2020 COVID-19 Impact Survey: Behavioral Health Crisis Providers

SURVEY 2:
June 1-11, 2020

tbdSolutions

Crisis Residential Association

AMERICAN ASSOCIATION OF SUICIDOLOGY

National Association of Crisis Organization Directors

Contents

Executive Summary

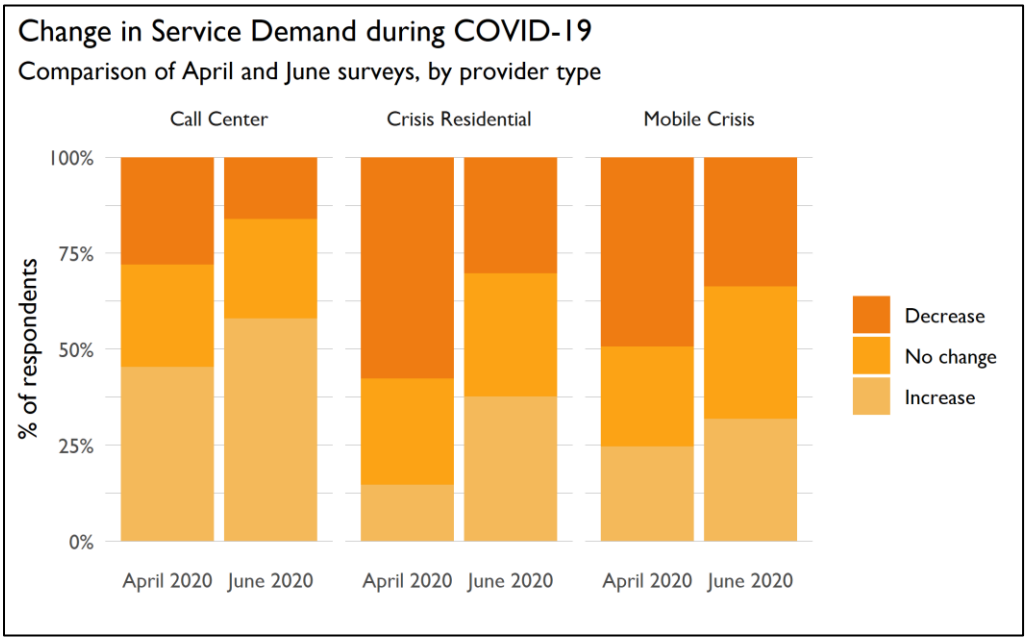
In April 2020, TBD Solutions conducted a survey of behavioral health crisis providers to understand the impact of COVID-19 on service delivery. Three national partners assisted in the distribution of the survey: the American Association of Suicidology, the Crisis Residential Association, and the National Association of Crisis Organization Directors. The survey received 362 responses and was quoted in many major publications, including the FCC Fact Sheet on the Implementation of the National Suicide Hotline Improvement Act of 2018.[1]

In June 2020, TBD Solutions administered a second survey to behavioral health crisis providers with assistance from the same partners, broadening the scope of participants and the expanding the number of questions. A total of 597 participants responded to the second survey (a 66% increase). The purpose of the second survey was to evaluate ongoing service trends, program impacts, and staff experiences as the pandemic continued to impact communities across the United States.

Respondent	Initial Survey	Updated Survey
Call Center	23.8% (n = 86)	25.3% (n = 151)
Crisis Residential	35.9% (n = 130)	34.3% (n = 205)
Mobile Crisis	40.3% (n = 146)	40.4% (n = 241)

Between the first and second surveys, all three provider types reported overall increases in service demand, with crisis call center experiencing the greatest increase by percentage, and mobile crisis teams reporting the greatest increase in total responses.

While narrative responses indicated a move towards normalcy and stability for some crisis workers, most respondents reported the toll of COVID-19 precautions having a lasting impact on care coordination, service delivery, and the well-being of crisis workers, supervisors, and persons served. Crisis workers with regular in-person exposure to persons served versus telephonic interaction reported regularly high levels of stress.



Survey results related to the issues these crisis providers are

[1] FCC Fact Sheet: Implementation of the National Suicide Hotline Improvement Act of 2018, page 3. June 25, 2020. Accessible at https://docs.fcc.gov/public/attachments/DOC-365165A1.pdf

experiencing fell into six main categories:

- **Staffing**: Stability/morale of direct support professionals, crisis counselors, clinicians, peer support specialists, and supervisors
- **Health Concerns**: Risk of staff contracting or spreading COVID-19 virus
- **Clinical Services and Client/Caller Support**: Presence/consistency of skill-building groups, clinical/process groups, support calls, or reliable treatment interventions of the intended scope, duration, and/or frequency
- **Equipment/Supplies/Technology**: Availability of Personal Protective Equipment and IT equipment to accommodate necessary adaptations
- **Operations/Sustainability**: The ability to operate the crisis service amidst fewer referrals/calls or decreased capacity in a fee-for service model, insufficient staff, or operating without increased funding to compensate staff for risk of exposure to infection
- **Community Resources**: The availability of outpatient therapists, homeless shelters, psychiatric hospital beds, primary care clinics, and other critical resources

Respondents with supervisory responsibilities reported a lack of available operational resources (PPE, technology, funding), risk of staff exposure to illness, managing service capacity, and increased demand for services among the greatest challenges experienced or anticipated in the next month.

When asked to describe changes to their workload and ability to do their job, respondents reported increased fatigue brought on by emotional and physical challenges, increased responsibilities and workload due to changes in service demand and staffing, and increased demands to adhere to health and safety guidelines pertaining to COVID-19.

Respondents reported an increase in the acuity of the people they serve, which they attributed to both increased psychosocial stressors brought on by COVID-19 as well as reduced access to available services. Some respondents reported observing increased resilience from the people they serve, citing more hopefulness than in the first weeks of the pandemic in the United States.

When asked about the current issues **mobile crisis teams** are facing, 73% of respondents reported care coordination issues and 69% reported concerns about keeping their staff safe and healthy. Over 42% reported a lack of critical supplies and equipment as a major concern. None of the respondents reported feeling overwhelmed by referrals or service volume. When compared to the April 2020 survey results, mobile crisis team survey results demonstrated a 50% decrease in reports of feeling overwhelmed by health concerns and a 29% decrease in concerns about lack of critical supplies & equipment.

When asked to indicate which issues **crisis residential programs** are experiencing, 77% of respondents reported care coordination issues and 73% reported concerns about the health and safety of their staff. Over half of respondents reported dealing with turnover due to health concerns (52%), and 50% reported feeling overwhelmed by the clinical intensity of individuals being served. Nearly half of respondents reported feeling overwhelmed by health concerns (49%), clinical intensity of persons served (46%), and having fewer staff available (43%).

When asked to indicate which issues **crisis call centers** are experiencing, 59% of survey respondents reported care coordination issues and 58% reported staff safety concerns due to health issues. Almost half of respondents reported feeling overwhelmed both by clinical intensity of callers (44%) and fewer available staff (41%), and over one-third of respondents reported feeling overwhelmed by call volume (37%).

Results of this survey show volume and referrals to crisis services have steadily increased compared to a considerable decline in April. While fewer respondents reported feeling overwhelmed by health concerns across all service types, care coordination issues continue to rank high on crisis providers' list of concerns as much of the behavioral health and social service ecosystem is still operating at suboptimal capacity, diminishing the ability for crisis providers to make timely referrals that would avoid longer visits or more costly and restrictive levels of care.

In order to assure high-quality and uninterrupted service delivery, behavioral health crisis workers should be afforded the same protections as their essential health care worker counterparts—namely, fair compensation that reflects the importance of their work, access to adequate supplies of PPE and health and safety products, and technology that provides flexibility and safety through minimal exposure to health risk.

Even if these accommodations are made available, some crisis services are still best delivered in person. Service delivery methodology should not be altered without serious considerations regarding its impacts—namely, the mental and emotional cost exacted on people in crisis by social and physical distancing, and the repercussions to the behavioral health ecosystem.

A full list of narrative responses is available at https://www.tbdsolutions.com/COVID_Impact_Survey_Addendum/.

Introduction

As the world has absorbed the severe and lasting effects of COVID-19, health care workers have accepted a unique position as essential workers with their own health and safety concerns to manage, often mirroring the very challenges of the people they are serving. Behavioral health care crisis workers face similar challenges as other health care workers but are not often recognized as essential or being on the front lines of the pandemic.

TBD Solutions partnered with the American Association of Suicidology (AAS), the Crisis Residential Association (CRA), and the National Association of Crisis Organization Directors (NASCOD) to administer a survey to behavioral health crisis service providers on the impact of COVID-19 on service delivery and volume.

This is the second survey of its kind conducted by TBD Solutions, with the first survey administered in April 2020. Unlike the first version, this survey was open to multiple crisis workers from the same organizations to gather additional perspectives from within a given crisis program.

TBD Solutions partnered with the University of Maryland to conduct survey analysis through topic modelling to identify response themes through open-ended questions.

This survey was underwritten by a grant from the Michigan Health Endowment Fund.

Method

The electronic survey sought information related to the issues currently experienced by crisis providers, changes in service demand during the COVID19 pandemic, the most considerable current or anticipated challenges faced by these providers, the impact of COVID-19 on job responsibilities and abilities, and the impact of COVID-19 on persons served. Respondents were asked to identify themselves by provider type and the state(s) where services are provided.[2] Respondents participated in a specific survey based on what services they provide in the community: Crisis Call Center, Mobile Crisis or Crisis Residential. The content of the service-specific surveys was consistent with slight changes in language to align with service types.

The survey was open from June 1-11, 2020. Participation was solicited through trade association listservs, forums, direct email outreach, state behavioral health administration outreach, and social media outlets with a focus on crisis service providers.

Surveys were open to anyone with the survey URL.[3] The first half of the survey was open to supervisors, and the second half was open to all respondents. Supervisor questions from the survey conducted in April 2020 were asked again in the second survey to provide a comparison over time. Responses were not verified as respondents self-identified as crisis providers. Some organizations providing multiple crisis services may have answered the survey more than once representing a different type of crisis program with each survey response. While the survey was structured to collect factual information about trends in volume by one program supervisor representative, some organizations may have provided multiple

[2] Some providers identified themselves as multi-state providers in the comment sections of the survey.
[3] Survey results were reviewed for signs of misinformation. Duplicate responses were removed from the survey count.

responses from different employees at the same crisis service location. Organizations were encouraged to invite multiple staff to respond to questions about their experiences and stressors.

About Topic Modelling

For our analysis of themes in open-text survey responses, we use topic modelling output provided by Dr. Phillip Resnik of the University of Maryland. Topic models are statistical models for discovering "topics" among open text responses by identifying numeric relationships between word occurrences. These models group survey responses which use similar words, as well as associating words which occur together in survey responses. The resulting patterns are called "topics".

For this analysis, we associated each response to a survey question with the topic to which it was most strongly related. We then reviewed the responses within each topic and developed manual descriptions based on common words and phrases. Where multiple topics generated by the statistical model were interpreted as being similar in type, these topics were combined, and the new topic groups were re-sorted to select the strongest theme for each survey response. Topics which did not include a clearly discernible theme for reporting were removed and the remaining scores were renormalized.

The "Strength" metric reported in the tables below is the average probability score for all survey responses associated with that topic. Since all open responses may be related to multiple topics, this shows how strongly the responses content was associated with the topic that was identified as the best.

Overall Results

A total of 597 crisis providers/staff responded to the three surveys, including:

Mobile Crisis Outreach Teams (241 Respondents)

Crisis Residential Programs (205 Respondents)

Crisis Call Centers (151 Respondents)

Overall participation increased from 362 respondents in the April survey to 597 respondents in the June survey, a 64% increase.

Respondents reporting about the change in volume/ referrals was limited to the supervisor portion of the survey.

