



Wake County Crisis System Assessment Report

MAY 2023

Prepared by: Human Services Research Institute

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- **The Wake County internal steering committee** for this project, whose members provided guidance throughout the assessment, sharing materials, answering questions, providing feedback, and helping us to make connections for interviews.
- **The staff and leadership at UNC WakeBrook**, who shared their time to give us tours, make staff available for interviews, and respond to questions and data requests.
- **Healing Transitions, Haven House, and NAMI Wake County** for helping us organize focus groups for people to share their experiences using crisis services in Wake County.
- **Focus group participants**, who generously shared their personal experiences receiving services and ideas for ways to improve the system.
- **WakeMed, UNC Rex, and Duke Raleigh Hospital**, whose staff provided data in response to our request and also participated in key informant interviews.
- All key informant interview participants for their time and candor.
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- **Wake County's Internal Behavioral Health Committee** for reviewing and providing valuable feedback on our report drafts.

Executive Summary

Introduction and Background

In July 2022, Wake County contracted the Human Services Research Institute (HSRI) and its partner the Technical Assistance Collaborative (TAC) to assess the county’s behavioral health crisis services system. The term “behavioral health” is used to encompass mental health and substance use disorder. The purpose of the study is to evaluate the current continuum of behavioral health crisis services in relation to national best practices and models, to identify strengths and gaps in available services, and to make recommendations for system improvements and use of county funds for services at the WakeBrook crisis facility¹.

Methods

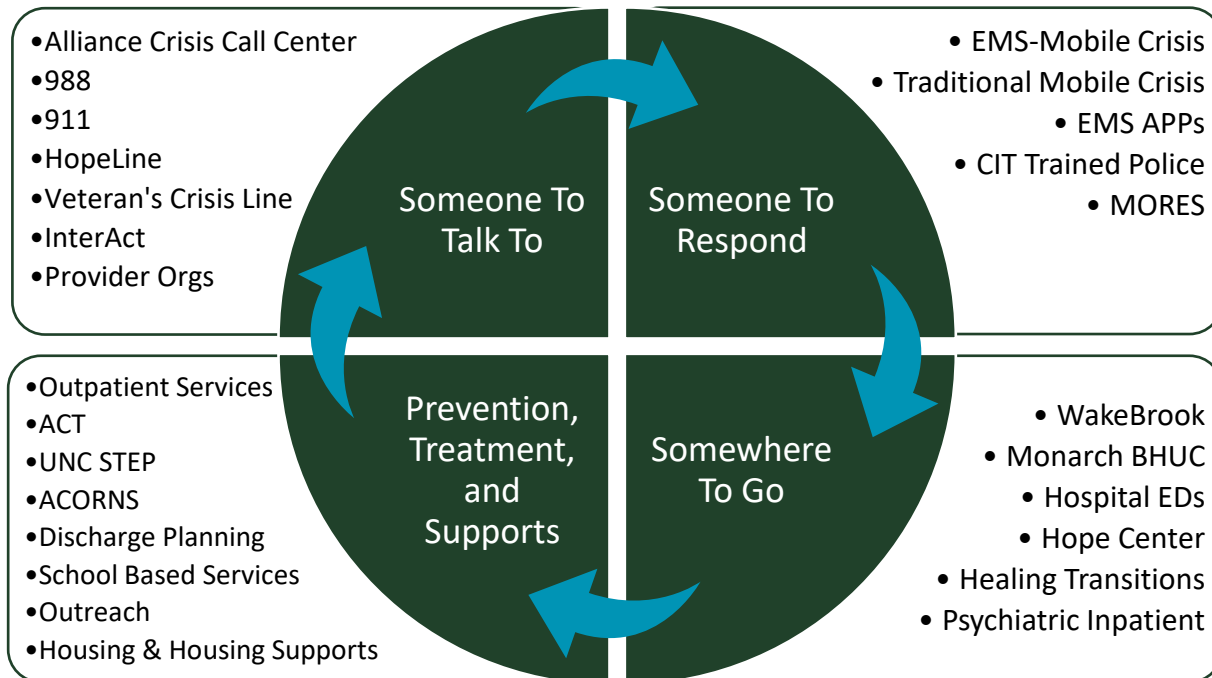
The assessment relied on quantitative and qualitative data and a review of national best practices and guidance for crisis systems. For quantitative data, we obtained data from Alliance Health, WakeBrook, the mobile crisis provider, and the county’s three hospital systems. For qualitative data, we conducted semi-structured interviews with 71 community members representing a range of behavioral health provider and social services organizations, hospitals, first responders, Wake County staff, Alliance leadership and staff, people who use crisis services, and others identified in consultation with the county. In addition, we conducted four focus groups with a total of 34 participants with lived experience using crisis services.

Summary of Key Findings

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) has put forth national guidelines for behavioral health crisis care of which the three core elements are: 1) **someone to talk to** (a regional crisis call line), 2) **someone to respond** (24/7 mobile crisis), and 3) **somewhere to go** (crisis receiving and stabilization facilities). Figure 1 provides an overview of Wake County’s assets across these three core areas, as well as prevention, treatment, and supports to prevent crises.

¹ Late in the project, during the writing of this report, UNC Health announced changes to its long-term plans to operate services at WakeBrook, of which the details were still unknown at the time of writing. Wake County will have to factor the developments of these plans into the response to the recommendations presented in this report.

Figure 1. Overview of Wake County Crisis Services Continuum



Wake County Crisis System Strengths

- Overall, many of the core services in an ideal crisis continuum are in place
- Commitment to behavioral health from community leaders
- Relative to similar communities around the country, Wake County has a good array of services, resources, and funding opportunities for behavioral health
- UNC WakeBrook provides a continuum of high-quality services in one location
- Overall good health of the population
- Innovative approaches, initiatives, and partnerships, such as the Familiar Faces initiative, ACORNS, peer-led Rapid Responders program, EMS enhanced mobile crisis, and WakeMed's behavioral health outreach and coordination initiatives, among others
- Community providers across sectors are committed to collaboration to address challenges, though coordination efforts could be improved

Wake County Crisis System Gaps

- The mobile crisis service does not have the capacity to fulfill its potential to significantly divert individuals from emergency departments
- There is an overreliance on calling 911 for behavioral health crises
- Lack of coordination with the new 988 crisis call line
- WakeBrook's crisis assessment unit is too often full and unable to accept referrals
- No transportation options beyond police and EMS is a critical gap in the continuum
- The county lacks a crisis respite or peer crisis respite
- There is lack of residential service capacity
- Lack of capacity at the county to oversee and help coordinate the system; there is no clearly defined crisis system coordinator (at the county or Alliance)
- No 24-hour emergency shelter for adults
- Lack of system-wide capacity to serve children and youth with complex needs
- Assertive Community Treatment (ACT) and other community-based intensive services could be improved to prevent unnecessary emergency department and psychiatric inpatient stays

Recommendations

The following are 12 priority recommendations to address the gaps and needs in Wake County. These recommendations are directed to the county in partnership with Alliance. The recommendations are organized into four categories: crisis services continuum, systemwide needs, social supports to prevent crises, and quality and coordination.

