider supporting pay for housing models as done in other states to address high utilizers"

"Patients don't have help to help them recover"

3. TREAT INDIVIDUALS IN NEED OF SERVICES WITH DIGNITY AND RESPECT

Focus group participants expressed concern and frustration from being treated with disrespect due to the lack of empathy for people living with mental illness and substance issues. These feelings prevent consumers from seeking care and engaging in services. Cultural competence of providers in hospital and community-based settings and peer supports were seen as needs for the system.

"Everyone should be treated as a person with value and worth"

"Where is the humanity of the mental health system? The average person treats their pets better than they do us. The system is definitely broken and won't be fixed until they hear what I am saying – not just listening to but hearing what I am saying."

"Stigma still persists"

"Consumers should have a greater voice when designing the system"

"Patients feel like they are treated poorly in EDs for mental health needs – patients feel like they are rushed out of EDs – need more compassion – now feel unwanted"

"Limited client choice in current system"

"Patients are expected to adapt to the system instead of the system adapting to patient needs"

"Need increased education and acceptance of recovery coaches and community health workers…"

4. DEVELOP COORDINATED SERVICES THAT ARE EASILY ACCESSIBLE AND READILY AVAILABLE

Stakeholders cited limited capacity, long waits, and challenges with service locations and hours as preventing early engagement in services and contributing to high-utilization of acute care (24/7) services. Stakeholders also identified navigation challenges, which included both a lack of knowledge about available services and how to access them, due to the complexity of the system. Consumers and families noted that frustration stems from administrative hurdles and eligibility requirements, delays/not receiving services, and provider mistrust.

"I had to become suicidal before they would do anything."

"There are too many organizations – health care and what have you – and none of them work together."

"There really is not a system"

"Services are available but not necessarily accessible."

"Health care homes and integrated care – have had less of an impact [in St. Louis]"

"New patients can't access CMHCs for needs – jams entire 'patient flow' as everyone else gets backed up"

"More lines of communication open among all providers"

"Coordinated efforts should be looked at with all CMHC providers and affiliates"

"Patients have to talk to many people, telling the same story"

"Improved communication/data sharing between inpatient and CMHC…"

"Same issues – nothing has changed since 2007/2008"

"Access for new people is a real problem- capacity issues at CMHCs, ceiling on services"

"Currently we have a wrong-door approach"

"Currently do not have a crisis response model – more of a referral system"

5. TRAIN PROVIDERS TO UNDERSTAND AND MEET THE NEEDS OF INDIVIDUALS WITH BEHAVIORAL HEALTH ISSUES.

Stakeholders acknowledged that there is a greater need for education on behavioral health in the community. Consumers and family members highlighted the need for trainings that target behavioral health and non-behavioral health providers (e.g. law enforcement and physicians) in evidenced-based models and cultural competency. Mental Health First Aid and specialized trainings for law enforcement were described as beneficial for crisis intervention.

"ED staff need mental health first aid training and a culture of 'Yes'"

"Training for ED staff on working with behavioral health trauma and psych patients to reduce stigma with serving these patients"

"More training for ED and law enforcement is needed"

"If you look at the individual client and try to satisfy their need, you're more successful"

"They need to meet people where they are; meet the needs where they are"

Qualitative Data Analysis

OVERVIEW

Qualitative approaches provide the opportunity to uniquely explore individuals' subjective perceptions and experience that would not be otherwise accessible. Group approaches therein allow individuals to interact, build on one another's comments and allow for facilitators to probe further for details and clarifications in real-time. For these purposes, qualitative data collection activities centered on understanding the current state and needs related to adult behavioral health in St. Louis, by gaining a community voice through participatory groups. The following sections summarize the approach taken and analysis of findings from five participatory groups conducted mid-June through July 2018.

Participatory groups explored observations and experiences in the community and/or with behavioral health supports and services, including resources and assets, needs, gaps, and barriers and opportunities. Additional qualitative sessions conducted by collaborators were also leveraged, including those of Gateway Housing First on behalf of BHN, Missouri Institute of Mental Health, the Women's Foundation of Greater St. Louis, the St. Louis Area Violence Prevention Collaborative, and the St. Louis Regional Health Commission.

METHODOLOGY

BHN facilitated participatory groups mid-June through July 2018, recruiting the participation of individuals with a relationship to the St. Louis City community, and key parties in adult behavioral health. Participatory groups consisted of interactive, semi-structured open-ended sessions designed to engage and empower group participants. Session design was informed by community member input whenever possible. In order to engage participants, a mix of techniques was used: nominal group technique (a structured approach to seeking input and developing consensus); divergent (meant to elicit individual perspectives); and convergent (meant to gain group

consensus or perspective). Groups consisted of 90-minute sessions with questions and activities to facilitate broad inquiry around community resources and assets, needs, gaps and barriers, and opportunities.

59 community stakeholders (consumers with lived experience, family supports/caregivers, and general community members/residents) and 22 providers of behavioral health or related services, engaged in BHN-led groups (*Table 3*). Participant demographics can be found in the tables that follow.

BHN also facilitated a full stakeholder meeting, two hours in length, and included invitations to all those who attended participatory groups and key BHN, St. Louis MHB, and RHC stakeholders. 49 individuals attended this event, which focused on interactive review of preliminary findings and development of strategic recommendation responses. Feedback from this session is largely reflected in the opportunities section at the end of this section.

Table 3. Participatory Group Details and Demographics

Stakeholder Group	Stakeholder Subgroup	Primary Location	Number in Attendance	Group Demographics
Community members	Adults with lived experience of receiving behavioral health services	North City	12	Race: 4 Caucasian, 8 African American Age range: 25–65+ Gender: 3 male, 9 female
		South City	22	Race: 2 African American, 16 Caucasian, 2 Multiracial, 2 other/unknown Age range: 18–64 Gender: 8 male, 14 female
	Support persons/family	St. Louis City	6	Race: 4 African American, 1 Caucasian, 1 multiracial Age range: 45–65+ Gender: 0 male, 6 female Family history of mental health services (self-report): 6/6 (100%) Family history of substance use services (self-report): 3/6 (50%)
	General community members	St. Louis City	17	Race: 13 African American, 2 Caucasian, 1 Multiracial, 1 Other/unknown Age range: 18–65+ Gender: 3 male, 14 female
Providers	Direct care community providers	St. Louis City and St. Louis County	22	Clinician and non-clinician frontline staff, and supervisors of community-based, acute care, and adjacent sector agencies providing supports or services to those with behavioral health concerns

Key stakeholder engagement, as well as inclusion of qualitative data prepared by Missouri Institute of Mental Health, the Women's Foundation of Greater St. Louis[5], and the St. Louis Area Violence Prevention Collaborative.

BHN leveraged notes including qualitative data generously provided by collaborating groups' recently conducted sessions. BHN worked closely with Gateway Housing First (GHF) to engage stakeholders working in and with histories of housing instability/homelessness. BHN drafted brief questions that address adult behavioral health and related housing concerns that were included in each of GHF's two sessions. BHN also collaborated with St. Louis Regional Health Commission to include data from the St. Louis Assessment and Triage Center Feasibility Study.

BHN systemically analyzed participatory group detailed notes taken in-session and physical products of engagement participatory group activities using a combination of techniques to ensure comprehensive review of qualitative products. Several phases of analysis and methods were involved in qualitative analysis for coding, including the use of pre-set codes (based on question set categories) and emergent codes developed using a grounded theory approach driven by responses (listing ideas or diagramming relationships, identifying word repetitions, keywords or quotes). This sought to illuminate common themes or patterns emerging, deviations from these patterns, role of environments or experiences related to their responses (e.g. health equity considerations or geography impact) and the need for additional data (including patterns that are similar to other or different from other report findings in the region).

Findings across all qualitative stakeholder participant types were assessed individually and in relation to one another to determine where commonalties and intersections emerged into major themes.

These reflect high levels of agreement and consistency within and among groups, however when the theme was discussed differently, these variations are emphasized and detailed.

Key Findings

Qualitative processes yielded rich findings, which are detailed further in the next section. Key findings noted here reflect consensus that emerged within and among stakeholder groups related to resources and assets, barriers and gaps, and opportunities in St. Louis adult behavioral health.

Prominent **resources and assets** identified included the domains of:

- Strong existing services and supports
- Expanded treatment services and settings
- Enhanced outreach and transitions of care
- Providers oriented toward and addressing behavioral health and recovery needs
- Collaborative provider relationships

Stakeholders then identified challenges and unmet needs that informed the following barriers and gaps.

Specific **barriers** that pose hurdles to accessing adult behavioral health assets included:

- Affordability of services
- Accessibility of services (physical access and communication)
- Availability of services
- Navigation
- Negative experiences and stigma

Gaps between needs and the systems services and supports included limited or lack of:

- Access and options for Behavioral Health Services

[5]Women's Foundation of Greater St. Louis. "I Hear You. I Am You. A St. Louis Region Listening Tour Report." 2017. www.wfstl.org/2017-listening-tour.

- Crisis prevention and response
- Intergenerational interventions and supports
- Services for specific populations
- Addressing broad recovery needs

Stakeholders also highlighted **opportunity areas** including:

- Enhanced access and navigation to behavioral health services
- Focus on follow-up and transitions of care
- Expanded training and public awareness
- Reducing barriers and environmental stressors

Detailed Findings – Resources and Assets

STRONG EXISTING SERVICES AND SUPPORTS

Across participants, individuals noted a substantial amount of adult behavioral health treatment services and options for behavioral health in the St. Louis region. Consumers noted that service delivery providers are numerous and varied in the services available. Specific provider resources noted across all stakeholder groups included:

- Clubhouses and psychosocial rehabilitation/illness management and recovery support day programs
- Community mental health centers
- Substance use treatment providers
- Hospitals

A high degree of awareness was noted across stakeholder groups of specific programs and agencies providing services. Consumers were particularly positive when describing providers with specialized services to work with particular needs or populations (such as substance use treatment providers serving women). Day programming and clubhouse services and opioid use disorder services were noted to be particularly strong in St. Louis City.

These settings provided services participants noted as essential, including:

- Case management
- Psychiatry and medication management
- Care coordination and referral and linkage
- Individual and group counseling.

Sessions with consumers with lived experience (specifically high utilizers of acute care engaged in diversion programming) indicated the above were among the most valuable services in addition to social and motivation support and barrier mitigation, such as transportation provided through in-community case management and flexible funding mechanisms. Consumers also noted positive experiences with provider guidance to housing and employment supports that were tremendously valuable to recovery.

Hospitals were flagged in all stakeholder groups as a primary resource for adult behavioral health concerns. Individuals discussed the benefits and challenges of this hospital role, highlighting the safety/respite and 24/7 nature of inpatient admissions and frustrations of needs often being un- or partially addressed in EDs, often escalating before greater support is available. Consumers and general community members also noted the value of referral and crisis hotline supports, as well as a need for greater support for navigation and connection to care. Notably, limitations in access and quality of services were noted as a key challenge in St. Louis City. All groups discussed geographic differences in the availability of or expansion of services, with areas in North City being identified those experiencing fewer resources.

EXPANDED TREATMENT SERVICES AND SETTINGS

Across all stakeholders, individuals noted that treatment services and service options regularly grow to respond to community need. The greatest increases in services noted include: substance use services (including Medication-Assisted Treatment and opioid use disorder services) and peer programming.

Additionally, stakeholders noted the growing range of settings in which services are delivered or mental health is addressed. These settings benefit adult behavioral health in both generating access to services and supports and in reducing stigma. A key example, was that of integrated behavioral health services within other care provider facilities, such as behavioral health consultant and team approaches and Medication-Assisted Treatment, both within primary care settings.

This growth was also noted as taking place in non-care settings. Community members also noted expanded mental health awareness in trusted institutions, particularly churches and faith-based settings, as well as in general community advocates through trainings like Mental Health First Aid and the Bridges to Care and Recovery program. Specialized training of law enforcement was described as beneficial, especially by consumers, when discussing crisis intervention. These expanded settings and domains in which behavioral health interventions are being strengthened allow for more effective community-level responses to behavioral health.

ENHANCED OUTREACH AND TRANSITIONS OF CARE

The regional strength of enhanced outreach and transitions of care efforts were noted as key community expansions. Across all stakeholder groups, outreach and care coordination (particularly "warm hand-offs") were emphasized as critical assets benefiting client outcomes in a complex system and for individuals facing complex needs. Consumers and providers discussed stronger transitions of care between care settings and at critical intervention points (such as post-opioid crisis/overdose) via outreach and transition-focused regional efforts (e.g. the Engaging Patients in Care Coordination (EPICC) Opioid Overdose Response Project). Consumers discussed such programming as helping when "I didn't know what to do next." Current and growing outreach efforts through faith-based institutions, community health, for homeless populations and hospital settings were highlighted.

PROVIDERS ORIENTED TOWARD RECOVERY OR SUPPORTING BROAD RECOVERY NEEDS

Strengths contributing to improved adult behavioral health included behavioral health and non-behavioral health providers that address a range of social determinant and environmental stressors towards recovery, though these were noted to be limited in availability and accessibility. As aforementioned, consumers with lived experience note that barrier mitigation, such as transportation and support for housing and employment, supports foster recovery. Consumers emphatically supported the concept that these needs are part of behavioral health and treating the "whole person." Moreover, providers who are culturally competent, trauma informed and understanding of the community context were seen as stronger and higher in quality by consumers and community members. Stakeholders across the board underscored the imperative for adults to see opportunities for recovery through peer engagement and meaningful positive activities which give them a link to the broader community.

> Organizations that offer barrier reduction increase service accessibility and enhance referral effectiveness.

Transportation assistance, home-based/in-community services, and navigation support within the system were reported to increase the likelihood of access to behavioral health services when and where they need it, preventing cycles of escalation. Consumers expressed the value of providers who deliver comprehensive treatment options and are able to address client needs beyond behavioral health needs, or accommodate these (e.g. after business

hour services or childcare). Consumers highlighted the positive outcomes associated with psycho-social education and interpersonal and life skills programming. Family and general community members noted the value of informal supports (such as family and social networks) and noted the asset of providers who engage with these natural supports, though training and support for family members was seen as limited.

Collaborative Provider Relationships

In discussing broader community strengths, providers also explained the benefits of collaborative community relationships with other agencies. Providers noted that a willingness to work collaboratively, formal and informal partnership with other agencies and opportunities for networking strengthened their daily practice and the system of care. Consumers, community members and providers noted the asset of referral networks and providers noted trusted relationships supported by consistent referral follow-through across behavioral health providers and care settings. Additionally, providers noted the presence of transitions of care programs previously discussed and Department of Mental Health special programs, such as Health Homes or Liaison programs (Community Mental Health Liaisons-CMHLs/substance use disorder liaisons-SUDLs) as cultivating opportunities for collaboration and strengthening service delivery options.

Detailed Findings - Barriers and Gaps

BARRIERS

While the aforementioned assets exist in the St. Louis City community, participatory group members noted significant difficulties in accessing theses resources. Reasons discussed are reviewed below, in order of priority established by participants.

Affordability

For adults, insurance access and coverage were noted to be key barriers, particularly without state-wide expansion of Medicaid. Cost of services (even those on sliding scale fee schedules) and follow-up medications were reported by consumers, family members and providers as fundamental challenges to engagement in care. Moreover, many discussed the cyclical nature this lack of access creates – for example, individuals may experience hospitalization, be discharged with referrals to community agencies and a prescription for medications, not fill those medications or access follow-up services due to cost, decompensate and return to hospital settings. Program options for the insured and underinsured that do not qualify for subsidized services but have limited coverage or face costly care options were specifically noted in family and general community member groups. Consumers noted the struggle of many adults with behavioral health concerns to meet basic needs and the stressors of choosing between items like food and housing and medications to maintain stability. Of note, consumers and providers discussed that funding for services is often unavailable without meeting specific criteria. For example, funds and treatment options are more available for those with opioid use disorders currently, but limited for other substances.

Accessibility

All stakeholder groups noted safe and affordable transportation as a significant barrier to accessing services. Even with public transportation present in St. Louis City, concerns such as cost and safety make utilization difficult. Transportation challenges are particularly present when multiple provider or service dates are needed to initiate or engage in services. Locations of services were emphasized as limited and perceived as not located in areas of high need, particularly far North and South City. The traditional model of office-based service delivery was seen as exacerbating these challenges as they require physically getting to and from services.

Additionally, the inability to contact or follow-up with consumers was raised across consumer and provider groups. Homelessness and frequent incarceration

were two notable challenges that posed barriers to consistent communication and access to providers, as well as limited consistent access to working phones.

