Lived experience in the Montana behavioral health crisis response system

Individual, family, and provider views of gaps in service and recommendations

REPORT INFORMATION AND ACKNOWLEDGMENTS

This report was written by Genevieve Cox and Brandn Green (JG Research & Evaluation) for the Behavioral Health and Developmental Disabilities Division (BHDD) of the Montana Department of Public Health and Human Services (DPHHS).

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SUMMARY

Developing care systems that are well equipped to respond to individuals who are experiencing a behavioral health crisis in Montana, including those related to substance use crisis and mental health crisis, is essential for achieving comprehensive healthcare and comprehensive social services systems within Montana communities. Despite the dedicated work of behavioral health providers and first responders, the existing crisis system in Montana includes significant gaps in and barriers to services. This study aims to enhance understanding of both gaps and facilitators to effective services from the perspective of those experiencing the behavioral health crisis system firsthand in Montana. The study included interviews with 26 individuals who have lived experience in receiving services within the crisis system (11 participants), work within the crisis response system (11 participants), or are family members of those who are high utilizers of the system (4 participants). Participants recounted experiences of recent crises up to 20 years prior to our interviews. However, most participants with lived experience (n = 8) recounted recent crises that happened within the last 5 years. All experiences that are shared in this report are those which happened in Montana for study participants.

We found that both providers and utilizers of the system identified common barriers to quality and ability to engage in ongoing care including stigma, a lack of long-term care facilities, staffing shortages, transportation and scheduling problems, isolation during crisis, a lack of follow-up care including case and medication management, provider bias and burnout, a lack of housing, low reimbursement rates, and poor communication/coordination between care entities. We also found that providers and utilizers identified common facilitators, or helpful parts of the Montana crisis system, that included compassionate providers with active listening skills, advances in telehealth services, and grants that have enabled organizations to implement innovative new programs.

Recommendations based upon the study findings include a need for case managers, expansion of peer support networks, mobile crisis response, and telehealth, and the creation of community drop-in centers and transitional living environments.

BACKGROUND

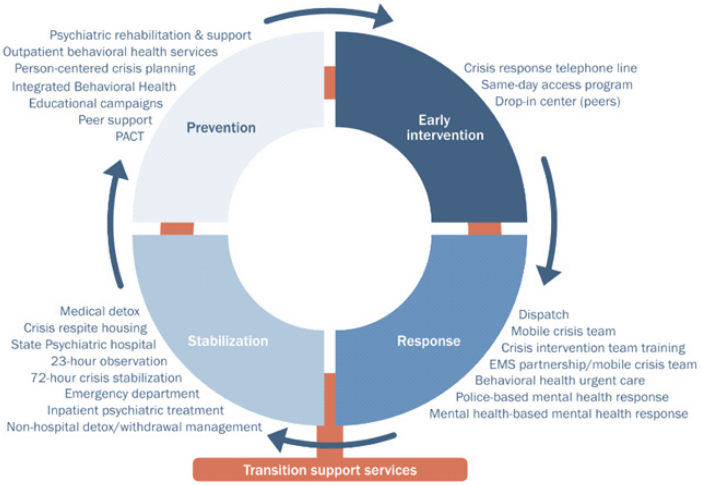
Over the past two years, JG Research and Evaluation (JG) has completed a series of quantitatively focused reports to better depict the behavioral health crisis response systems within seven Montana counties. These reports have been completed for the counties of Silver Bow, Flathead, Gallatin, Lewis and Clark, Missoula, Ravalli, and Yellowstone. The aim of these reports has been to support and inform the efforts of coalitions within each county that are working to improve the behavioral health crisis response systems in Montana. This current study expands on these findings by offering perspectives from the individuals and providers utilizing and working within the behavioral health crisis system in Montana.

For these series of studies, the definition of a behavioral health crisis has been any situation in which an individual is a danger to themselves or others and/or is unable to care of themselves or function effectively in the community (National Alliance on Mental Illness). A behavioral health crisis is an adverse event that has been caused by substance use, an untreated or mismanaged mental health disorder, or a combination of the two.

Substance use crisis—The primary cause of a crisis or emergency is the misuse of a substance
Mental health crisis—The primary cause of a crisis or emergency is a mental, behavioral, or neurodevelopmental condition
Suicide ideation, suicide attempt, and self-harm—The primary cause of a crisis is thinking about, considering or planning for suicide, or undertaking non-fatal self-injurious behavior with or without the intent to die.

The behavioral health crisis care continuum is a framework for understanding the general pathway of a crisis and depicts how a crisis system can optimally function.

Figure 1. Behavioral Health Crisis Care Continuum



JG Research and Evaluation, 2021

In each county report, JG has used the four main components of the behavioral health crisis continuum (early intervention, response, stabilization, and prevention) to organize reports and structure understanding of behavioral health crisis response system. These stages informed the conceptualization of interview questions for participants of this current study and the organization of findings.

METHODS

A recent systematic review of existing qualitative studies that examined mental health and addiction related emergency department visits completed by Li et al. (2021), did not include a single existing study exploring patients' perspectives of how to improve existing community crisis services. The authors reported that they were unable to identify any studies from this perspective. Thus, a qualitative study of patients in the behavioral health crisis system in Montana greatly expands our existing understanding both within Montana, and in crisis response systems nationally. The current study adds qualitative context to existing JG reports by documenting the lived experience of providers and individuals within the system in Montana.

The purposes of this study are to:

- Uncover and document how those with lived experience of the crisis response system view system components, including existing barriers and facilitators of care.
- Expand understanding of the experiences of providers within the behavioral health crisis response system in Montana, including existing barriers and facilitators of care.
- Document recommendations on best practices for responding to a behavioral health crisis in Montana from the perspective of individuals and families who have been in crisis and providers who work with them.

Research questions include:

1. How do individuals and families in Montana experience and understand their personal behavioral health crises within Montana's emerging behavioral health crisis system?

2. In what ways does the experience of individuals, families, and practitioners inform barriers, facilitators, and best practices for care for initiating treatment and sustaining recovery for patients experiencing behavioral health crises in Montana?

STUDY DESIGN

DATA GATHERING

One member of the research team conducted 26 interviews with individuals who have experience within the behavioral health crisis system across 9 counties in Montana. Both rural and urban counties were sampled including Custer, Gallatin, Glacier, Hill, Lewis and Clark, Missoula, Silver Bow, Valley, and Yellowstone. The interviews included 11 individuals who have experienced (or have ongoing experience with) crisis and utilized crisis services themselves, 4 family members of frequent crisis system utilizers, and 11 providers who work within the system.

JG applied for and received Institutional Review Board (I.R.B.) approval from Western IRB. To initiate the study, one pilot interview was conducted with a key informant. After pilot findings were reviewed, and the interview guides were updated, the research team continued to sample interviewees using snowball sampling, or a chain referral method of sampling interviews. Interviews were conducted over Zoom. After explaining the aim of the study, a verbal consent script was read. All interviewees gave verbal consent to participate in the study and for the interviews to be recorded. The interviews ranged in length from 45 minutes to 1.5 hours. Participants were given a $20 gift card to Amazon.com or Town Pump as a thank you for their time. All interviewees were granted anonymity and pseudonyms are used in this report to ensure protection of participant identities.

DATA ANALYSIS

Audio recordings of the 26 interviews were transcribed and analyzed utilizing Atlas.ti software by the same member of the research team who conducted the interviews. Coding was conducted in two phases of open and focused coding. The resulting coding scheme included 86 codes. As data analysis progressed, the research team continued to meet to discuss initial findings and to refine the coding scheme. All quotes have been lightly edited for clarity and are presented anonymously to protect the privacy of those who were willing to participate in this study. Names used in the report to enhance the ease of reading are pseudonyms.

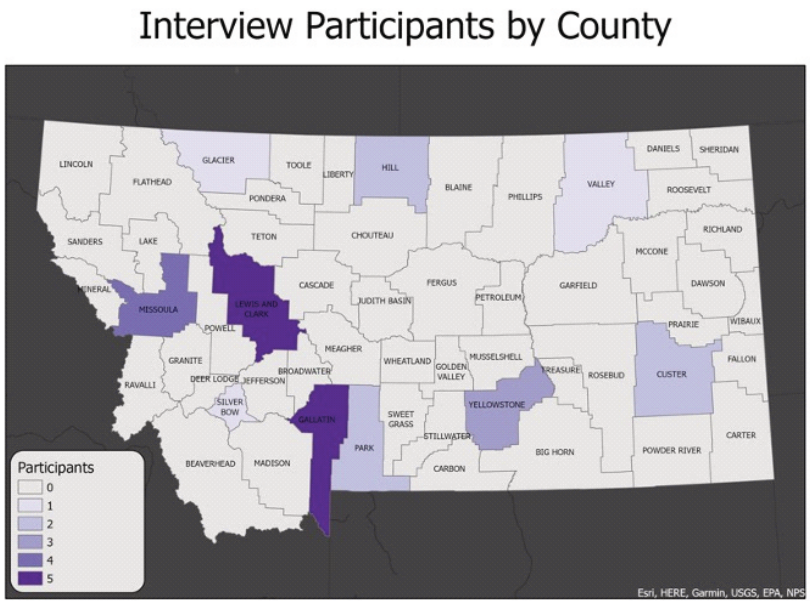
LIMITATIONS

Although prior research has shown that snowball sampling is a particularly robust method of sampling in vulnerable communities over other forms of qualitative sampling (e.g. Valerio et al. 2016), snowball sampling nonetheless has limitations. The cross-section of interviewees is not necessarily a geographically representative measure of experience in Montana. Moreover, sampling in communities with higher degrees of stigma around behavioral health conditions and crisis can be challenging, as participants might not wish to be forthcoming about their own experiences. However, the interviewees in our study expressed strong commitment to improving quality of service for individuals within the behavioral health crisis system in Montana. Further studies might expand the scope of this current study and build upon the findings.

Table 1. Profile of study participants

Participant type	Crisis type	Provider type
Family (4 participants)	MH (4 participants)	
Individuals (9)	SUD (2) MH (7)	
Individual and Provider (2)	SUD	Nonprofit service provider
Provider (8)		Behavioral health provider
Provider (1)		Nonprofit service provider
Provider (1)		Social service provider
Provider (1)		Law enforcement

Many patients in crisis present with a co-occurring mental illness and substance use condition (NAMI 2018). This was similar in our interviewees, as there was some overlap between those who had experienced both mental health crisis and substance use crisis. Moreover, there was some overlap with individuals having been through crisis themselves and beginning to work within the crisis system, as they reported a personal motivation to be able to provide service to others in crisis.