Crisis Services Continuum

1. **Continue investment in WakeBrook as a crisis “hub” for Wake County.** There is need for expanded capacity for the crisis assessment service to be able to accept all referrals 90% of the time. Serving as the crisis “hub,” there is need for more coordination with mobile crisis. There is also need for peer staff to play a more central role in services at WakeBrook.
2. **Expand and invest more in mobile crisis.** In model crisis service systems, mobile crisis teams effectively divert crises from emergency departments and EMS/law enforcement, but in Wake County the service is insufficient to fulfill this potential. We endorse the recommendations put forth in a prior evaluation of the mobile crisis service. Consider co-location of mobile crisis teams out of WakeBrook and/or EMS/police. Coordinate with SouthLight to plan expansion of mobile crisis as part of the federal CCBHC grant.
3. **Establish a peer-run crisis respite.** A crisis respite is a voluntary, short-term, overnight program that provides community-based support staffed by people with lived experience of

mental health or substance use challenges. Research studies have shown peer respites reduce guests' likelihood of using inpatient or emergency services, are cost effective compared to inpatient services, and improve guests' feelings of healing, empowerment, and satisfaction.

4. **Establish residential treatment options outside of WakeBrook.** While there is an advantage of having step-down residential treatment connected to the continuum of services at WakeBrook, the county should explore the possibility of establishing a residential option in the community, particularly for substance use disorder.
5. **Invest in transportation options to minimize use of law enforcement for transportation.** In partnership with Alliance, develop a comprehensive transportation plan that includes options for private vehicles, taxis, specialty mental health transport, and mobile crisis. Establish a county-wide alternative to police transportation; Oklahoma's RideCare program is an example.

Systemwide Needs

6. **Expand the role of peer support throughout the behavioral health system.** A significant role for peers is a core principle of a model crisis system and is lacking in Wake County. Alliance should sponsor trainings for certified peer specialists that meets state standards. County funds could be used to create financial incentives for recruitment and retention. Consider establishment of a county advisory board/steering committee composed of peer specialists and individuals with lived experience to focus on community engagement.
7. **Focus on enhancing culturally and linguistically accessible services and supports.** System leaders should intentionally work to build trust with culturally diverse communities, including new immigrants, refugees, and the LGBTQ+ community. Examine the makeup of existing advisory boards and create a plan to increase representation of underrepresented groups.

Social Supports to Prevent Crises

8. **Continue to prioritize housing for people with mental health and SUD needs** and enhance coordination and cross-sector collaboration to streamline process. Evaluate prioritization of housing subsidies related to individuals with behavioral health needs. Consider funding for rapid rehousing program and expanding access to 24-hour shelter. Make housing a priority for the Familiar Faces initiative.
9. **Ensure access to comprehensive services for youth and families.** Review capacity and quality of Alliance's intensive community-based services for youth and families such as the Community Inclusion Planning service.

Quality and Coordination

10. **Expand county capacity for behavioral health system coordination and oversight.** Establish a position for a crisis coordinator at the county to help oversee and coordinate the system. Alliance has a central role in system accountability, but more capacity at the county is needed, especially in anticipation of Medicaid expansion. Desired characteristics of a coordinator: experience with behavioral health quality and performance improvement, cross-system

collaboration, and ideally lived experience. Consider additional SOAR case manager position in anticipation of Medicaid expansion and targeted to re-entry population.

11. **Promote awareness of 988 in the community and improve coordination between 988, 911 dispatch, and Alliance's crisis call center.** Identify funding opportunities to enhance communications around 988. Place promotional materials in public spaces. Initiate discussions with the state DHHS to better understand coordination needs and barriers.
12. **Expand/develop measures for performance monitoring for the crisis system.** Review list of performance measures included in this report and select measures that meet county needs for performance monitoring and quality improvement. County contracts should include requirements for data for the selected measures. Establish a public-facing data dashboard that is reviewed regularly at crisis collaborative meetings.

Project Overview

Background and Purpose

Wake County is the most populous county in North Carolina and one of the fastest growing counties in the United States.² Despite the overall good health status of its population and relative wealth of resources associated with proximity to universities, medical centers, and the State Capital, Wake County is experiencing challenges with accessibility, accountability, and coordination of its crisis system, some of which are common to many localities and others that are specific to Wake County.

Alliance Health manages all public behavioral health and developmental disability services in Wake County through a combination of Medicaid managed care, waivers, and state and county funds, of which Wake County commits over \$30 million annually. The largest portion of the county's funds—over two-thirds—is dedicated to crisis and intensive services primarily for individuals without health insurance, including around \$14 million annually to support services at WakeBrook, a 24-hour crisis facility operated by the University of North Carolina Health System (UNC Health) in Raleigh at the time of this study.

The vision and priorities for the county's behavioral health system were developed through a collaborative effort involving government leaders, hospitals, and community organizations, outlined in the county's Behavioral Health Plan³ last updated in 2021.

In July 2022, Wake County contracted the Human Services Research Institute (HSRI) and its partner the Technical Assistance Collaborative (TAC) to assess the county's behavioral health crisis services system. The purpose of the study is to evaluate the current continuum of crisis services in relation to national best practices, to identify strengths and gaps in available services, and to make recommendations for system improvements, most needed services, and most effective use of county funds, taking into consideration potential state and federal policy changes that might impact behavioral health services in the coming years. While the focus of the needs assessment is on crisis services, we also examine more broadly the intersections of crisis services and related behavioral health and social services.

² Routley N. (2022, June 16). *Mapped: A Decade of Population Growth and Decline in U.S. Counties*. Visual Capitalist. <https://www.visualcapitalist.com/mapping-a-decade-of-us-population-growth/>

³ Wake County Behavioral Health Plan FY22-FY23

Approach and Methods

HSRI works with states, counties, and jurisdictions to assess and improve service systems. Our approach to this assessment is based on a conception of crisis services as the fulcrum of a balanced behavioral health system, mediating between community-based services and intensive facility-based treatment. Optimally, high quality community-based services prevent unnecessary crisis service utilization, and effective crisis services prevent unnecessary inpatient admissions. Thus, an effective crisis service system ensures that people are transitioned to intensive treatment in a smooth and timely manner when medically necessary; for others, it ensures they are stabilized and safely transitioned back to community-based services.

An effective crisis service also engages successfully with hospital emergency departments, primary care providers, law enforcement, and other community partners such as child welfare, schools, and programs addressing housing and homelessness. If community-based services are inadequate, crisis services become overburdened, resulting in failure to serve the primary function of diversion from more restrictive and costly services and an unsatisfactory experience for individuals in crisis. Likewise poor law enforcement practices or shortcomings in hospital emergency departments have the same detrimental consequences. Accordingly, we assess Wake County's crisis services in the context of the overall continuum of care, in a dynamic relationship with the quality, capacity and accessibility of community-based supports and intensive treatment settings.

The effectiveness of crisis services is also influenced by adequacy of funding by diverse payors for various populations, and by governmental policies, regulations, and standards. If these are poorly managed by crisis service provider organizations, the impact will be negative for people, the system, and the community. Without adequate funding, clear policies and proper training, the crisis system may serve only as a conduit to more restrictive services. Therefore, these factors also must be considered when assessing the crisis system.