Availability

Consumers, family members, providers and community members, noted an understanding of the limited capacity and long waits experienced by individuals seeking behavioral health services and supports. Connecting to accessibility challenges, many available services were reported to be limited due to not being available within the City or at ideal hours. This was seen as preventing engagement in services and contributing to high utilization of acute care (24/7) services.

Navigation

Stakeholders identified navigation challenges which included both the lack of knowledge about available services and how to access them, due to the complexity of the care system. Many providers indicated eligibility requirements, turnover of staff internally and across agencies, and challenges like lengthy and difficult applications for services or benefits, inhibit their ability to effectively and efficiently navigate consumers. Consumers and families noted that administrative hurdles and eligibility requirements result in frustration, delays/not receiving services and provider mistrust.

Negative Experiences and Stigma

Consumers raised significant concerns over provider perceptions of those with behavioral health needs, particularly substance use issues. Consumers, including high utilizers of acute care, discussed poor and disrespectful treatment in acute care settings. Cultural competence of providers in hospital and community-based settings and a need for peer supports were raised as systemic needs. Particularly among consumers and families, it was noted that negative past experiences provide a significant barrier to the act of treatment-seeking and ultimate engagement in services. These experiences often accumulate over time and are worse for those who may have been engaged in multiple sectors, such as criminal justice or social services. Past experience and cultural competence barriers were noted as significantly contributing to consumer distrust of providers and generate stigma even in perceived "safe spaces."

Stigma concerns were worsened by fear of labeling, medication-centered interventions, and concerns of legal or workplace implications of having behavioral health diagnosis.

GAPS

Qualitative data analysis of participatory sessions highlighted predominant themes related to unmet needs in St. Louis City adult behavioral health.

Access and Options for Behavioral Health Services and Supports

Across all stakeholder groups, the accessibility of behavioral health services was noted to be limited for St. Louis City adults. Participants noted barriers in multiple dimensions related to access including limited capacity, prohibitive cost, challenges with location and hours in which services were offered, and significant delays in treatment resulting in escalation of needs/symptoms.

Several specific behavioral health services were cited as limited and key gap areas. Lack of access to psychiatry and medication management access was the universal top area highlighted across stakeholder groups. Balancing this, consumers and family members underscored the need to support non-medical interventions such as counseling or clubhouse/psychosocial/illness management and recovery support models. Additional specific services or service delivery methods repeatedly named across stakeholder types included:

- Psychiatric access and medications
- Earlier identification and intervention

- Outreach/in-community services
- Services in critical geographic areas of need and to vulnerable populations
- 24/7 crisis access/response services (*see below*)
    - Acute/inpatient care
    - Longer-term care/after-care services, particularly following a crisis or from hospitals to community-based services (such as Intensive Outpatient Programs)
    - Co-located services in community

While many of the above encompass evidence-based practices, there was an explicit need identified by consumers and family members to expand evidence-based practices (e.g. dialectical behavior therapy) to promote access to services that are proven effective and provide options to consumers. Additionally, this was seen as an opportunity to promote higher quality of services by more consistent delivery of services and impact for the consumer.

Crisis Prevention and Response

Crisis presented as a key challenge in St. Louis City adult behavioral health. The related unmet needs encompassed both crisis prevention and crisis intervention. Discussion of crisis prevention identified a gap in early identification and early intervention in both the disease course and life course. General community and family members stressed a lack of early identification of needs. All stakeholders noted a concern that behavioral health needs are often addresses only when they reach crisis levels, engaging hospitals and law enforcement. As one consumer noted, "I had to become suicidal before they would do anything." Crisis response gaps were emphasized in the few options consumers, family and community members saw for those in crisis. Consumers noted a knowledge of limited options unless expressing a risk to themselves or others and indicated some endorse these symptoms in order to access services, despite lack of actual symptoms.

The need for a respite, detox or other safe spaces surrounding crisis were detailed across all stakeholders. Providers emphasized components of shelter, noting 24/7 safer, emergency shelter options were among the most dire needs, to strengthen opportunities to engage individuals towards stability. All stakeholders noted limited inpatient resources. Consumers also highlighted transitions of care support needs post-crisis, particularly from hospital inpatient to community, to foster connection to subsequent care. Consumers noted priority gaps in this arena for those who are most vulnerable – those newly diagnosed, not engaging in services historically, and those with limited financial or insurance supports.

Intergenerational Interventions and Supports

Consumers and family members noted that family-focused services are limited. Consumers and family noted the need for intergenerational approaches to address behavioral health needs of multiple family members.

Adult services were reported as rarely being geared toward recognizing the role of parenthood, particularly in the barriers residential treatment and in-community needs (e.g. childcare) present to service engagement. Family-focused approaches for adults also are insufficient in that family/caregiver education on behavioral health concerns/effective responses and engagement in adult services is not regular practice. This was reported by consumers to exacerbate stigma within families and did not serve to strengthen natural supports.

Services For Specific Populations

Another core gap area identified across participants was tailored services to vulnerable populations. When discussing these needs, consumers noted a need for training in services for and working with specific populations. Provider groups noted a need to increase expertise and cultural competency to

meet some of the specific needs/characteristics of consumers in the St. Louis area. Without this, feelings of mistrust or fear of the impact of seeking support are exacerbated. Adult populations with specific needs noted throughout qualitative data collection included:

- Vulnerable communities (Areas/zip codes experiencing high poverty and risk indicators – Far North St. Louis City and Far South St. Louis City)
- Criminal justice-involved individuals
- Transition-age youth and young adults
- Individuals with co-morbid behavioral health and physical health needs
- Individuals with co-occurring mental health and substance use needs/substance use populations
- Adults who are homeless or housing unstable
- Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ+)

Addressing Broad Recovery Needs

All stakeholders noted gaps in providers' current ability to meet the comprehensive recovery needs, that also frequently serve as barriers to engagement. All stakeholders also noted that many adults struggle to meet basic needs. Transportation was noted as a top barrier and insurance access and prohibitive service (especially medication) costs was a key hurdle to care. Housing instability and homelessness were also identified as factors that influence ability to engage in behavioral health services, by consumers, community members and providers. Simply put, these barriers themselves are unmet critical needs and intensify unmet behavioral health needs. Additionally, the issue of adults that do not have engaged family members and need to make greater legal decisions posed challenges, identified by consumers, family members and providers. Guardianship supports were named as a gap with barriers of difficulty and cost of guardianship, and few supports for those with a legal guardian who is not a family member.

Community members and consumers noted limited opportunity for positive community involvement and a need for psychosocial education and skill building for recovery and independent living.

Repeatedly, the role of community environment and violence were noted as prevalent issues and community members and providers called for expansion of trauma awareness and trauma related services in behavioral health settings.

Opportunities

ENHANCED ACCESS AND NAVIGATION TO BEHAVIORAL HEALTH SERVICES

Resoundingly, stakeholders noted that while there are many services in the region, system complexity makes these difficult to locate. Moreover, there exists a pressing need to increase capacity, improve timeliness and reduce restrictions so more people can access care when they need it. All stakeholder types noted a desire for additional programs and services for supporting existing and emerging adult behavioral health concerns, detailed in gap areas above. Consumers and community members noted a need for easier access to and support in navigating the complex network of services and supports to foster engagement (particularly when individuals are motivated to engage) and improve outcomes for adults with behavioral health concerns. Investment in referral and linkage hotlines and physical locations or other "navigator" roles were suggested as opportunities to more fully leverage services. While technology poses an opportunity for information sharing, consumers, family members and community members stressed the add value of one-on-one, personal support. Providers used the language of establishing stronger "front doors" and "no wrong door" as ways to make it easier for clients to navigate the behavioral health system.

FOCUS ON CRITICAL TRANSITIONS OF CARE

All stakeholders noted the possible impact of strengthened support at critical transitions of care. All discussed the importance in continuity of care and consistent follow-up as impacting consumer outcomes. These included creating or expanding:

- "Warm hand-offs" between provider staff and agencies at referral and linkage
- Longer-term supports through case management
- Intensive Outpatient Programs/Partial Hospitalization/ other "step-down" services

Additionally, expanding existing successful transitions of care programming discussed in resources and assets were noted. Relatedly, educating ER staff and the community about these programs was suggested. Utilization of collaborative care models was nominated to strengthen providers' capacity for care coordination within and across agencies to support client/family transitions and navigation of the service delivery system, particularly in primary care and behavioral health care settings. Consumer and community stakeholders noted successes to build on integrated behavioral health services in other care settings and community agencies (e.g. churches and primary care settings), and nominated that these models could be replicated and leveraged, particularly in St. Louis City.

EXPANDED TRAINING AND PUBLIC AWARENESS

All stakeholder types noted a need for greater education on behavioral health topics in the community. Community members and consumers particularly noted the opportunity to increase in public awareness of adult behavioral health topics, responses, and greater awareness of resources on a global level. These stakeholders noted the opportunity for subsequent stigma reduction to enhance treatment seeking. Opportunities to train in trauma, Mental Health First Aid, and general knowledge about mental health and substance use were nominated across consumer, family, and community member groups. Trainings that target behavioral health providers and non-behavioral health providers (e.g. physicians and law enforcement) in evidence-based models and cultural competence were similarly emphasized in consumer, family, and community member groups. Accentuating the need for provider training, high utilizers of acute care recommended education and training on mental health and substance use disorders to help mitigate the stigma they feel and subsequently improve care for themselves and others. Additionally, training and certification of peers in recovery might provide an opportunity for expansion of peer support programming.

REDUCING BARRIERS AND ENVIRONMENTAL STRESSORS

As previously noted, all stakeholder types stressed the opportunity to address the social determinants that impact adult behavioral health and service engagement. Opportunities included the possibility of transportation support and initiatives, partnering with and expanding community resources in addressing recovery needs, and funding provider ability to assist with basic/recovery needs (housing, food). Consumers nominated low-cost methods such as aiding consumers in apartment or job searches as beneficial to supporting the whole individuals and achieving improved outcomes. Advocacy strategies focusing on governmental funding and insurance access were also nominated.

Assets and Barriers

COMMUNITY ASSETS/STRENGTHS

Consumer

Increased treatment options

- Medication-Assisted Treatment (MAT)
- Detox facilities and programs
- Peer support programs
- Psychosocial Rehabilitation (PSR)

Strong existing resources and support settings

- Day programs and clubhouses
- Inpatient/outpatient services
- Hospitals
- Churches
- Programs for opioid users

Housing/shelter and homeless services

- Recovery housing
- Temporary/transitional housing
- Wraparound services
- Housing for pregnant women
- Rent assistance

Agencies addressing recovery needs:

- Primary care, mental health, and dental
- Transportation
- Food pantry
- Employment skills and vocational rehabilitation
- Social and general life skills
- Personal growth, acceptance, and confidence building skills
- Mental health education
- General education (e.g., GED)
- Referrals

Enhanced outreach

- Emergency Room Enhancement (ERE) Liaison
- Engaging Patients in Care Coordination (EPICC)

Increased support through criminal justice system

- Probation and parole
- Mental health court

Family

Increased treatment options

- Mental health and substance use
- Programs for opioid users
- Group and peer support programs

Strong existing resources and support settings

- Intensive outpatient care
- Dialectical Behavior Therapy (DBT)
- Inpatient care for individuals with severe psychiatric issues and poor treatment compliance
- Case management
- Respite services
- In-home care and home visits
- In-home skill development and daily activity training
- Private practice clinicians
- Community health centers
- Hospitals
- Churches
- Colleges/universities
- Suicide hotline
- Agencies that accept uninsured clients

Enhanced outreach

- Hospital outreach

Interpersonal support

- Families
- Parents

Community

Increased treatment options

- Medication-Assisted Treatment (MAT)
- Counseling
- Peer support programs

Strong existing resources and support settings

- Caretaker training and support
- In-home care/services
- Senior centers
- Churches
- Crisis intervention services and personnel
- Trained community members (e.g. Mental Health First Aid)
- Referral centers (e.g., 2-1-1)
- Employee assistance programs
- Urgent care clinic
- Emergency room (ER)
- Hospitals
- Inpatient and outpatient psychiatric care and facilities
- Skilled nursing care
- Rehabilitation facilities
- Schools
- Community center
- Private practice clinicians

Enhanced outreach

- Clinical and social service outreach
- Community health fairs

Housing/shelter and homeless services

- Wraparound services for individuals with housing instability
- Substance use treatment for women with children

Interpersonal support

- Family member
- Neighbor
- Friend

Provider

Increased treatment options

- Programs for opioid users
- Detox facilities and programs
- Medication-Assisted Treatment (MAT)

Provider collaborations/ programs

- Numerous providers and service options in the region
- Collaboration among providers
- Referral network
- Referral follow through
- Networking and partnerships among community providers
- Team approach to working with clients, and dedicated staff
- Highly educated and skilled workforce
- Health homes

Strong existing resources and support settings

- Wraparound services
- Holistic approach to recovery
- Schools
- Universities
- Housing First model
- Inpatient and outpatient services
- Community mental health centers
- Same day access
- Health clinics
- Psychosocial rehabilitation programs
- Clubhouses

Enhanced outreach

- Multiple outreach programs
- Homeless outreach
- Substance use disorder liaison (SUDL)

Assets and Barriers *(cont.)*

Consumer	Family	Community	Provider
BARRIERS			
Limited treatment options • Lack of available DBT treatment • Lack of funding for non-opiate substance users • Limited medication options • Lack of psychiatrists **Financial barriers** • Limited or no insurance coverage • Having insurance is a barrier to some services • Prescription medication and services cost too much **Provider accessibility and availability barriers** • Limited/inconvenient hours of operation • Long wait lists • Eligibility requirements • Provider administrative hurdles • Lack of ongoing support outside of hospital (at transition) **Consumer accessibility barriers** • Limited knowledge of available services • Lack of identification • No transportation • No phone • Criminal record • Motivation for change challenges **Housing/residential instability** • No rental assistance for alcoholics and non-opioid users • Limited housing options • Low affordable housing stock • Lack of homeless shelters and transitional housing for women **Family barriers** • No childcare • No support from family members	**Limited treatment options** • Lack of psychiatrists • Limited outpatient resources • Limited detox availability **Financial barriers** • Limited or no insurance coverage • Treatment/therapy is too expensive • Psychiatrist does not accept insurance **Provider accessibility and availability barriers** • Long wait lists • Many outpatient services are not in the city **Consumer accessibility barriers** • Limited knowledge of available services, including respite services for caretakers • No transportation • Denial and embarrassment due to mental health stigma • Lack of knowledge about mental illness • Not motivated to change • Inability to stay compliant with treatment • Feelings up hopelessness because of poverty environment • Frequent incarceration **Family barriers** • Difficult to obtain guardianship	**Financial barriers** • Limited or no insurance coverage • Treatment/therapy is too expensive **Consumer accessibility barriers** • Limited knowledge of available services • No transportation • No phone • Homeless/housing instability • Denial and embarrassment due to mental health stigma • Fear and lack of knowledge about mental illness • Do not trust medical establishment • No time	**Limited treatment options** • Lack of funding for non-opiate substance users • Physicians hesitant to prescribe mental health medications due to substance abuse concerns • Lack of physician knowledge about mental health intervention • Limited evidence-based peer support services **Financial barriers** • Limited or no insurance coverage • Private insurance does not cover case management services **Provider accessibility and availability barriers** • Limited/inconvenient hours of operation • Long wait lists • Lack of communication and care coordination between providers • Lack of health and food services in North St. Louis City and County • Case manager turnover • Eligibility requirements • Lengthy and difficult applications • Limited capacity **Consumer accessibility barriers** • Not aware of available services • Lack of identification • No transportation • No phone • Unstable health due to homelessness/housing instability and/or lack of ongoing support outside of hospital • Mental health stigma **Housing/residential instability** • Not enough emergency and overnight shelters • Long wait lists