RESULTS

When discussing their own behavioral health crises, or their experiences helping those in crisis, participants recounted personal stories that included examples of difficulties or gaps in service in the Montana crisis system that they identified as barriers to getting adequate treatment or sustaining recovery. Participants also discussed facilitators to care, or positive parts that help enable the system to run well, which facilitated their ability to access services, receive treatment, and eventually sustain recovery. Below, results are organized by the two overarching research questions for this study. Part I presents the participants' narratives of their personal crises within Montana's behavioral health crisis system. Part II focuses on the second research question which includes the identification of barriers, facilitators, and recommendations for improving the behavioral health crisis care system in Montana.

PARTICIPANTS' UNDERSTANDING AND EXPERIENCES OF BEHAVIORAL HEALTH CRISIS

This research concentrated on the question, "How do individuals and families in Montana experience and understand their personal behavioral health crises within Montana's emerging behavioral health crisis system?" In responding to interview questions about their experiences, individuals recounted stories of emergency room visits, stays in jail, residing in longer-term institutions for mental health illness, suicide attempts, experiences of stigmatization and marginalization, feeling isolated, and also being in recovery from both substance use and/or mental health crisis. Most participants experienced multiple mental health or substance use crises as part of sustaining recovery.

Triggers and experiences during crisis

Participants spoke about what triggered their crises. Two participants noted grief from the loss of their young children as precipitating their mental health crises, one discussed a genetic history of bipolar disorder, one participant discussed the loss of housing during COVID and the financial strain of an unplanned pregnancy, while others explained how changes in life circumstances (i.e., divorce) triggered their underlying mental health issues into full-blown crises. Multiple participants recounted their own histories of growing up in familial environments where substance use or dysfunctional familial relationships might have predisposed them to substance use or mental health issues.

> *My dad was a heroin addict. He took us to AA meetings, but he would sell dope on the staircases. And just always with different women, never had any structure or stability…I didn't know what that [structure] was like until I was incarcerated because I felt safe there. But then I kept going back because I felt safe....I felt safe for myself because I was sometimes my own worst enemy as far as self-sabotaging because things weren't easy out here. So, I would go in there to have three meals a day and everything was on a timeframe. And I don't know how to explain that. I was more comfortable just because I felt safe that no one could hurt me anymore and I couldn't have hurt myself anymore.*

This participant implies that a history of substance use and abuse within her family generated an underlying inability to create her own life structure, and gave her a predilection to feel safe when incarcerated, as it provided a stark contrast to her family and personal life. She went on to explain that her father physically and emotionally abused her mother and she moved out of the house when she was 12 years old. She was then homeless on and off following her move out of both incarceration and her family home, and used substances on and off for the next twenty or so years.

When discussing their experience of behavioral health crisis, some participants were able to recognize they were in the throes of a behavioral health crisis and ask for help, while other participants recounted others intervening on their behalf.

> *When I noticed myself pacing, and that wasn't the first time, it was just one time that I finally decided to reach out for help… I was experiencing anxiety, and I was very clear that I'd been pacing in a triangle. And furthermore, I had a nervous tick in my arm that I'd never really had. It had been coming on over the months in my left arm and once in a while in my leg. I've always been a person that used chiropractors because I've got an immediate success and relief from them, so I was managing my nervous tick by getting neck adjustments… But finally, my pacing and generalized anxiety got to the point where I had to become a part of the Western medical system. So, I went up that first time to the emergency room with my sisters, and that's how I got involved with the system.*

Charles continued to explain that his mental health had been declining for years from being what he called a corporate "work-a-holic". After he started to feel a high level of anxiety from his job, he quit the job and moved to be back in Montana and closer to his family. He explained that little by little, and over the course of a few years, he withdrew into himself, not leaving his house for months, and as he says, "dropped out of the system". He no longer worked, no longer had health insurance, and got to the point where he did not feel like he could care for himself. Luckily, his sisters were able to support his recovery. He also credits the behavioral health system in Montana and particularly support groups provided by the National Alliance on Mental Illness (NAMI) as resources that helped him to stabilize.

In the initial stage of crisis response, providers are reacting to the behavior of individuals in crisis and attempting to stabilize them. One provider describes the first "24 hours" of responding to an individual in crisis.

> *We go back every 24 hours and meet with the client again, because we have to keep them in the hospital that they arrived at. Hospitals got to put them inpatient with a one-on-one staff, which they hate doing. We try to determine, are you still in that level of crisis?* ***Because sometimes 24 hours of not having to be overwhelmed with all your stuff at home, you have a better frame of mind and you can deal with… We can now send you back home.*** *Cross our fingers and send people back home. We try to make the best safety plan that we can. Here's all your steps if you start feeling this way again. Here's these preventative substances. You can go home, right? Maybe somebody else needs to hold onto your medication for you. Somebody needs to take the guns out of the house. Somebody needs to call and check in on you every day. Whatever that might be.*

This mental health professional and member of a crisis response team notes that sometimes all that patients' need is a moment away from home to reset in a safe environment. A safety plan is also a part of the initial response.

Emergency department visits

Multiple patients who have utilized an emergency department (ED) of Montana's hospitals noted that the environment of the ED is not particularly calming or welcoming for someone going through a mental health crisis. From the symbolic boundary of a high desk with security guards, to the continued beeping of computer monitors, to being asked the same question over and over by different providers—participants noted that the ED environment is often anxiety-provoking, rather than healing.

> *For somebody who's having severe anxiety, asking the same question over and over, meeting new people, seeing new faces, seeing things being ripped open and things being jabbed into you, only increases your anxiety.*

Charles went on to explain that upon his next visit to the same ED a month later, he was kept waiting for three hours because he was known at the ED and they did not see his particular case as urgent. Understandably, the ED staff attended to patients with what they perceived as immediate life-threatening conditions before him. After waiting for three hours, a nurse gave Charles, in his words "a list of phone numbers and acronyms" to call since the nurse knew that the psychiatrist on staff would

not be in to work until 8am the next day and overnight is a long time to wait. Charles explained why this ED practice was anxiety-provoking for him, rather than helpful.

> *Charles: When somebody's got anxiety or depression, giving them a list of acronyms with phone numbers after them is another slap in the face. That may put them down for the count. They may be going back to the emergency room, just because of that trigger....*
>
> *Interviewer: Could you tell me a little bit about what you found triggering about that so I can better understand?*
>
> *Charles: Oh. Well,* ***people with anxiety, people with depression, they're covered with shame and guilt because they don't fit in****. They know that, especially recluses like myself. You got nothing but shame, and then you see an acronym. And it's just another thing you don't know.*

Overall, Charles expressed gratitude for the help he'd been given from the ED he visited, but he would like to see small changes that could lessen the potential experience of what he calls "shame" among those who seek out help at an ED.

For those experiencing periods of acute mania as part of their mental illness, the ED experience can be mixed. One woman with a long history of periods of mania as part of her bipolar disorder recounts her experience in the ED.

> *The cops I don't think were trained for ... What is it? CRT or CIT? CIT? I don't think they had that. And so, they literally handcuffed me and treated me like a criminal. They didn't explain where they were taking me or why. It was a very scary experience because that was my first experience in 2013 of having mania in [town]. I was standing in the middle of the street ... waving cars on. I had some bizarre behavior. I got charged with that stuff and I had to go with the legal system...The [ED] nurses were great. They knew what they were doing. It was the police that didn't. When I was calm and talking to somebody at the ER, even the manner that the cop came in to take my handcuffs off really freaked me out. He was very aggressive, he was very harsh, and scary and I was sitting there calmly cuffed. To answer your question about the most detrimental, it would be when the police don't know how to handle somebody kindly. Yeah. I would say the lady that was helping me, she put an injection in my arm to help me calm down. I don't even know what they gave me, but then the police took me to Warm Springs after that.*

Participants explained that their experiences with law enforcement were varied. Some had positive interactions with law enforcement, while others wished for more crisis training for police officers as a method for increasing awareness of mental health conditions among law enforcement to increase the likelihood that they will be able to achieve their objectives while being thoughtful about the experiences of the individual having the crisis.

Stigma and marginalization

Both providers and individuals who had been through behavioral health crisis themselves highlighted that stigma can be a barrier to individuals accessing prevention services and treatment.

> *We're really working against a big stigma. And that's the other thing, people come in, and they're in crisis, but then* ***they're also in crisis over their crisis because it's not appropriate to be in crisis****. So, it's like this compounding effect. As you're talking with people in crisis, it's apologies, and, 'I'm so sorry. And I know you guys are busy and there's other people to help.'*

This provider noted that in her experience, people in mental health crisis were embarrassed about their crisis. Her response demonstrates an understanding as a provider of this additional level of strain surrounding crisis above and beyond the crisis itself. A man diagnosed with Bipolar I and post-

traumatic stress disorder (PTSD) from the sudden death of his three-month-old baby describes that drop-in support centers help to mitigate stigma for him.

> *They [drop-in center that is no longer available] did a pretty good job of keeping people connected. And that's where I met the first person that would talk openly about his mental illness. And that was big because for whatever, 10 or 12 years, the only one I talked to was my doctor. Otherwise, it was a big secret, because of the stigma...Yeah. I still don't like sharing it. I, now, if somebody asks me what I do, I just tell them I teach mental health recovery classes. If they have a problem with it, that's their problem. But I kind of got to be quiet about it, if I were to apply to work somewhere else,* ***I don't know that I'd want people to know my mental health diagnosis, because there's so much stigma****. You read about, or watch on the news, when you have some mass shooter or some crazy deal going on and then they'll say, 'Oh yeah. And he was bipolar.' So, it can have some stigma.*

This man described how a bipolar diagnosis is stigmatizing, but he also continued to explain that he felt the gender dynamic of being a man in Montana contributed to wanting to keep his mental health diagnosis a secret.

Some participants described feeling marginalized by providers. Two separate participants mentioned the same psychiatrist they saw via telehealth as part of medication management during their period of stabilization into recovery. The participant below had been in alternating episodes of depression and mania when she started visiting this psychiatrist.