To conduct the analysis, we gathered quantitative and qualitative data and used a mixed methods approach. For quantitative data, we obtained data from Alliance Health, WakeBrook, Therapeutic Alternatives, and the three hospital systems (WakeMed, UNC Rex and Duke Raleigh Hospital) to examine use of crisis services, emergency department encounters for behavioral health, and the demographic characteristics of people who used crisis services. We used public use data sources to describe population characteristics and trends, prevalence of behavioral health conditions, and social determinants of health in Wake County, comparing rates to neighboring counties and state and national benchmarks, when available.

For qualitative data, we conducted semi structured interviews with key informants between November 2022 and February 2023. The list of people to include in interviews was developed in consultation with the county and its internal steering committee for this project, with an aim to capture a wide range of perspectives from crisis service providers, county and Alliance leadership, first responders, advocates, housing and homeless services providers, hospitals, representatives from Alliance’s Consumer and Family Advisory Committee, and others, prioritizing engagement with members of historically marginalized or underrepresented communities. A list of organizations that participated in key informant interviews is provided in [Appendix A](#). The interviews were conducted primarily virtually. In addition, we conducted four in-person focus groups with people with lived experience using crisis services in Wake County. The focus groups were held at Healing Transitions (one on the men’s campus, one on the women’s campus), Haven House, and a fourth group organized by NAMI Wake County. Interview and focus group participants who were participating outside of a paid job were compensated \$25. We collected basic demographic information from interview and focus group participants; these demographic characteristics are included in [Appendix A. Table 1](#) shows the number of interviews and focus group participants.

Table 1. Number of interviews and interview/focus group participants

# of Key Informant Interviews	41
# of Interview Participants	71
# of Focus Group Participants with Lived Experience	34

In addition to qualitative and quantitative data, we conducted a scan to identify national guidelines and best practices for behavioral health and crisis systems, including relevant examples of models and services from other jurisdictions.

Wake County Community Context

Wake County is the most populous of North Carolina's 100 counties, with a population of 1,129,410, according to the 2020 U.S. Census.⁴ The county is comprised of 12 municipalities, among which the most populous is Raleigh, the county seat and state capital. Other municipalities are (in order of population size) Cary, Apex, Wake Forest, Holly Springs, Fuquay-Varina, Garner, Morrisville, Knightdale, Wendell, Rolesville, and Zebulon. Raleigh is part of the region known as The Research Triangle (Raleigh, Durham, and Chapel Hill), and Wake County is home to seven colleges and universities.

With economic opportunities and proximity to higher education and the state capital, Wake County is a desirable place to live and work; accordingly, the population has grown by 62 people per day over the past decade⁵ and continued growth is projected.

Demographic Characteristics

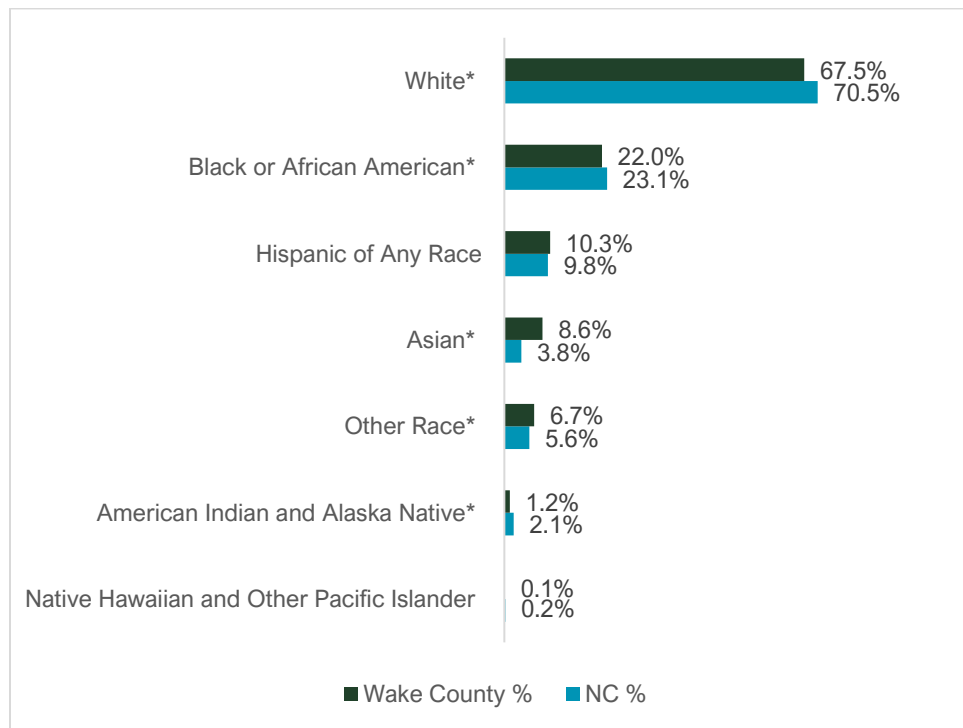
According to the latest (2021) Census data, roughly two-thirds (68%) of Wake County residents identify as White alone or in combination with one or more other racial identities, followed by Black (22%), Hispanic (10%), Asian (9%), other race (7%) and American Indian or Alaska Native (1%).⁶ Figure 2 compares the distribution of race and ethnicity in Wake County to that of the state. The largest difference is the higher percentage of residents identifying as Asian in Wake County (9% vs. 4% statewide). The percentage of Wake County residents identifying as White or Black or African American is slightly lower than the state average.

⁴ U.S. Census Bureau. (2020). Decennial Census, 2020. Retrieved Sept. 16, 2022, from: https://data.census.gov/cedsci/table?q=p2&g=0100000US_0400000US37_0500000US37183&tid=DECENNIALPL2020.P2

⁵ *Wake County Growth and Population Trends*. Retrieved Dec. 29, 2022, from <https://www.wakegov.com/departments-government/planning-development-inspections/planning/census-demographics/growth-and-population-trends#:~:text=More%20than%201%20million%20people,people%20moving%20to%20this%20region.>

⁶ U.S. Census Bureau. (2021). 2017-2021 American Community Survey 5-Year Estimates, Table DP05. Retrieved Dec. 21, 2022, from: https://data.census.gov/table?q=0100000US_0400000US37_0500000US37183&d=ACS+5-Year+Estimates+Data+Profiles&tid=ACSDP5Y2021.DP05

Figure 2. Race and Ethnicity in Wake County Compared to State Average



Source: U.S. Census Bureau. (2021). 2017-2021 American Community Survey 5-Year Estimates, Table DP05. Retrieved Dec. 21, 2022, from: https://data.census.gov/table?q=0100000US_0400000US37_0500000US37183&d=ACS+5-Year+Estimates+Data+Profiles&tid=ACSDP5Y2021.DP05 Notes: The categories for race represent “Race alone or in combination with one or more other races.”

* = Indicates there is no overlap in the margin of error for the county and the state values, suggesting a meaningful difference; Hispanic or Latino of Any Race does not have margin of error available for Wake County, so no comparison to North Carolina can be made.