Assets and Barriers *(cont.)*

Consumer	Family	Community	Provider
UNMET NEEDS/GAPS			
Treatment options • Medication and support for co-occurring conditions • Medication-Assisted Treatment (MAT) • Dialectical Behavior Therapy (DBT) • More individualized treatment plan options • Non-opioid substance use treatment (e.g., alcohol, methamphetamine) • More medical detox programs and facilities • More peer recovery counselors **Housing/shelters** • Need more shelters • Temporary housing for parents with children **Transportation** • Transportation to/from appointment and pharmacy **Cultural competence and sensitivity** • More crisis intervention team (CIT) officers • More respect from medical staff for those with substance use issues **Family support** • Childcare • Education and training for family members **Community resources and education** • Need more community centers • More public education about mental health **Legal assistance** • More disability lawyer assistance	**Treatment options** • Dialectical Behavior Therapy (DBT) • Suicide prevention for young adults **Social determinants of health** • Need to address community poverty and crime issues that lead to stress and trauma **Young adult services/programs** • Need more programs for youth transitioning to adulthood • More employment opportunities **Knowledge of available services** • Need assistance navigating the health care system **Transportation** • Transportation **Education and Outreach** • Public needs more education about mental health • More outreach to schools and neighborhood **Other** • Need more resources for those with Alzheimer's • Need more services, support programs, and education for parents and caretakers of individuals with severe mental illness	**Treatment options** • Support groups for clients, family, and caretakers • Trauma informed care • Need more clinicians that can recognize and diagnose mental illness • Need more psychiatrists • Suicide prevention for young adults **Financial** • Psychiatrists that accept Medicaid • Long-term care/treatment (e.g., insurance coverage is not long enough) • Insurance for medications **Follow-up** • Improved follow-up and ongoing care by providers and first responders **Social determinants of health** • Need to address community poverty and crime issues that lead to stress, trauma, and feelings hopelessness • Need better nutrition **Family support** • Support for parents/guardians in poverty, especially single parents • Support/services for entire family because stress, trauma, and mental illness runs in families **Transportation** • Transportation to/from services **Cultural competence and sensitivity** • Improved mental illness training for police and first responders **Advocacy** • Need to advocate more for mental health needs/concerns	**Treatment options** • Treatment for individuals with co-occurring diseases • Intensive outpatient psychiatric care for individuals with severe mental illness • Day programs • Longer-term psychiatric inpatient care • Greater focus on prevention • Need more screening and early intervention • Greater emphasis on continuity of care • Need more home-bound services **Family** • Need more services for clients' children because they are predisposed to mental health issues **Cultural competence and sensitivity** • Need more culturally competent providers, especially for non-English speaking clients **Accessibility** • Need more timely access to services **Financial** • Need more affordable medications (e.g., partner with pharmaceutical company for reduced price) **Housing/shelters** • Need more emergency shelters • Easy access to hygiene products/services **Legal assistance** • Need more funding for legal representation/assistance • More disability lawyer assistance **Guardianship** • More guardianship education for providers and clients

Assets and Barriers *(cont.)*

Consumer	Family	Community	Provider
VULNERABLE POPULATIONS			
Criminal justice-involved individuals • Need post incarceration programs and services • Need longer supply of medication post release from jail/prison • Need better medical treatment and medication while in jail • Need for housing for those with sex offense history **Pregnant women/parents** **Men** • Lack of available services **LGBTQ+** • Needs safe place free from discrimination • Sober living • Detox treatment **Youth and young adults** • Need psychosocial skill development • Prevention/Upstream	**Criminal justice-involved individuals** • Need post incarceration programs and services **Senior citizens** **Youth and young adults**	**Criminal justice-involved individuals** • Need post incarceration programs and health services **Youth and young adults** • Particularly African Americans **Individuals in violent/high crime geographic areas** **Homeless**	**Youth and young adults** • Especially those who are homeless, victims of violence, and in North St. Louis City **Men** • Limited services, especially for single individuals with no kids and no insurance **LGBTQ+** • Clients need a safe place • Young adults are especially vulnerable

Assets and Barriers *(cont.)*

Consumer	Family	Community	Provider
OPPORTUNITIES			
Workforce expansion • More psychiatrists • More recovery counselors • Certified MO Peer Specialists • More male role models, peer support, and counselors • Explore employment outreach options (e.g., VISTA volunteers, student loan forgiveness) **Cultural competence** • Better trained, and more culturally competent counselors **Expand program and service options** • More medical/substance use detox, including in hospitals • Long-term outpatient care • More in/outpatient treatment centers, doctors, and counselors • More in/outpatient groups and group options • Increase length of treatment **Services/programs for young adults** • Substance use treatment and psychosocial rehabilitation for young adults • Day program for young adults with mental illness • Programs for youth transitioning to young adulthood **Housing/shelter** • More housing and shelters for women, families, abused men, and disabled under 55 years old • Sober living for families • Housing with wraparound services • More non-section 8 leasing options • Felon friendly housing • MAT housing • More mental health support for those who are homeless	**Workforce expansion** • More health and social service navigators **Expand program and service options** • More mental health and substance use services • 24-hour service availability • Early life assessment and intervention • Address social determinants of health **Education and outreach** • Educate public about mental health • Campaign to reduce stigma	**Housing/shelter** • Homeownership instead of rent assistance • More housing and apartments **Access and navigation** • Simplify navigating the healthcare system • Develop a resource guide for residents • Educate public about available resources • Need a resource center in every neighborhood **Expand and improve programs** • Community centers with extended hours, and all health, employment, and social services under one roof • More support groups • More counseling • Referral services • Expand and improve ongoing treatment and follow-up **Social determinants of health** • Address social determinants of health, particularly crime/violence • Invest in neighborhood recovery programs **Employment and education** • More job training, and skill development programs • Invest in schools **Outreach** • Utilize mobile health units to raise awareness **Advocacy** • More mental health advocacy groups	**Treatment options** • More Medication-Assisted Treatment (MAT) centers • Methadone clinics • Medication subsidies • Treatment for non-opiate substance users **Expand program and service options** • 24-hour peer respite and drop-in centers • 1:1 case management with dedicated phone • More services for young adults • Increase behavioral health screenings and early intervention at hospitals and primary care providers • Counseling • Services for sickle cell/chronic illness population • Care that is customized to fit individual's needs • Youth prevention programs for clients' children • More helplines and assistance (e.g., housing, utilities, etc.) for individuals with severe mental illness • Holistic community-based programs focused on health, empowerment, employment, psychosocial skills, etc. • Childcare • Wraparound services **Housing/shelter** • Housing First • Safe and supervised 24-hour shelters that provide health and child care • More shelters and meals for men, women, families, and young adults

Assets and Barriers *(cont.)*

Consumer	Family	Community	Provider
OPPORTUNITIES *(cont.)*			
Transportation • Bus fare **Financial opportunities** • More funding/grants like STR • More insurance **Community resources** • More community resource centers and clinics **Education and outreach** • Educate public about mental health • Outreach to churches • More education for families and individuals with mental health and substance use issues **Family** • More support for fathers and families **Employment** • More employment opportunities **Phone/utilities** • More phone and utility assistance **Legal assistance** • Increase the number of affordable legal representation			**Housing/shelter** *(cont.)* • Family recovery shelters that offer counseling, education, and parenting skills • Support and assist churches wanting to become overnight shelters • Sober living **Evidence-based practice** • Require providers to take a competency course **Financial** • Partner with pharmaceutical company to reduce prescription costs • More funding **Outreach** • Increase public awareness of mental health issues and services **Legal assistance** • Holistic legal services

Voice of the Customer Report:

SUMMARY OF VOICE OF THE CUSTOMER AND STAKEHOLDER FEEDBACK SESSION

Background

On September 5, 2018, the St. Louis Regional Health Commission (RHC) hosted a public meeting regarding its 2018/2019 "Behavioral Health Assessment and Triage Center (BHATC) Initiative."

Specifically, 37 individuals provided detailed feedback in the initial drafts of the "Voice of the Customer", "Psychiatric Stabilization Center Lessons Learned", "Crisis Patient Flow", and "Environmental Scan" sections of the 2018 St. Louis Regional Behavioral Health Assessment at various "feedback stations." Stakeholders were asked to comment upon what key findings resonated with them, what seemed inaccurate or needed further clarification, and what elements were missing for a complete picture of the current state Behavioral Health "system" in St. Louis City/County. In addition, participants were invited to provide comments via email to RHC staff; subsequent emailed comments have been summarized with the feedback from the September 5 session in this document.

Overview of Stakeholder Input

1. Many respondents commented that the documents presented fairly represent their impressions of the current state of the behavioral health "system" in St. Louis. Very few edits were requested of the assessment draft (*edits noted below*). Most of the comments supported or amplified the key findings of the assessment as presented.

2. Several respondents stated that the system in 2018 much resembled the system described in the RHC's 2006 Behavioral Health Assessment, with the notable exceptions of new STR funding for opioid use treatment, and the new programs of the BHN.

Comments (recorded verbatim) provided on each section of the Assessment include:

VOICE OF THE CUSTOMER

"Same Issues – nothing has changed since 2007/2008"

- "Educational tools have increased (MHFA)"

"Access for new people is a real problem – capacity issues at CMHCs, ceiling on services"

"More support services (esp. Housing) needed to make any new crisis system work"

"Providers should have a fair share of "new" and "recurring" individuals – not happening in the system now – consistency at the CMHC level needed (access to care needed instead of ED use)"

"Patients feel like they are treated poorly in EDs for mental health needs – patients feel like they are rushed out of the EDs – need more compassion – now feel unwanted"

"Health care homes and integrated care – have had less of an impact [in St. Louis]"

"Newer Services for opioids – more funding through STR"

"Consumers should have greater voice when designing the system"

"Stigma still persists"

LESSONS FROM THE PSC

"Good attempt at a collaboration with DMH, SSM, BJC"

"Didn't have consensus on inpatient beds and crisis services – division in community politically – split the $$$ – no shared vision, with investment so low"

"Hospitals gained leverage because they benefited from beds; community didn't bring $$$"

"Where will a sustainable funding source come from this time?"

"Collaboration has to be biggest piece – financially sustainable model that supports vision"

- Map out funding sources
- Short-term acute treatment waiver from State
- Combining physical and mental health payment models

- Buy-in could be more of a barrier than geography
- Challenge: ED will still be path of least resistance for law enforcement
- Haven't matched access with patient needs for crisis
- Co-located with hospital for access

"Need different staff [than PSC] – needs to be independent and collaborative – training and culture"

"Need continuity of care model – hand off after hospitalization model"

"Not all beds are always staffed, so we don't have a true idea of access. Some people have to be isolated or have private rooms (e.g., transgender), so some beds are left empty. There aren't actually 50 staffed beds currently

"Bed space tight"

"4–6 day ED wait for psych access – we don't know what to do with these people"

"Shortage in workforce – especially culturally competent workforce"

"Need to create buy-in among law enforcement"

BEHAVIORAL HEALTH "SYSTEM" PATIENT FLOW

"Limited client choice in current system"

"Eligibility restrictions from referral organizations [are limiting]"

"Currently we have a wrong-door approach"

"Patients are expected to adapt to the system instead of the system adapting to patient needs"

"New patients can't access CMHCs for needs – jams the entire 'patient flow' as everyone else gets backed up"

"People in crisis/repeaters need social assistance – but none are available...people don't know how to follow-up"

"Patients don't have help to help them recover"

"No social worker or to help divert ED patients for behavioral health help...homeless are delivered to ED instead of community setting"

"More training for ED and law enforcement is needed"

ENVIRONMENTAL SCAN – COMMUNITY MENTAL HEALTH CENTERS (CMHCS)

"Key takeaway – St. Louis City/County community mental health providers serve a lower percent of the population that other regions of the State"

"Key takeaway – St. Louis City/County agencies do not utilize all of their potential dollars – yet they remain inaccessible to many (even with Medicaid)"

"Should we address why the under-utilization of dollars in St. Louis City/County? Does anybody know why?"

"State allocated dollars should be spent in St. Louis City/County"

"Data showing fewer people served per capita in St. Louis City/County doesn't account for acuity level or intensity level of services provided...should we address acuity or complexity in numbers served [in the report]?" (note – edit to assessment made based on this feedback)

"Why do we have such less service in St. Louis City/County...do St. Louis providers provide more services to less people, are people 'less sick' in St. Louis than other places in MO and need less care, or is something else going on?" (note – edit to assessment made based on this feedback)

"Resonates – the problem of STL Admin Agents not drawing down all their money – recommendation: to open up funds to other providers in St. Louis region to serve the population"

"Resonates – need for greater recovery – recommendation: development of more recovery/wellness services"

"Coordinated efforts should be looked at with all CMCH providers and affiliates"

"DMH should work with mental health community to provide access with excess funds"

ENVIRONMENTAL SCAN – SUBSTANCE USE DISORDER PROVIDERS

"Look for more co-located opportunities for SUD/hospital clinic partnerships"

"MAT clinics/walk-in models could be developed with STR funding"

"Ensure coordination between SUD efforts & FQHCs, CMHCs, SUD with Gateway & SUD funds"

"Need even more MAT services in the region"

"Need increased education and acceptance of recovery coaches and community health workers by hospital systems"

"More inpatient SUD services are needed – we need a bed available when the patient is ready"

"Additional support services and care management and therapy services are needed to prevent relapse"

"Good that services are increased, but still does not meet overall demand"

ENVIRONMENTAL SCAN – CURRENT CRISIS SYSTEM

"Currently do not have a crisis response model – more a referral system"

"What can BHR do to make the region's crisis beds utilized?"

"Need a better set of inclusion/exclusion criteria to better use of crisis beds"

"What exactly does BHR do in crisis cases?"

"We need to increase the number of crisis beds in St. Louis City/County"

"Need to identify why crisis bed(s) are not utilized and expand the beds"

"BHR requires patient to talk to BHR themselves to get served – often the patients aren't willing"

"Is there any law enforcement interaction with BHR?"

"Most don't know the services offered by BHR…does average public know to call BHR?"

"From an advocate's perspective, using the line, you don't feel 'coordinated'"

"BHR is an unnecessary middle-man"

"What are the outcomes – how well is it working – is there any data?"

"Are ED staff trained on BHR services and appropriate expectations?"

"Looks coordinated, but does not feel coordinated"

"[Crisis services] are not always accessible in our [hospital] facilities"

"Patients have to talk to many people, telling the same story"

"Data is needed on how well the services are working – we need outcomes"

"Only 1 crisis/respite bed that is under-utilized – this is a BIG need in our region – many not aware of the need"

"50% of the people said referral did not meet needs (MOBAP) – no connection with CMHCs"

"Evaluate more effective ways to work together with CMHCs for direct admit"

"Expand outreach for those who don't show for Next Day Urgent service – track it"

ENVIRONMENTAL SCAN – INPATIENT BEDS

"Why not admit we were wrong in decreasing psych beds and ask State to re-open acute beds?"