Respondent	Volume/Referrals	Initial Survey	Update Survey
Call Center	Decrease	27.9% (n = 24)	16% (n = 13)
Call Center	Increase	45.3% (n = 39)	58% (n = 47)
Call Center	No change	26.7% (n = 23)	25.9% (n = 21)
Crisis Residential	Decrease	57.7% (n = 75)	30.3% (n = 33)
Crisis Residential	Increase	14.6% (n = 19)	37.6% (n = 41)
Crisis Residential	No change	27.7% (n = 36)	32.1% (n = 35)
Mobile Crisis	Decrease	49.3% (n = 72)	33.6% (n = 37)
Mobile Crisis	Increase	24.7% (n = 36)	31.8% (n = 35)
Mobile Crisis	No change	26% (n = 38)	34.5% (n = 38)

Overall survey results identified six main categories of issues these crisis providers are experiencing during this time:

- **Staffing**: Stability/morale of direct support professionals, crisis counselors, clinicians, peer support specialists, and supervisors
- **Health Concerns**: Risk of staff contracting or spreading COVID-19 virus
- **Clinical Services and Client/Caller Support**: Presence/consistency of skill-building groups, clinical/process groups, support calls, or reliable treatment interventions of the intended scope, duration, and/or frequency
- **Equipment/Supplies/Technology**: Availability of Personal Protective Equipment and IT equipment to accommodate necessary adaptations
- **Operations/Sustainability**: The ability to operate the crisis service amidst fewer referrals/calls or decreased capacity in a fee-for service model, insufficient staff, or operating without increased funding to compensate staff for risk of exposure to infection

- **Community Resources**: The availability of outpatient therapists, homeless shelters, psychiatric hospital beds, primary care clinics, and other critical resources

This report provides an analysis and summary of survey results with samples of narrative responses to open-ended questions. Some results are summarized across all provider types, other results are summarized between first and second survey responses, and some are categorized by provider type (Mobile Crisis, Crisis Residential Programs, Crisis Call Centers).

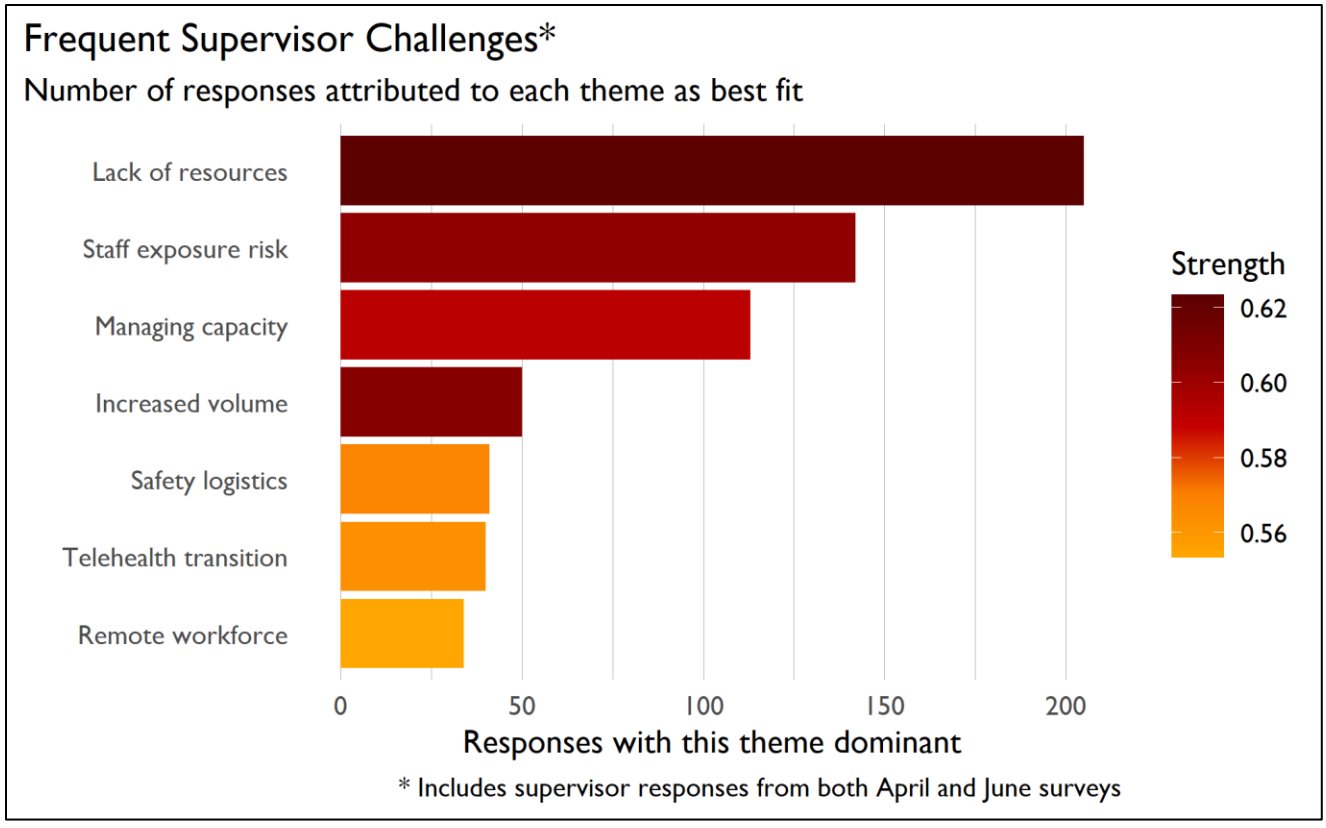
Results from this section are summarized across all provider types.

A full list of narrative responses is available at https://www.tbdsolutions.com/COVID_Impact_Survey_Addendum/.

Themes Related to Supervisor Challenges

The survey asked supervisors to identify the challenges they are facing. The graph below shows the most prominent themes identified from responses to the open-text survey questions across all service types related to supervisor challenges, specifically:

- "Please describe the two greatest challenges your crisis team is currently facing, or you anticipate facing in the next month."



Lack of Resources: **Lack of resources including PPE, funding, staffing, referrals, technology, etc.**

- *"We have a non-sufficient supply of PPE and other basic supplies such as paper towels, toilet paper, and hand sanitizer. We have such a limited staff available that losing any member in any of our facilities will seriously impact our service to our consumers and stress the workload of our remaining staff members."*
- *"Continued struggle to get police and community agencies to aid us due to their fears of the virus, inpatient units not taking COVID positive patients"*
- *"Knowledge of clinics and resources to refer callers to that are accepting new patients, especially medication management"*
- *"lack of suitable applicants for staffing, lack of resources to refer people for treatment"*

Staff Exposure Risk: **Risk of COVID exposure and resulting impact on staff availability and morale**

- *"Currently, the greatest concern is fear of exposure. In the coming weeks, we anticipate we could experience workforce crisis if multiple staff are exposed or become sick."*
- *"Lack of coverage to maintain our 24/7 service. We don't have enough people to cover shifts"*
- *"1. One of the greatest challenges has been not having adequate staffing, as well as staff losing hours from work d/t a decrease in census. 2. Encouraging employees continue to work. Employees are complaining that because we are considered essential staff, compensations should be in place to take care of employees by the employer who are able to work i.e. not having to take leave without pay (LWOP), if their hours are decreased, not having to use vacation time to get paid a full salary, etc."*
- *"1-Providing services to children/families who are isolated from their natural supports/more likely to become overwhelmed and need support, and have limited benefit in receiving services via phone/video visits, and many low-income consumers who don't have access to technology to receive remote supports. 2-Safety in sending consumers to inpatient hospitals for inpatient behavioral health care outside of our area (we are very rural- no inpatient care is available in our County)…"*

Managing Capacity: **Managing capacity during fluctuating demand for services while also protecting against exposure during re-opening**

- *"With the State reopening and the agency bringing staff back on site, I expect an increase in positive cases within our agency and community. This could impact my work force. The civil unrest has created an additional level of trauma to our community and the crisis staff are having to focus on COVID and the behavioral health issues that occur as well as the issues as a result of the civil unrest"*
- *"This is just coming to our rural community. Concern that calls will begin to come in when people are experiencing financial strain due to layoffs or furloughs due to non-essential businesses closing. Increase in calls and enough facilities to accept clients in crisis. Medical clearance may take much longer and expose clients while in the ER waiting for placement."*
- *"Reduced client capacity by 50% to insure that each client has their own room thereby reducing potential infection and increase social distancing in facility As a fee for service provider concerned about the inevitable revenue short fall"*
- *"Clients want to be able to go into the community and are unable to do that. Because they cannot go out their anxiety and depression have been increasing and they are struggling to maintain their composure at times. This will keep increasing due to the facilities staying in the red while the rest of the county is green."*

Increased Volume: Staffing issues related to the increased volume of calls or referrals, as well as increased acuity

- *"Increased call volume due to crisis; not enough manpower to support the increased volume"*
- *"PPE supplies, staffing issues related to illness, dealing with presumptive cases at the CSU"*
- *"Uncertainty about when the crisis center will re-open and increase in call volume without enough staff/volunteers to support callers"*
- *"We've had 3 staff quarantined, if more people require this, it will impact our workforce availability. An increase in call volume is anticipated with increase cases in the region of covid19."*
- *"1. moving back to more in person responses (vs. telehealth), anxiety of staff in making this shift 2. increased complexity and intensity of presenting issues of youth calling hotline."*

Safety Logistics: Implementing and managing the logistics of COVID safety protocols

- *"Staff getting the COVID 19 virus or clients having it and spreading it to others. Closest ED refusing to test for COVID 19"*
- *"We also serve as an overnight respite facility and cannot operate as such. This has led to our overnight respite clients becoming crisis clients. While we now have greater capacity for crisis clients, there are still times we can't serve them. Hiring freeze has resulted in complications replacing staff that cannot work or have left for a variety of reasons."*
- *"Fears of face to face contact during interview. Need for COVID-19 test during medical clearance and psychiatric facility acceptance"*
- *"Trying to decide when to go to a home to avoid a child going to the ED and keeping staff safe"*

Telehealth Transition: Issues related to telehealth and teleconferencing

- *"Safety concerns with having to present face to face to complete assessments. Technology for doing telehealth mobile services is not currently available."*
- *"Tele video conferencing being available on site with a crisis is occurring. Keeping our mower responders healthy."*
- *"Mobile crisis workers are currently not going out to complete assessments due to COVID, which makes an accurate assessment more challenging to complete."*
- *"Two challenges are a reduced workforce and lack of technology at the local emergency rooms/hospitals to provide face-to-face assessments. Our local ERs have seen a significant number of positive COVID-19 cases that includes their workforce. This has created a barrier to safely accessing these facilities without increasing risk of exposure. Without the appropriate technology, only phone assessments can be completed at this time."*

Remote Workforce: Maintaining staffing of a remote workforce, including hiring, onboarding, and supervision

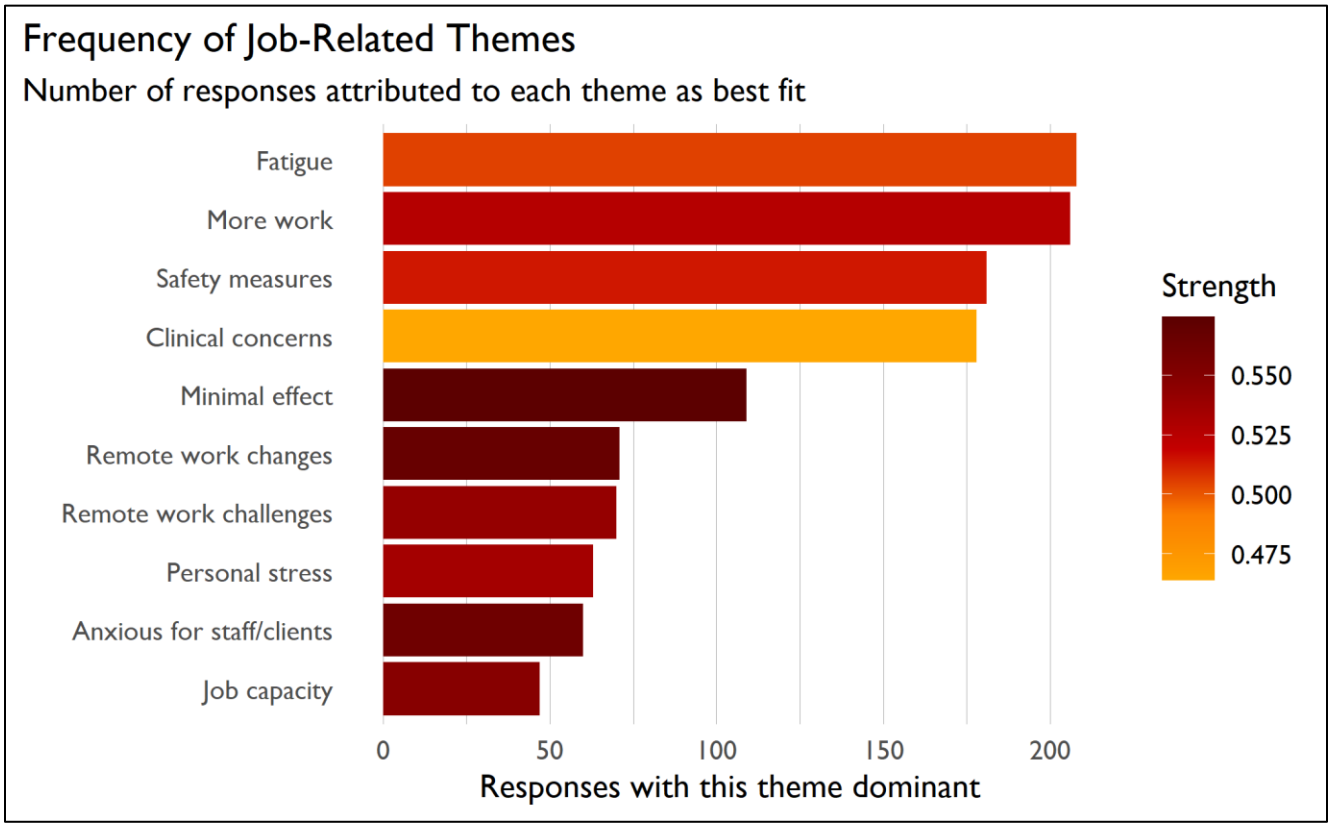
- *"1. Adapting to having most of our staff working remotely 2. Supporting our staff in managing stress/vicarious trauma/compassion fatigue; keeping them healthy and safe, mentally and physically, as they spend 8 hours a day supporting others"*