With respect to age, Wake County’s population is generally younger compared to the age distribution statewide, with a higher percentage of residents ages 25 to 44 years (30% vs. 26%) and a lower percentage age 65 and over (13% vs. 17%). Nearly one quarter of Wake County residents are under the age of 18, similar to the state average.⁷

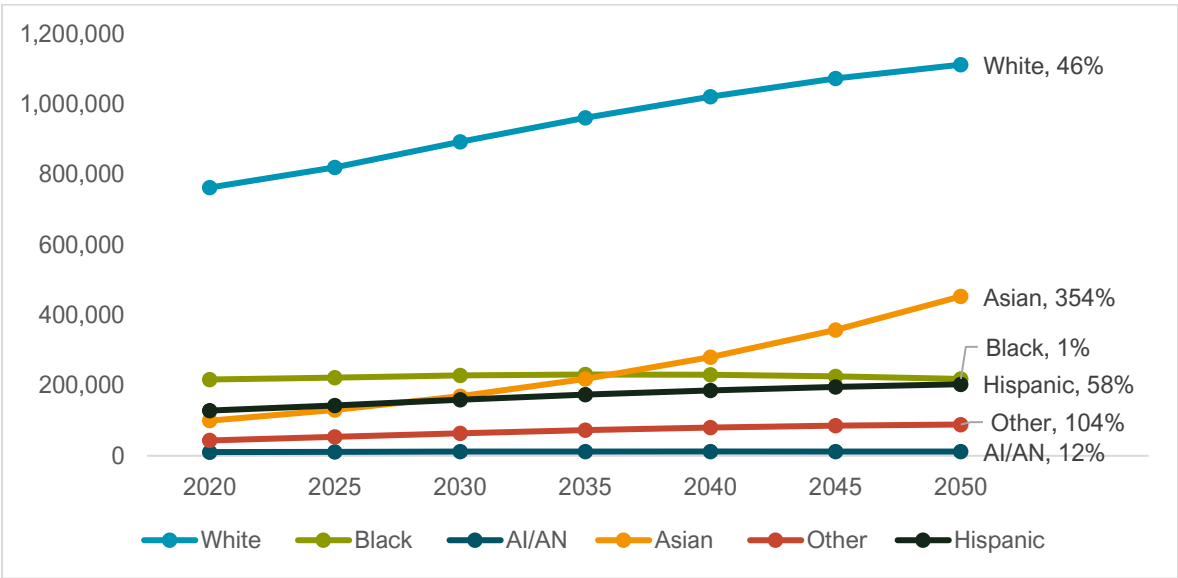
A higher percentage of Wake County residents are foreign-born compared to the state average (14% vs. 8%) and speak a language other than English at home (18% vs. 12%). Spanish is the most prevalent other language spoken at home (8%), followed by other Indo-European

⁷ U.S. Census Bureau. (2021). Population Estimates Program, County Characteristics Resident Population Estimates 2021 and Population Estimates Program, Annual Estimates of the Civilian Population by Single Year of Age and Sex for the United States and States: April 1, 2020, to July 1, 2021. Retrieved Sept. 15, 2022, from <https://www2.census.gov/programs-surveys/popest/datasets/2020-2021/counties/asrh/cc-est2021-agesex-37.csv> and <https://www2.census.gov/programs-surveys/popest/tables/2020-2021/state/detail/sc-est2021-agesex-37.xlsx>

languages (4%), and languages of Asia and the Pacific Islands (4%). About 1 in 20 Wake County residents speak English less than “very well.”⁸

Between 2010 and 2020, the population of Wake County grew 25%, more than double the rate of population growth in the state (10%). All 12 municipalities saw growth. Wake County grew by approximately 62 people per day, making it one of the fastest growing counties in the nation.⁹ Figure 3 shows projected population growth by race and ethnicity through 2050, with trends similar to the past decade. The county’s Asian population is projected to increase significantly, growing by 354% between 2020 and 2050; the Black population has the smallest projected growth at 0.8%. As shown in [Table 2](#), the population ages 65 and older is projected to grow by nearly 200% by 2050. Overall, this continued rapid increase in growth will have a resulting increase in demand in behavioral health services across the entire continuum of care, although the extent of this impact is not expected to be proportional with growth and will depend on factors such as community economic and social wellbeing, etc.

Figure 3. Projected Population Growth in Wake County by Race and Ethnicity



Sources: North Carolina Office of State Budget & Management, State Demographer (2022) *Population Estimates/Projections Data: Sex, Race, Age Groups (2000-2050)*. Retrieved December 15, 2022, from <https://www.osbm.nc.gov/population-projections-age-group-data/download?attachment>; North Carolina Office of State Budget & Management, State Demographer (2022); *Hispanic Origin by Race (2010-2050)*. Retrieved December 15, 2022, from: <https://www.osbm.nc.gov/population-projections-hispanic-origin-data/download?attachment>

⁸ U.S. Census Bureau. (2021). 2017-2021 American Community Survey 5-Year Estimates, Table DP02. Retrieved Dec. 21, 2022, from https://data.census.gov/table?q=internet&g=0100000US_0400000US37_0500000US37183&d=ACS+5-Year+Estimates+Data+Profiles&tid=ACSDP5Y2021.DP02

⁹ Wake County North Carolina. (2022, Feb. 11). *Wake County in Focus*. <https://s3.us-west-1.amazonaws.com/wakegov.com-if-us-west-1/s3fs-public/documents/2022-02/04%20-%20Demographic%20Insights%20%282022.02.01%209PM%29.pdf>

Notes: Each line is labeled with the Race or Ethnicity it represents, followed by the percent change in population for that Race or Ethnicity between 2020 and 2050. AI/AN= American Indian or Alaska Native.

Table 2. Projected Population Growth in Wake County and NC by Age

	Wake County Population in 2020	Wake County Population in 2050	% Change Wake County	% Change NC
Under 18 years	252,244	338,062	34.0%	24.3%
18 to 24 years	106,696	138,103	29.4%	16.2%
25 to 44 years	333,682	495,608	48.5%	28.7%
45 to 64 years	301,815	517,508	71.5%	30.6%
65 years and over	138,183	396,125	186.7%	69.7%

Sources: North Carolina Office of State Budget & Management, State Demographer; Population Estimates/Projections data by Sex, Race, Age Groups (2000-2050). Data accessed 12/15/22 from: <https://www.osbm.nc.gov/population-projections-age-group-data/download?attachment>