"Observation – BJC as largest health care provider has significantly less beds than other hospitals in the region"

"CMCHs and hospitals need to continue to work to refer for longer-term care"

"Challenges – wait times of 5–6 days in an ED is inhumane; seems like little coordination between inpatient and ED is occurring"

Recommendations:

- Improved coordination between ED and inpatient psych units
- Improve capacity to better serve psych patients
- Expand partnerships with Hospital Community Linkages (HCL) project – connect patients directly to CMHC – especially new patients
- Better partnerships for increasing number of psychiatrists, APNs in the region – shared staff and direct admits from CMHC with shared documents with privileges
- Improved communication/data sharing between inpatient and CMHC – alerting system so meds aren't completely changed, further de-stabilizing patient – longer scripts to support

ENVIRONMENTAL SCAN – EDS

"EDs have become the dumping ground for the entire system"

"Co-location of crisis services at the ED/hospital is important"

"Designate one hospital as a behavioral health ED and focus services there"

"Convince hospitals to invest in own staff"

"DMH needs to have community mental health providers step-up"

"Community needs to add transitional housing – up to 90 days"

"Better transition from ED to community provider – enhance ERE and add peers and behavioral health staff in ED"

"Expansion of all our roles – police/ED staff/Community provider – must reduce barriers"

"EDs take an increased role assessing, triage, stabilize – community providers need to be ready"

"St. Louis EDs are not set up to handle volume and complexity of care of behavioral health patients"

"EDs don't have the comprehensive services required to provide high quality, efficient care [to this population]"

- "One or two comprehensive crisis centers would work better than trying to get the comprehensive services in all EDs in the region"

"ED staff need mental health first aid training and a culture of 'YES'"

Observations:

- Given high boarding times for psych patients, EDs have a responsibility to create a better system to serve patients in a behavioral health crisis
- Facilities remain poorly equipped to address needs of behavioral health patients in St. Louis City/County"

Recommendations:

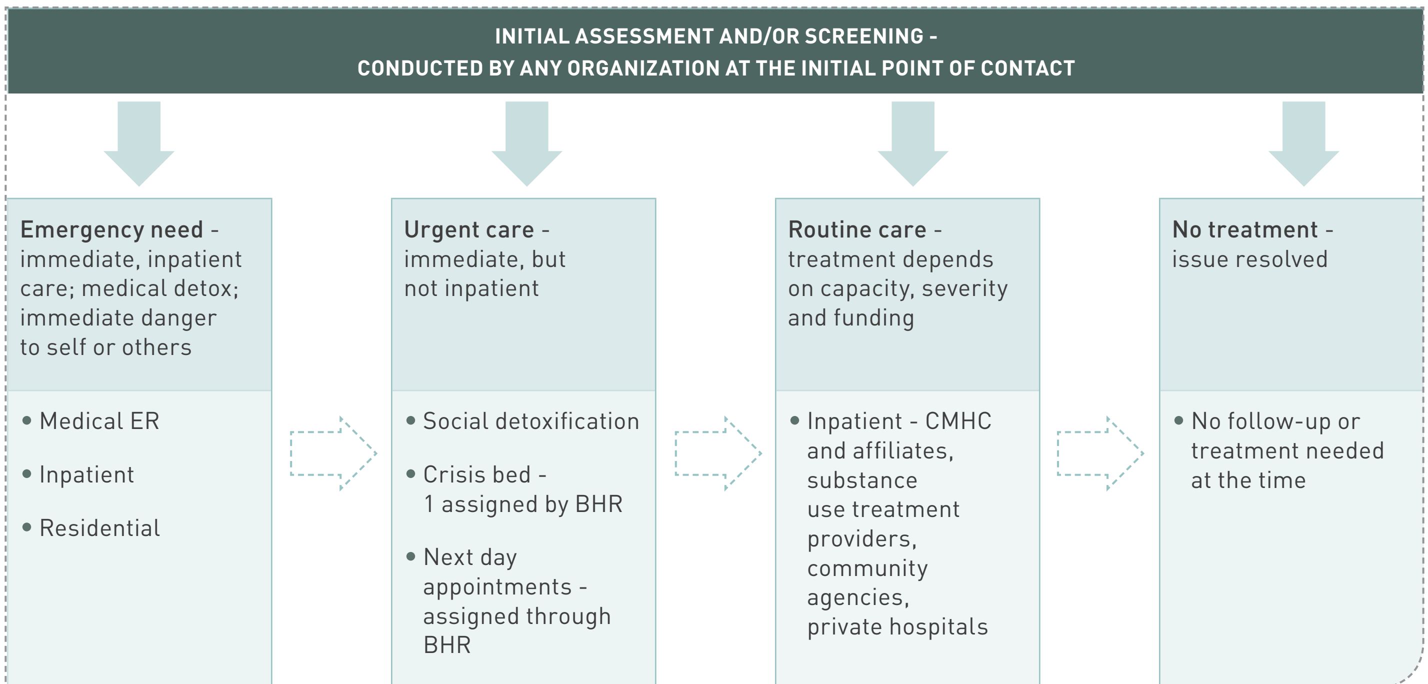
- Training for ED staff on working with behavioral health trauma and psych patients to reduce stigma with serving these patients
- Integrate special areas equipped with trained staff or consider co-located behavioral health clinic adjacent to ED for triage with CMHC patients
- More partnerships/co-location with SUD providers/ ED staff to support connection to care
- Due to increase in SUDs, train more physicians to start MAT in the ED and get expedited access to longer-term SUD services
- Consider supporting pay for housing models as done in other states to address high utilizers"

Crisis Patient Flow

Initial Point of Contact into the Crisis Behavioral Health System

Crisis Patient Flow

Initial Assessment and/or Screening



Community Mental Health Access Report

Key Conclusions

- Access to community behavioral health services for adults in St. Louis City/County, as currently provided, will be a significant barrier to the successful operation of a "Behavioral Health Assessment and Triage Center" (BHATC) for the region; however, potential to increase access to such services exists.
- Unless significant reforms are undertaken in the Eastern Region, a St. Louis-based "Behavioral Health Assessment and Triage Center" model may not be able to triage many of its patients to long-term community behavioral health supports, given the constraints of the current community-based "system" in St. Louis.
- Long term community-based behavioral health services are a key component of the operational model in Kansas City. While they have experienced similar access/capacity constraints in connecting individuals from the triage center, they have been able to operate due to the development of other supported services to include affordable housing options, crisis respite services, and funding to support case managers who treat the patient until they are able to be connected.
- Under the auspices of the BHN, area community mental health centers have recently been meeting to discuss collaborative efforts to increase access to care and integration in the Eastern Region. The BHATC model's success may be contingent upon successful implementation of these efforts.

Background/History

In 2006 and 2010, the St. Louis Regional Health Commission (RHC) and its partners created assessments of the community behavioral health "system" in St. Louis City/County (see *www.stlrhc.org* for full reports).

In 2017/2018, the RHC and its partners reviewed the key findings of these assessments with consumers/customers, stakeholders, advisory boards, and other community members, assessing if the key findings from these reports had changed over the past decade. In addition, recent operational data from regional community health centers has been reviewed by the Commission, its advisory boards, and workgroups in 2017/2018. Key conclusions from the assessments in 2006, 2010, and recent discussions/analyses indicate the following:

Key Elements of the St. Louis City/County Community Mental Health "System"

1. The potential to substantially increase access to community mental health centers providers

2. Inaccessibility of community mental health center access points

3. Relatively fragmented/non-integrated services between community mental health centers and primary care services, and between community mental health and substance use providers

4. Inadequacy of funding/access for non-Medicaid eligible individuals (non-disabled adults)

1. THE POTENTIAL TO SUBSTANTIALLY INCREASE ACCESS TO COMMUNITY MENTAL HEALTH CENTERS PROVIDERS

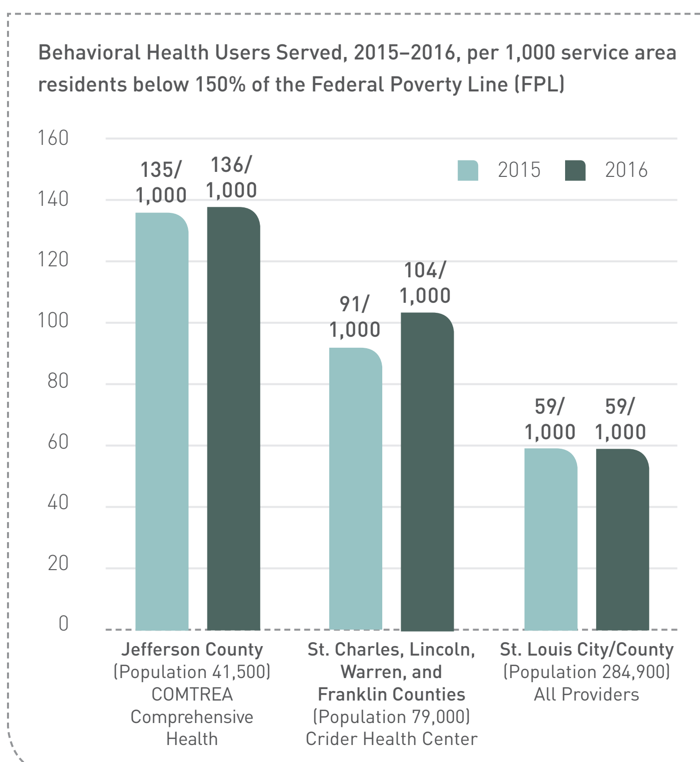
In 2016, the five community mental health centers (DMH sponsored Administrative Agents and Affiliates) in St. Louis City/County served nearly 16,000 people, in a territory of approximately 1.2 million people, as follows:

Community Mental Health Center	Individuals Served
BJC Behavioral Health Insurance	8,039
ALM Hopewell Center	3,558
Places for People	2,370
Independence Center	1,387
Adapt of Missouri	720

As a comparison, publicly funded facilities in Jackson County (Kansas City, MO region) served 13,574 residents for serious mental illness in a territory of approximately 692,000 people.

This variance in service rates is not new. In 2006, the RHC reported that "the money invested in the Eastern Region [includes Jefferson, St. Charles, Lincoln, Warren, Franklin Counties] public behavioral health system served a much lower percentage of the population than the percentage of people served in other regions of the state. For example, the state Comprehensive Psychiatric Services 2005 expenditures in the region served 7.5 citizens per 1,000 population (reported by the CPS Division) which is less than half the penetration rate of 15.9 per 1,000 observed in the Northwest Region (Kansas City region) and a statewide average of 12.4 people per 1,000. This finding may suggest the need for increasing community-based treatment options in the region."

As another comparison, in 2017, the RHC compared the number of people in poverty served by community mental health centers in St. Louis City/County, Jefferson County, and St. Charles/Lincoln/Warren/Franklin Counties, as follows:



As noted in the chart, community mental health centers in St. Louis City/County region provide significantly fewer services, per capita, to low-income individuals than their Eastern Region counterparts.

Note that this analysis does not account for the level of services provided to individuals, nor the acuity of the patient population, which may explain some of the variance noted between regions – further data collection and analysis by the State of Missouri and the BHN may be warranted.

Access for Newly Admitted Users to Community Mental Health Services in St. Louis City/County

The access issues in St. Louis City/County are even more pronounced when examining the ability of individuals newly needing services of the community mental health system. The community mental health centers in St. Louis City/County admitted 4,431 individuals in 2016 that were "new users" of the community mental health system. The Board of Probation and Parole in St. Louis indicates a greater than three-month wait for access to psychiatric services for individuals leaving the correction system in need of mental health treatment – often, clients do not receive such services due to this wait time.

Stakeholders interviewed during the "Voice of the Customer" process indicated that the limited focus on a "recovery model" by the St. Louis City/County behavioral health system is a systemic factor in limiting access to community mental health centers, especially for new users. According to consumers and some area providers, many community mental health center patients in the region are being seen for a lengthy timeframe, without discharge (or a "back-door"). One consumer summarized the thoughts of many when they commented, "once you are in the system, you are in forever"; another described the

experience as being "stuck in a spider's web." Hence, the available community mental health service slots in the region may be utilized by a relatively small number of individuals, and access is constrained for individuals needing new appointments.

In 2009, the RHC reported that "the majority of consumers (63%) within [community mental health providers] had been served for either less than one year or for over five years...the RHC recommends that the State of MO, BHN, and St. Louis community further analyze this data to understand if alternative service delivery to the "up to one year" and "greater than five year" populations may increase system capacity long-term." Such initiatives are still to progress in the Eastern Region.

Further research by the State of MO and the BHN into this dynamic may be warranted as community mental access initiatives are implemented in the St. Louis region in the future.

Under-Utilization of DMH Funding by Community Mental Health Centers in St. Louis City/County

In 2017, the Department of Mental Health (DMH), State of Missouri reported that two of the community mental health centers in St. Louis City/County were significantly underspending their potential DMH allocations each year, further showing the potential to increase access to community mental health services in St. Louis City/County.

For example, in 2017, the community mental health centers in St. Louis City/County did not "draw down" an estimated $3 to $6 million (net), a under-utilization of 10–15% of the total State community mental health center funds available to St. Louis City/County annually.

At the end of the fiscal year, these funds are reallocated to other portions of the State that do provide the volumes of services to justify this level of funding. As the State's annual allocation formula is based upon the number of people in poverty/need in each region, this "underspending" by St. Louis City/County community mental health centers is another key indicator of the potential to increase access to these services in the region.

Estimated "Gap" of Service in St. Louis City/County

According to SAMHSA's National Survey on Drug Use and Health: Model-Based Prevalence Estimates, 180 number of people per 1000 have had any mental illness in the past year, thereby potentially needing access to community mental health services. Applying this estimated to the St. Louis City/County region would equate to approximately 236,190 number of people in need of community mental health services in St. Louis City/County. The national estimates for adults with a serious mental illness in any given year is 5–7% of the population, or between 65,000 and 91,000 in St. Louis City/County.

As the safety net population served by the public system is approximately 25% of the total population, one can estimate that the total need for community mental health services in any given year for the safety net population is nearly 60,000 people; for severe and persistent mental illness, the estimates would be between 16,000 and 23,000.

As noted earlier, the community mental health system in St. Louis City/County reported serving nearly 16,000 individuals in 2016.

The conclusion that access to community based mental health services in St. Louis City/County is inadequate to the need is not a new one. In 2006, the RHC reported that:

"existing capacity for community based mental health and alcohol and drug abuse services is not meeting service demand."

"the Eastern Region served a much lower percentage of the population than the percentage of people served in other regions of the State…less than half the penetration rate observed in the Northwest Region (Kansas City region)."

"access to timely [community mental health] services is a problem throughout the mental health system. Long waits were reported by focus group participants – waiting thirty days or more to be enrolled in a service, and then enduring long waiting times when they finally secure an appointment with a provider… overnight stays in crowded emergency rooms are a frustrating experience."

Improvement Efforts Currently Underway

Certified Community Behavioral Health Clinic Model Implementation

In October 2015, Missouri was one of 24 states that received a Planning Grant from the federal Substance Abuse Mental Health Services Administration (SAMHSA). This grant prepared for implementing a federal demonstration project designed to pilot a Medicaid prospective payment system for community behavioral health services provided by organizations meeting new national standards for community behavioral healthcare. According to stakeholders, it is hoped that the new Certified Community Behavioral Health Clinic (CCBHC) model in Missouri may increase access to, and the quality of, community behavioral health in the years ahead.

However, according to DMH's website, "the Division of Behavioral Health (DBH) determined that 19 community behavioral healthcare organizations serving 25 of the state's 28 behavioral health service areas were in substantial compliance with the new federal standards for 'Certified Community Behavioral Health Clinics' (CCBHCs), and that they were eligible to participate in the Demonstration Project." To date, 15 organizations have moved to this new model in Missouri. Unfortunately, the two Administrative Agents in St. Louis City/County (*BJC Behavioral Health* and *ALM Hopewell*) have yet to participate in the CCBHC Demonstration Project. One St. Louis-based affiliate, Places for People, is participating. The State of Missouri has made additional funding available for community mental health centers that are participating in the CCBHC model. It is hoped that as the CCBHC model is required and then implemented by DMH across all community mental health centers in the State, access to services will improve in St. Louis City/County.

Initiatives of the Behavioral Health Network of Greater St. Louis (BHN)

One of the major outcomes of the 2009 RHC planning process was the formation of the BHN, which now serves as the regional planning and coordinating body for behavioral health services in the Eastern Region. Under the auspices of the BHN, area community mental health centers have recently been meeting to discuss collaborative efforts to increase access to care. It is hoped that concrete plans for improvement will be developed by the region's community mental health centers, vetted with consumers and community stakeholders, and implemented in the near future.

One emerging best practice for the region has been the development of a collaborative model with regional community mental health centers – the Emergency Room Enhancement (ERE) Initiative. The ERE project, coordinated by the BHN, facilitates an integrated 24/7 region-wide approach that targets high utilizers of emergency room and inpatient settings, with the primary goal of reducing preventable hospital readmissions. BHR (who serves as the Eastern Region's Access Crisis Intervention provider) is a key partner, providing after-hours/weekend scheduling, as well as telephonic and mobile outreach crisis services for consumers referred to the ERE project.

Each of the seven Eastern Region CMHCs have designated at least one person to participate on the ERE Outreach Team. While the ERE Outreach Team members are employees of their "home organizations," they focus their work on ERE Outreach, receive referrals and guidance from the ERE Outreach Coordinator, and participate in weekly Outreach Team meetings to strategize about ERE clients and receive ongoing training. The team performs time-limited, focused outreach services for clients engaged with the ERE project, including: rapid identification, assessment, and referral at point of contact; crisis intervention services and coordination of care to community services based on need; and use of "Flex Funds" to address client engagement barriers. Substance use providers facilitate access to treatment for individuals with a co-occurring substance use/mental health diagnosis. In order to improve coordination, the ERE project connects with two other successful community projects – the Integrated Health Network's Community Referral Coordinator (CRC) program and DMH's Community Mental Health Liaison project (which collaborates with police Crisis Intervention Teams, CIT).