> *I met him on a computer screen. I'm very grateful to him, but I have... Given my time with him, I do have some issues... Initially he was very helpful as I sort of got my wits back about me and started to make some progress. Then there started to be some issues. Ultimately, he's just very old school, and in my opinion not always aware…He was very helpful, but he did make a comment to me that was like, 'You're about as bad a bipolar as I've ever seen.' But sometimes he would make these comments that were... And this is what I ran into later with him, these comments that were just judgmental, and made me feel highly marginalized. And, he is a huge proponent of lithium, that's his go-to medication. And again, it's just my opinion of him. And lithium definitely has its place, but it... And there weren't too many options at that point, since I had had the reaction to Lamictal that I had had. But, especially now with some of the research that's coming forward with things like Esketamine, and even the clinical trials on Psilocybin and things like that, it's just like he...* ***I had to do the research, but there was just a closed-mindedness…But as I started going down a path of recovery and healing, he was not always very open to my ideas****.*
>
> *Instead, he wanted to up my lithium, and I'm like, '****you're not hearing me****.' And this is after seeing him for a year and a half…Because lithium, it makes me feel like I'm in a fog, and that my cognitive abilities are slowed…And that's very frustrating. And my thyroid was beginning to get affected.*

A family member of a patient of this same psychiatrist discussed that she also did her own research regarding medication management, but that this same provider was not open to discussing other options with her either. The family member felt that it was because some of the newer medications require more monitoring and the psychiatrist—and by extension the organization in Montana—did not want to take the extra time to monitor the newer medications.

One provider noted that so-called "chronic" patients who are known to institutions, especially those with a history of violent behavior, might have a more difficult time accessing services because of "being known" to institutions. Later, she went on to explain what she viewed were the difficulties with having few longer-term solutions for high utilizers of the system.

> *Sometimes people don't want to take a client... Not to delude ourselves that there's still a lot of judgment going on, even in the mental health field and sometimes it's just like, 'Yeah, we don't want this. We don't like this kind of thing,' and whatever. It can be very frustrating…I know it's an overburdened system...So I think I get more frustrated with the fact that the system is not equipped to handle our mental health needs at*

this time.

Chronic folks tend to be under the categories of our homeless population, our substance abuse folks that are comorbid, substance abuse/mental health issues, and so they can't get their mental health needs treated. It takes longer and that's not in their wheelhouse, so they go to drugs. Then your real high psychosis folks that realistically, if they are not very consistently monitored and treated, they're going to quickly decompensate and end up in a crisis. So it's probably a very unpopular thought, but I've noticed back east as well as here, without institutions available for our seriously chronic mental health population, this is what causes a lot of our issues in the community. There are folks that their mental health is so severe that they really can't meet day to day needs... family members are exhausted trying to take care of them, if they have family available. While I recognize that institutions became abusive and such, ***there is still a big need for a loving and caring place that can safely house someone and provide that constant round the clock care that we just don't have.*** *So those folks are showing up a lot.*

This provider shows understanding of the tensions between an "overburdened" system, past abuses by longer-term institutions, and those whose "mental health is so severe that they can't meet day to day needs". During the interview, this participant did not reflect on the policies that shape bed capacity for long-term facilities. Other providers and individuals echoed the sentiment that the system needs solutions for high utilizers, especially for those patients who are known as having a violent history.

Another reason for patient marginalization, even if unintentional on the part of an individual provider constrained by institutional policy, includes being gender nonbinary or trans. Maria, a transwoman, has a history of mental health concerns, largely due to societal discrimination and marginalization surrounding her gender. She currently utilizes a crisis center in one of Montana's urban areas while working to secure permanent housing and deal with legal issues of custody of her son. She explains that LGBTQ+ individuals might feel marginalized by providers and organizations that are religion-focused in Montana.

*What I really did not like in the [name of organization] was the fact that because religion, no offense towards religion or anything, because I believe there are good people that practice religion. But having that forced upon us…****A lot of the LGBTQ community****, I'm not sure if they felt the same. But* ***being around a religious establishment or being forced to focus on that aspect of it, it does no good for us because we have been shying away from it for so long****. And it's been used against us several times, whether or not it's to serve as one's justification for their actions, or it's to say, 'You're going to hell'…And that's not right either, because who are you? You're not God. I believe that we all answer to the good Lord when we enter the gates to heaven, regardless of the transition or homophobic tendencies.*

Maria felt that religious beliefs of religion-focused care institutions could make those in vulnerable communities feel marginalized, specifically those with gender and sexual identities that have been identified as problematic by the given religious organization. Maria explained a religious shelter would not let her into the women's shelter due to her male genitalia and because her gender is female, she is not allowed into the men's shelter. These barriers created a bind for her when she is in need of shelter services. She went on to explain that additionally, the jail system in Montana is not fully set up for trans-individuals since inmates are often divided by biological sex. As a result, trans-individuals might be further stigmatized if placed in isolation, rather than being grouped by their gender.

*They do separate by biological sex. Because I'm considered, what's called intersex according to the system, transgender. I was not allowed in a room with anybody else, I had to be placed in my own room. And that was kind of upsetting…****we are who we say we are, whether we're trans male, trans female.*** *We don't deserve, like for my instance, when I was incarcerated for self-defending myself, they* ***denied to recognize my gender****. And they wanted to put me in the population with the men…It took a mental health worker to say, 'Get over yourselves, it's the 21st century.' And to defend that point he said, 'She is not going in the regular population because she is a safety concern.' Because of the fact of being raped or abused with the guys. And I was placed in an isolation cell and it was very hard.*

Maria went on to explain that she would have preferred to be placed with the women, so she had someone to talk to, rather than be in isolation. In the case of Maria, as with others in crisis, improving access to community-based crisis intervention services that can support their needs can prevent individuals from escalating to higher-levels of care.

Isolation, separation, and "going it alone" during and after crisis

Both those who had mental health crises and/or substance use crises noted that being put in isolation during a behavioral health crisis actually magnified their symptoms. Maria continued to describe her crisis and the initial response.

> *I think that the clients are pretty much left for a free for all. You would try to ask for some advice or ask for some help and you'd kind of get ignored…But then by the time they come around to it, you've already tried either cutting yourself or hurting yourself with whatever items you have available in there. So, when you do something like that,* ***you're put in a cell and it's a padded cell, and you don't get any communication with anybody****, you're pretty much in isolation because you're a harm to yourself and others. And then they determine whether or not you're eligible for Warm Springs, which that's, another state hospital. And right away when I was in there, I noticed a lot of people being shackled and taken by the Sheriff's department, to be taken up to Warm Springs…****That is enough to really set a person's PTSD and anxiety off in the first place. Much less being treated like you're a criminal because you tried to take an attempt on your life*** *or whatever the case was…So they put the belt around you, they loop the chain through the loop. They put you in like a handcuff, sort of shackles, and then they shackle your feet and connect the two. And that right there is just very stressful.*

Another individual who had multiple suicide attempts describes how it felt to be taken into isolation in an ED in an urban area in Montana.

> *Taking someone who is suicidal into a backroom and leaving them alone is probably not the best idea. Yeah. It was ridiculous.* ***It just compounded, I guess, the feeling that I felt of hopelessness and aloneness, and that even when I was making an attempt to get help, I didn't matter. I was an inconvenience****. And I think because so often people with mental illness feel like there's that, 'Well, if you pull yourself together' or, I think, 'You're making it worse than it is,' that kind of reaction. So, that kind of felt like I wasn't taken seriously.*

This woman went on to describe an earlier time in her life when she was going through a divorce and her children were not speaking to her. She attempted to complete suicide by swallowing a bottle of undetermined pills.

> *When I woke up there was just blood all over the walls because I had vomited obviously all kinds of stuff. And so, I still didn't feel good. I mean, I felt terrible. So, I called suicide prevention and they told me to go and have my blood pressure checked. So, I went... Yeah. I know. I've been kind of Lala land, kind of like, 'What? I'm here?' And I felt horrible, and I went down to urgent care, and I didn't tell them that I had just made a suicide attempt. And I said, 'Could you check my blood pressure?' And they did and whatever, and then I came home and I still felt terrible. So, I finally decided to call Poison Control. Best place ever…When I had the first call to suicide hotline, funny thing, they play this like, 'Oh, be happy, be happy' song, and I'm having just recovered from an attempt. So, I don't have a lot of... Really, this was still 10 years ago, so maybe they've changed. But I mean, they did not help me. Anyway, so then I called the Poison Control, and they were great. They were just like, 'What'd you take? Get down to the hospital.' So, I was in the hospital for three days because I had done quite a bit of damage.*

Having received what she perceived as no help from the suicide hotline or urgent care, Poison Control served as the mechanism by which she finally went to the ED. She also implies that hearing the song "Don't worry, be happy" when on hold with the suicide hotline was not helpful to her in the moment; she did not feel like she was being taken seriously.

After the birth of her daughter, Antonia experienced post-partum depression and relapsed into using methamphetamine. A stranger called law enforcement in the city she lived in when the stranger saw Antonia walking in an alley and acting erratically with her baby. Antonia describes that at the time she was manic, suffering from post-partum depression, and in her emotional state thought she needed to hide her three-month-old baby somewhere to keep her safe. Law enforcement responded and they wanted to take her to the hospital, but she asked law enforcement to take her to jail since she had been in jail multiple times in her youth and felt more comfortable with it. She requested a female officer for herself and to take her baby but did not receive one at first. Once she got to jail, she was put in isolation, which she explains only exacerbated her symptoms. Below she describes the transition between this scenario, her state of mind, and how being put in isolation in jail made her feel.

> *I am dehydrated. I am crying. I hear my daughter in my head. I am going through some hormonal and emotional distress. I can't talk to these cops. I was told not to trust them. I was trained one way…They don't care. No compassion…I was handcuffed, in the backseat. I don't know why. So then, a female officer finally came, and I was trying to talk to her, so, you know, like, 'Don't you have kids? This is hard on me right now'…She wasn't budging either. You could see she wanted to budge, but it's not the protocol.*
>
> *They had me in isolation, which was booking, and I thought that I would assume the population, but I didn't. They kept me in isolation, in this really big room that I thought they were going to just suffocate me in, of course. So, my mind, here I go in my mind, they don't tell me nothing. They don't tell me, 'CPS is now involved.' They don't tell me if my daughter, if…Who knows how long I was in booking, in isolation, which is not good for anybody, with no talking to me.*
>
> *So, I would have been better in population because the girls in there would have shown me compassion. They would have treated me like a person and like a human, and helped me get through that struggle, and just the energy from other people. The talking, the conversation would have gotten me out of my head, rather than staying in my head and thinking all these, oh my gosh. The thoughts that were going in my head where I was thinking that my daughter was hurt so bad.*

Antonia describes how being kept in isolation while under the influence of drugs and simultaneously in an emotionally distressed state worried about her daughter was terrifying. She explained that she was having panicked thoughts that her daughter had been hurt during her arrest since she had not been told where or how her daughter was. Over the course of her life, she'd had multiple experiences being incarcerated which gave her a certain comfort level around other women in jail. For her, being isolated without social interaction while in such an emotionally charged state was more harmful. Interestingly, not one of the participants in this study preferred being put in isolation to being with other people regardless of the type of behavioral health crisis.

Being alone and unsupported during a crisis also means that practical matters, such as transportation to care, are complicated.