Social Determinants of Health and Mental Health

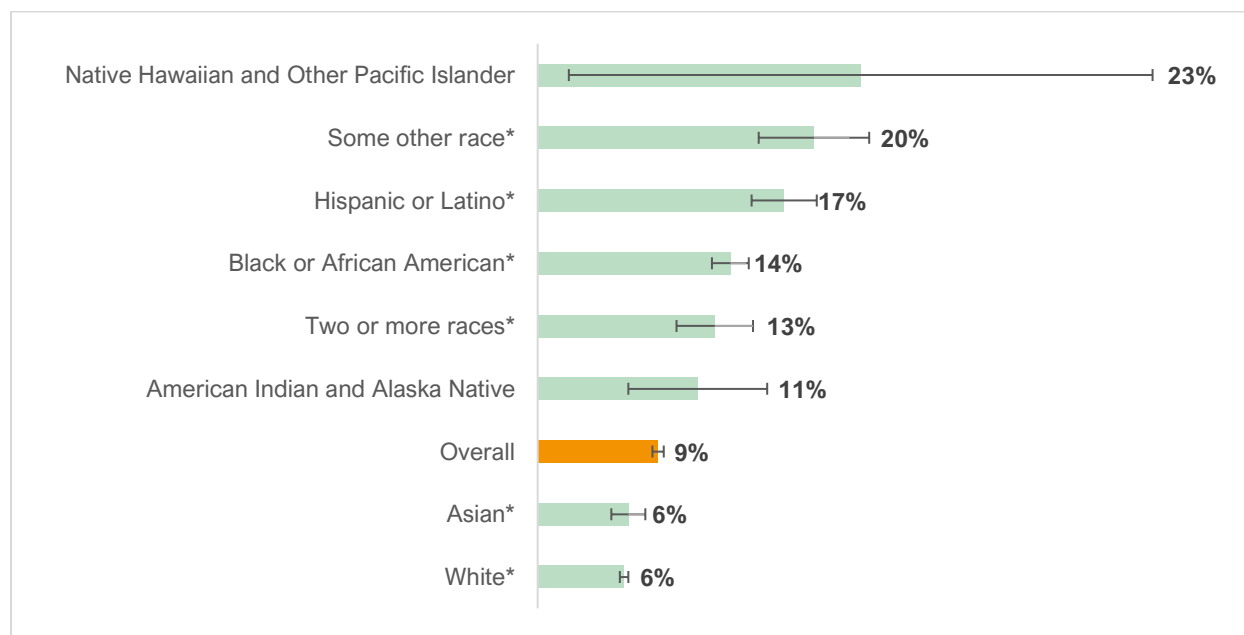
In recent decades, health care professionals, researchers, policy makers and organizations have increasingly emphasized the importance of social determinants of health (SDOH)—the recognition that much of population health is determined by factors outside health care systems. An extension of this framework is the recognition of social determinants of mental health (SDOMH). The “core” social determinants of mental health are:¹⁰

- Racial discrimination and social exclusion
- Adverse early life experiences
- Poor education
- Unemployment, underemployment, and job insecurity
- Poverty, income inequality, and neighborhood deprivation
- Poor access to sufficient healthy food
- Poor housing quality and housing instability
- Adverse features of the built environment
- Poor access to health care

¹⁰ Michael T. Compton, M.D. , M.P.H. and Ruth S. Shim, M.D., M.P.H. (2015). “The Social Determinants of Mental Health.” *FOCUS* 13(4): 419-425.

At the population level, Wake County rates well across measures of SDOH. For example, according to the 2022 County Health Rankings,¹¹ of the 100 counties in the state, Wake County ranks No. 2 in Social and Economic Factors, No. 1 in Quality of Life, and No. 3 in Clinical Care. Wake County residents have higher rates of educational attainment and lower rates of poverty and unemployment compared to state averages. However, although the population overall is relatively well off with regard to SDOH and SDOH, there are disparities that are risk factors for poor mental health and behavioral health crises that should be the concern of the entire community. [Figure 4](#) and [Table 3](#) show stark racial and ethnic disparities in poverty and homelessness in Wake County, the root of which are systemic factors including racism and other forms of discrimination that have systematically disadvantaged people of color, and especially Black people, in the United States. [Figure 4](#) shows the percentage of people in poverty in Wake County is 9% overall, but lower among White and Asian community members and higher among other racial and ethnic groups. [Table 3](#) shows the rate of Black people experiencing homelessness in Wake County is about 10 times higher than the rate among White people (30.3 per 10,000 population versus 3.4 per 10,000 population).

Figure 4. Percent of People in Poverty in Wake County by Race and Ethnicity



Source: U.S. Census Bureau. (2021). *2017-2021 American Community Survey 5-Year Estimates, Table S1701*. Notes: * = Indicates there is no overlap with the margin of error for the “overall” rate, suggesting a meaningful difference. Race categories are alone not in combination with other races, other than “Hispanic or Latino” which is any race.

¹¹ County Health Rankings. (2022). *Wake, NC*. <https://www.countyhealthrankings.org/app/north-carolina/2022/rankings/wake/county/outcomes/overall/snapshot>

Table 3. People Experiencing Homelessness by Race and Ethnicity

	Wake County Count	Wake County Rate (per 10,000)	NC Rate (per 10,000)
Overall	974	8.6	8.9
White	259	3.4	5.6
Black or African American	659	30.3	21.5
American Indian and Alaskan Native	11	10.4	5.3
Asian or Pacific Islander	10	1	1.4
Some other race or multiracial	35	8	8.1
Hispanic/Latino	72	5.6	4.1

Source: The North Carolina Institute for Public Health at UNC-Chapel Hill (2022, April 29). *2022 Live Well Wake Data Dashboard: Housing, Neighborhood, & Physical Environment: Homelessness*. The data are based on 2020 Point-in-Time counts. Retrieved Sept. 26, 2022, from <https://livewellwake.org/priorities/>

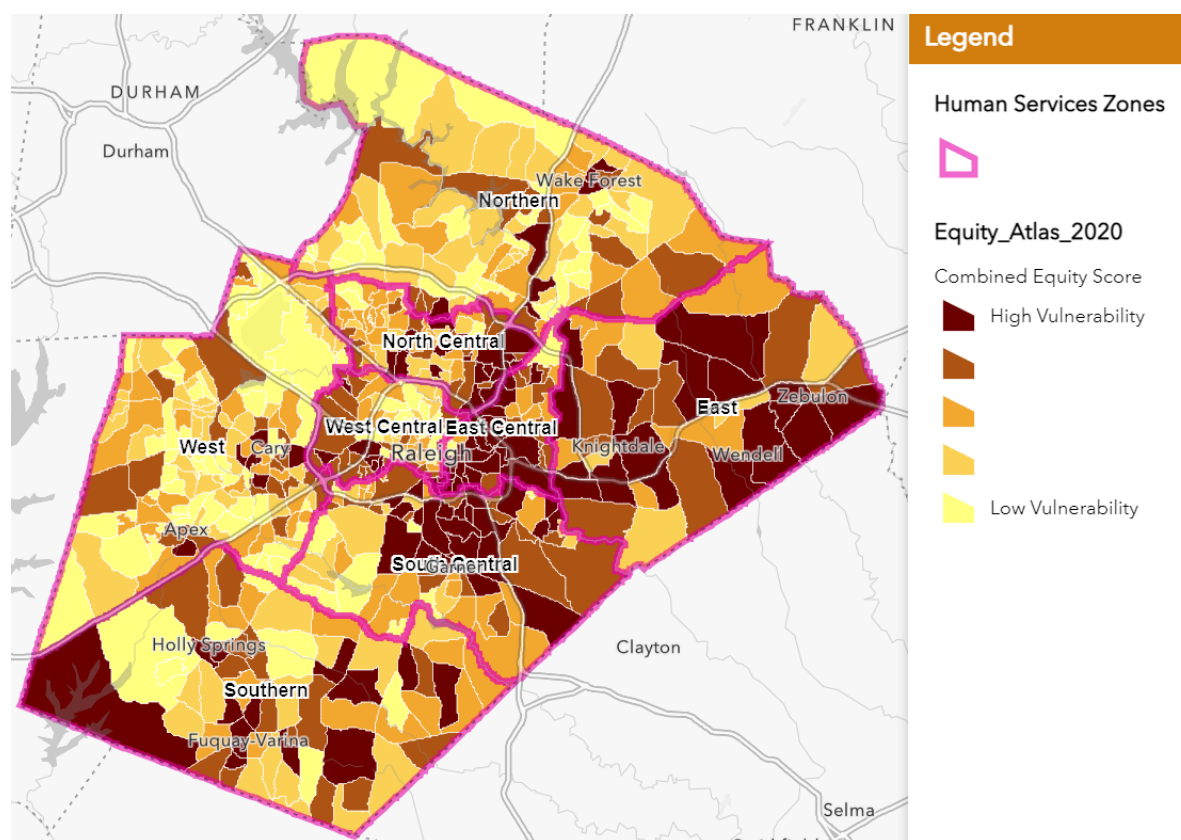
Lack of health insurance limits access to health care including behavioral health services. In Wake County, according to the latest Census (2021), 91% of residents have health insurance; this translates to nearly 95,000 residents who are uninsured. While 91% of residents have health insurance, the rate among Hispanic or Latino residents and those identifying as some other race is considerably lower at only 71% and 64%, respectively.¹²