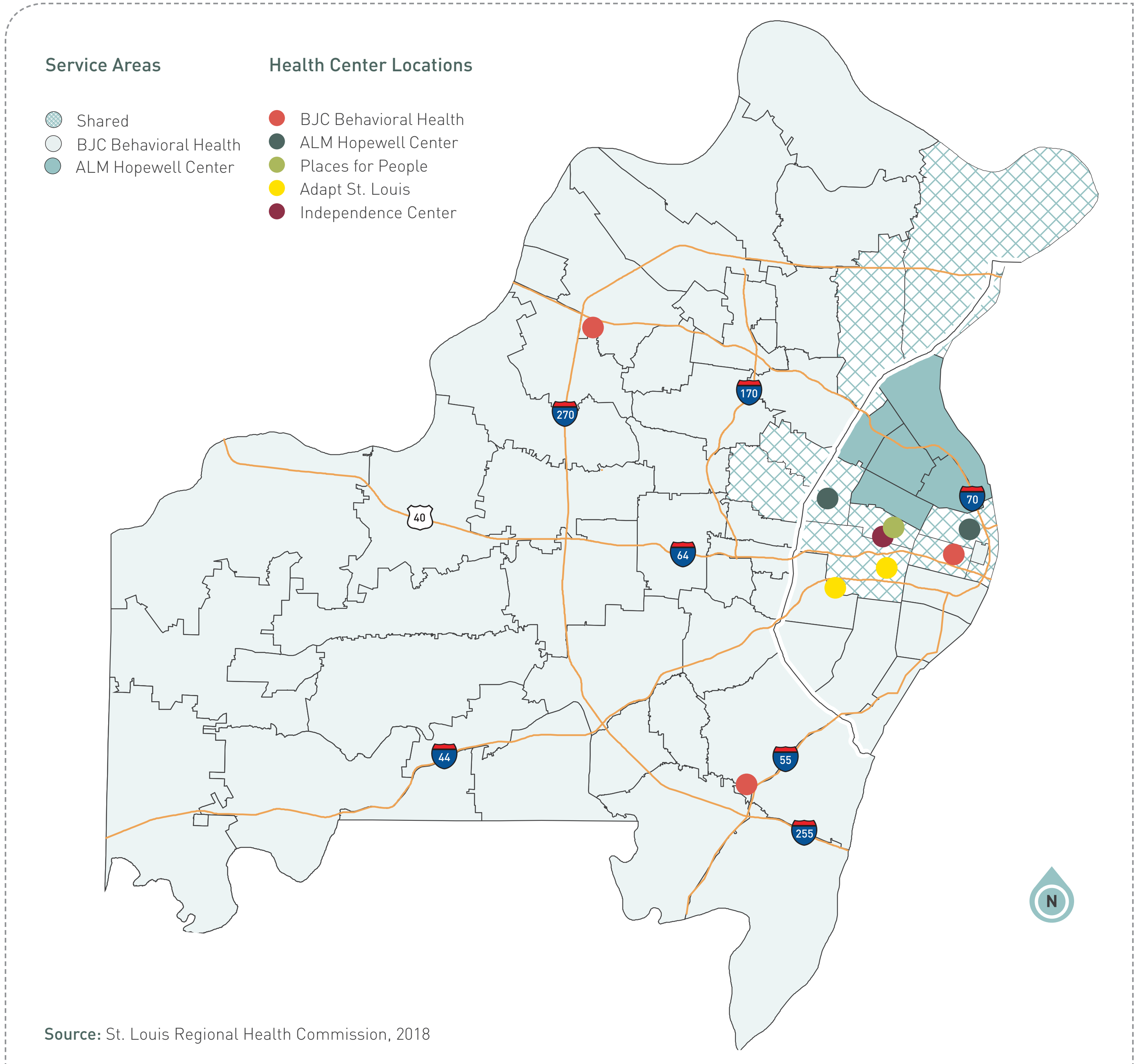
2. INACCESSIBILITY OF COMMUNITY MENTAL HEALTH CENTER ACCESS POINTS

Community mental health centers in St. Louis City/County operate at nine main locations for the adult population:

- BJC Behavioral Health (Central) – Downtown St. Louis (14th and Olive)
- BJC Behavioral Health (North County) – Bridgeton (McKelvey)
- BJC Behavioral Health (South County) – Green Park (South Lindbergh)
- ALM Hopewell – Downtown St. Louis (14th Street)
- ALM Hopewell – West End (Delmar Blvd.)
- Places for People – Mid-St. Louis City (Lindell & Sarah)
- Adapt St. Louis – South City (Hampton)
- Adapt St. Louis – Forest Park Southeast (Chouteau Ave.)
- Independence Center (Forest Park Ave.)

See next page for Community Mental Health Center in St. Louis City and County Map. ▶

Map 8: Community Mental Health Centers in St. Louis City and County



Source: St. Louis Regional Health Commission, 2018

A central theme of all previous assessments has been the lack of geographic access to community-based mental health services in St. Louis City/County. Major population areas of high need, such as North City, much of North County, and South City have difficulty accessing the limited number of community mental health sites, which are not located near their neighborhoods. This factor is compounded by the poor public transportation options in these areas, as chronicled in previous RHC and partner assessments.

Limitations of the Administrative Agent Structure in St. Louis City/County

In Missouri, individuals are designated to receive state-funded treatment from community mental health centers based upon the zip code in which they live, which is called the "Administrative Agent" structure. Client choice for community mental health services is often limited by the individual's home address, due to how State payments "flow" to community mental health centers.

There are fewer administrative agents in the St. Louis region than in the Kansas City region. Kansas City has five administrative agents (Truman Medical Center Behavioral Health, Swope Health Services, Tri-County Mental Health Services, Comprehensive Mental Health Services, and ReDiscover), while St. Louis has only two administrative agents (BJC Behavioral Health and ALM Hopewell Center) with three additional affiliates (Places for People, Adapt St. Louis, and Independence Center).

In 2009, the Commission unanimously approved a set of recommendations to improve behavioral health services in the Eastern Region of MO. The first recommendation was to "increase consumer choice when seeking behavioral health services," with the top priority that "individuals may seek services from any Eastern Region administrative agent or affiliate regardless of where they live in the Eastern Region." However, stakeholders report that a patient's place of residence remains a barrier in accessing community mental health services in the Eastern Region.

3. FRAGMENTED/NON-INTEGRATED SERVICES BETWEEN PRIMARY CARE AND COMMUNITY MENTAL HEALTH CENTERS, AND BETWEEN COMMUNITY MENTAL HEALTH AND SUBSTANCE USE PROVIDERS

In its 2006 report, the RHC reported limited coordination between the behavioral health care system and the physical health care system, as well as limited coordination and awareness between mental health and substance abuse providers. This status was reiterated in the RHC's 2009 work and in subsequent documents from the BHN.

This lack of service integration is complicated and compounded in St. Louis City/County due to the organizational fragmentation of the health care safety net in the region. As a comparison, in Jefferson County, the Federally-Qualified Health Center (FQHC), DMH community mental health Administrative Agent, and DMH-funded substance use disorder C-STAR provider are all under the umbrella of one organization (COMTREA), which then receives Jefferson County Mental Health and Children's tax funding directly. In St. Louis City/County, there are four FQHCs, one Public health department (St. Louis County) providing primary care services, two Administrative Agents (community mental health centers), three affiliates of the Administrative Agents, and seven State-funded substance use treatment providers, with local mental health taxes being separately managed by two stand-alone "authorities."

In 2009, the RHC recommended that providers should begin to "combine services into 'one-stop shops'...by increasing services though collaborations, partnerships, affiliations or mergers." However, the St. Louis City/County safety net system remains highly fragmented, with programmatic or operational gaps between providers serving the same population base.

Progress toward integration has been made in recent years, including the merger of Community Alternatives and Places for People, the merger of Betty Jean Kerr People's Health Center and Hopewell (an Administrative Agent in St. Louis City), new expansions of mental health services by FQHCs, and formal service partnerships between community health centers and community mental health centers, such as Places for People/Family Care Health Centers and BJC Behavioral Health/Affinia.

In addition, the programs of the BHN bring together providers in a highly collaborative manner to serve the region and have become a national best practice for regional coordination.

Despite progress, the organizational complexity and fragmentation of the system in St. Louis City/County remains a challenge. Without significant reform concurrently, a new "Behavioral Health Assessment and Triage Center" will have significant challenges triaging consumers/patients into a community-based setting, not only due to an inadequacy of access, but also due to the complexity and fragmentation that currently exists in St. Louis City and County.

4. INADEQUACY OF FUNDING/ACCESS FOR NON-MEDICAID ELIGIBLE INDIVIDUALS (NON-DISABLED ADULTS)

In 2006, the RHC's Behavioral Health Assessment concluded that "due to the way funding of mental health services flows from the State's Department of Mental Health, individuals with mental illness in the safety net system are often unable to access care unless they are in a crisis situation, or have a diagnosis of 'severely and persistently mentally ill.' As a result, the system has been forced to increasingly rely more on inpatient – or ED – care, instead of providing less restrictive care before individuals are in a crisis. Because of specific State guidelines that dictate who qualifies for state funded services, individuals who suffer from non-chronic, non-crisis illness rarely receive treatment in the public mental health system."

This factor is complicated in St. Louis City/County due to the imbalance of funding and focus on children's services vs. adults. In Missouri, children can be covered up to 300% of the Federal Poverty Level (FPL) by Medicaid; generally, adults are not covered by Medicaid unless disabled, pregnant, or a parent that makes less than 19% of FPL (or less than $5000 annually). Also, in 2008, St. Louis County voters established a sales tax that generates approximately $40 million annually to support children's mental health services. This imbalance in funding is compounded by the fact that the St. Louis County Children's fund does not reimburse providers for mental health services for parents of children, unless the child is present during the session.

Not surprisingly, area mental health providers have shifted their focus to providing mental health services to children in response to these significant funding incentives. Recent expansions, such as the new Lacy Clay Center for Children's Health (*operated by Hopewell*) and school-based health centers, have focused on these new revenue opportunities.

While serving children is a laudable endeavor, behavioral health science is clear that, in many instances, the impact of services to children has limited efficacy without concurrent treatment to the adult family members who may be experiencing the impact of mental illness, substance use disorders, toxic stress, and/or trauma. Also, the imbalance in funding between adults and children only exacerbates the systemic access issues faced by community-based mental health services that serve the adult population in St. Louis City/County, as providers have shifted their hiring/staffing practices toward children's mental health services. More analysis in this area is warranted by the State of Missouri, BHN, and mental health funders in the future.

Substance Use Disorder Providers Report

Key Conclusions

- Significant progress has been made in recent years in the availability of substance use disorder treatment in St. Louis City/County for individuals who are insured or use opioids. There is still a gap for individuals who are uninsured or have other substance use disorders.
- Several important programs have been created and have succeeded in St. Louis City/ County in substance use disorder treatment; these programs should be supported, grown, and not replicated, as improvement efforts are undertaken.
- Any new Behavioral Health Assessment and Triage Center will have important supports already in place (e.g. substance use disorder treatments) to enable the model's success..
- Significant challenges remain to the "system," including an inadequate number of residential/ detox beds, limited housing options for substance use disorder clients, and an underdeveloped system of outreach for those needing, but not actively seeking, services.

Background/History

In 2006 and 2010, the St. Louis Regional Health Commission (RHC) and its partners created assessments of the community behavioral health system in St. Louis City/County (see *www.stlrhc.org* for full reports).

In 2018, the RHC and its partners reviewed the key findings of these assessments with consumers/ customers, stakeholders, advisory boards, and other community members, assessing if the key findings from these reports had changed over the past decade. In addition, recent operational data from regional providers has been reviewed by the Commission, its advisory boards, and workgroups in 2017/2018. The following is a summary of the conversations and analyses:

Key Elements of the Behavioral Health System for Substance Use Disorders

Substance use disorder is a maladaptive pattern of substance use leading to clinically significant impairment or distress. The Department of Mental Health provides public substance use disorder services through a network of contractors who operate treatment and detoxification programs.
St. Louis has eight DMH-contracted substance use providers in the region (*Preferred Family Healthcare, Queen of Peace Center, West End Clinic, Assisted Recovery Centers of America (ARCA), BASIC, Center for Life Solutions, Gateway Free and Clean, New Beginnings*). In addition, many providers do not contract with DMH and provide important services to safety net clients in the community, including various community health centers (FQHCs), counseling agencies, and private, for-profit and not-for-profit practitioners.

Despite the efforts of this network of providers, in 2006, the RHC reported that a significant gap existed between the number of people needing substance use disorder treatment and the ability to serve them in the region, with a "conservative" estimate of 70% of the individuals dependent on substances going untreated in any given year.

Specifically, national estimates state that approximately 10% of the population in the United States is classified as needing substance use treatment (see *https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.pdf*). Applying these estimates to St. Louis City/County, one can estimate that more than 120,000 individuals misuse or are dependent on substances. Assuming that the need for services is at least as high for the safety net population in our region, it can be estimated that at least 40,000 safety

net individuals in St. Louis City/County need treatment for substance use disorders. As a comparison, the two largest non-profit, DMH funded substance use disorder centers in St. Louis, Preferred Family Heath Care and Queen of Peace, reported serving 8,000 individuals in 2016 in the RHC's most recent Access to Care Book (see *www.stlrhc.org*).

The burden on the health care system and the behavioral health system, in particular, has only intensified since 2016, with the well-documented rise of opioid addiction over the past decade.

In fact, St. Louis has seen more of a burden than other regions in the State, as:

- St. Louis City and St. Louis County are ranked the highest in the state for total number of overdose deaths, with St. Louis City ranked the highest of five counties for death rate. The top three counties with the highest mortality rate are in the St. Louis metropolitan area.
- According to Missouri Hospital Association, the highest statewide rates of hospital utilization for opioid overuse are in the St. Louis metropolitan area.
- A vast difference in opioid related overdoses and death rates exists between the Eastern Region and Western Region (Kansas City) of Missouri. For example, in 2015–2016, the Eastern Region had 1,030 drug overdoses, a rate of 22.7 per 100,000, while the Western Region had "only" 217 overdoses, a rate of 7.9 per 100,000.[6] In 2017, St. Louis City and County had 1,589 deaths, while Jackson County had 308. *Note: this higher burden of disease is an important factor to consider as comparisons to the "Kansas City" model are made during the "Behavioral Health Assessment and Triage Center(s)" planning process.*

Substance use disorder has particular treatment challenges: unlike most other diseases, only 10% of the people needing treatment actually seek treatment at any given point. The lack of treatment-seeking increases the importance of investments in outreach and ongoing case management/support to ensure a person enters into and remains in a treatment setting.

Advancements in substance use disorder treatments since 2006

Since the 2006 RHC Behavioral Health Assessment, several important advancements have been made to improve the treatment of substance use disorders in St. Louis City and County. These models offer important linkage points for any new Assessment/Triage Center, provide models for future investment so regional leaders do not have to "recreate the wheel," and offer hope that the referral process for individuals needing assistance may be successful. These improvements include:

MISSOURI OPIOID STATE TARGETED RESPONSE (OPIOID STR) PROJECT

The Opioid STR project has expanded access to integrated prevention, treatment, and recovery support services for individuals with opioid use disorder (OUD) throughout the State, with strong support being delivered to St. Louis City/County. The primary focus is on rigorous, multidisciplinary provider training and education on evidence-based treatment services to uninsured individuals with OUD presenting for care within state-funded programs. Primary prevention activities center on increased awareness and decreased availability of opioids, led by local agencies in high-risk areas. Prevention of overdose deaths is accomplished through training clinical providers and at-risk individuals on overdose education and Naloxone Distribution practices, and providing telemedicine didactic and consultation services to primary care providers treating chronic pain. Recovery support services are provided in the form of Recovery Community Centers, recovery housing, and recovery management checkups, all delivered with a focus on peer engagement. The State of Missouri DMH is leading the project, with administration, implementation, and evaluation activities provided by the Missouri Institute of Mental Health (MIMH) – University of Missouri, St. Louis, as well as healthcare agencies, additional academic institutions, and content experts throughout the state.

[6]Vital Stats DHSS

The initiative has provided more than $20 million over two years in the State of Missouri for substance use disorder support. As a result of this investment, and other initiatives listed below, some uninsured adults that seek treatment have access within 48 hours, especially priority populations, such as pregnant women, IV drug users (*use last 30 days*), and Department of Corrections referrals noted as high risk.

Stakeholders have reported that concerns are being raised that with the emphasis on opioid treatment, individuals seeking treatment for other drugs/alcohol are experiencing longer wait times; further research by the State of MO and/or BHN may be warranted in this area.

THE EPICC OPIOID OVERDOSE RESPONSE PROJECT

Through Opioid STR funding and a collaboration of regional substance use treatment providers and area hospitals, the BHN has piloted infrastructure to expedite access to Medication-Assisted Treatment (MAT) and coordination of care from EDs to community-based settings. EPICC (Engaging Patients in Care Coordination) creates access to MAT, Recovery Coach peers, and other treatment services for those who present with or recently experienced an opioid related overdose. Recovery Coaches perform outreach 24/7. They accept referrals, enhance engagement, and maintain contact in order to support retention in services, foster recovery, and reduce overdose rates that have reached epidemic levels in the Eastern Region. EPICC also works closely with MO Hope Project to provide opioid overdose education and distribute Narcan (a medication that blocks opioids and reverses overdose) to prevent overdose and reduce harm.