- *"Staffing–we will not be able to orient new staff to add to the current staff so our staff will be working longer hours."*
- *"Trying to hire and train new staff (following AAS accreditation requirements) and providing enough supervision for new staff after training."*
- *"As the majority of the Crisis Call Center staff are working remotely, the challenges are technical challenges (supported by wonderful IT, however) and continued connection and communication. No real challenges, just do better when we remain connected."*

Issues Related to Job Role and Ability

The graph below shows the most prominent themes identified from the open-text survey questions related to job role and ability across all crisis service types, specifically:

- "How has your professional role changed since that time, if at all? (Responsibilities, workload, expectations, etc.)"
- "Since that time, how has your ability to do your job been impacted, if at all? This could include emotional, mental, or physical impact."
- "How do you feel your ability to perform your job functions has been affected?"



Fatigue: Ability affected by emotional and physical challenge and fatigue

- *"The emotional/mental impact of the stress and needing to address anxious callers who were experiencing my same stress was difficult. I didn't/don't know what to tell people who are worked up about COVID, because I am as well and there is not a whole lot of reassurance to provide during unprecedented times."*
- *"We have had to make changes as a team to remain connected to each other and families we serve. Decrease in travel time to meetings has allowed for time to do other tasks."*
- *"Disconnect has become slightly more difficult, but coworkers have been an immense support system on our team. My ability to address issues within the team or professionals we work along side with has been significantly reduced – phone calls versus in-person conversation have a markedly different impact."*
- *"I think I have been impacted emotionally, mentally and physically. Emotionally, it has been challenging to balance my own fears, family and friends while still going in to work during this time. Mentally, it has been draining and challenging. Physically, I was isolated from friends and family due to continuing to going into work and trying to limit my exposure. It has been a challenging experience."*

More Work: Increased workload and responsibilities due to safety, volume, attrition, etc.

- *"The work load was more since about half of our team was put on temporary leave. Our pay was cut but the consumers was still in need of assistance."*
- *"Lesser employees on the team requires a higher workload for each employee but working from home has been helpful."*
- *"Increased workload, responding in the community despite COVID, marketing expectations."*
- *"pay rate and hours were cut, workload and responsibilities moderate increase due to layoffs"*

Safety Measures: Logistics related to additional precautions and safety protocols

- *"Each staff was required to be monitored for symptoms of COVID-19 each time they worked, monitoring forms were added, assuring PPE was available was added to duties, securing additional monitoring equipment was available became a responsibility, being aware of each staff members concerns or fears was essential, having resources available to address those concerns and fears was essential, assuring all up to date information was available to each staff member and filling shifts when we lost staffers..."*
- *"I have spent more time in virtual meetings; it is ironic that in our non-Covid world we met once a month or once a quarter - and now grantors and other funders are wanting to meet weekly - way more time consuming and puts more pressure on my time."*
- *"time spent learning about PPE, covid, public health , return to work guidelines, testing options"*
- *"Greater challenge to staff facility. Greater responsibility to ensure PPE and cleaning supplies available/present on site. Enforcement of new staff and client expectations not previously present (i.e. wearing masks, social distancing)"*

Clinical Concerns: Stress related to client acuity, volume and change in clinical approach (i.e. telehealth)

- *"More responsibility as there are more frequent callers that are in crisis. More people seeking hospitalization due to not being able to get into see a doctor. People are running out of medications. There are minimal people in the office so there is a lot more responsibility on the front line workers answering all calls."*

- *"Emotionally drained from seeing consumers not able to go visit family or have outings. Where I work, House Supervisor, was out on medical leave at the start and just returned, causing lots of mental stress and anxiety."*
- *"More challenging cases- we are expected to find solutions to problems that have either never existed or were never involved in crisis work. Definitely more work with less resources. I think many of us have been expected to be counselors rather than assessors."*
- *"We adapted to taking calls completely remotely which we had never done before so I am much more involved in with the day-to-day tasks of switching the phone lines and even answering calls at time because we are under-staffed."*

Minimal Effect: Ability to perform has not been adversely affected

- *"There has been general stress, but nothing out of the ordinary"*
- *"I still feel I am able to do my job successfully, but am looking very much forward to some time off!"*
- *"My CMH has done an excellent job with providing tools and support to its employees. As I report to my office Mon-Fri concerns that I may be exposed to covid-19 and take it to my family are worrisome/stressful. I utilize ppe at work and while in the community to reduce risk. I am capable of performing my job functions with some distraction of covid-19."*
- *"I am fortunate that I've been able to work (remotely) without any impact in that regard. However, working from home does not provide the distinct line between work and home life. It can be challenging."*

Remote Work Changes: Neutral or positive impact of shift to phone and telehealth

- *"Assessments completed via telephone. Unfortunately our agency would not allow clinicians to complete telehealth assessments via video. We have been unable to go into hospitals to complete level of care assessments, and there have been more individuals being sent directly inpatient due to the lack of face to face assessments."*
- *"During the pandemic time, we as crisis workers were no longer required to assess individuals face-to-face as it was allowable to assess via phone/video over the phone. We were unable to provide face-to-face in emergency rooms during that time. Clinical supervisors need to be contacted before mobile is contacted to ensure that it is necessary for mobile to be engaged, which was not necessary previously."*
- *"I am traveling less, utilization of telehealth, working from home"*
- *"Providing few intakes/access screenings, less client demand"*

Remote Work Challenges: Challenges with working remotely

- *"It has been hard to work remotely and lose the sense of team and family from those at the office. Most staff report feeling lonely and are happy for the days they get to come to the office."*
- *"It is difficult to ensure you have the appropriate things in your home bc trucks are delivered to stores typically in the morning when I would be at work."*
- *"The biggest change in my role was working remotely from home for early 12 weeks and supervising the work of the treatment remotely."*
- *"As a very part-time worker, I stopped working and only recently (within the last few days) resumed my shifts. Most shifts were covered by regular (i.e. no PRN) workers. Prior to COVID, I was working 1 night shift per week."*

Personal Stress: Stress due to fear, isolation, and changes in routine

- *"COVID 19 must be considered in every decision made, who can work from home, who is essential, keeping staff engaged who work from home, constantly changing guidelines, etc."*
- *"Stress. Anxiety. Adjusting to wearing masks and being severely asthmatic. Stress with teaching our children school work at home. Adjusting our schedules to work around our work schedules, teaching school as it was online. Being around family more than usual (not that it was a bad thing)."*
- *"I was home thinking of my co-workers throughout the day. I was concerned and worried for their safety. I also felt like I abandoned them even though my doctors said I did not belong at work due to my health issues."*
- *"I became more anxious about my own health and well-being and worried about the impact it would have on me if I became sick and with no financial means to access for myself and my son"*

Anxious for Staff/Clients: Anxiety due to safety concerns for staff and clients

- *"Increased stress due to the unknown, staff concerns, staff not wanting to work due to fear"*
- *"greater work because of less staffing, conflicts among staff members due to differing levels of concern"*
- *"safety concerns were unexpected due to unexpected potential for violence"*
- *"Tough to carry feeling of responsibility to have all my staff need to do their jobs, in spite of national shortages of supplies. (Rationally, I know I can't control these things, but when staff look to leadership for help in doing their job, it falls to me to provide answers.)"*

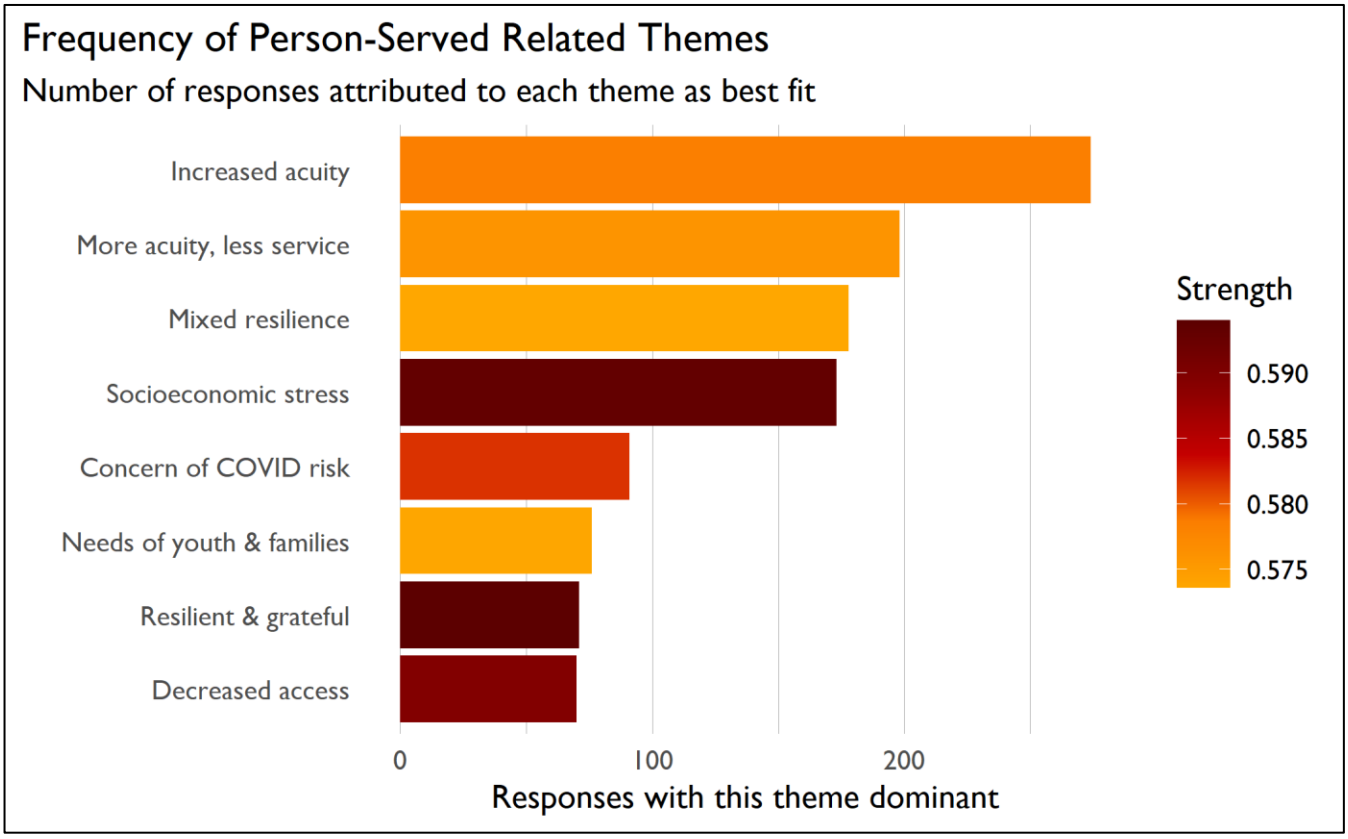
Job Capacity: Concerns regarding ability to perform job well

- *"Due to layoffs from about 1/3 of the company, I've had to work for a different county, take on additional roles of chart reviews. We're now working from home - which seems to be beneficial and saves some money in traveling expenses."*
- *"For some reason we have had fewer requests for consults, and thus fewer we have referred to a psychiatric hospital. I have not yet had the challenge of receiving and sending FAX info. So far it has been more convenient for me, but I am sure in some ways it will be more of a challenge. We are not skyping yet, so I miss seeing the person face to face."*
- *"Due to working in a jail through a grant and lack of technology and privacy in that jail, I am unable to fully do my job. I have been able to coordinate a couple things, but have not been able to have any contact with my targeted population."*
- *"Because of our building, we are unable to see people in the building for walk in services. We are seeing them outside if weather permits. If it is not nice out, we will see a person on our locked psychiatric unit. We have increase calls for people distressed because the clinic is not taking intake appointments."*

Issues Related to Persons Served

The bar graph below shows the most prominent themes identified from the open-text survey questions related to person receiving services across all crisis service types, specifically:

- "How have the people you serve been impacted during this time? How have their needs or presenting problems changed or increased in complexity?"
- "When thinking of the people you serve, what changes have you noticed in their demeanor, hopefulness, or resiliency?"