Risk factors based on social determinants of health are not evenly distributed across Wake County. [Figure 5](#) shows a map of the county color coded according to the Social Equity Atlas, a measure of community health and well-being based on socioeconomic and demographic data from the U.S. Census.¹³ Areas in East, East Central, North Central and South Central Wake County tend to have the highest vulnerability according to the Wake County Social Equity Index. These areas include Eastern Raleigh (including to the north and south), Knightdale, Wendell, Zebulon, and Garner.

¹² U.S. Census Bureau. (2021). 2017-2021 American Community Survey 5-Year Estimates, Table S2701. Retrieved Dec. 22, 2022, from https://data.census.gov/table?q=S2701&q=0100000US_0400000US37_0500000US37183&tid=ACSSST5Y2021.S2701

¹³ Wake County North Carolina. *Social Equity Atlas*. <https://www.wakegov.com/departments-government/planning-development-inspections/planning/social-equity-atlas>

Figure 5. Map of Wake County Social Equity Index



Source: Wake County North Carolina. (2020). *Social Equity Atlas: Social Equity Reference App*.
<https://wake.maps.arcgis.com/apps/webappviewer/index.html?id=e70aa7f8d3d349b187ad9fb46d2ae4de>

Prevalence of Behavioral Health Conditions

Table 4 shows several measures of prevalence of mental health and substance use among adults (age 18-plus) in Wake County compared to the state average using data from County Health Rankings (2022). Wake County has a lower prevalence of reported poor mental health and frequent mental distress and a higher prevalence of adult binge drinking compared to the statewide average (Table 4). These rates are based on data collected in 2020 and therefore do not reflect the impact of the COVID-19 pandemic on behavioral health. While county-level data on the impact of COVID on behavioral health were not available at the time of writing, national data show symptoms of anxiety and depression increased during the pandemic, especially among those who experienced job loss, young adults, and women. Alcohol-induced death

rates also increased, with rates increasing the most among people of color and people living in rural areas.¹⁴

Table 4. Behavioral Health Prevalence in Wake County Compared to NC

	Wake County	NC
Poor mental health days		
Average number of mentally unhealthy days in past 30 days	3.8*	4.4
Frequent Mental Distress		
% of adults reporting 14+ days of poor mental health per month	12%*	14%
Excessive Drinking		
% of adults reporting binge or heavy drinking	21%*	17%
Alcohol-Impaired Driving Deaths		
% of driving deaths with alcohol involvement	28%	26%

Source: County Health Rankings. (2022). *Wake, NC*. <https://www.countyhealthrankings.org/app/north-carolina/2022/rankings/wake/county/outcomes/overall/snapshot>

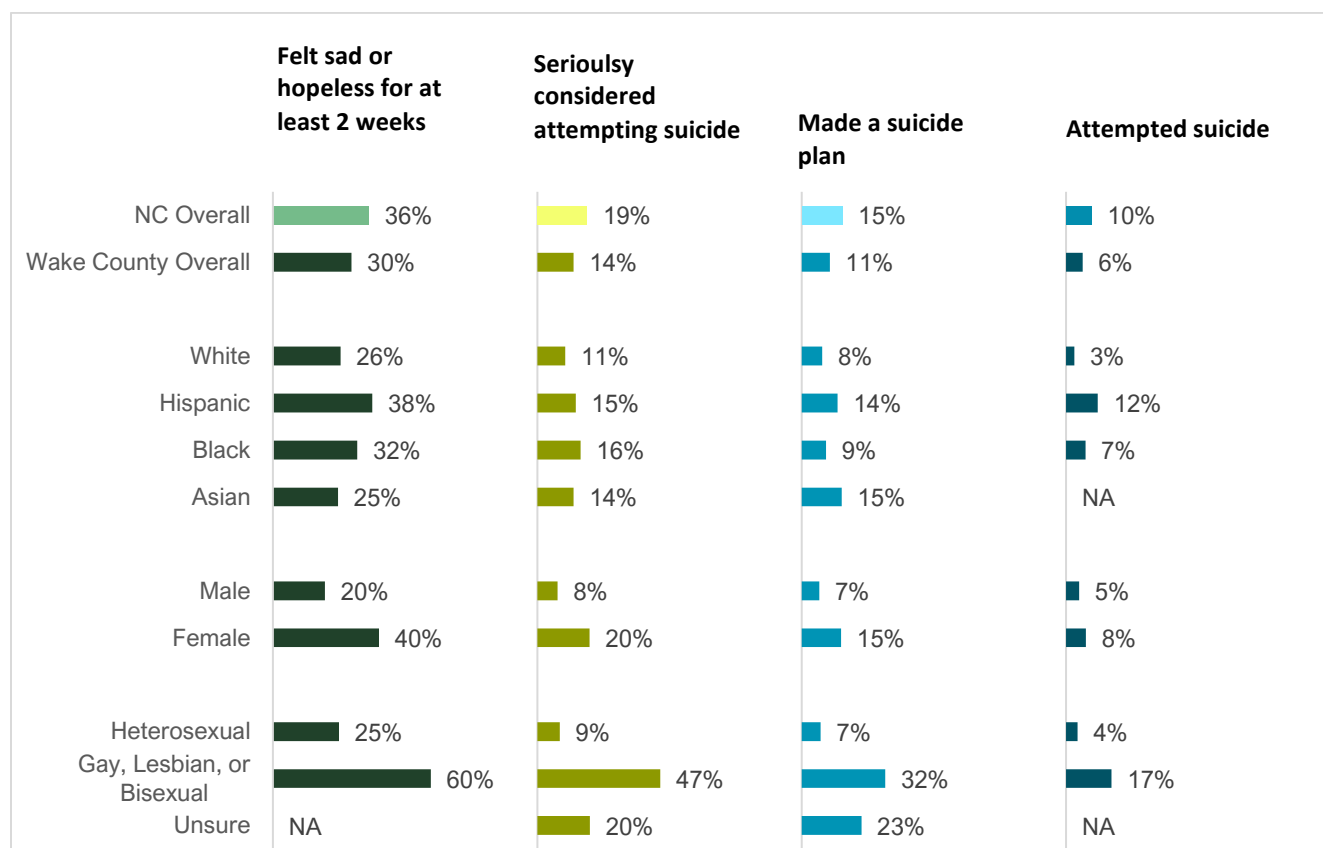
Notes: * = Indicates the state average falls outside of the margin of error for the county, suggesting a meaningful difference.