EMERGENCY ROOM ENHANCEMENT (ERE) INITIATIVE

The ERE project, described more fully in the "Community Mental Health Center" section of this report, also advances access to substance use services, as many of those served by the ERE project have co-occurring (mental health and substance use) needs.

MEDICALLY-ASSISTED TREATMENT (MAT) ENHANCEMENTS FOR OPIOID USE

Since 2006, the science of substance use disorder treatment has evolved. Now, as its clinical efficacy is more widely understood, MAT for opioid use is becoming more widespread and accepted. Recently, community health centers in St. Louis, with the assistance of STR funding and other supports, have been training primary care physicians to better manage substance use disorders in the primary care setting. While still an emerging practice, this advancement will substantially increase access to services.

However, as of 2018, St. Louis has a shortage of physicians with the necessary training and certification to provide this treatment. As enhancements to the crisis-system are made through the BHATC initiative, training primary care providers in substance use disorder treatment will be a critical point-of-service and collaboration.

Continuing Challenges of the System – 2018

- The Federal Medicaid Institutions for Mental Diseases (IMD) exclusion:

A Federal regulation, called the "IMD exclusion," prohibits the use of federal Medicaid financing for care provided to most patients in mental health and substance use disorder residential treatment facilities larger than 16 beds. The exclusion is one of the very few examples of Medicaid law prohibiting the use of federal financial participation (FFP) for medically necessary care furnished by licensed medical professionals to enrollees based on the health care setting providing the services. The exclusion applies to all Medicaid beneficiaries under age 65 who are patients in an IMD, except for payments for inpatient psychiatric services provided to beneficiaries under age 21. Furthermore, the exclusion has complicated efforts to use Medicaid to provide nonhospital inpatient behavioral health services. Due in large part to this restriction, residential treatment and detox beds are limited throughout the St. Louis region, as providers limit their capacity to no more than 16 beds due to financing limitations.

- As documented elsewhere in this report, St. Louis has limited housing options available with a structured living environment for those with a substance use disorder. To add to the shortage, many available beds are only available for women or have strict guidelines for remaining in the facility, leaving EDs and/or correction facilities as the place of last resort when individuals reach a crisis state in their disease.
- Treatment agencies have noted that engaging and retaining individuals in treatment after the initial visit has been a challenge, which may result in repeat overdoses or emergency room visits.
- Community behavioral health providers have noted the challenge of offering the necessary outreach services to the most vulnerable populations needing substance use disorder services, especially as 90% of the individuals needing treatment do not seek it at any given point in time. The limited financial models for outreach services will be a significant constraint to any crisis model being recommended by BHATC stakeholders, as individuals will continue to intersect with the law enforcement/EMS/ED systems until effective outreach services are co-currently developed in the region.

Emergency Department Access Report

Key Conclusions

- Missouri Hospital Association (MHA) data identified 8,726 unique patients in the region who had more than one ED visit with a substance use disorder (SUD) and serious mental illness (SMI) or co-occurring diagnoses during the same time frame, representing the potential target population for an Assessment and Triage Center.
- Despite almost twice the total annual number of ED visits for SMI patients as compared to SUD patients, it appears that the high-utilizer SUD patients have an outsized impact on ED utilization.
  - SUD patients with six or more ED visits represent between 13–14% of the total ED visits, while SMI patients with 6 or more ED visits represent between 7–8% of the total annual ED visits.
- Payor mix challenges exist for hospital EDs serving a high proportion of SUD patients vs. SMI patients.
  - 72–79% of SMI patients have some form of insurance
  - Less than 60% of SUD patients have a payor source
- Access to the ED and a required medical screening exam does not guarantee evidence-based or timely behavioral health care in that setting, due to long boarding times and a lack of coordination with downstream behavioral health providers.

ED Analysis

According to the RHC's 2017 Access to Care Book, 18% of total ED encounters are for individuals with a behavioral health diagnosis. Significant ED data suggests that individuals with behavioral health issues, including SMI and SUD, have major challenges accessing services in the City of St. Louis and St. Louis County. In November 2017, the Missouri Hospital Association's St. Louis Metropolitan Hospital Council (SLMHC) reviewed ED-level data from its member facilities along with RHC's Access to Care report.

FINDINGS INCLUDED:

- Behavioral health-related ED encounters in the St. Louis region increased 55% over a five-year period between 2011–2015, with a spike of growth (11%) from 2014 to 2015. This accounted for 32% of the total ED encounters in 2015.
  - More recent MHA data shows a 6% decrease in SMI visits, but a 3% increase in SUD visits between 2016–2017, indicating more need for crisis intervention for substance use patients.
- Approximately 8,500 unique individuals in the region had more than one ED visit with a SUD or SMI diagnosis in the 2014–2016 calendar years. SUD reoccurring users (individuals that visit the ED six or more times) represent 13–14% of total annual ED visits, and SMI reoccurring users represent 7–8% of total annual ED visits.
  - Current MHA data indicates a decrease of 3.8% in the total number of unique individuals with behavioral health visits from 2016 to 2017. The same data indicates this is also true specifically for SMI visits. In contrast, repeat ED visits for SUD increased by 4%.

Recent MHA data provided for this feasibility study indicates average ED boarding times of 7–8 hours for behavioral health patients needing inpatient beds, with patients having to wait 5–6 days in some instances.

- The impact of boarding is costly both in terms of quality and financially. In 2015, The Joint Commission discussed the impact in a "Quick Safety" brief on psychiatric care in EDs. Boarding behavioral health patients:
  - Increases psychological stress on patients who may already be in depressed or psychotic states
  - Delays mental health treatment that could mitigate the need for a mental health inpatient stay

- Consumes scarce ED resources
- Worsens ED crowding
- Delays treatment for other ED patients – some of whom may have life-threatening conditions
- Has a significant financial impact on ED reimbursement

ED providers and hospital administrators in St. Louis noted not only the increasing numbers of behavioral health patients they treat each year, but that their facilities remain poorly equipped to address these individuals' needs because of a variety of issues, including regulations, policies, training, culture, stigma, and the lack of integration and connectivity to other settings in the community.

- During voice of the customer stakeholder engagements, consumers and families noted the lack of integration and service connection as major barriers to escaping a repeated cycle of ED visits (see *Voice of the Customer Report*).
- Several consumers and family members talked about the ED discharge process, which involved getting a list of resources from the hospital social worker and/or case manager. They noted the lists were usually very generic and included information that did not apply to their individual needs, had outdated contact information, and left them frustrated with their seemingly few options to access needed services.
- Hospital staff reported frustration concerning the lack of knowledge and/or ability to connect patients to services and social supports. Providers highlighted that the SMI and SUD utilizers they saw most frequently were either patients who were persistently mentally ill, or consumers who seemed to be "trapped in the ED revolving door." Consumers, families, and providers were all frustrated by the current crisis system that kept leading them to the ED.
- Additionally, stakeholders noted that although therapeutic management of behavioral health patients in the ED presents unique and complex issues, there does not appear to be a defined set of diagnostic tests that can be ordered to determine the course of care, and many facilities do not have the on-site services necessary to provide appropriate care. Nor does every providers have a recovery or trauma-informed orientation, training or waiver for Medication Assisted Treatment, or adequate access to consults from specialty providers.

The following table from MHA shows behavioral health usage for EDs for 2015–17, as follows:

Table 4. Behavioral Health Diagnosis for EDs in St. Louis Region

	Substance Use Diagnosis			Serious Mental Illness Diagnosis		
	2015	**2016**	**2017**	**2015**	**2016**	**2017**
1 visit	5,357	5,455	5,794	16,994	16,925	16,483
2–5 visits	1,925	2,034	2,148	4,297	4,419	4,085
6–10 visits	273	283	286	298	271	241
11–25 visits	126	125	125	54	64	50
26–50 visits	18	26	12	-	-	-
51+ visits	-	-	-	-	-	-
TOTAL	**7,699**	**7,923**	**8,365**	**21,643**	**21,679**	**20,859**

Inpatient Psychiatric Bed Capacity Report

Key Conclusions

- A dramatic 42% decrease in psychiatric (psych) bed capacity over a two-decade period (1990-2010) placed substantial demands on the community-based system, EDs, and correctional facilities.
- Inpatient psych bed capacity remains inadequate to fully meet demand, especially during "peak periods," despite significant hospital investments over the past eight years to increase psychiatric bed capacity.
- Due to capacity constraints at certain "peak" points during the year, patients can wait up to several days in area EDs waiting for psychiatric services.
- Any crisis-based solution, such as a Behavioral Health Assessment and Triage Center, will not fully relieve the pressure on area EDs due to continued bed capacity constraints in the region at peak periods; further bed reductions, if they occur, will only intensify this dynamic.

Background/History

In 2006 and 2009, the St. Louis Regional Health Commission (RHC) and its partners created assessments of the community behavioral health system in St. Louis City/County (*see www.stlrhc.org* for full reports).

In 2018, the RHC and its partners reviewed the key findings of these assessments with consumers/customers, stakeholders, advisory boards, and other community members, assessing if the key findings from these reports had changed over the past decade. In addition, recent operational data from regional providers have been reviewed by the Commission, its advisory boards, and workgroups in 2017/2018. Key conclusions from the assessments in 2006, 2010, and recent discussions/analyses indicate the following:

Inpatient Psychiatric Bed Capacity in St. Louis City/County – Historical Trends

In 2010, the RHC reported that the Eastern Region of MO had experienced an 817-bed decrease in acute care psychiatric beds over a 20-year period, with an 89-bed decrease in 2008 and 2009. In 1990, the Eastern Region had 1,955 acute care beds dedicated to psychiatric care, according to data provided to the RHC by the State of Missouri, Department of Mental Health. By early 2010, this number had declined to 1,138, equating to a 42% decrease over the 20-year period, with substantially less staffed psych beds on any given day in 2009.

Stakeholders reported at that time, and continue to report today, that the significant decrease in bed capacity during this period has placed a strain on the community-based system to meet the demand for mental health services. Area EDs and law enforcement/corrections officials also reported seeing a significant burden of care shifted to their settings due to the reduction in bed capacity.

In 2009, the acute care, psychiatric staffed bed and occupancy rates were reported as follows: ▶

2009 Hospitals (all beds)	City	Total Psych Staff Beds	Percent Occupied	Total Beds in Hospital	% of Total Beds in Region	% of Total Psych Beds in Region	% Psych Beds vs. Other Beds in that Hospital
Barnes-Jewish Hospital	St. Louis City	46	74%	1,258	17%	6%	4%
St. John's Mercy Medical Center	St. Louis County	72	86%	979	13%	9%	7%
St. Anthony's Medical Center	St. Louis County	74	66%	568	8%	9%	13%
St. Luke's Hospital	Chesterfield	0	N/A	551	7%	0%	0%
SSM DePaul Health Center	Bridgeton	99	81%	476	6%	13%	21%
SSM St. Mary's Health Center	Richmond Heights	35	90%	446	6%	4%	8%
Missouri Baptist Medical Center	St. Louis County	0	N/A	434	6%	0%	0%
St. Louis University Hospital	St. Louis City	40	58%	332	4%	5%	12%
SSM St. Joseph Health Center	St. Charles	92	81%	331	4%	12%	28%
Christian Hospital	St. Louis County	40	67%	256	3%	5%	16%
St. Louis Children's Hospital	St. Louis City	0	N/A	250	3%	0%	0%
Jefferson Regional Medical Center	Festus	42	66%	192	3%	5%	22%
Forest Park Community Hospital	St. Louis City	42	72%	178	2%	5%	24%
SSM Cardinal Glennon Children's Hospital	St. Louis City	0	N/A	176	2%	0%	0%
St. Alexius Hospital Broadway/Jefferson	St. Louis City	91	70%	169	2%	12%	54%
SSM St. Clare Health Center	Fenton	0	N/A	158	2%	0%	0%
Des Peres Hospital	St. Louis County	0	N/A	142	2%	0%	0%
SSM St. Joseph Hospital West	Lake St. Louis	0	N/A	126	2%	0%	0%
Barnes-Jewish St. Peters Hospital	St. Peters	0	N/A	110	1%	0%	0%
CenterPointe Hospital	St. Charles	84	77%	84	1%	11%	100%
Barnes-Jewish West County Hospital	St. Louis County	0	N/A	84	1%	0%	0%
Hawthorn Children's Psychiatric	St. Louis County	28	86%	52	1%	4%	54%
Progress West HealthCare Center	O'Fallon	0	N/A	42	1%	0%	0%
Shriners Hospitals for Children	St. Louis County	0	N/A	42	1%	0%	0%
TOTAL		**785**	**-**	**7,436**	**100%**	**100%**	**11%**

The RHC reported that "based on this 2009 data, 86 psych beds would have been "open" on an average day in the Eastern Region post-Metropolitan Psychiatric Center closure if all operated at a 85% maximum capacity level." However, the RHC acknowledged that "adult psychiatric beds account for 58% of all acute psych beds in the Eastern Region. Geriatric beds account for 18% of all psych beds in the Eastern Region, and Child/Adolescent beds account for 23% of all psych beds in the Eastern Region. Due to the operational and clinical challenges of mixing the adult, child, and geriatric psychiatric populations, it is important to note that the Eastern Region may experience capacity constraints in one population on a given day (such as adult or children)."

At that time, the RHC recommended that "the State should work with the Missouri Hospital Association (MHA) to create an 'Eastern Region Hospital Collaboration Agreement' for psychiatric services. Included in this agreement will be protocols for the transfer of patients evaluated in the Community-Wide Psychiatric/Substance Abuse Intake & Stabilization Unit and determined to need inpatient medical care, as well as a protocol for equitable participation by hospitals in court-ordered involuntary hospital admissions."

Current State of Inpatient Psychiatric Bed Capacity – 2018

In 2018, the acute care, psychiatric staffed bed and occupancy rates were reported as follows:

Hospital	Total Licensed Bed Capacity[7]	Reported Staffed Bed Capacity ADULT	Reported Staffed Bed Capacity GERIATRIC	Reported Staffed Bed Capacity ADOLESCENT/	Total Staffed
Barnes Jewish Hospital	46	36	10	0	46
Barnes Jewish Hospital-PSC	50	50	0	0	50
CenterPointe Hospital	104	70	14	20	104
Christian Hospital	40	0	0	0	0
Mercy Hospital - Jefferson	38	22	12	0	34
Mercy St. Anthony's Medical Center	74	52	0	22	74
Mercy Hospital - St. Louis	87	56	16	13	85
SSM Health DePaul Health Center	124	96	0	28	124
SSM Health St. Joseph Health Center - St. Charles*	22	0	22	0	22
SSM Health St. Joseph Health Center - Wentzville	77	39	0	31	70
SSM Health St. Louis University Hospital	40	40		0	40
SSM Health St. Mary's Health Center	46	22	24	0	46
St. Alexius Hospital**	91	34	30	0	64
TOTAL	**839**	**517**	**128**	**114**	**759**
				TOTAL UTILIZATION:	**90%**

[7]As reported by DMH, "Licensed Psych Beds in Missouri" Updated 7/2018; https://health.mo.gov/safety/healthservregs/pdf/MOlicPsychBeds.pdf

*SSM Health St. Joseph Health Center-St. Charles has an additional 20 substance use disorder beds, of which 10 are staffed/open

**St Alexius currently utilizes 14 adult female, 20 adult Male, and 30 geriatric beds. They have an additional 14 that are being renovated and are offline, with plans to renovate others as well.

Since 2010, several hospitals in the Eastern region have made a significant commitment to increase staffed psych bed capacity. The following organizations added additional beds, as noted below:

Organization	Number of Beds
Barnes-Jewish Hospital	50
SSM DePaul	15
CenterPointe	20
Mercy Hospital (formerly St. John's)	13
SSM St. Mary's Hospital	2

In addition, recently, St. Louis Children's Hospital has formally announced plans to add child/adolescent psychiatric inpatient capacity for the region in the near future.

Despite various hospitals' efforts to increase bed capacity, the Eastern Region has still seen a 3% decrease in the number of staffed psych beds since 2009.

Therefore, enhancing bed capacity in the region will be of critical importance to the success any "crisis solutions" or assessment/triage center models developed during this planning process.

Remaining Challenges of the System

Stakeholders report that ready access to a psych bed is not always available, especially at peak times and/or for patients with complex needs. While recent 2018 data from the Missouri Hospital Association suggests that the average boarding time for a psychiatric patient in an ED in St. Louis is 7–8 hours, EDs report that approximately 10% of their patients may wait 12–24 hours. In a few instances, patients have had to wait up to 5 or 6 days in an ED while treatment options are secured; the ED cannot discharge someone who remains a threat to self or others without securing necessary services. As noted in the 2009 RHC report, "community hospitals in the Eastern Region report that the community ED setting is a clinically inappropriate environment to safely treat persons in psychiatric crisis due to facility constraints, environmental factors present in hectic ED settings, and issues of staff training."