- **Increased Acuity**: **Increased mental health symptoms including anxiety, anger, hopelessness, paranoia, and comorbid health issues**
  - *"Increase in substance use issues, increase in relapses of substance use issues, increase in severity of mental health symptoms."*
  - *"Consumers are fearful of seeking psychiatric hospitalization, medical attention, even fearful of having MCOT staff in their homes. Consumers are not addressing their medical needs, it can be difficult to treat their mental health and psychiatric needs when they are not addressing their medical needs. We have seen an increase in high BP, resting heart rate, and consumers refusing to see their PCP for follow up."*
  - *"Everyone's anxiety level has increased. The increased complexity is mainly due to their chronic underlying conditions being exacerbated by fear, anxiety and social isolation."*
  - *"The clients I service has been having some increased symptoms due to the fear of Covid 19 and the stay at home orders."*
- **More Acuity, Less Service: Increased acuity compounded by difficulty accessing needed resources**
  - *"complicated grief, financial struggles, family conflict, isolation-difficulty accessing MH services"*
  - *"Due to isolation and limited contacts with others, needing more time and attention from crisis staff (longer calls, more intense topics). Economic, family stressors increased"*

- *"They have increased in complexity b/c it can be more difficult to link them to necessary resources (e.g. homeless shelters are all shut down) ,"*
- *"All individuals we have served have complex needs however some of them have been unable to see their providers because they're not providing telehealth, have a poor home life, inability to work causing financial distress"*

Mixed Resilience: Mixed positive and negative responses regarding resilience

- *"The children are struggling to understand and are restless, causing frustrations, problems transitioning/adjusting, and increase in emotional disturbance and behavioral problems. Adults appear less hopeful, struggling with environmental changed and reduced support systems."*
- *"The clients I serve have been suffering from increased depression and less resiliency in bouncing back. I'm hoping that will change as F2F contacts are allowed again."*
- *"Their hopefulness today is a lot higher than when the pandemic first started. Everyone was in a huge panic at first."*
- *"For the most part, people have remained hopeful and resilient"*

Socioeconomic Stress: **Mental stress related to quarantine isolation, financial issues, housing, etc.**

- *"The longer the quarantine goes on, the more likely people will have difficulty "pushing through" as there is no end in sight."*
- *"Lots of frustration with restrictions and not being able to discharge to places that have commitment to them."*
- *"Everyone is under more stress with the pandemic, the accompanying loss of employment and income for many and with the entire country facing an uncertain future. People with existing anxiety and depressive disorders are obviously going to be more impacted than those without, often resulting in an exacerbation of symptoms."*
- *"Presenting problems have certainly been more reflective of isolation, anxiety of the future, difficulty in adjusting to a new environment and depression."*

Concern of COVID risk: **People worried about risk of COVID and its impact for self/others**

- *"They too are worried about contracting Covid-19. Their worried about their family and friends as well. Their mental health is affected. They are anxious and depressed. They are limited on socialization. They need support and may feel abandoned and isolated."*
- *"The clients feel safe within the building; however, they are becoming less hopeful in being able to be within the community and being able to see friends and family."*
- *"Some struggle, many question either need of isolation or fear of getting covid19"*
- *"They are scared and concerned because of the uncertainty."*

Needs of Youth & Families: **Increased needs related to youth and families, including stressors with school and home environment**

- *"Students - kids are our main population. They are now doing distant learning from home, so there has been a significant decrease in referrals. Good for them, bad for us."*
- *"We provide services to youth so not as much direct impact on them. Staff needed to monitor what they were saying around the youth. Some parents did not want their youth placed due to COVID 19 concerns."*

- *"Kids have not been in school for months or able to socialize with friends and this seems to have increased depression for many as well as lead to more conflict with parents over getting school work done. Many clients have had their ongoing services interrupted by covid-19 such as not even seeing their therapists over teletherapy for several months."*
- *"We serve youth ages 5-17. We were surprised to see the presenting issues were not primarily related to COVID 19 and youth were not discussing concerns related to the pandemic. This does not mean that it has not exacerbated existing issues. Social isolation related to quarantine has seem to impact the youth served the most."*

Resilient & Grateful: People are resilient, grateful for program, with reluctant social distancing

- *"Since most every service is being provided telehealth we have found that our clients have been dramatically affected, not from not getting services, but from having their routine in services upended. We are finding that our specialty court population particularly seem to be relapsing more frequently - our counselors and therapists, once they realized this, stepping up their individual sessions with these individuals and, I am happy to say, everybody is back with their program."*
- *"Our staff report that overall our clients are doing well and are appreciative of the continued services in a slightly different platform."*
- *"Some individuals have done very well while others have struggled significantly with the lack of contact with others and social supports. Many other individuals have not understood recommendations such as social distancing."*
- *"More people coming together and working collectively to get through this difficult time. Staying faithful and grateful for each day."*

Decreased Access: Impact of decreased access and move to telehealth

- *"The hospitals and police are used to crisis going mobile to the hospital and we did not during this time. Assessments are done best through mobile. Our community partners have mentioned they miss the mobile aspect of services. I feel that the Clients also benefit from mobile. Unfortunately we are not allowed to have people in the building if it can be prevented and this is also difficult. People reach out to crisis for face to face support and some crisis can be diverted by meeting 1:1."*
- *"Not being able to provide as much in person services has made an impact, especially in cases where the consumer does not have the technology to do online services"*
- *"Our calls are down as our walk ins. Some people are fearful services will not be "normal" for sometime."*
- *"People everywhere are testing positive. If they are testing positive, they may not be accepted into appropriate inpatient facilities. Where do they go? How long and where do they quarantine before they will be placed for stabilization? Hard questions that need answers."*

The following pages provide detailed analysis of survey results separated by provider type: Mobile Crisis, Crisis Residential and Crisis Call Centers.

I. Mobile Crisis

Mobile Crisis Outreach Teams (MCOTs) are comprised of some combination of clinicians, paraprofessionals, law enforcement officers, and persons with lived experience with mental illness, known as peer support specialists. MCOTs serve people in a mental health crisis by meeting them almost anywhere in the community, from homes and schools to places of employment and public spaces. MCOTs divert people from unnecessary Emergency Department and psychiatric hospitalization when other effective community-based alternatives are available.

Why Mobile Crisis Outreach Teams are Important During COVID-19

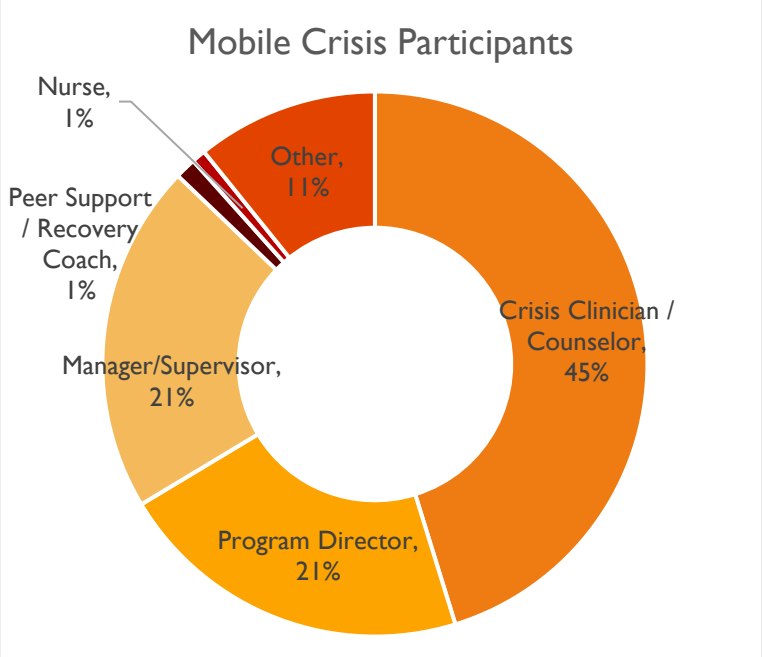
At a time when hospitals are focusing their resources on COVID-19+ patients, people experiencing a mental health crisis need viable alternatives for mental health screening, assessment, and referrals to available services without having to enter a hospital or Emergency Department. Telehealth solutions can also allow first responders to virtually connect MCOTs with individuals in crisis if MCOTs are forced to work remotely.

Mobile Crisis Survey Results

Participation from mobile crisis team respondents increased from 147 in the April 2020 survey to 241 in the June 2020 survey, a 64% increase.

Mobile Crisis Survey Participants

Of the 249 mobile crisis survey respondents, 109 (45%) identified as a Crisis Clinician/Counselor, 51 (21%) identified as a Program Director, 50 (21%) identified as a Manager/Supervisor, 3 (1%) identified as Peer Support/Recovery Coach, 2 (1%) identified as a nurse, and 26 (10%) identified as Other.