Figure 6 shows the prevalence of self-reported mental health and thoughts of suicide among high school students in Wake County using data from the 2019 Youth Risk Behavior Survey (YRBS). Students in Wake County had lower rates of poor mental health compared to the state average, but there are notable disparities by ethnicity, race, and gender. Hispanic students had the highest rate of feeling sad or hopeless for at least two weeks in the past year and were more likely than White students to have attempted suicide. Across all measures, students who identify as gay, lesbian, or bisexual had much higher rates of poor mental health and feelings of suicide compared to heterosexual students. The 2021 YRBS data were recently released but county-level data were not yet available at the time of our analysis; however, state-level data for North Carolina show the percentage of high school students who felt sad or hopeless significantly increased from 36% in 2019 to 43% in 2021.¹⁵

¹⁴ KFF, 2023, The implications of COVID-19 for mental health and substance use. Retrieved March 2023 from: <https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/>

¹⁵ NC YRBS High School Survey 2021, Trend Analysis Report: <https://drive.google.com/file/d/1YmrCtiUfVcDGYiR0VhKdA7VQj8hrUNLL/view>

Figure 6. Prevalence of Mental Health and Suicide Among Wake County High School Students by Race, Gender, and Sexual Identity



Sources: County-level Youth Risk Behavior Survey (YRBS) 2019 data were provided by Wake County (N=1,118 high school students). State-level data: CDC (2019). *High School YRBS: North Carolina 2019 Results*. Retrieved January 25, 2023, from <https://nccd.cdc.gov/youthonline/App/Results.aspx?LID=NC>

Notes: The “NC Overall” category is provided for comparison to Wake County. All the demographic categories are for Wake County. “NA” indicates fewer than 30 students in the subgroup for “Unsure” and fewer than 100 students in the subgroup for “Asian.” There were significant differences (based on t-test analysis with $p < 0.05$) among the following groups for each question: Felt sad or hopeless for at least two weeks: Hispanic > Asian; Hispanic > White; Female > Male; Gay, Lesbian, or Bisexual > Heterosexual; Seriously considered attempting suicide: Black > White; Female > Male; Gay, Lesbian, or Bisexual > Heterosexual. Made a suicide plan: Asian > White; Female > Male; Gay, Lesbian, or Bisexual > Heterosexual. Attempted suicide: Hispanic > White; Gay, Lesbian, or Bisexual > Heterosexual.

The rate of drug overdose deaths has increased in Wake County over the past 20 years, reaching its highest rate in 2021 according to the latest data, similar to the statewide trend. The drug overdose death rate in Wake County is lower than the state average (20.1 vs. 36.2 per 100,000, respectively, in 2021).¹⁶ In Wake County, Non-Hispanic whites have the highest overdose death rate at 16.9 deaths per 100,000, but since 2015 the rate has increased the

¹⁶ NCDHHS. (2021). *Opioid and Substance Use Action Plan Data Dashboard*. Retrieved Jan. 24, 2023, <https://www.ncdhhs.gov/opioid-and-substance-use-action-plan-data-dashboard>

most among Black and Hispanic community members, rising over 200% for both groups, also in line with statewide trends.

Suicide mortality rates have stayed fairly consistent, with a slight increase, from 2014 to 2019 in Wake County.¹⁷ 2016-2020 5-year suicide mortality rates in Wake County are similar to Mecklenburg County, and lower than the state average. During this period, Wake County had a suicide mortality rate of 9.2 per 100,000, while the state rate was 13.4 per 100,000. Other counties suicide mortality rates were: 9.5 per 100,000 in Mecklenburg County; 8.1 per 100,000 in Durham County; and 10.1 per 100,000 in Orange County.¹⁸

Potential and Upcoming Changes to Impact the System

In addition to continued population growth, there are other upcoming and potential upcoming changes that would have an important impact on the crisis system in Wake County. These changes should be considered in any planning efforts.

- **Medicaid expansion.** At the time of writing, North Carolina was one of 11 states that has not yet expanded Medicaid under the Affordable Care Act (ACA). The expansion bill was approved by legislature on March 30, 2023, paving the way for roughly 600,000 state residents to become eligible. The Raleigh area has the lowest uninsured rate in the state, but it has been estimated that 28,000 people in Raleigh would gain coverage with Medicaid expansion.¹⁹ Medicaid expansion will have implications for the county's provision of its behavioral health dollars, a large portion of which cover care for the uninsured and will have implications for service capacity throughout the system.
- **Roll-out of the Tailored Plan and Tailored Care Management.** As part of the state's transition to managed care, Medicaid has been reorganized such that beneficiaries with significant behavioral health needs will receive services under the Tailored Plan, a whole-person approach to integrated care with additional intensive behavioral health services. Under the plan's Tailored Care Management (TCM) benefit, beneficiaries will have a single designated care manager to provide care management that address physical health, behavioral health, intellectual and developmental disabilities (I/DD), traumatic brain injuries, pharmacy, long term services and supports, and other health needs. This has potential to improve coordination of upstream care to prevent crises requiring higher care. Rollout of the Tailored Plan and TCM is expected in October 2023.

¹⁷ The North Carolina Institute for Public Health at UNC-Chapel Hill (2022, April 29). Mental Health and Substance Abuse: Suicide Dashboard. Live Well Wake. Retrieved Sept. 28, 2022, from <https://livewellwake.org/priorities/>

¹⁸ North Carolina State Center for Health Statistics. (2022). 2022 County Health Data Book: 2016-2020 Race-Specific and Sex-Specific Age-Adjusted Death Rates by County. <https://schs.dph.ncdhhs.gov/data/databook/>

¹⁹ Simpson M., and Brett-Turner E. (2022, Nov.). *Who Would Gain Coverage under Medicaid Expansion in North Carolina?* Urban Institute. <https://www.urban.org/sites/default/files/2022-11/Who%20Would%20Gain%20Coverage%20under%20Medicaid%20Expansion%20in%20North%20Carolina.pdf>

- Expansion of psychiatric inpatient capacity.** In February 2023, WakeMed obtained preliminary approval for its Certificate of Need (CON) to develop a 150-bed Behavioral Health Center; as of the writing of this report the location is yet unknown. The facility will have five units: a 30-bed adolescent unit (ages 13-17), 30-bed young adult unit (ages 18-25), 30-bed dual diagnosis unit, 30-bed adult unit, and 30-bed geriatric unit (ages 65+). Building is expected to commence in 2024 and opening by late 2026. This will significantly expand inpatient capacity in Wake County, although Medicaid would not reimburse care for individuals ages 21 to 64 in such a facility under its Institute for Mental Disease (IMD) rule, so it is yet unclear what the capacity will be to serve individuals with Medicaid or without health insurance. In addition to WakeMed's expansion, other hospitals in the state have plans to develop psychiatric beds which will have impacts for the system in Wake County.
- Certified Community Behavioral Health Clinic.** In 2022 SouthLight was awarded a three-year, \$4 million grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) to serve as the county's first and only Certified Community Behavioral Health Clinic (CCBHC). CCBHCs are designed to expand access to comprehensive mental health and SUD services to residents regardless of insurance status or ability to pay. SouthLight is currently in the process of planning its services and programs under the grant, which will include access to same-day behavioral healthcare, mobile crisis services, treatment for opioid use disorder, primary care, and other community-based treatment and care coordination.