> *The last time that I went up to Great Falls Hospital for [suicidal behaviors and ideation] I drove myself [over three hours]. On the way over, I kept thinking all I had to do is just go off the side. I mean, expecting a person who's suicidal to drive [three hours] to Great Falls is very odd…Because obviously whether you send someone to Warm Springs or they're expected to go someplace else, it's ridiculous. It's absolutely ridiculous that we don't have a psych ward in town here.*

Transportation and local capacity for high-acuity care settings in a rural state remain an ongoing issue. This participant recounts that there are no psychiatric options in her city which means that she has had to drive long distances for help.

Family members of those with ongoing mental illness generally noted they also felt like they were alone in their struggles to cope with crisis; with nowhere to turn. A mother of two children with mental illness, one of which is diagnosed with schizoaffective disorder bipolar type takes full-time care

of one of her young adult children. She provides around the clock full-time care and moved cities in Montana in the last year to be closer to services. She describes herself as "lucky" given that her job allows her to work from home.

> *But the lucky thing is that is, like I'm in my office right now and I have my office at home, I don't have to travel. And I've worked for the government for 30 years. So, I'm lucky because I don't know how I'd be able to do it with [child]. I'd have to take a lot of sick leave and time off work. Because I have to give them medicine at 8:00, noon, 4:00 PM and 8:00 PM. And like now it's time to cook dinner.*

She went on to describe how she keeps sharp objects in a locked drawer in her house to prevent her child from hurting themself or others. She tried placing her child in a full-time care organization in Montana, but described "horrific" conditions that led her to bring her child back home.

Experiences for high utilizers of the system

Below, this mother explains what she perceives as negative changes in the long-term care provided by the State Hospital.

> *The State Hospital has drastically changed over about the past five years. They used to keep patients for many months until they were actually well, and stable and they don't do that anymore. From the minute the patient arrives, they're working on their discharge plan. Both of my children in the past two years have been in and out of there, they've let them out and they've been back in within a week...I've had to deal with the [county name] County prosecutor, many, many times to provide information and proof, email, text, audio taped, voicemails that my child was extremely manic and dangerous…They kept letting them go.*
>
> *So, the judge would let them go or the hospital would let them go. So within about a month, my child was in and out of the State Hospital like four times...they discharged my [younger adult child] to a motel room. And they don't care, they'll discharge them to shelters. And all that does is make the person worse because there's no one to help with medication, they're not stable. They're still psychotic and they're releasing them.*

This same parent also described "horrific" conditions within the last year in a different long-term care institution for her young adult child. This institution was paid via a combination of out-pocket expenses and Medicaid.

> *They [long term care organization] could have killed my child. For one, they had them on Clozapine, and you're supposed to raise it 25 a week. They were raising it a hundred. Never monitored their heart rate, didn't monitor their blood pressure. Didn't put them on anti-seizure medicine, didn't put them on medicine to prevent drooling at night. Nothing, did nothing. Clozapine causes major constipation, okay? Major. They didn't give them the medication for constipation…Their room was horrific. They hadn't given them a trashcan, or a laundry basket. And when I went to their room and saw their room, the room was filth, and the sheets were filthy. People they're sedated, they sleep through the night. So, my child had wet the bed, nobody had gone in to help them…I mean, we're paying $450 a month out of pocket to live there, plus thousands a month from Medicaid. And they can't give my child a laundry basket or a garbage can?*

One challenge within the system that contributes to recurrent engagement, is that state statute requires the hospital to release individuals as soon as they are "stabilized," to ensure that they are not providing intensive care to individuals who could successfully function at a lower level of care. This statue is to be followed even in the event that a lower level of care is not available within the community.

Family members of those with diagnoses like schizoaffective disorder or bipolar disorder described trying to advocate for their family members and difficulties navigating legal issues. These issues might be caused by violent outbursts when their family members were in psychosis, reimbursements from Medicaid, and lack of long-term recovery solutions.

I think there's a lot of people out there that struggle because they kind of don't know where to turn to, or even finding group homes is not the easiest thing. I went through quite a lot trying to find my child a place at a group home and there's a shortage. And so that was kind of a disappointment for me that the ones here in [town] were neglecting my child in so many ways that just, I was really disappointed. Because I thought maybe they could actually live there and that I could live nearby.

Exhausted family members and individuals noted they felt they didn't "know where to turn to" for continuing ongoing care for their family members or themselves.

Families, providers, and individuals are not the only participants who noted they struggled to find support. A police officer explained that generally law enforcement in Montana don't "feel supported or [adequately] supportive" when it comes to high utilizers of the behavioral health crisis system. They recounted a story about a violent youth that the hospital did not want as an admitted patient given his known violent behavior.

They brought in this kid from the juvenile justice system because they needed mental health treatment. So, they brought him to [name of hospital]. He basically started destroying things in there and they're fearful that he's going to hurt somebody. We go up there…The officer basically gets him under control, handcuffs him, brings him in the car. Officer talks to him. He said, 'Okay, we're going to bring him back in.' They [the hospital] said, 'No, we're not taking him. We refuse to take him. We will not take him. You guys need to deal with him.'

So, that puts us in a horrible spot because we can only take people to detention facilities if they've committed certain crimes. So, doing like we do a lot of times is we've got to figure out what to do. We got to come up with a solution...No detention facility in the state of Montana would take him because they've all dealt with him and they didn't want him back. So, guess what? Here we are. [Hospital] won't take him, none of the detention facilities will take him. So, we drove this kid to [another city] and released him to his grandma because the grandma was the only person in the state we could get a hold of that would take this kid.

A system that has few options for those with ongoing conditions often leads to burnout for providers. They see the same recurrent problems in the same individuals, with few options for treatment.

Provider burnout

For well-meaning providers like Tara, heavy caseloads and duties of follow-up care can lead to burnout which could negatively impact their ability to provide care.

Tara: I worked for [organization name]...And that was kind of rough. I liked it and I learned a lot, but they really overload their employees and I didn't feel like the quality of care that I would have wanted was there…I can't speak for the whole company, but we had to meet with every client three times a week for billing. So you end up with, you have 40 people that you got to meet with three times a week, so you can't spend no time with them because you're trying to make contacts all the time. ... And I always felt like a number, so I was really offended by that. So, I spent a lot of time taking people to AA and trying to work around that. But then I was overworked because I'm trying to meet the demands of what the company wants and trying to care for people.

Interviewer: Do you think that has something to do with Medicaid procedures and billing?

Tara: Yeah. I'm a peer support but I'm taking on a caseload and now I'm doing case management, peer support treatment plans. And that's not what I got into peer support for. I mean, peer support is designed to build relationships. Build relationships, share your lived experience and help people achieve their goals on their journey. Not to play the role of a therapist, a case manager, a peer support, and then still have quality care and time with people.

Wearing many different hats in a low-paid role could lead to burnout for providers like Tara. Later, she went on to explain how this is particularly the case for those who are in recovery themselves.

> *For me being in recovery, when you're doing the work we do, you kind of need to be supported too. Because you relive your own trauma. You see people using, all those things that make you crazy in the head. So, you're out doing all these different things, but you're not able to take care of yourself. The one thing I did like about [name of organization] is they do let you take mental health days…But when you're going to get behind, somehow, it's hard to do when you got your own caseload and you're worried about it. And then they're so busy that when I would ask for certain things to be done for me, employer or some of my coworkers would forget to do it or their people were more important...So I was always scared to take time off if I made commitments to people because I didn't want to ruin the relationship for me because I relied on somebody else.*

Even if employers offer perks like mental health or paid vacation days, it can be difficult for the behavioral health provider to actually use these days. If staffing shortages exist, or there is no mechanism in place to continue to provide care to clients who could have crises, a provider won't feel comfortable taking the rest they require to recharge and continue to fulfill their demanding role. Moreover, others who work within the crisis system such as law enforcement, are also subject to burnout when adequate community health services don't exist for the increasing number of individuals experiencing crisis in Montana.

After crisis

After crisis, many individuals explained they feel they must navigate the system without guidance, especially if they do not have any family. One woman diagnosed with Bipolar I and a history of being admitted to institutions and emergency departments due to her mania explained that staffing shortages led her to schedule multiple medication management appointments in advance. She said that she has often had offices cancel appointments. Without continuing medication management, her Bipolar I can easily shift into psychosis so she schedules 2-3 appointments at a time to avoid a lapse in case of cancellation. A different participant diagnosed with Bipolar I, PTSD, and ADD describes that her therapist left the practice due to an overload of patients and she had to "get up to speed" with this new therapist. After the new therapist shifted to working part-time, she had a similar experience where multiple appointments were cancelled in a row. She describes how this kind of ongoing transition can be hard on someone experiencing depression and trying to prevent relapsing into acute crisis.

> *Sometimes it's like everything you can do, especially when you're in a severely depressed state, to... Even if that is on the phone, to even get on the phone and talk, so to have them... And again, that resiliency thing, to have them cancelled, yeah. And this happened over time, like five times where appointments were canceled on me... And then the provider shortage, just the limited options of who to see when you don't have financial resources and you only see who you're directed to see.*

This participant discussed how she had lived out of her car at different points in her life until a relative in Montana let her stay with her until she stabilized. She explained that the two times she had experienced severe mania and then depression, she had trouble doing everyday life tasks such as getting out of bed and showering. When appointments are cancelled or other disruptions occur, she clarified it was very difficult for her to compensate. However, she did go on to explain that she was grateful for all the help she'd been given through the Montana behavioral health crisis system, even with the challenges.

Later on in our interview, Tara describes what it felt like leaving jail after a long history of substance use.

> *When I got out of the system or out of incarceration, I didn't have anybody, and my family had left me. Everybody kind of disowned me because of my behavioral issues and my substance use. And, of course,*

there was some mental health that no one really noticed or tried to address. So, I would get out and I had so many fines and all these things, demands to meet with the courts and no job, nowhere to live. And if I got a job, I had nowhere to shower to get ready for work. It was just a big mess. So, my goals are to link and assist and to have a successful re-entry so people don't have to return to the system.

She knows firsthand that leaving incarceration with no support or housing can be difficult. This is part of the reason she's chosen to continue to work with others with substance use disorder.

Other participants, mainly providers, also described a lack of coordination after crisis between the individual, families (if the person experiencing crisis has one), and different providers and/or institutional mechanisms at the community level.

Someone coming out of the State Hospital too. When they come back to [town] or wherever they're coming back, I'm not sure the communication between the institution and where they're going back to is very well developed. I think sometimes it is, but oftentimes it's not...oftentimes a lot of frustration for them not knowing, and at times when the system broke down in communication…I can recall at least a number of cases, trying to transition to a spot that would be more helpful for them and communication broke down and they were back on the streets, for lack of a better term, almost immediately...