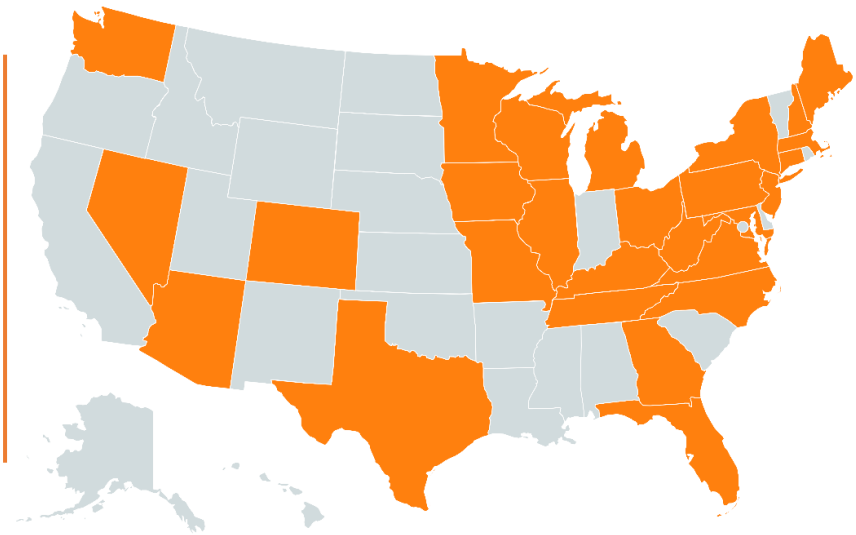


Locations of Participating Mobile Crisis Providers

Providers from 27 states (52%) responded

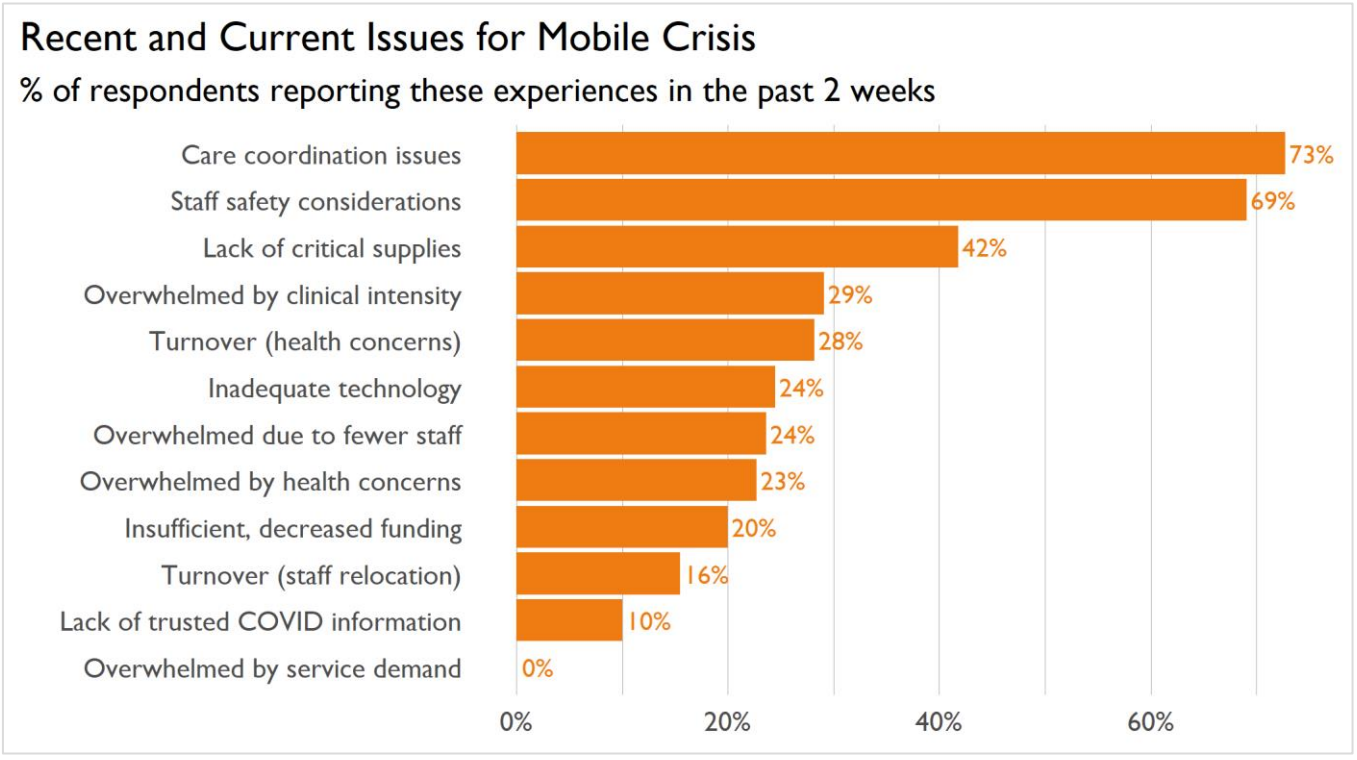
Highest Participation:
Michigan: 47
Texas: 44
Wisconsin: 33

Of the 27 states represented, **16 states (59%) had multiple participants of the survey**



Mobile Crisis Challenges

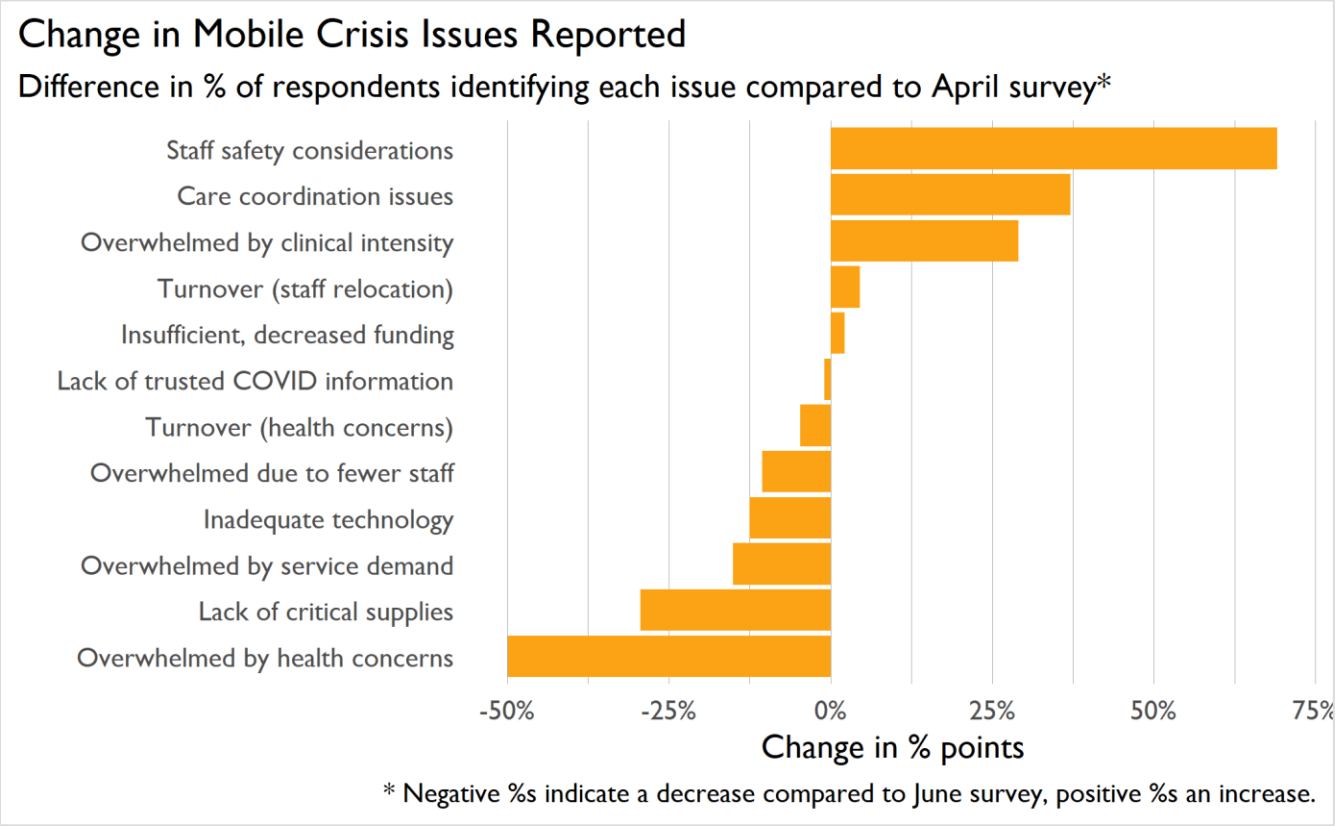
When asked about the current issues mobile crisis teams are facing, 73% of respondents reported care coordination issues and 69% reported concerns about keeping their staff safe and healthy. Over 42% reported a lack of critical supplies and equipment as a major concern. No respondents reported feeling overwhelmed by referrals or service volume.



Change in Issues Reported Compared to Initial Survey

When compared to the April 2020 survey results, mobile crisis team survey results demonstrated a 50% decrease in reports of feeling overwhelmed by health concerns and a 29% decrease in concerns about lack of critical supplies & equipment.

Compared to the April 2020 survey, respondents reported a 69% increase in staff safety concerns, a 37% increase in care coordination issues, and a 29% increase in feeling overwhelmed by clinical intensity.

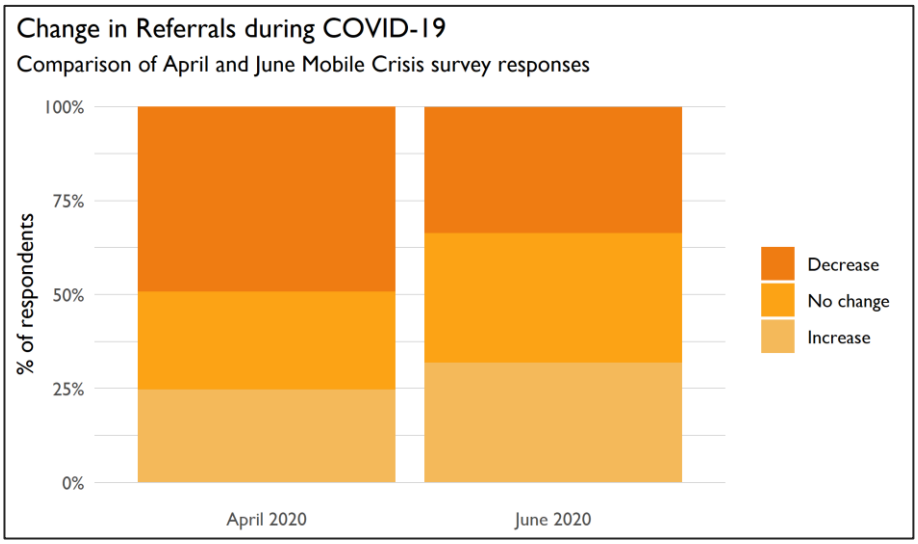


Changes in Mobile Crisis Referrals

Survey respondents were asked if they have seen a change in referrals for mobile crisis services in the past two weeks. Responses across mobile crisis programs were quite mixed, with an almost equal distribution of responses to all three options. 35% of respondents reporting no change in referrals, 34% reporting a decrease in referrals, and 32% reporting an increase in referrals.

Type of Change	Initial Survey	Update Survey
Decrease	49.3% (n = 72)	33.6% (n = 37)
Increase	24.7% (n = 36)	31.8% (n = 35)
No change	26% (n = 38)	34.5% (n = 38)

This table shows the June 2020 survey results compared to the April 2020 survey results. A higher percentage of mobile crisis respondents reported an increase in referrals in the previous two weeks (32%) compared to the April survey (25%), and a lower percentage of respondents reported a decrease in referrals (34% vs. 49%). Respondents reporting no change in referrals rose from 26% to 35%.



II. Crisis Residential

Crisis Residential Programs (CRPs) are residential alternatives to psychiatric hospitalization. Over 700 adult CRPs and 100 youth CRPs exist across the United States. These programs are referred to by many different names across the country, including Crisis Residential Units, Crisis Stabilization Units, Community Crisis Stabilization, Crisis Respite, Facility-Based Crisis, and many others.

Why Crisis Residential Programs are Important During COVID-19

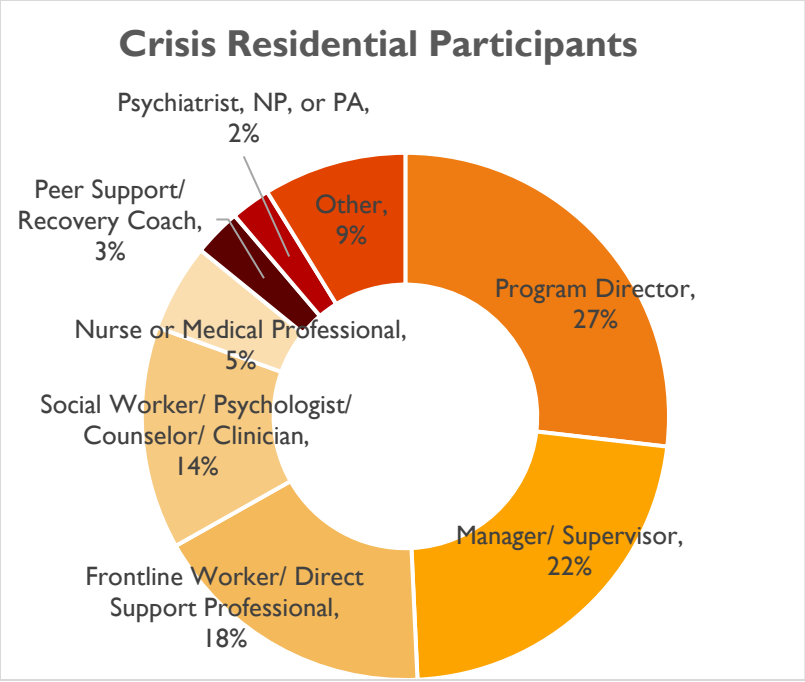
CRPs provide an effective and cost-efficient diversion from psychiatric hospitalization, instead serving people in small to moderately sized (6 to 16 beds) homelike environments. For individuals experiencing a mental health crisis who would benefit from in-person social rehabilitation, treatment and support, CRPs are the ideal setting for crisis stabilization and recovery.