Behavioral Health Response (BHR) Crisis Access Report

Key Conclusions

- BHR crisis intervention services offer the only immediate mental health response service 24 hours a day, 7 days a week in partnership and funded by the area's four administrative agents.
- BHR has a unique data-sharing relationship with Community Mental Health Centers (CMHCs) that allows for connection to next-day follow up at partner CMHCs for up to 10 appointments in the St. Louis City/County on business days.
- BHR's call center handled 75,114 crisis calls in 2017, and reported that approximately 368 (less than 1%) of their total encounters were referred to CMHCs for next day appointments.
- BHR provides mobile outreach services to 2% of its callers. Outreach recipients are diverted from emergency personnel and hospitalization 90% of the time.
- BHR manages one crisis bed in the St. Louis region, and reports that it remains under-utilized. The current process calls for CMHCs to contact BHR to authorize use of the crisis bed. Crisis beds are under-utilized because setting requires high level of functioning and exclusion and inclusion criteria are quite restrictive. Yearly utilization of available days is under 5%.
- BHR provides an array of telehealth services to organizations across the nation; Missouri Baptist Medical Center is the only St. Louis-area hospital that has contracted with BHR for ED-based virtual services.

Background/History

Established in 1994, BHR is a private nonprofit corporation, the hub for an Access Crisis Intervention (ACI) system that provides 24-hour access to mental health services to residents of the City of St. Louis, and the counties of St. Louis, St. Charles, Franklin, Jefferson, Lincoln, Warren, Iron, St. Francois and Washington. The region's four administrative agents contract with BHR to handle calls after hours, on weekends, and on holidays. BHR's stated goal is to remove the barriers to accessing crisis mental health services.

BHR provides real-time phone counseling, crisis intervention, intake and referral, telebehavioral and mobile outreach services for mental health and substance use support.

BHR's crisis hotline and mobile outreach services are provided free of charge to the public by paid professional staff who have master's degrees and meet Missouri's criteria for Qualified Mental Health Professionals.

BHR'S specific offerings include:

- Crisis line services
- Crisis text services
- Crisis chat services
- Clinical call center services
- Follow-up case management
- Telebehavioral health intakes
- Virtual ER assessment and placement
- After hours call center services
- Mobile crisis services

A recent review of BHR crisis services and data has been assessed for use in the limited-scope Behavioral Health Assessment and Triage Center Feasibility Study. Recent discussions/analyses indicate the following: ▶

Key Elements of BHR's Crisis Intervention Service Portfolio:

- Data-sharing between BHR and CMHCs allows for relatively timely referral management and navigation for consumers needing help to access the right supports in the behavioral health system (as compared to accessing the CMHS system via non-crisis services)
- Additional capacity is needed for face-to-face crisis behavioral health support

1. Data-sharing between BHR and CMHCs allows for relatively timely referral management and navigation for consumers needing help to access the right supports in the behavioral health system.

- While regional behavioral health services are available predominantly during traditional business hours, BHR's regional Access Crisis Intervention hotline provides 24/7 telephonic crisis intervention and mobile outreach services. These services are available to the entire region, regardless of an individual's income, insurance coverage or engagement in services. In 2016, BHR received 70,246 crisis calls and majority of these calls resulted in referral to community-based services. Follow up appointments at CMHCs could be routine referrals, next-day appointments, or urgent appointments (within 2 business days) and is meant to ensure ongoing safety and linkage to needed support.

There are a total of 18 next day urgent appointments available on business days, each CMHC provides a dedicated number of slots for residents of their respective region:

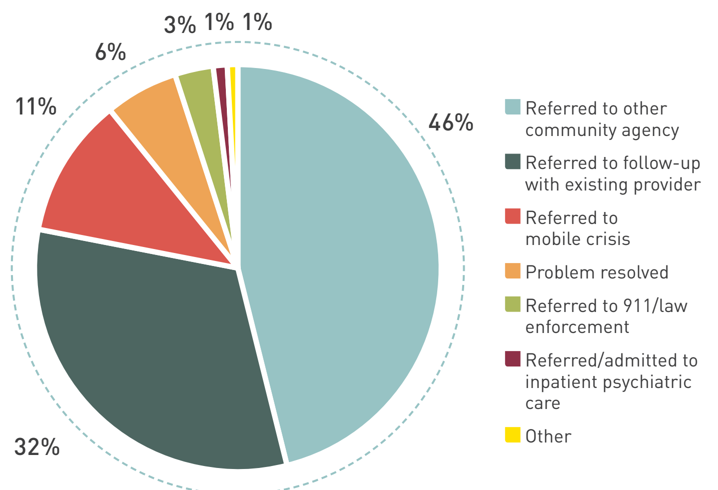
Organization	Number of Next Day Urgent Appointments
BJC	8
Hopewell	2
COMTREA	4
Compass	4

- In 2016, BHR connected 38% of mobile outreaches to urgent appointments with providers of community-based comprehensive psychiatric services, as compared to 43% in 2015. During the same period, the percentage of mobile outreaches referred to other community agencies increased from 19% in 2015 to 24% in 2016.

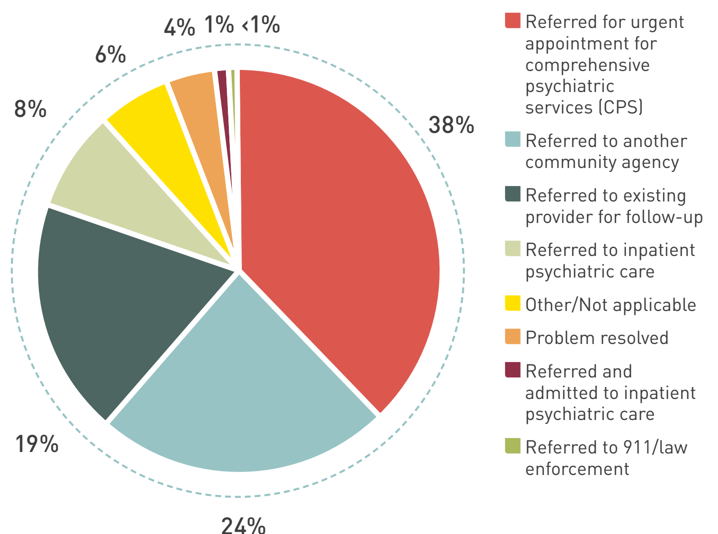
2. Additional capacity is needed for face-to-face crisis behavioral health support

- According to RHC's 2017 Access to Care Data Book, BHR's Access Crisis Intervention (ACI) hotline received 70,246 crisis calls in 2016 – an increase of 6% from the 66,226 calls in 2015 and comparable to the 69,797 calls in 2014. BHR provided in-person crisis intervention through 1,473 mobile outreaches – a decrease of 9% from the

CRISIS CALL OUTCOMES (N=70,246)



MOBILE OUTREACH OUTCOMES (N=1,473)



1,620 provided in 2015 and a decrease of 6% from the 1,573 provided in 2014. 2016 resolution outcomes vary by service type, as seen in the charts on the following pages:

- BHR recently provided data for 2017 as well, recording 75,114 ACI calls, a 6.9% increase over 2016. BHR provided 1,317 mobile outreaches in 2017, a 10.6% decrease for in-person interventions compared to 2016. 368 patients (less than 1%) from 2017 ACI and mobile encounters were referred to CMHCs for next-day follow up care. Approximately 80% of calls are from individuals in the St. Louis City and County service area.

- BHR manages one crisis bed in the St. Louis region, and reports that it is remain under-utilized. The current process calls for CMHCs to contact BHR to authorize use of the crisis bed. Crisis beds are underutilized because setting requires high level of functioning and exclusion and inclusion criteria are quite restrictive. Yearly utilization of available days is under 5%.

- BHR's robust use of telehealth in other parts of the country is not matched in the St. Louis region. For example, BHR has a significant presence in Alaska – a state (like Missouri) experiencing high rates of suicide and crisis behavioral health need. There are key lessons to be learned from BHR's experience in other markets.

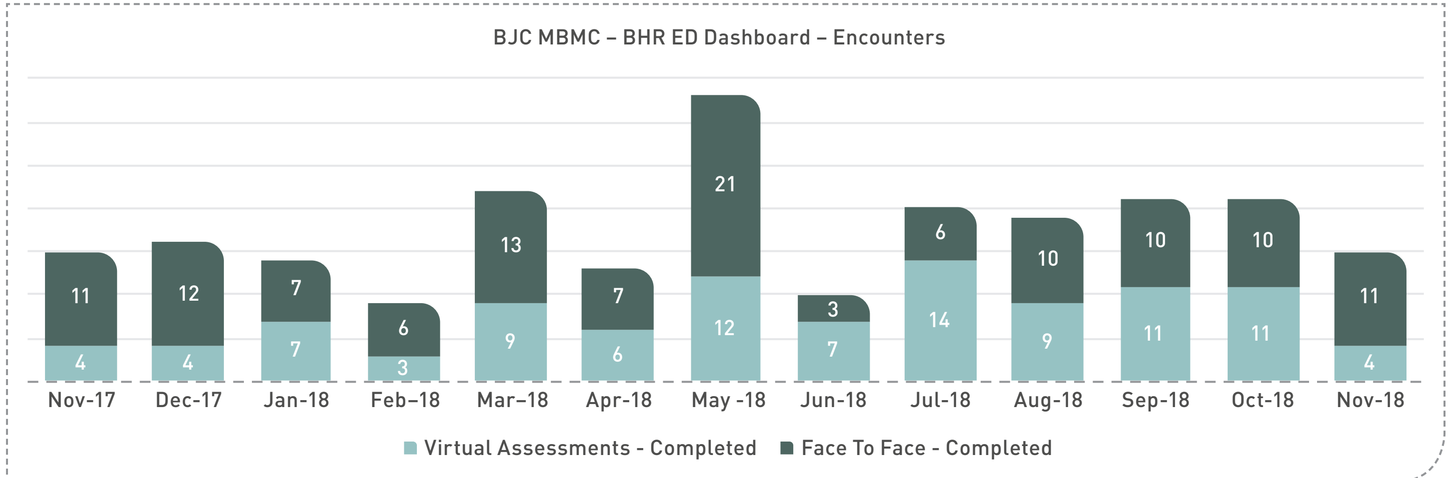
    - Misalignment exists between providers and consumers with access to care a consistent challenge. As a whole, the United States has one qualified mental health provider for every 790 citizens.

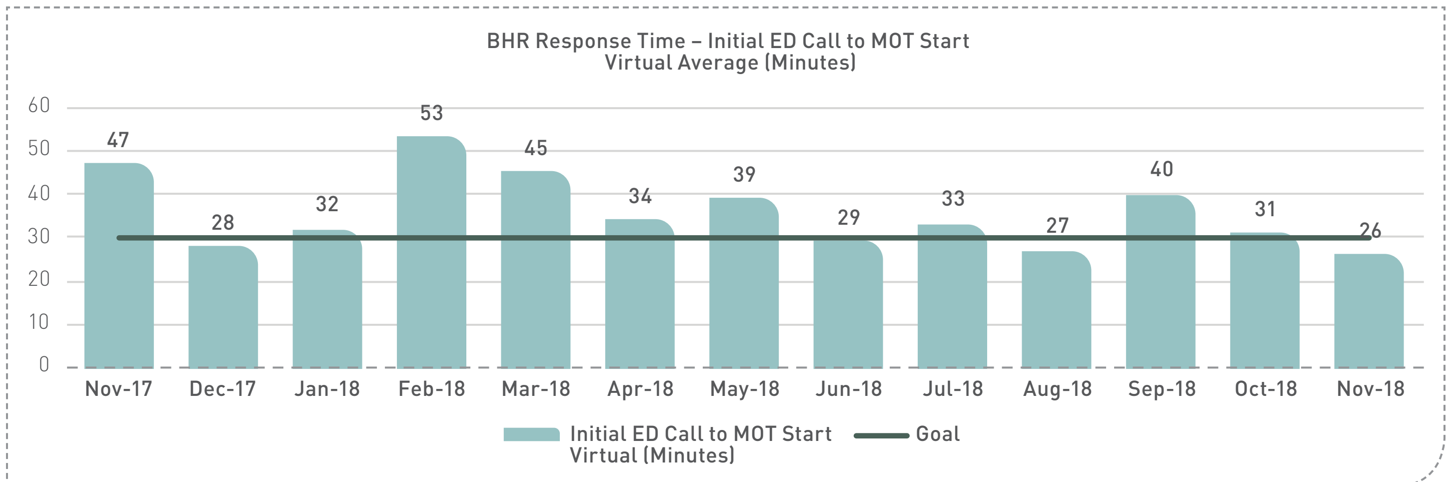
    - BHR is a key proponent of expanding virtual care to behavioral health populations and could serve as a knowledgeable adviser regarding expanding access within the current behavioral health system.

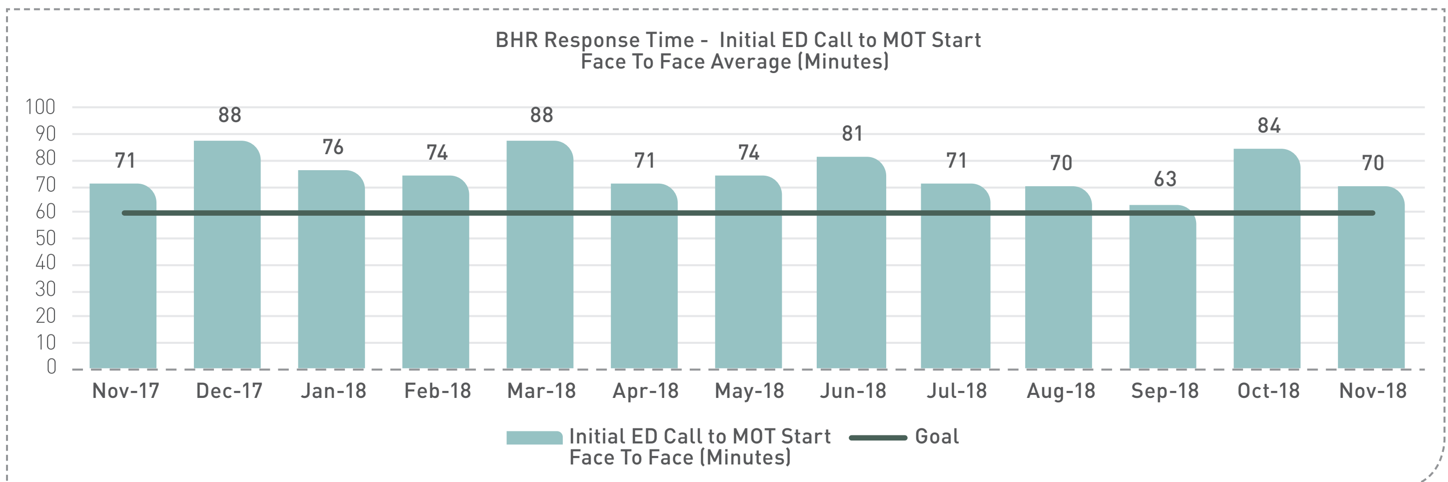
See the following pages for BHR/Missouri Baptists Outcomes Dashboard. ▶

BJC Missouri Baptist Medical Center (MBMC) / Behavioral Health Response (BHR) Pilot Dashboard – ED