Well, part of it is the handoff. Communication was there, but the handoff wasn't getting from one person to another, from one support mechanism to another support mechanism, wasn't there and that bridge didn't happen. Yeah, ***I can think of at least one case, probably two, where a person ended up in crisis at least for another two years****. And then seeing them after that, and much doing much better, but* ***they had two more years of crisis that may have been avoided****.*

This provider explains that without support after crisis, individuals will likely continue to experience problems. Without support and follow-up, these problems can last much longer than the initial crisis.

CRISIS EXPERIENCES INFORMING BARRIERS, FACILITATORS, AND BEST PRACTICES FOR CARE

Part II of these findings focus on addressing the second research question for this study, "In what ways does the experience of individuals, families, and practitioners inform barriers, facilitators, and best practices for care for initiating treatment and sustaining recovery for patients experiencing behavioral health crisis in Montana?" Barriers for care and eventual recovery that participants noted ranged from staffing shortages to lack of coordinated family therapy and follow-up care to reimbursement constraints. After discussing barriers, we then discuss facilitators within the systems and recommendations that have been informed by organizational and systems-level barriers.

Barriers to accessing care

Lack of space, facilities, and providers

Across the board, providers, family members, and those who have been through crisis themselves noted a lack of behavioral health providers and space in facilities dedicated to these needs in Montana. Participants also noted that they perceive a gap in facilities for youth mental health treatment and for those adult patients who have ongoing mental health or substance use conditions.

One man who experiences depression and anxiety which have led to his multiple mental health crises and emergency department admissions, confirmed that the wait between going to the emergency department and getting on track with medication, due to lack of providers, is challenging for patients.

> *So, I get out of the hospital, and they give me all this information, all these phone numbers I can call, all these help agencies. And within two days I have a Medicaid card. Well, so I say, 'Well, I'm ready. I want a therapist, and I want a psychiatrist. I know that's a part of the recovery process.' But guess what, Montana happens to be short on both. So, it took me a two week wait to even see a therapist. It took me more than a month and quite an elaborate screening process to make sure that I was right for the psychiatry company that I go to.*

Another participant who experiences periods of mania and suicidal ideation, also explained that it took her three weeks to access a psychiatrist for medication and while waiting for care, she was "just sort of white knuckling it through".

Providers also explained that people experiencing substance use crisis have to wait for beds in treatment facilities to open.

> *So, a lot of times in Montana, there are not beds or places open for them to start treatment timely. You might wait three weeks, six weeks for an open position. In that time, it's very critical the person has support and wraparound services to continue their sobriety. And I feel that's missing in the crisis. If someone's trying hard to stay clean and the services aren't there, services are not there timely for them, it's a lot more risk of using.*

This provider highlights the lack of space in treatment facilities and the importance of wraparound services to recovery. By and large, providers affirmed these important issues of lack of staffing and treatment facility space.

Crisis response in a geographically large rural state is a real challenge. One therapist noted that sometimes there was a 4-5 hour wait for a crisis response team due to the need to travel long distances between counties. She went on to explain that although a great resource for rural communities, telehealth and assessments completed remotely could not fully solve this problem. For example, if the patient is assessed and referred to inpatient treatment, there are still questions about providing continuing service in the moment for that person experiencing crisis.

> *What am I [person experiencing crisis] supposed to do now? Do I walk out the door and wait for someone? Do I have any money? Do I have any application or paperwork? Do I have even transportation? So, there's that huge gap too, because how do we respond to that? And so, a lot of times it's just this constant kind of revolving door of a bandaid like, yes, we got you stabilized for a few days, but then are we really, really addressing any of that need or issue? Not really.*

> *And knowing all along that, 'I already been here and done this four times, I know the routine, you guys can't help me. Yeah, you're going to connect me to somebody, but that's, as far as it gets.' It's not only really taxing and difficult on our system, but* ***its super taxing and difficult on the individuals that we're trying to serve too, because we're doing no justice for them as well. All they're getting are negative feedback, more barriers, more roadblocks and not really getting the support that they're needing****. And then it's just really, in many ways, supporting their thoughts already about like you know that this system is broken and it has not helped me and it's continuing to not help me.*

As a staunch advocate in her community for a crisis stabilization center, she went on to explain that "a safe spot" with a "hot meal", and a "place to nap" would really benefit those experiencing crisis more so than jails or emergency rooms.

Financial and reimbursement requirement constraints

Financial models for reimbursement and sustainable billing also represent considerable barriers to quality care in Montana and the stability of organizations that provide care. Grants have enabled organizations to try new programs, but it creates an environment of instability when organizations are

always in search of the next grant or have to rely on changing reimbursement rates from the State of Montana.

> *Participant: If money wasn't a worry, you could do a lot of amazing things. What we've been able to do so far has been in thanks largely to [foundation name] and grants to allow us to implement these new programs to carry payrolls on new folks as we get this going, rather than incurring costs. Because I don't think there's a behavioral health professional in this state or organization that has much distress tolerance for going into a project and going, 'Well, we're going to lose money the first year.' It's just not there, you don't have that capacity to lose.*
>
> *Interviewer: Earlier, you said that reimbursement sources, you wish you didn't have to rely on them. Could you explain what that looks like?*
>
> *Participant: Probably 65% to 70% of the clients that we serve in eastern Montana, and this probably goes statewide for people in the west too, are on Montana Medicaid. So, the services that we provide, whether it's one to one therapy, group therapy, case management, day treatment, there's a set Medicaid rate of what you're going to receive.* ***Sometimes that's enough to carry you and sometimes it's not****. Just a couple years ago with the state, you remember the uproar about case management rates being cut. When you have agencies that have been in business 30 years and due to a 2% or 3% rate cut in case management, they're looking at having to lay people off and go out of business, it's ridiculous.*

One former behavioral health social service administrator who also went through a personal mental health crisis during the early height of the COVID-19 pandemic, also noted that financial constraints, like dwindling reimbursements rates, has directly led to providers, such as peer support specialists, having to shoulder more and more responsibilities and more stress.

> *One of the things to go were reimbursement rates to lowering those for case management, for community-based rehab and support services. They started implementing peer support services, which is good as a supplement, but places started having to use them as a replacement...I guess a good comparison would be like this.* ***If you have somebody suffering from alcoholism, it's like saying we can't afford to pay the licensed addiction counselor, but we're going to give that money to a sponsor who's also suffering from the same thing…***
>
> *I mean, peer support is great as a supportive thing, but it's not a replacement, and so when reimbursement rates started dropping...all of a sudden...They wanted to move to, not a treatment model, but a recovery model where people come in, get fixed, and get put out, a medical model for mental health, which does not work. In other words, the body is not just a machine that we can fix by replacing a part mentally.*

He continued to explain that recovery from behavioral health crisis is not a "catchall" that can neatly fit into reimbursement structures. In his role as a social service administrator before his personal crisis, he found he had to get creative to be able to still provide services in his organization and not cut positions after dwindling reimbursement rates. His organization ended up grouping together people in group therapy so that "instead of five people seeing five different therapists five different times, it was one therapist seeing five people so that we could bill it once." Below, he explains the problem from a structural, rather than organizational, point of view.

> *Every time mental health services are cut, it causes a state crisis…They're trying to move towards institutionalizing people again, asylum 1940s type stuff and that's horrific, that's inhumane, but every time they cut mental health services of any kind, jails start filling up because people aren't getting services. They start acting out publicly, and it's not their fault, and the police don't know what to do with them, so they can either go to jail or they can go to hospital.* ***Both of those cost more money than it would to just invest in mental health services to begin with, which would also increase people's chances of recovery, which would increase their chances of getting a job and paying taxes and investing in the economy that's investing in them****, but that doesn't happen here, and I've watched*

that play out over and over again.

I guess the only thing I would say is stop cutting services from DPHHS. If you really want to, I hate to say it, solve the homeless problem, put it in their parlance, which I hate that, but if you're willing to help people, if you really want to get taxes to go down, and you want more people contributing, and you want less people who are suffering from homelessness, how about you support it instead of victim blame and actively cut services for them because it's like you're punishing them for having a disease while also denying them any access to get help.

From his point of view, the economics of cutting funding is more costly in the long term for all people, organizations, and budgets involved.

In addition to problems like smaller reimbursement rates, there is also a considerable level of documentation required to keep track of what is reimbursed and what is not. This puts a large time burden on organizations. A former provider turned administrator in eastern Montana explained that she must keep detailed tracking of scheduling for patients in recovery due to MACT and Medicaid requirements. She said, "We would never schedule someone to see our chemical dependency counselor, and someone to see a mental health for an outpatient appointment. You wouldn't put those together on the same day…because Medicaid will only pay for one service." In other words, patients have to come back two different days instead of having two appointments in one day due to reimbursement requirements. These kinds of rules in a rural environment are inefficient for those traveling long distances, and create an extra administrative burden on organizations with few resources to begin with.

This same provider also explicated that TRICARE comes with its own set of rules and barriers for their agency. TRICARE is the health care program for active-duty service members, active-duty family members, National Guard and Reserve members/families, as well as retirees, and family members of individuals in the uniformed services.

I know that there's a ton of money, supposedly, for behavioral health. But for example, for TRICARE, we serve a high amount of veterans up here. There's a ton of veterans who would love services. We don't accept TRICARE. They won't pay for any services from anyone without a doctorate degree. You need to have a doctoral degree for TRICARE to pay for anything. We're a nonprofit agency. We can't employ a $120,000 a year psychologist. We can't afford that. Together, three of our therapists don't make that. You know what I mean? No, we can't help any of those people.

Medicare will only pay for this, this, this, and this. Medicaid will only pay for this, this, this, and this, and only if this is the secondary. And the other insurance will only pay for 60% of it...Even with our sliding fee scale, people can't afford an extra $50 a month. Not up here. Everyone's too poor.

In other words, although TRICARE would enable more services for Veterans, from the perspective of this interviewee, the organization cannot afford to employ a provider with a level of education that TRICARE requires.

In addition to reimbursement challenges and navigating insurance, one therapist explained that as a counselor in private practice, she spends a lot of her personal time navigating crisis response for her clients.

I have 17 years of experience in being a counselor. I have a high level of tolerance for risk. That's not the case for private practitioners in [city], not everyone. We have several that do, but not a lot. But really what it comes down to is that collaborative approach. For one clinical hour that I would spend with that client, I was sharing with you about who had that acute crisis of mania, for one clinical hour with her, I would spend probably five collaborative hours per week before she was hospitalized and then after.