Crisis Residential Survey Results

Participation from crisis residential program respondents increased from 130 in the April 2020 survey to 205 in the June 2020 survey, a 58% increase.

Crisis Residential Survey Participants

Of the 205 Crisis Residential survey responses, 55 (27%) identified as a Program Director, 46 (22%) identified as a Manager/Supervisor, 36 (18%) identified as a Frontline Worker/Direct Support Professional, 28 (14%) identified as a Social Worker/ Psychologist/ Counselor/ Clinician, 11 (5%) identified as a Nurse or other Medical Professional, 6 (3%) identified as a Peer Support/Recovery Coach, 5 (2%) identified as a Psychiatrist, Nurse Practitioner, or Physician's Assistant, and 18 (9%) identified as Other.

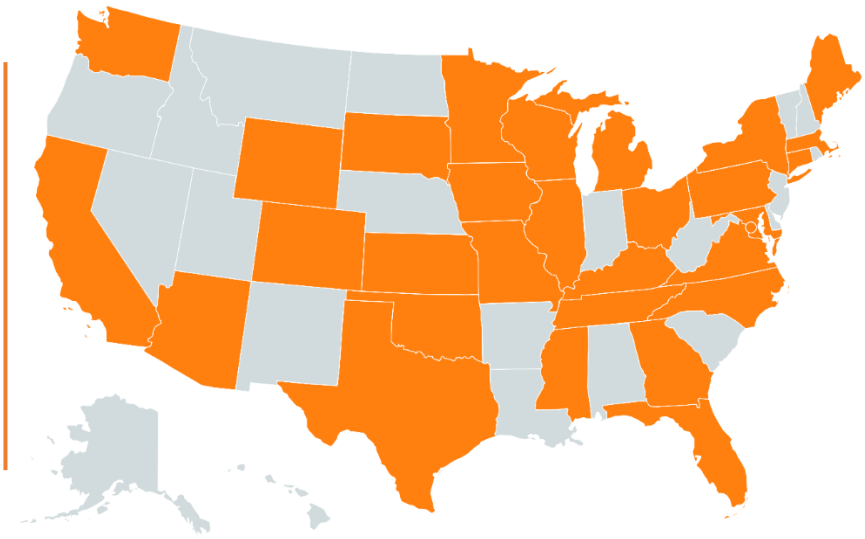


Locations of Participating Crisis Residential Providers

Providers from 29 states (58%) responded

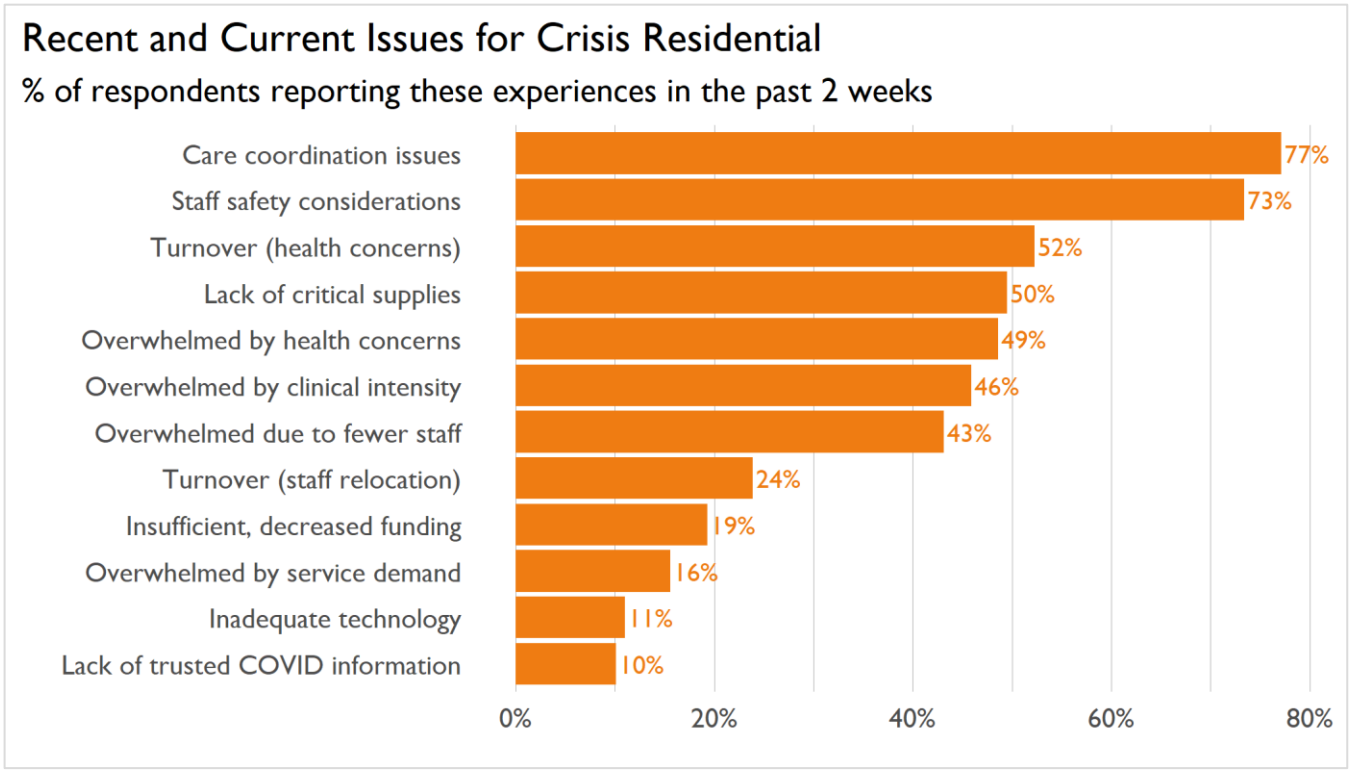
Highest Participation:
California: 49
Michigan: 26
Texas: 20

Of the 29 states represented, **19 states (66%) had multiple participants of the survey**



Crisis Residential Challenges

When asked to indicate which issues the CRPs are experiencing, 77% of respondents reported care coordination issues and 73% reported concerns about health and safety of their staff. Over half of respondents reported dealing with turnover due to health concerns (52%), and 50% reported feeling overwhelmed by the clinical intensity. Nearly half of respondents reported feeling overwhelmed by health



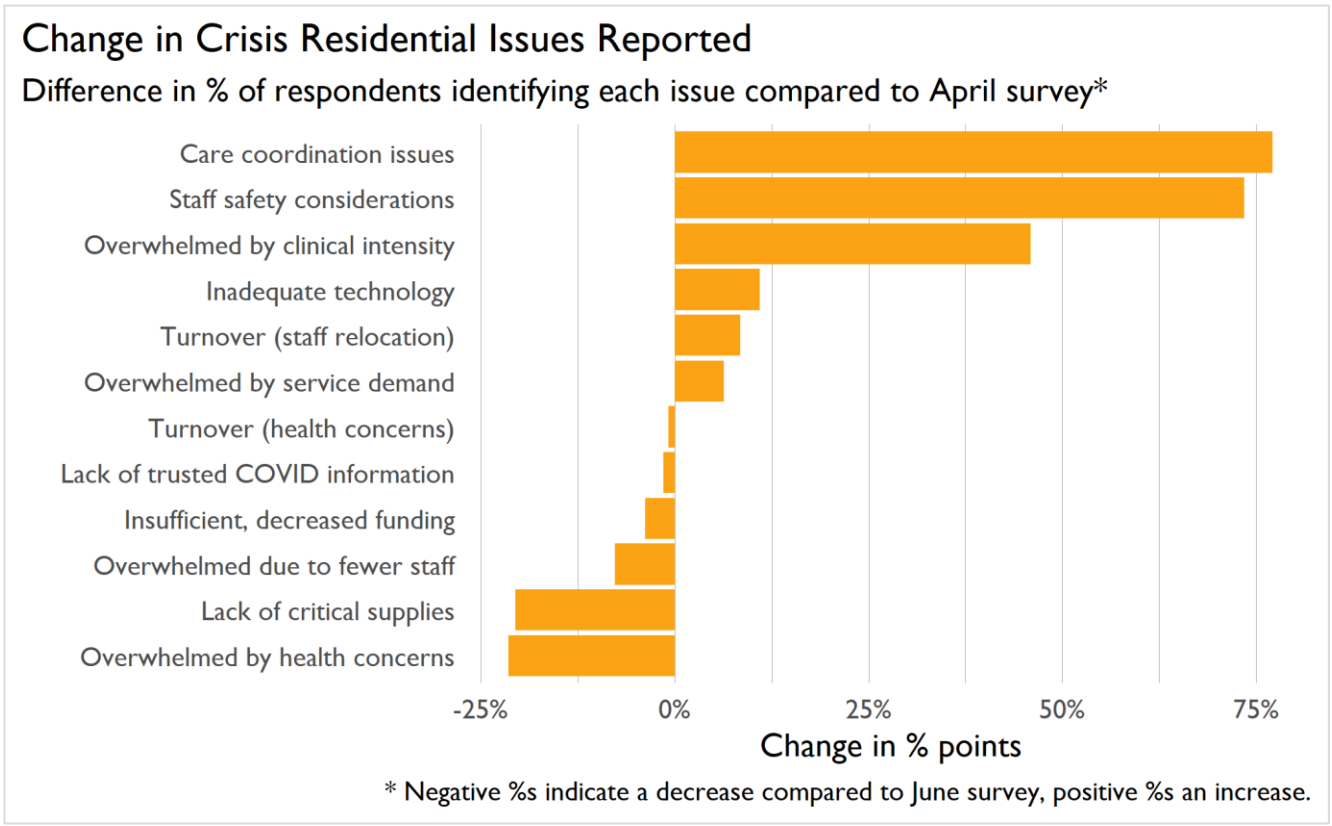
concerns (49%), feeling overwhelmed by clinical intensity (46%), and feeling overwhelmed due to having fewer staff available (43%).

Change in Issues Reported Compared to Initial Survey

Compared to the April 2020 survey, crisis residential respondent results indicate the following:

- 77% increase in reported care coordination issues
- 73% increase in staff safety considerations
- 46% increase in feeling overwhelmed by clinical intensity.

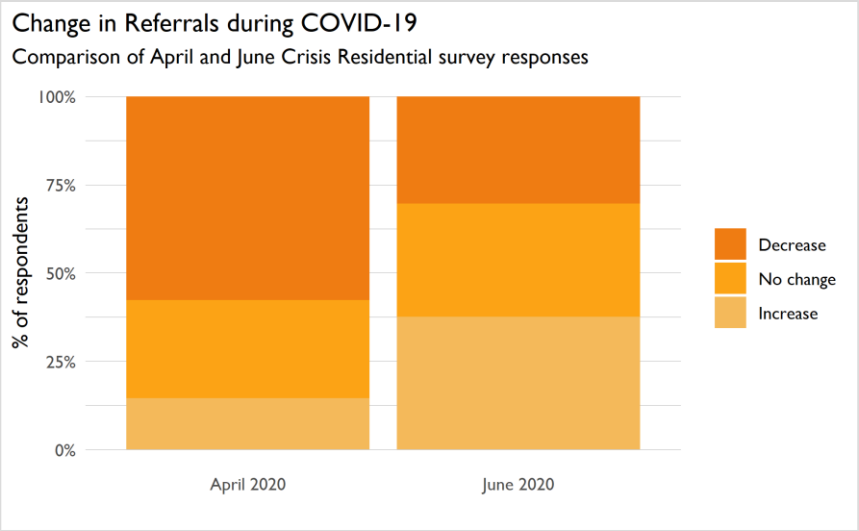
Respondents also reported feeling overwhelmed by health concerns at a rate 21% less than the first survey, and fewer respondents concerns about a lack of critical equipment & supplies (21% less than the first survey.



Changes in Crisis Residential Referrals

Participants answered the question "Please indicate the type of change you have seen in your referrals or occupancy and use the "Other" section to share the approximate change % and any additional information."

38% of respondents reported an increase in referrals to their CRP, while 32% recorded no change, and 30% reported a decrease in referrals. When compared to the initial survey results, the percentage of CRPs reporting an increase in referrals increased from 14.6% to 37.6%. The table below shows the June 2020 survey results compared to the April 2020 survey results.