THROUGHPUT/FLOW

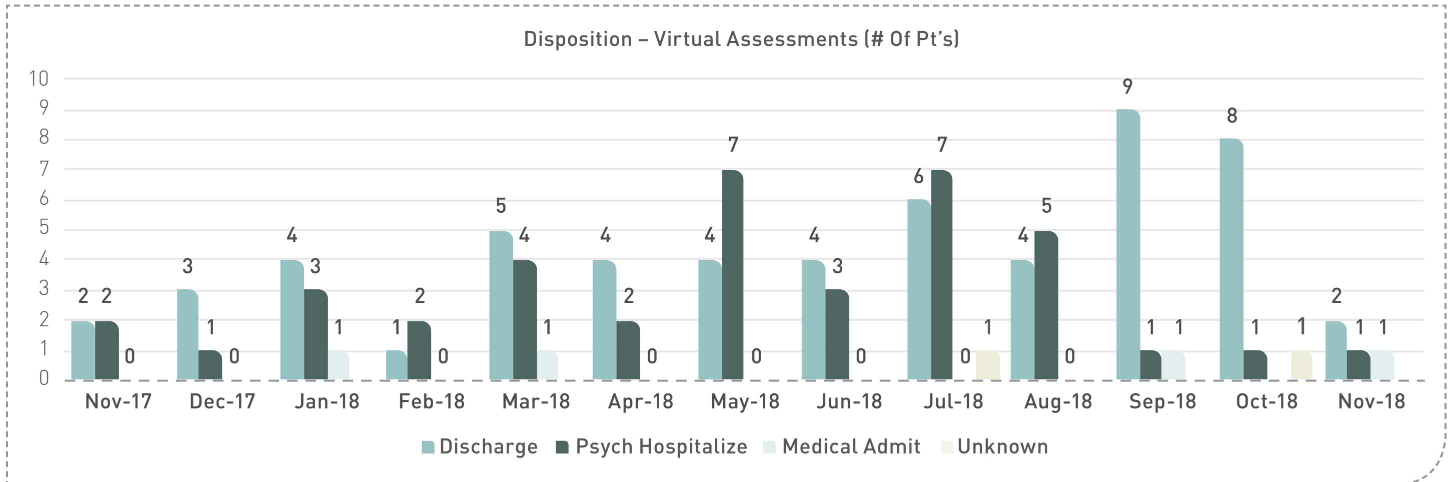


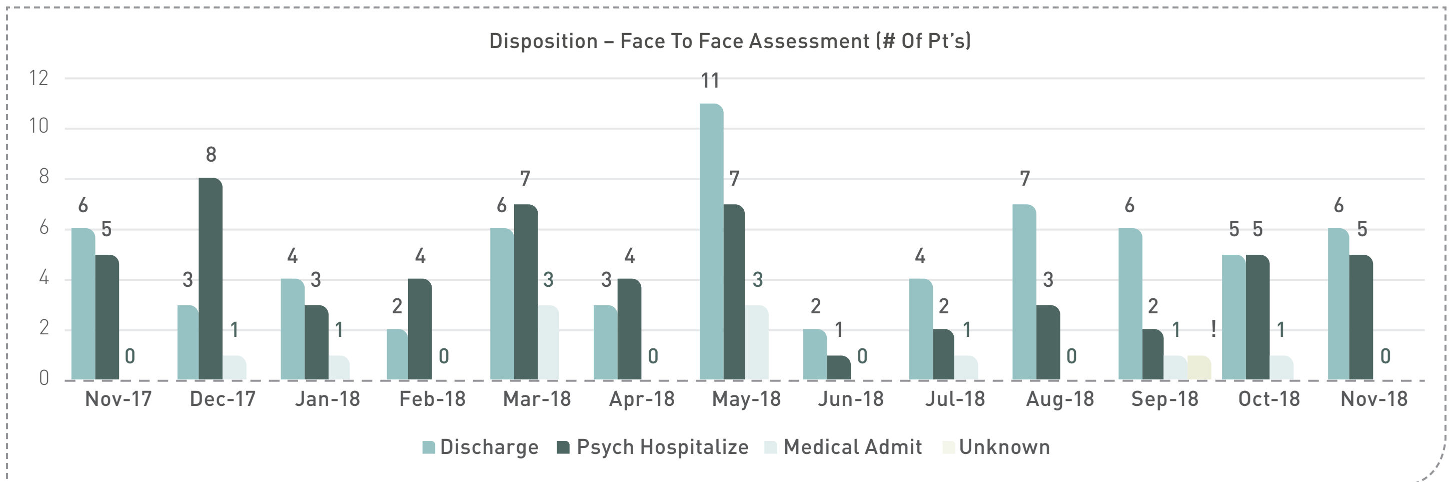


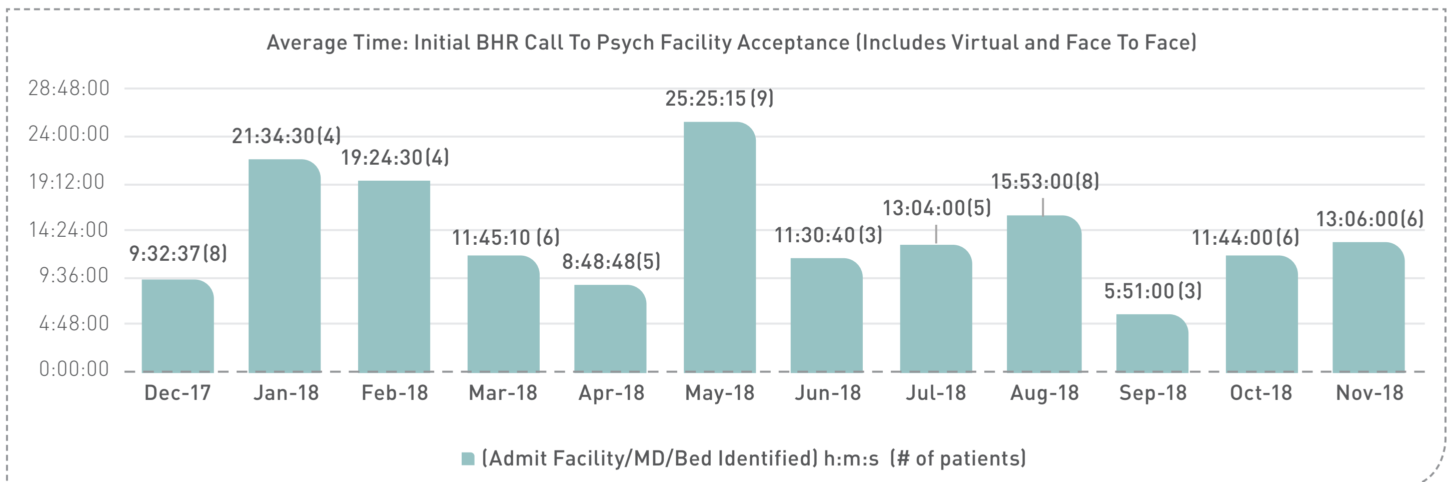


BJC Missouri Baptist Medical Center (MBMC) / Behavioral Health Response (BHR) Pilot Dashboard – ED

PROCESS OUTCOMES

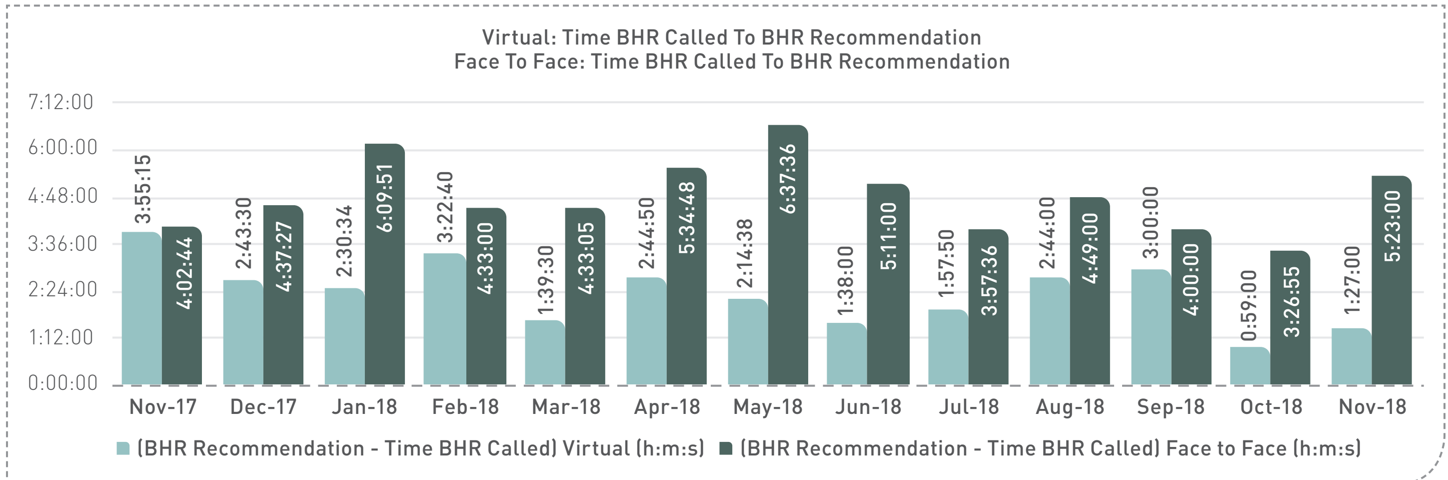


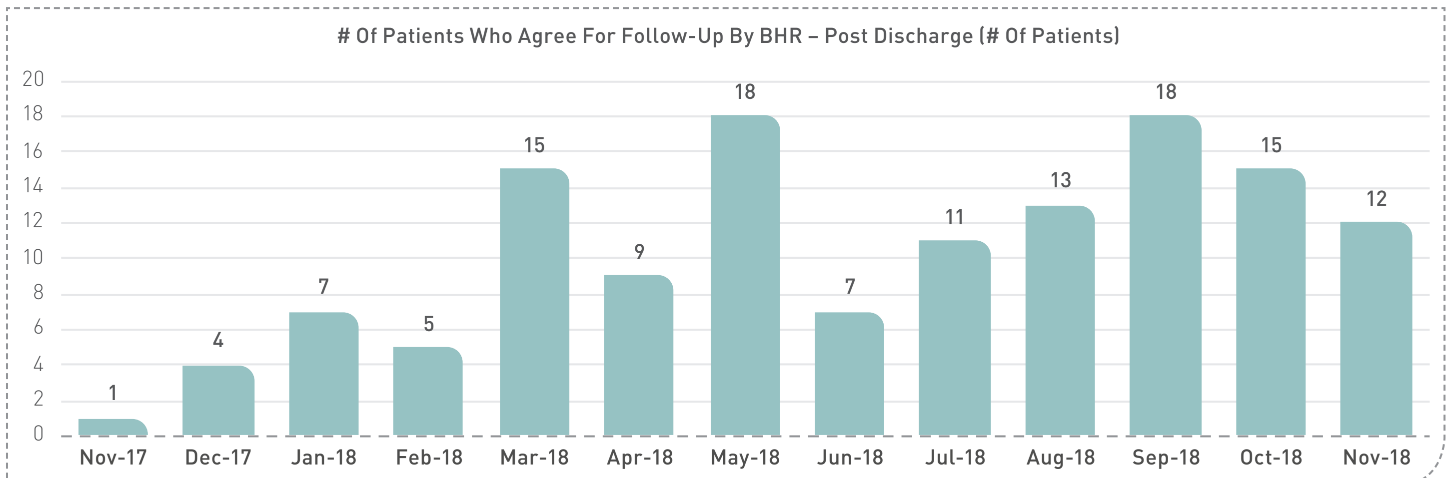




BJC Missouri Baptist Medical Center (MBMC) / Behavioral Health Response (BHR) Pilot Dashboard – ED

PROCESS OUTCOMES





Patient/Client Satisfaction (Dec. 2017 – August 2018)

As a patient at MBMC, did you find support services, follow up of BJC/behavioral health support to be helpful in meeting your needs?
YES: 30, NO:3

Did referrals you received meet your individual need? YES: 24, NO:9

As a patient at MBMC, did the support, services and follow up provided by BJC/behavioral health support improve your healthcare experience?
YES: 20, NO:10

Is there anything we can improve on or a different service you would like to see from us in the future?

- Everything was great: 8
- "States the physician "spoke his language" and felt supported by MOT.
- Had concerns with professional sitter.
- Staff was kind, wonderful and attentive
- Staff was kind, wonderful and attentive
- Frustrated with slowness of process. - 2
- Looking for chronic pain referrals
- Did not like MD or 1'st MOT. 2'nd MOT was better.
- TeleEd was new to me, but helpful. I did not mind talking to someone over computer.

Appendix A: BHATC Planning Team Roster

BEHAVIORAL HEALTH ACCESS AND TRIAGE CENTER PLANNING TEAM ROSTER		
Name	**Title**	**Organization**
Sean Hogan	President, co-chair	St. Anthony's Medical Center
Opal Jones	President and CEO, co-chair	Doorways
Irene Augustin	Director of Human Services	City of St. Louis
Shawn Billings	Project Manager	Missouri Hospital Association
Pat Coleman	Chief Executive Officer	Behavioral Health Response
Jama Dodson	Executive Director	St. Louis Mental Health Board
Kim Donica	Executive Director	The SPOT
Robin Edwards	Program Director	City of St. Louis Jail
John Eiler	Former Administrator, Behavioral Health	Community Representative
Wil Franklin	Chief Operating Officer	Hopewell Center
Callan Howton	Chief Executive Officer	Haven Recovery Homes
Jackie Hudson	Volunteer	National Alliance on Mental Illness - St. Louis
Justin Idleburg	Lead Catalyst	Nehemiah's Mission St. Louis
Dan Isom	Executive Director	REJIS Commission
Laurent Javois	Regional Executive Officer – Eastern Region	Missouri Department of Mental Health
Rajeev John	Manager, Adult Behavioral Health	Affinia Healthcare
Barbi Karl	Vice President Behavioral Health	BJC HealthCare
David Kessel	Chief Operating Officer	Employment Connection
Donna King	Regional Administrator	Missouri Department of Corrections, Division of Probation and Parole
Jackie Landess	Chief of Mental Health Services	St. Louis County Jail
Aaron Laxton	Program Manager	Missouri Safe Project
Sean Marz	Director of Training and Technical Assistance	Alive & Well Communities
Rev. Ken McKoy	Pastor	NightLIFE, Progressive Zion AME Church
Percy Menzies	President	Assisted Recovery Centers of America
Patty Morrow	Vice President, Behavioral Health	Mercy
Gary Morse	Vice President of Research and Development	Places for People
Cheryl Oliver	Former Executive Director of St. Louis Effort for AIDS	St. Louis Effort for AIDS
Sgt. Sally Panzer	CIT & Officer Wellness Program Coordinator, Crisis Negotiation Coordinator	St. Louis Metropolitan Police Department
Rob Poirier	Clinical Chief Emergency Medicine	Washington University School of Medicine, Barnes-Jewish Hospital
Cori Putz	Senior Vice President of Treatment Services	Preferred Family Healthcare
Sgt. Gary Robertson	St. Louis Area CIT Police Coordinator	St. Louis County Police Department
Mark Routburg	Health Clinic Promoter	STL Health Safety Net
Spring Schmidt	Division Co-Director	St. Louis County Department of Public Health
Michelle Shafer	Vice President	SSM Behavioral Health
Richard Torack	Court Administrator	St. Louis Municipal Court
Mikel Whittier	RE-LINK Program Manager	St. Louis Integrated Health Network
Karl Wilson	Former CEO of Crider/Commissioner	Dept of Mental Health - Mental Health Commission
Hope Woodson	Director	St. Charles County Department of Public Health

Appendix B: BHATC Design Criteria

Best-practices/standardization

- Using right professionals to conduct screening/assessment
- Referral "best practices"
- Standardized protocols

Collaboration/coordination/integration

- Integrated "fully', behavioral health and physical health services
- Coordinated/aligned assessment (e.g. sharing info with multiple agencies)
- Integration with community health centers (e.g. healthcare homes)

Housing

- Emphasize collaboration and integration with mental/physical health care
- Continuum of Care system is tracking high-utilizers regionally (homeless/housing need) with potential to share
- Expanded residential capacity
- Higher threshold for behavioral health problems in transitional living programs

Interpersonal communication

- Humanizing treatment/support
- No stigma or judgment
- Trauma-informed

Linkage to services

- Expanded BHN programs (e.g. Bridges to Care and Recovery, link to faith communities)
- Linking program that ensure patients receive priority for services (e.g. ERE, CRC hospital linkages)
- More transfer/connections between access points

Navigation

- Knowledgeable navigators that stay with patient
- Team care (e.g. case managers, peer navigators, nurse coordination of services)
- Peer navigators/recovery coaches (e.g. EPICC program)

Reimbursement/funding

- Address limitations of fee for service reimbursement
- Funding streams that integrate service delivery, which results in decreasing care siloes

Resource/knowledge/data sharing

- Knowledge of resources by staff to know how to help families get services/support
- Patients share their story only 1 time (build into EMR)
- CIMOR (state IT system) addresses info sharing to some extent, but needs to be updated in a timely manner

System access

- Geographic eligibility (e.g. administrative agent structure) is enhanced or removed as a barrier
- No wrong door
- Walk-in access with same day service (open access)

System/provider capacity

- Telehealth
- Lack of provider capacity (e.g. waiting lists) is addressed
- Workforce constraints are addressed

Easy access for law enforcement

- Less than 10 minutes to drop-off clients
- Coordinated training on center criteria and operations with departments