This provider is often on the phone with the ED of the local hospital or with her client's spouse navigating care that she is not paid for. In order to provide adequate care, it often means going above and beyond what she is paid for the one clinical hour of care. In the longer term, this is an unsustainable model of care.

Statutes regarding protected information and protective custody

A father of two adult sons with mental illness, one of whom completed suicide, mentioned several times that Health Insurance Portability and Accountability Act (HIPPA) prevented him from knowing the status of his sons' health.

> *HIPAA in my view, I'll say it's well intended, but I think it has a lot of problems...If they would have said to me, 'Fred needs a residential care facility right away, we are waiting for an opening. He's had suicide attempts.' I would have said, 'Help me find a place in the United States that I can get him into. If we need to hire a private nurse to get on the plane with Fred and myself, to help us get him back to that institution, just tell me.' I have the financial resources...I'm 77, what am I going to do with my money? Help my children. They need help, it is my priority. Anyway, they told me, 'If he comes back one more time.' And I think that was after his death. After his death they told me that.*

This dedicated father felt he lost one son and currently is working to help his other adult son navigate his bipolar disorder. For him, HIPPA prevents him from knowing what is going on with his son's current care—especially given that his son sometimes suffers from delusions which prevent him from being able to make choices for himself and had a directly negative impact to have the information necessary to care for his other son. The participant did not discuss any efforts on the part of his sons to provide consent to him receiving medical information.

Some statues in Montana may contribute to individuals experiencing multiple crises. A police officer from an urban area spoke about the gap in services that often mean the same individuals cycle through crisis again and again.

> *In order to release someone from the state hospital, they have to release them to some sort of housing. And a lot of these folks don't have any sort of housing, so they release them to a shelter and it's not necessarily the city they came from. So, we're getting folks dropped off at our shelter and lot of them we'll deal with 20 or 30 times in a week.*

> *Your average law enforcement person in [city] would be very happy if we had someone that we could hand off to at the lowest level. Or in my opinion, the best is either a co-response or some of these calls don't need law enforcement there at all…What I would like to see is some sort of community response to mental health problems so law enforcement doesn't just keep going over and over and over again to the same individuals and there are no resources where we can hand them off…Pretty much for the last 30 years, the primary response to people that are an immediate threat to themselves or someone else has been law enforcement.*

He went on to explain that the crisis mobile response in his city has had mixed results and the mobile response staff "burned out pretty quickly". He articulated that the "team" aspect of "Crisis Intervention Team" training for law enforcement in Montana is missing because he has "crisis intervention trained officers" without enough resources to be in a team. Moreover, he explained that there has been a steady increase in the number of crisis calls each year, which prevents law enforcement from doing other important parts of their jobs. He says the statues in Montana are written such that law enforcement are the only entity who can place a person in protective custody. Following that, once someone goes to an emergency department, there is often nowhere to take people afterwards following the acute moment of crisis.

Silos of organizations and care

Multiple providers explained what they perceived to be "silos" of care, where there was a lack of coordination and communication between organizational entities.

> *There are all these silos and I guess it's not just mental health. So, law enforcement does this but don't interact with the drop-in center unless they call with a problem and [the crisis center] don't interact with the homeless shelter, unless they have a problem. Criminal justice services deal with people on prelease...and then we have [name] County Public Health Department and they do this. Everybody just works on their own thing, and nobody really interacts very well. I think that's the biggest problem with most of this.*

These "silos" also extend to problems after clients leave institutions in different cities with linking them to continuing care in their home communities. A counselor in a different urban part of the state echoed this sentiment.

> *So, whether someone's transitioning from inpatient or transitioning from an acute care facility…The gap is the communication transfer and follow through between that team, whether it's inpatient or a CRT, community-based CRT, and the transition to services.*

Almost all providers in this study discussed difficulties in supporting effective transitions between points of care in the overall system. As discussed in the first part of these results, individual participants who have experienced crisis themselves also felt this lack of coordination through experiencing a lack of support in transitions and follow-up care.

A counselor recounted the story of a pregnant client who experiences mania and has been to the ED of the local hospital 13 times in two weeks. After not sleeping for days, her client's spouse takes her to ED where they sedate her so she can sleep, but other parts of the care continuum remain disconnected.

> *I think that is a very siloed approach to mental health. When really what we know and what the research and the data tells us is that, that collaborative approach and a team approach is really what's going to help sustain wellbeing and help people navigate these acute crises. In my perfect world, if she enters into the ER, she is diverted to inpatient psychiatry for assessment. And then, there is observation in a safe, comfortable place where there are attentive medical and mental health providers. And then there's this coordinated care with a psychiatrist, counselor, psychiatric nurse practitioners and supportive staff where we can see this baseline adjust Seroquel to eliminate the psychotic features and allow this person to rest. Because sedating her doesn't solve the problem. It's because the problem is the chemical levels, her hormonal levels, and a need for an increase in Seroquel during the acute manic episode.*

This counselor does not believe that there is sufficient communication between the stages of care following acute response. Moreover, this counselor articulates that there is not a staffed "safe, comfortable place" for the pregnant client to recover from one of her episodes in the city they reside in. She shared that her client continues to cycle through periods of mania, followed by ED visits, followed by recovering at home.

"Silos" of care also extend to not including the whole family surrounding youth who have been through crises.

> *I have discovered in most of the kids that I see in crisis placements that come to the ER, they've been in a facility. There is a difference between acute obviously and the residential. But in both cases, I was never hearing from families that there was a lot of family work being done. We have a bunch of silos going on. So, you send them off to manage the situation in an acute nature, but then you send them back without really having tied it together with how will your family now help you.*

This provider maintained that introducing elements of family therapy would increase recovery for youth going through crises.

Lack of housing

Almost every provider, family member, or individual who had been through crisis mentioned a lack of housing as a barrier to care and eventual recovery. From homeless single mothers who could not take their children or pets into treatment centers to time limits, to the lack of affordable or transitional sober housing, the dearth of transitional and/or supportive housing options in Montana remains a significant barrier to sustaining recovery in Montana.

> *Housing's a huge, huge challenge statewide, probably nationwide, but certainly statewide.* ***So how do you start doing better when you don't have a place to stay?***

Some participants mentioned the need for a sober-living type of environment for those working through recovery, while multiple others mentioned the need for transitional housing after individuals were released from hospitals, jails, or treatment facilities. One administrator explained that keeping "people out of crisis" entails making sure that basic "human needs are met, whether that's contentedness with others, food, shelter, or clothing".

Facilitators for accessing care

Although participants did note problems or barriers to care in the crisis system in Montana, they also discussed beneficial parts of the system that were helpful for them in their experiences. Current helpful aspects of crisis prevention, early intervention, and response in Montana that participants discussed included providers with a "calm" presence and active listening skills, training in trauma-informed care and therapy education on Adverse Childhood Experiences or ACEs, and behavioral health protocols in place for middle and high schools for students in crisis such as identifying students who might be struggling with mental health and linking them with a therapist. Multiple participants also noted that the shift during the early part of the COVID-19 pandemic to telehealth and tele-psychiatry from in-person treatment only, has largely increased access to therapists, psychiatrists, and nurse practitioners in a rural state.

Multiple providers indicated that the problematic "silos" of care and lack of communication between entities could be mitigated by more partnerships between organizations and ways for individual counselors in private practice to link up with one another. As the counselor with a "high tolerance for risk" explained earlier in this report, counselors in private practice do not have an organization to support them in navigating difficult situations or paperwork. They often spend more hours than they are reimbursed for on individual clients. She advocated for more "intensive outpatient services…[with a] systems approach".

As a part of building partnerships between organizations and entities of care, one administrator describes her partnership with [name of organization] for telehealth and that the key to building networks is not being "territorial".

> *We have the partnership with [organization] and that's evolved into county tribal matching grants, where we're opening three MPATH units. And I think the biggest thing that has been effective is just 100% transparency. You can't go into this and be territorial and think, 'Well, how can I make more money than so and so at this?' When I say transparency, it's really saying, 'This is the honest to God cost, what it's going to cost us to do this. This is what you need.' How do we come together with us recognizing hey, maybe the benefit's going to be better client care than financal. And I don't mean to be a martyr when I say that at all. I'm just saying it's putting aside any personal agendas and really thinking like, 'Okay, how are we going to do this?'*

This administrator went on to explain that she is "surrounded by a really good team". She said her leadership style included a lot of "respect and autonomy" and that she doesn't "micromanage".

This same administrator explained a system they are developing for crisis care response through stabilization back in the community. She describes what this process looks like.

> *These folks are already presenting at the emergency room with no place to go, they're taking up ICU beds because people don't know what to do with them. So, an individual comes in, in behavioral health crisis. Once they are medically stable, meaning just the medical side, like yeah, they're okay, they are going to leave the emergency room and come into what is called the MPATH unit. And this is a non-clinical room where there might be a couch, a television, coffee, snacks, whatever. Within two hours of them entering that MPATH unit, they're going to be assessed by [telehealth]. We'll also have a peer support individual that's a part of that MPATH unit through our agency. And treatment begins immediately, as well as after care planning...Let's say that through medication, whatever, they're not able to deescalate to a point where the psychiatrist feels they can go home, our partner in [city] has four inpatient psych beds. So, if the person had to go to [institution], that would be the next stop. We would then work on discharge from there, bringing them back into the community and wrapping services around. That might mean them being served by one of our MACT teams in the community or outpatient, whatever is appropriate. [Telehealth organization] would also continue with that individual for psych med management. Worst case scenario, they're going to go to the State Hospital. If that happens though, we want the same process to happen back as far as notification and then we're on it to be able to help that person navigate back into the community.*

In smaller communities in Montana, it might be easier to better coordinate systems of care along the continuum due to strong relationships between organizations. But by and large, providers noted good communication and coordination between care entities facilitated better response and stabilization.

RECOMMENDATIONS FROM PARTICIPANTS

Participants had a variety of well-informed and creative recommendations, grounded in their own experience, to broadly improve the crisis response system in Montana. Participants advocated for a focus on prevention, more case managers, mobile crisis response teams, meetings between different organizations, expanded telehealth and tele-psychiatry but with in-person follow-up, real-time dashboards, expanded family therapy, and an increase in community drop-in centers and transitional living environments.

Prevention, rather than response

Largely, participants were in agreement that more time could be spent on working to prevent behavioral health crisis through a better network of community mental health centers, case workers that helped to manage continued recovery, or other facilitators, rather than through prioritizing resources for response rather than recovery.