Type of Change	April '20 Survey	June '20 Survey
Decrease	57.7% (n = 75)	30.3% (n = 33)
Increase	14.6% (n = 19)	37.6% (n = 41)
No change	27.7% (n = 36)	32.1% (n = 35)

III. Crisis Call Centers

Crisis call centers provide phone, chat, and text support to people experiencing emotional distress. Over 700 crisis call centers exist in the United States, and some are referred to as suicide prevention hotlines. Crisis call centers are often the first point of access for people experiencing a mental health crisis, de-escalating individuals and connecting them with helpful community resources.

Why Crisis Call Centers are Important During COVID-19

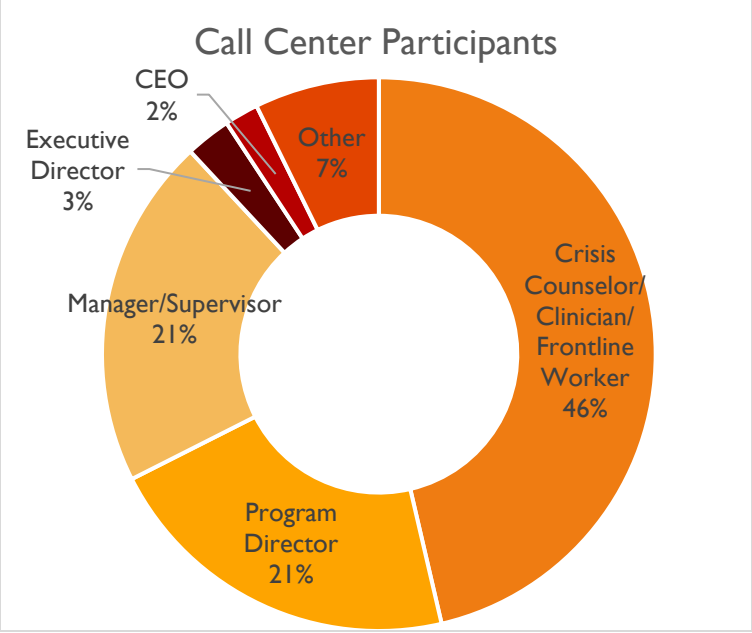
As the resources designed to respond to community emergencies (911, first responders, and Emergency Departments) are being heavily utilized to respond to COVID-19-releated emergencies, people in a mental health crisis need a place they can turn for help. With proper support and referrals, crisis call centers can help decrease the utilization of higher levels of care, such as the emergency department or psychiatric hospital.

Crisis Call Center Survey Results

Participation from crisis call center respondents increased from 86 in the April 2020 survey to 151 in the June 2020 survey, a 76% increase.

Crisis Call Center Survey Participants

Of the 151 Crisis Call Center survey responses, 70 (46%) identified as a Crisis Counselor/Clinician/Frontline Worker, 32 (21%) identified as a Program Director, 31 (21%) identified as a Manager/Supervisor, 4 (3%) identified as an Executive Director, 3 (2%) identified as a CEO, and 11 (7%) identified as Other.

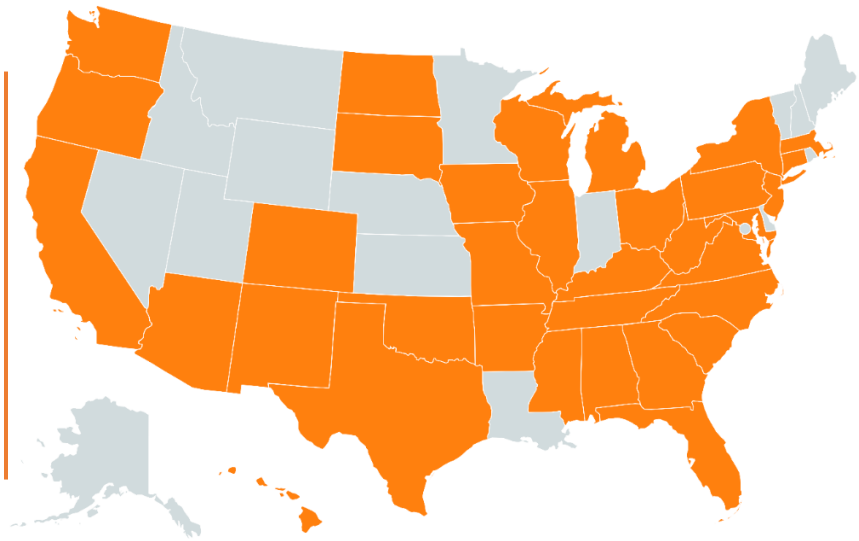


Locations of Participating Crisis Call Centers

Providers from 34 states (68%) responded

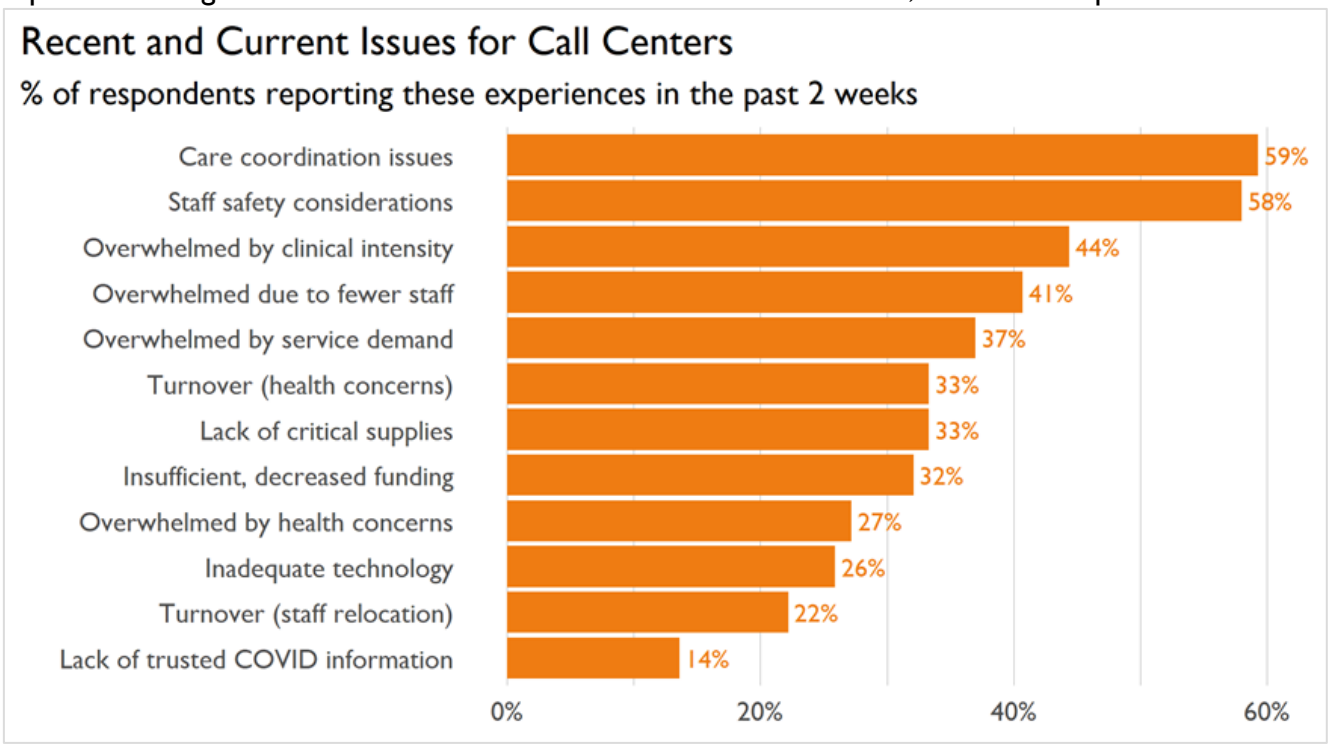
Highest Participation:
Michigan: 30
Pennsylvania: 15
Texas: 12

Of the 34 states represented, **21 states (62%) had multiple survey participants**



Crisis Call Center Challenges

When asked to indicate which issues Crisis Call Centers are experiencing, 59% of survey respondents reported having care coordination issues due to health concerns, and 58% reported staff safety



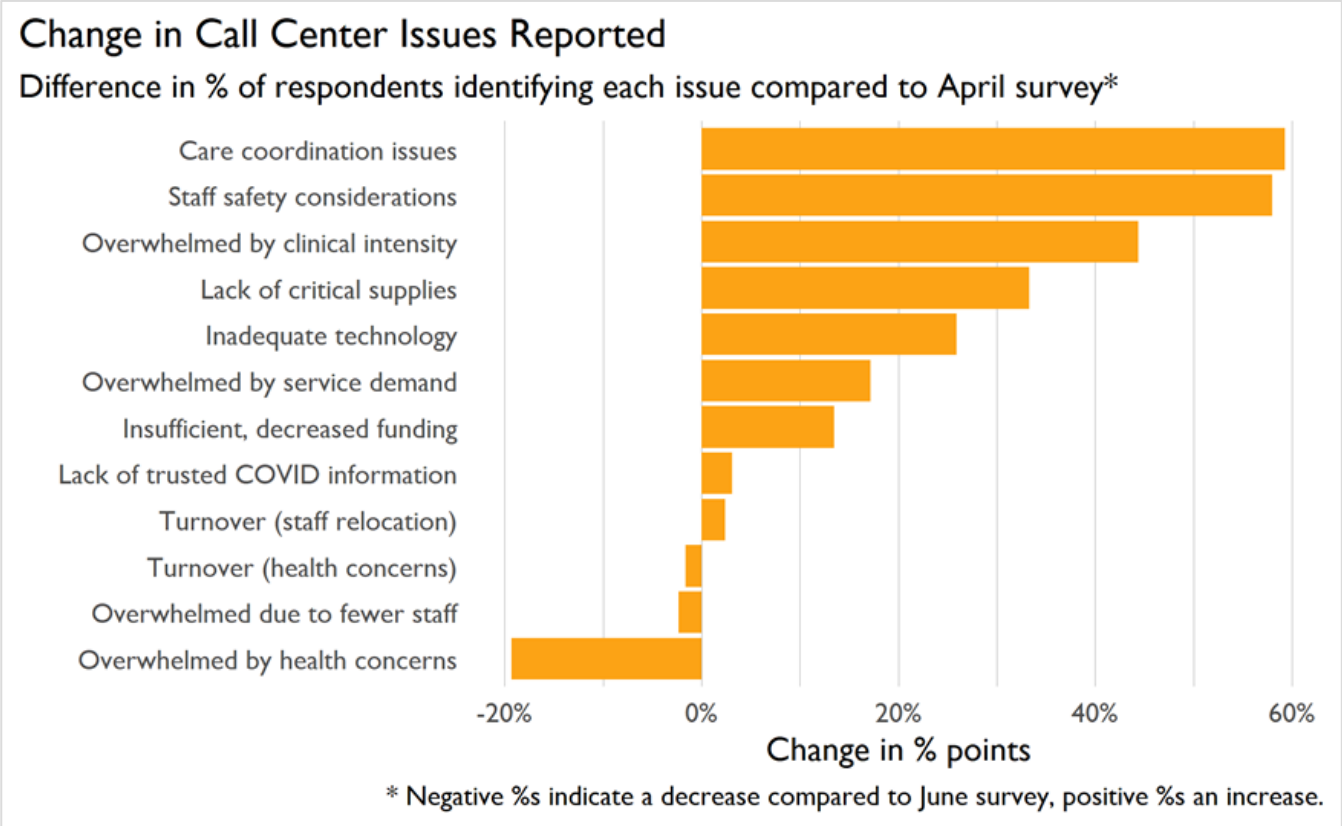
considerations. More than 2/5 of respondents reported feeling overwhelmed both by clinical intensity (44%) and fewer available staff (41%), and over 1/3 reported feeling overwhelmed by call volume.

Change in Issues Reported Compared to Initial Survey

Compared to the April 2020 survey, results from crisis call center responses indicate the following:

- 59% increase in care coordination issues
- 58% increase in staff safety considerations
- 44% increase in feeling overwhelmed by clinical intensity
- 33% increase in lack of critical supplies
- 28% increase in inadequate technology to work remotely or adapt as needed.