> *If we focus on prevention rather than intervention, we can do much better.*

> *Let's do something on the front end so we keep people out of crisis. We're never going to eliminate crisis, we get that. But the better and more effective we can be preventative with resources, that's where we're going to invest our time and money.*

Generally, participants maintained that better prevention and follow-up care including linking the "siloed" components of the system would improve the response to behavioral health crisis. Specific recommendations for prevention services included teachers in middle/high schools and health providers being trained in mental health first aid and crisis response, grants for therapists to provide counseling services free of charge, and school protocols for youth in crisis being in place. We also

discuss recommendations below including continuing case managers who know the needs of their clients before crisis escalation, ongoing family therapy for families of at-risk youth, and community health centers where participants' ongoing mental health needs could be better monitored prior to escalation.

Case managers and support networks

Both patients and providers explained that those who have been through behavioral health crisis could benefit from a case manager who could potentially help usher them through continuing care, including medication management. A mental health professional, who is also a member of a mobile crisis response team, explains that crisis centers can be beneficial to acquire immediate medication. However, a case manager who continues to track a patient's care, would be beneficial for continuing care.

> *Typically, to get into a psychiatrist right now is a month or more wait. People a lot of times, they have let their meds go. They are not calling until it's starting to become a crisis, and they can't afford the month or so wait. So, I would love being able to use a crisis house to be able to say, 'Here you go. We can jumpstart this process.' What would have been ideal then is after they left the crisis house, if we would have the case manager to follow that.*

According to this provider, crisis centers can fill an immediate gap in medication management. However, case managers could continue to facilitate care.

At least half of the providers interviewed brought up the need for case managers to continue the line of care after initial response and stabilization, including by law enforcement. They largely indicated that expanding a network of case managers would support systems of response in Montana.

> *Law enforcement doesn't feel supported, and I don't think we're supportive in the respect of we'd love to help, but we're not the people that can help. We're the people that handle the crisis and go to the next crisis and go to the next crisis. And that's not what these folks need. These folks need someone, and you hear it over and over again, is caseworkers. Basically, someone that can help them, that can take them from that crisis and be able to get them beyond the crisis and start to rebuild their life.*

This police officer acknowledged that law enforcement cannot adequately help those in behavioral crisis beyond the initial response. He posited that better equipped mobile crisis response teams would be helpful, but also that the need exists for continued case management as individuals enter recovery.

Another provider details the important role that case managers could play with providing stabilized care and recovery and preventing future crises.

> *We wiped out case management in mental health a few years back…After a person visited, we recognized that they're not really good organizers, so we're not really sure we're getting to all our appointments…Case managers helped pull that all together. They were boots on the ground kind of folks… Because it's one thing for me to say, 'I'm referring you for outpatient therapy,' but a case manager makes sure you're attending outpatient therapy. Because the outpatient therapist, if you just stop showing up for appointments, they're just like, 'Whatever.' They don't go track you down…Then you don't show up again, you're off my list. Case manager is the one checking in on that to hopefully cover those bases before you get thrown off a bunch of people's lists that could be helping them.*

This provider believes that revisiting the model of assigning case managers to different individuals could prevent them going back into crisis by providing some accountability and follow-up.

In addition to case management, participants affirmed that external support in the form of expanding the peer support network, engagement with patient advocacy organizations, and more access to

support groups could also aid in sustaining recovery for individuals. Charles, the participant with multiple ED visits due to his anxiety and depression, recounts how NAMI has been integral to his continued recovery.

> *So, I have to say that NAMI was a big part of my recovery and understanding of how severe and how epidemic mental illness is in our society at this point. But NAMI helped me to understand that there is help out there and it doesn't look strange or weird.*

Charles continued to explain that he had been brought up by his parents in Montana to believe that people with mental illness were somehow "strange" or "weird" but that NAMI helped normalize mental illness and remove the stigma attached to it. As a transwoman, Maria also explains that support groups are beneficial to normalizing differences between individuals.

> *Coming out in the city of [name] as a whole has not been an easy process, and it's been actually a really hard struggle. And I would like to see some more resources become available for the LGBTQ community.*

> *And then just kind of the support system, I think there's a big need for support groups. Just kind of helping individuals relate to one another and just kind of tell their story and how they were able to overcome these challenges that we all face. I think we all face the same challenges regardless of how we identify.*

Antonia, the individual quoted earlier who went through a behavioral health crisis with her three-month-old daughter, described a concept of a peer support specialist that begins right at the end of incarceration.

> *My vision is to be there when somebody is released from jail. Walk them through right there, take them to wherever they have to go, the resources. I had to go to pretrial services. So, just relate and let them know that, 'This is okay' to feel whatever they're feeling…have the number by the phone next to the bail bonds so that people can automatically start getting peer support. That's where the healing begins, is right there, and life doesn't stop on the outs, you know, but it stops on the inside [jail], and you lose everything when you're stuck there waiting for the system to catch up with life.*

Antonia is currently in training to be a peer support specialist. Her personal experience provides a unique perspective on how isolating and difficult it can be leaving jail and putting your life together after substance use crisis.

Family therapy

According to multiple providers, the system as a whole should increase the availability of family therapy within communities. Therapy that includes the whole family of those youth who have been through crisis might function as both a prevention mechanism and a mechanism sustaining recovery.

> *There's a lot of folks and youth and families that can benefit from a well-organized, good, therapeutic program in a residential setting that does a lot of family therapy, removes kids from a very negative environment, one that they've created a lot of negative patterns and habits in, and helps to teach them new patterns and habits, and then transfer that with family involvement, to be able to go back home them.*

Two providers who consistently work with youth mentioned the need for continued family therapy in Montana.

Systems-level dashboards

One mobile crisis responder who spends a good deal of her time calling organizations looking for open beds noted that a statewide real-time dashboard showing site bed counts would be helpful.

> *Some kind of dashboard where you could find out your resources are. There are so many times I would be taking transfer calls from these outlying facilities and emergency departments, and we would have no capacity. If the State, and maybe that's thinking way too big because I know how bureaucracies are run, but if they could develop something, some system of reporting that was accessible to people that needed an inpatient bed, or needed a service that showed where the capacity was and what type of capacity that would be. And I don't know if that's inpatient, outpatient, whatever, some main resource portal for people looking for services.*

However, she also explained that this dashboard should be accomplished without somehow burdening crisis workers to update them in real time. In other words, the dashboard would be helpful but it should not be just more thing that crisis workers have to document in an already stressful and time sensitive role.

Community drop-in centers and transitional living locations

Both providers and individuals who have experienced behavioral health crisis explained that they would like to see an increase in the number of transitional living locations and community drop-in centers. Participants noted that comfortable home-like drop-in centers, with everyday services such as internet, showers, or a living room, would benefit communities that did not currently have one. A major gap in crisis care in Montana according to providers, exists in the follow-up care in prevention and stabilization.

> *To be honest, there's a huge lack of continuum of care and the services that we're able to provide in our community. We have basic general outpatient services. We have some crisis services, and we have follow-up care, but we don't have any stabilization services. We don't have a lot of preventative services... How to fill those gaps? I think a crisis center or something along those lines. I also think a drop-in center would be a good option as well. Someplace where people are just comfortable coming for help, where they feel like they can just drop in at any time, and it's less structured.*

This provider recounts that in her view, prevention and stabilization are the parts of the continuum of care that need the most focus on Montana. She believes a drop-in crisis center in her community that provides a lot of necessary services in one place would begin to fill this important gap. Multiple other providers, including some who have been through crises themselves, also agreed that a comprehensive drop-in crisis center with a "living room feel" in their communities would be beneficial. Within a given community, there may be separate and complementary roles for a low-barrier drop-in center, crisis stabilization, and crisis receiving. Each of these are areas of need in Montana, and interviewees spoke of them interchangeably. As these types of programs and activities are developed, it will be important to have local providers communicate with community partners and residents about the specific characteristics of the given program.

Maria, the trans participant who has been through multiple mental health crises, noted that transitional and supportive housing models, going beyond a more temporary drop-in center, would be helpful. She brought up the example of one such organization that she believes could serve as a model to be replicated in Montana.

> *I've been looking at models called like Clubhouse International… I think that would be an awesome resource just for the state of Montana as a whole, because they can house anywhere from one to 500 individuals. And they're not just overnight, they're anywhere from six months to a year's time, depending on the individual's needs. They have transitional living, and then during the day, every client is an employee. So, they teach them life skills, to cooking, janitorial work, maintenance, grounds keeping just basic stuff to help them feel appreciated and get them back out into society and be an asset instead of a deficit.*

Maria, who has experienced homelessness herself, went on to explain that having a place to sleep and a guaranteed shower ***"makes you feel human…instead of [like] some animal in the street"***. Attributes of the drop-in or temporary living centers that participants would like to see include

laundry facilities, a meditation room and mindfulness classes, internet/wifi and a computer lab, free therapy services, reading assistance, medication management, support group meetings, living rooms, showers, a music room, anger management classes, a food pantry, 24/7 availability where you can be screened and still be admitted late at night, detox facilities, parenting classes and babysitting enabling parents of young children to attend therapy, a workout room, help with administrative forms for food assistance and Medicaid, planning for the future and employment, sober transitional housing, and legal services.

IMPLICATIONS AND RECOMMENDATIONS

The following general recommendations build upon the suggestions given by providers and utilizers of the behavioral crisis system in Montana.

1. Expand and build institutional partnerships, networks, and case management:

Our sample of providers likely represent dedicated individuals as instanced by their willingness to respond to requests for interviews and donate their valuable time. Without these committed individual providers, it is likely that the system as a collective whole would not function as satisfactorily. This is problematic and unsustainable because the burden then falls on the individual provider to go above and beyond their occupational role to meet the substantial needs of those in crisis. Without the adequate support of a collective system buffering the effects of physically and emotionally draining occupations, dedicated individual providers might have a higher propensity for burnout.

As providers and law enforcement indicated, the "silos" of care leave individual providers, patients, and family members feeling isolated, unsupported, and with few options to coordinate and receive care along the continuum. Case managers that follow and support a client's individual needs (including medication management) and progress in recovery could begin in the emergency department, upon release from jail or behavioral health institution, and/or a drop-in crisis center. Targeted case management is reimbursable via Medicaid, and there may be a need to consider broader definitions of clients who can be served via this funding mechanism. Additional sources of funding may be needed to cover less intensive care coordination if it remains a non-funded service under Medicaid in Montana. Expanding case management and care coordination might improve the "hand-off" from jail (in the words of one provider) or transition from institution to the community. These grants could include a component of administrative support from the State and guidelines for administrators within organizations that provide clear, specific, and measurable benchmarks for success. After meeting these objectives, grants could be followed up by reliable and continued funding mitigating the instability that short-term grants may perpetuate.