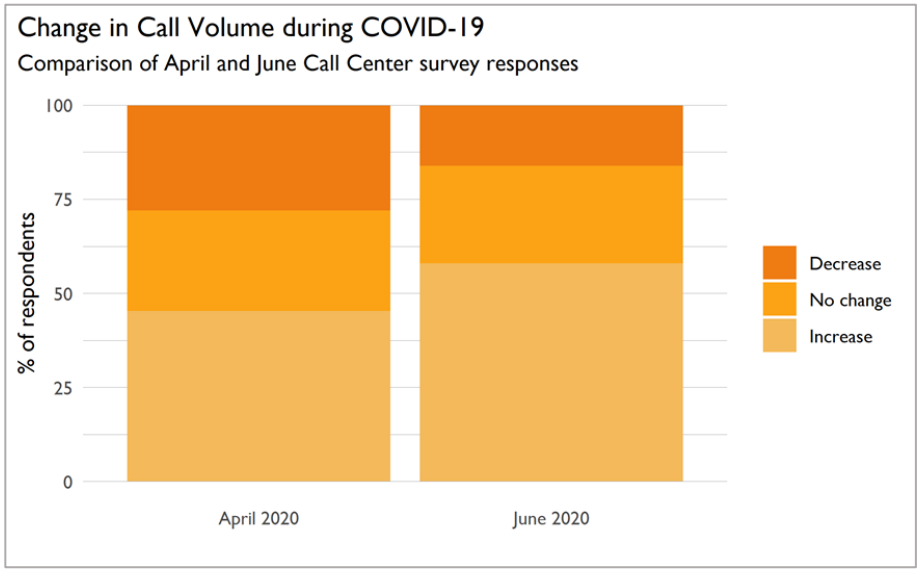
Fewer respondents reported being overwhelmed by health concerns (19% less than the first survey).



Changes in Crisis Call Center Volume

Participants from Crisis Call Centers answered the question "Please indicate the type of change you have seen in your call volume over the past two weeks and use the "Other" section to share the approximate % change and any additional information."

58% of respondents reported an increase in call volume, 26% reported no change, and 16% recorded a decrease in call volume. Respondents opting to report specific details about **increases** in call volume reported increases from 9% to 100%. Respondents opting to report specific details about **decreases** in call volume reported decreases from 7% to 50%.



Type of Change	April Survey	June Survey
Decrease	27.9% (n = 24)	16% (n = 13)
Increase	45.3% (n = 39)	58% (n = 47)
No change	26.7% (n = 23)	25.9% (n = 21)

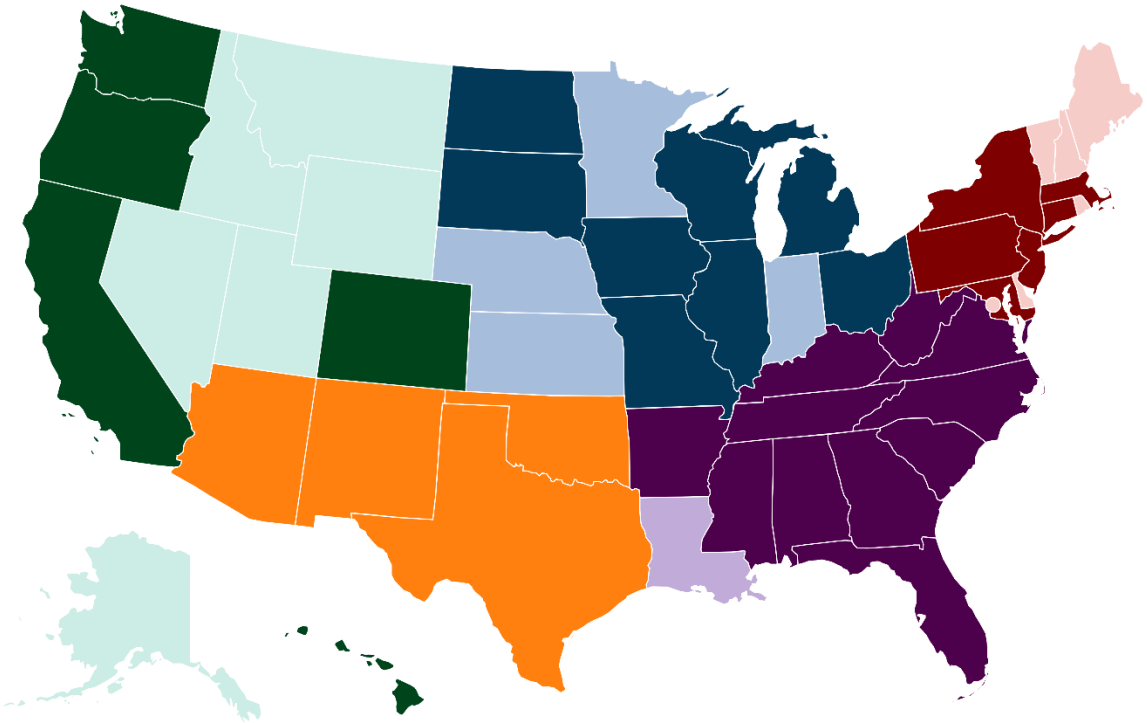
Regional Analysis

Survey responses were also analyzed based on the region of the country where the crisis call center provider is located to provide insight on where call volume differences were most prominent.

West
14/151 (9%) respondents

Midwest
65/151 (43%) respondents

Northeast
29/151 (19%) respondents



Southwest
17/151 (11%) respondents

Southeast
26/151 (17%)

The regional summary includes states categorized into the following five regions:

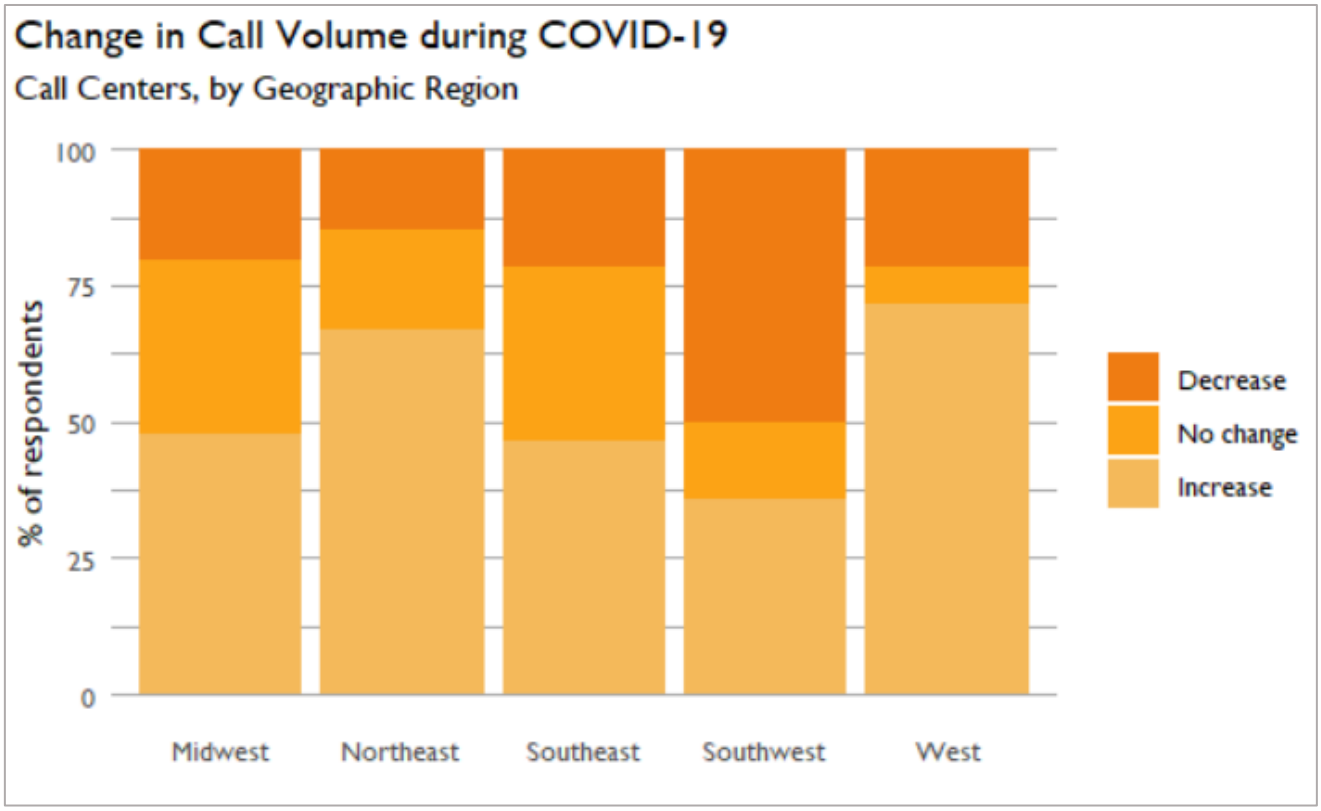
West: Colorado, Wyoming, Montana, Idaho, Washington, Oregon, Utah, Nevada, California, Alaska, Hawaii

Southwest: Texas, Oklahoma, New Mexico, Arizona

Midwest: Ohio, Indiana, Michigan, Illinois, Missouri, Wisconsin, Minnesota, Iowa, Kansas, Nebraska, South Dakota, North Dakota

Northeast: Maine, Massachusetts, Rhode Island, Connecticut, New Hampshire, Vermont, New York, Pennsylvania, New Jersey, Delaware, Maryland

Southeast: West Virginia, Virginia, Kentucky, Tennessee, North Carolina, South Carolina, Georgia, Alabama, Mississippi, Arkansas, Louisiana, Florida



Respondents in the Western states recorded the greatest increase in call volume (71%) followed by respondents in the Northeastern states (67%). Respondents from Southwestern states reported the largest decrease in calls (50%).

Region	Change in Volume	Responses	%
Midwest	Decrease	17	20.2
Midwest	Increase	40	47.6
Midwest	No change	27	32.1
Northeast	Decrease	4	14.8
Northeast	Increase	18	66.7
Northeast	No change	5	18.5
Southeast	Decrease	6	21.4
Southeast	Increase	13	46.4
Southeast	No change	9	32.1
Southwest	Decrease	7	50.0
Southwest	Increase	5	35.7
Southwest	No change	2	14.3
West	Decrease	3	21.4
West	Increase	10	71.4
West	No change	1	7.1

Conclusion

Crisis call centers, mobile crisis teams, and crisis residential programs play a critical role in the behavioral health care system, providing timely access to care in community settings with cost-effective and outcomes-driven solutions. During the COVID-19 pandemic, these services' ability to divert people from Emergency Departments while connecting individuals to appropriate, available services has helped to mitigate the unintended consequences of social distancing—increased anxiety, depression, hopelessness, and deaths of despair.

Despite months of adjustment and adaptation, many issues persist in the behavioral health crisis continuum, including a consensus across all crisis provider types of challenges related to care coordination. An interconnected system of crisis services is susceptible to dysfunction if providers are not operating at their optimal level, leaving fewer options for people in crisis to receive care and potentially delaying critically important treatment.

The value of a physically and mentally healthy behavioral health crisis professional cannot be understated as they stand to help and support countless persons in crisis. Communities that experience attrition of their behavioral health crisis workforce may experience detrimental outcomes, especially as survey results demonstrate that the frequency and acuity of persons seeking crisis care are increasing.

In order to assure high-quality and uninterrupted service delivery, behavioral health crisis workers should be afforded the same protections as their essential health care worker counterparts—namely, fair compensation that reflects the importance of their work, access to ample amounts of PPE and sanitation supplies, and technology that provides flexibility and safety through minimal exposure to health risk.

In addition, funding models for behavioral health crisis services should be re-evaluated to assure their long-term sustainability in periods of low utilization or fragmented care coordination with other impacted care partners.

Even if these accommodations are made available, some crisis services are still best delivered in person. Service delivery methodology should not be altered without serious considerations regarding its impacts—namely, the mental and emotional cost exacted on people in crisis by social and physical distancing, and the repercussions to the behavioral health ecosystem.

About This Survey

This survey was underwritten by a grant by the Michigan Health Endowment Fund.

For more information, visit https://mihealthfund.org/.

About TBD Solutions

TBD Solutions (TBDS) is a consulting, training, and research firm specializing in behavioral health crisis system design, function, and performance. Formed in 2011, TBD Solutions is committed to the values of high-quality, cost-effective, and client-centered care that effectively meets the urgent and ongoing needs of individuals receiving services.

Learn more at www.TBDSolutions.com.

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