One benchmark for success could include an organizational climate that supports self-care and well-being for providers. Studies have shown (e.g. Cummins, Massey and Jones 2007) that "compassion fatigue" for providers can be partially mitigated with personal wellness action plans and strong relationships between administrators and providers. Grants might also be made available for individual therapists to provide a set number of "free" counseling services for patients and providers themselves to buffer the effects of compassion fatigue.

Statewide in-person and online conferences for those in the behavioral health crisis system could also aid in developing and cementing connections between organizations and individuals while also providing support and increasing professional capacity and resiliency. Sessions within this conference could also include integrating individuals who have been through crisis alongside providers. Additional sessions might include topic areas such as trauma-informed care, maintaining provider well-being, and sustaining support groups. Currently, monthly calls are held with crisis coalition leads from County-Tribal Matching Grant CTMG grant recipients. To continue to build on these relationships, in-person or online conferences which also include others outside of grantees, such as general community members, community health providers, individuals, and families, would also be beneficial. It also should be noted that this study took place during year 2 of COVID-19, and that interviewees were feeling a unique absence for in-person conferences due to the need to restrict these types of events for the health and safety of Montana residents.

2. Envision a comprehensive strategy for a state-supported network of recovery supports that are human-centric in design and include a network of drop-in, crisis receiving, and transitional housing:

Both providers and individuals who experienced crisis agreed that housing remains a salient need in Montana. Combining short-term and longer-term, transitional housing alongside services in drop-in or crisis receiving that help those experiencing behavioral health crisis "feel human" (in the words of one individual) like living rooms would be a step in the right direction. Participants explained that these centers should not replace long-term institutions or stable housing, but rather would augment them and reduce the significant burden experienced by emergency departments and law enforcement.

3. Continue to expand the presence of mobile crisis teams and ensure that law enforcement partners for mobile crisis teams take a client-centric view in engagements.

The prevalence of mobile crisis response teams in Montana has increased in the past three years, and views of interviewees may not reflect the implementation of these new practices within many communities, as some interviewees experienced an older version of the crisis response systems in Montana. Insights from interviewees who did engage with mobile crisis teams, as well as those who did not, reinforce the value of efforts to expand this program model in Montana. From the view of participants in this study, mobile crisis response teams offer an opportunity for those in crisis to first encounter mental health professionals, peers, and law enforcement who are sympathetic and expert at responding to a mental health need. Ensuring that this type of engagement is widely available across the state may be a challenge but should be an essential objective that informs geographic access to mobile teams as well as the workforce for these programs.

4. Articulating and restructuring system-level care protocols, objectives, and goals:

Implicit in many of the participants' narratives included a recognition of the patchwork behavioral health crisis system made up of distinct and isolated parts with few systems-level supports or systematic protocols they could rely on or have the resources to meet. Many providers reported receiving reduced rates for reimbursement for services, which may have led to families reporting decreases in the current quality of care. In other words, organizations must do more with fewer resources which likely decreases the ability to provide quality care. Possible solutions include developing a clear and systems-level classification for care accountability and reporting, improving the presence of Community Mental Health Centers, developing lists/recommendations for protocols for managing transitions and transportation from jail or institutions to other sites, creating a Statewide dashboard of lists for services including substance use treatment beds that does not increase occupational burden for providers, implementing fidelity and performance measures that can be used to ensure standardization of care across provider types, and regularly producing and updating a universal list of support group meetings and resources for individuals and families.

APPENDIX: INTERVIEW GUIDES

INDIVIDUALS WITH LIVED EXPERIENCE

1. Tell me a bit about yourself and the kinds of behavioral health crises you've experienced?
    a. Multiple crisis? Kinds of crisis? Symptoms?
    b. Life before the crisis? Ways engage with community before? (i.e. friends, community, housing, family, employment, etc.)
2. During your crisis, when did you or someone else recognize that you were having a crisis?
    a. Call 211? 911?
    b. Who responded?
    c. Where were you taken?
3. During your crisis, what happened after you were taken to (ED, jail, or community health center, etc.)?
    a. Who would you say helped the most? How? Why? (Peer support specialists, behavioral health aids, call center, law enforcement, nurses, physicians, etc.)
        i. (law enforcement) Know if law enforcement Crisis Intervention Teams (CIT) trained? Mental health counselor show up with LE?
    b. If the Emergency Department was part of your care, what could have been improved? What did they do well?
    c. (If not admitted to ED) What might have kept you from going to the Emergency Department? Would you have rather gone there? Or elsewhere?
4. After your crisis, what was your experience and care?
    a. Detox facility? Different setting? Further services? Services available in jail? Length of time in jail?
    b. Some of the most helpful things here? Some of the least helpful things?
    c. Who were the most important people to getting you stabilized after the crisis?
5. From the perspective of someone now in recovery having been through a crisis, what might help support you in recovery?
    a. What are you doing when you feel you're at your best?
6. Is there anything else you'd like to tell me or that we didn't cover?

FAMILY MEMBERS

1. Tell me a little bit about yourself and how you've come to be involved in (ways referred to research as a family member).
    a. Kind of crisis of family member? Multiple crisis?
    b. Life of family member before the crisis?
2. At what point did you recognize your family member was having a crisis?
    a. Help with the crisis? How?
    b. Call 211? 911?
    c. Approach them or they approach you?
3. Who responded to the crisis and where was your family member taken? (Mobile response team, EMS, law enforcement?)
    a. How did the crisis response go?
        i. What could have been better?
    b. Best part of care? Worst part of care?
    c. Most important providers of care?
4. After the crisis, how was the care for your family member?
    a. Detox facility? Further services? Services in jail?
    b. What was the most crucial component of helping your family member get stabilized following the crisis?
    c. Most important providers after the crisis?
5. From the perspective someone who has helped a family member through a crisis in Montana, what advice would you give that might improve the overall response system?
6. Is there anything else you'd like to tell me or that we didn't cover regarding the existing systems in place in Montana for behavioral health crisis?

PRACTITIONERS

1. Tell me a little bit about the aspects of your job that have to do with behavioral health crisis?
    a. What drew you to this profession?
    b. Are there things you think you well regarding responding to crisis?
    c. Job affect personal life? Why or why not?

2. When a patient comes in (or you are called) in the middle of a behavioral health crisis, what is the typical kind of process you go through?
    a. Differ by SUD or mental health? Describe a more "serious" crisis?
        i. Are some types of patients harder to handle than others?
    b. Points in the system where treatment/care consistently gets held up? Why?
    c. (EMS)
        i. When transporting patients, what kinds of considerations do you take into account?
    d. (Law enforcement)
        i. Have you ever had to use physical force during someone's behavioral health crisis? Why or why not?
3. When thinking of your job/role, what types of things might help the patients in the middle of a crisis? (types of rooms/environment? Resources? Etc.)
    a. Any particular examples or instances with a patient in crisis where a tactic or resource worked really well?
        i. Most crucial component of stabilizing a patient?
    b. Beneficial training?
    c. Major barriers to doing your job? Facilitators?
    d. In what ways do you feel supported in your job? In what ways could you be better supported?
4. After someone in crisis has been stabilized, what are some of the things that might benefit them?
    a. Better intermediate setting?
    b. Refer patients to other services? Why or why not?
    c. Any particular considerations with being stabilized in jail versus a different setting?
5. If you had to make one recommendation that would help your organization or someone doing your job after a crisis, what would you recommend?
6. What ways do you think would provide the best ongoing reporting to the State of Montana regarding the status of the behavioral health crisis system in Montana?
7. Is there anything else you'd like to tell me or that we didn't cover?

CODING SCHEME

Provider crisis narrative
- Provider SUD crisis triggers
- Provider MH crisis triggers
- Provider Crisis prevention
  - Provider Prevention barriers
- Provider Crisis early intervention
  - Provider interpersonal crisis skills
  - Provider drug test
  - Provider early intervention barriers
- Provider Crisis response
  - Provider crisis response Violence
  - Provider Threat response
  - Provider crisis bias or values
  - Provider call 911
- Provider Crisis stabilization
  - Provider Stabilization barriers
  - Provider Resource refusal
- Provider barriers narrative
  - Provider bureaucratic barriers
  - Provider environmental/physical barriers
    - Provider burnout
    - Provider time barrier
    - Provider legal issues
    - Stigma
- Provider MACT/PACT
- Provider telehealth
- Provider financial barriers and/or facilitators

Individual crisis narrative
- Individual SUD Crisis Triggers
- Individual MH Crisis Triggers
- Individual Crisis prevention
  - Individual crisis prevention barriers
- Individual Crisis early intervention
  - Individual crisis early barriers
- Individual Crisis response
  - IC presentation of self
  - IC response barriers
    - IC lack of providers
    - IC transportation problems
    - IC time barrier
  - IC response facilitators
    - IC bureaucratic facilitators
    - IC family support
  - ED facilitators
    - ED staff facilitators/training/supports
  - ED barriers
    - ED barriers narrative
    - ED bureaucratic barriers
    - ED environmental/physical barriers
- Individual Crisis stabilization
  - IC stabilization barriers
  - IC recovery narrative (include providers)
  - IC financial barriers

Family crisis narrative
- FC prevention
  - FC prevention barriers
  - FC prevention facilitators
- FC early intervention
  - FC early intervention barriers
  - FC early intervention facilitators
- FC response
  - FC response barriers
  - FC response facilitators
- FC stabilization
  - FC stabilization facilitators
  - FC stabilization barriers

Nonprofit crisis center/org
- NC facilitators
  - NC staff facilitators/training/supports
- NC barriers
  - NC barriers narrative
  - NC bureaucratic barriers
    - Subjective protocol
    - Communication problems
  - NC environmental/physical barrier

Law Enforcement crisis narrative
- LE crisis prevention barriers
- LE crisis early intervention barriers
- LE crisis response barriers
- LE crisis stabilization barriers
- LE facilitators
  - LE staff facilitators/training/supports
- LE barriers narrative
  - LE bureaucratic barriers
  - LE environmental/physical barriers

Recovery and Recommendations/facilitators
- Provider stabilization/services recommendation
  - Provider Private room
  - Provider Resource refusal
  - Provider case manager
  - Provider Housing
  - Provider medication management
  - Provider General recommendations & frustrations
  - Provider family therapy
  - Provider staff facilitators/training/supports
  - Provider wrap around services
  - Provider peer support
  - Provider resource center
  - Coalition
- Individual stabilization/services recommendation
  - IC ED recommendation
    - IC ED case manager recommendation
  - IC short resource list recommendation
  - IC support mtgs recommendation
  - IC housing recommendation

Provider Job Description Provider job title Career choice reason Negative job associations Individual crisis involvement description (kind of like "job")	**Call/mobile response** 211 barriers 211 facilitators 211 recommendations State of MT preferred communication Geography

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