National Best Practices in Crisis Care

There have been numerous efforts in recent years to establish national standards and guidelines for behavioral health crisis systems. These efforts seek to provide communities with guidelines and examples of best practices for system improvement. In 2020, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) published “*National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit*.”²⁰ The toolkit outlines core elements and best practices for crisis systems, including minimum expectations and suggested performance measures for each domain. The toolkit is intended to support program design, development, implementation, and continuous quality improvement for a system that meets community needs. The three core elements identified are:

1. **Someone to call** – 24/7 regional crisis call centers
2. **Someone to respond** – 24/7 mobile crisis teams response
3. **Somewhere to go** – crisis receiving and stabilization facilities

Each level, when functioning well, reduces the need for the next more intensive level up to avoid emergency department and inpatient. These core elements have become widely known as a framework for crisis systems; thus, we use them in this report to assess the extent to which available crisis services in Wake County align with the expectations and best practices set forth in each domain.

In addition to the three core elements, SAMHSA identified six essential principles that should underpin the entire crisis service delivery system, with implementation guidance for each principal. The six principles are:

1. Addressing recovery needs
2. Significant roles for peers
3. Trauma-informed care
4. *Zero Suicide*/Suicide safer care
5. Safety/security for staff and people in crisis

²⁰ SAMHSA, 2020. National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit.
<https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>

6. Crisis response partnerships with law enforcement, dispatch, and EMS

Another recent report detailing best practices in crisis care is The National Council's 2021 report, "Roadmap to the Ideal Crisis System: Essential Elements, Measurable Standards and Best Practices for Behavioral Health Crisis Response."²¹ This comprehensive report seeks to provide more detailed guidance for communities in developing, implementing, and monitoring a robust crisis system, with detailed examples and case studies throughout. It puts forth an organizing framework comprised of three central domains, with associated indicators within each. The report provides a detailed scorecard in each of these domains for community self-assessment. We also refer to these criteria in our assessment of Wake County's system.

1. **Accountability and Finance** – Accountability and responsibility for designing, financing, operating, and monitoring the crisis system
2. **Crisis Continuum: Basic Array of Capacities and Services** – A comprehensive continuum of best practice crisis system components, including the full complement of functions, programs and staffing resources needed for successful operation
3. **Basic Clinical Practice** – Best practice crisis intervention strategies, clinical practices and staff core competencies to provide services throughout the continuum

Other notable reports describing best practices and guidance for community leaders in developing effective and responsive crisis systems include, but are not limited to:

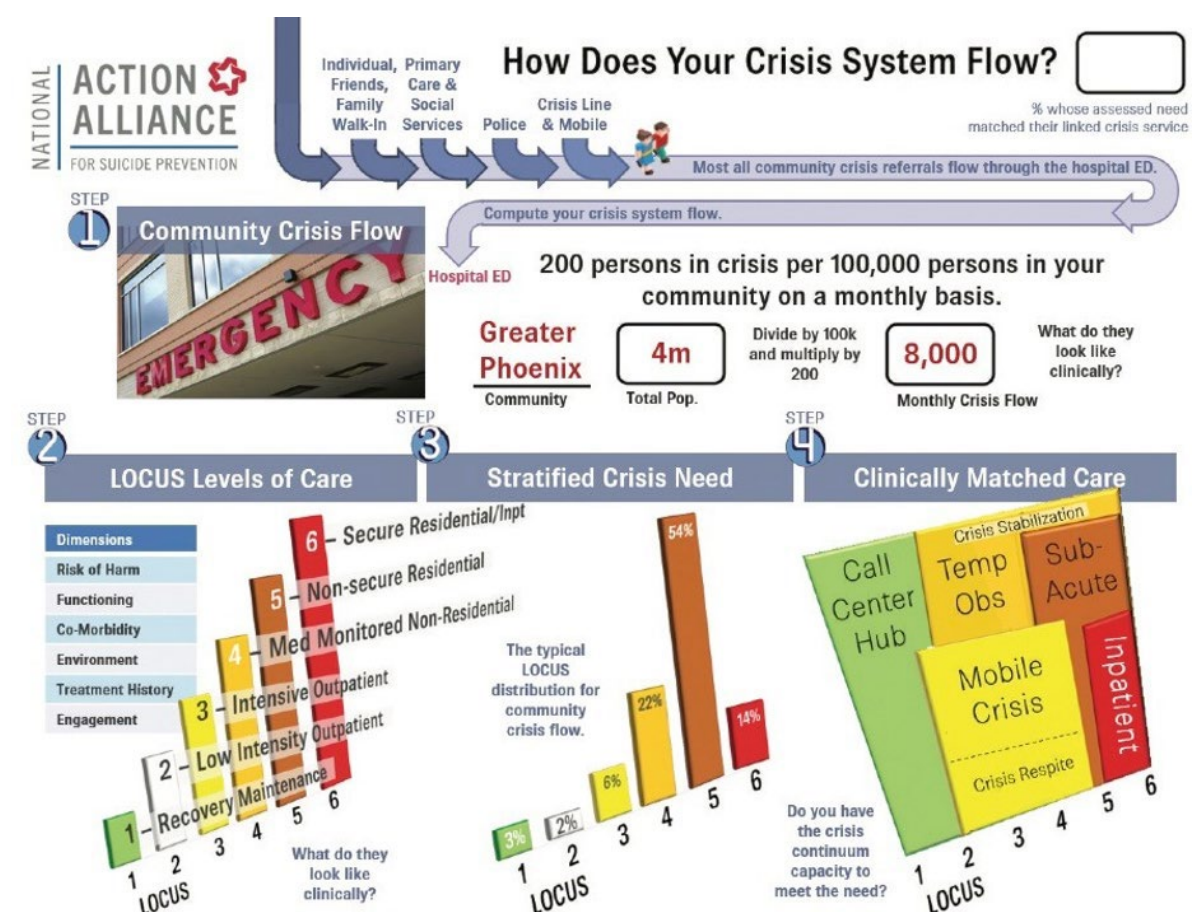
- NASMHPD's Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care (2017); Ready to Respond: Mental Health Beyond Crisis and COVID-19 (2021); and From Crisis to Care: Building from 988 and Beyond for Better Mental Health Outcomes (2022 compendium)
- Arnold Venture's Behavioral Health Crisis and Diversion from the Criminal Justice System: A Model for Effective Community Response (2020) and accompanying guide
- Crisis Now: Transforming Services in Within Our Reach (2016)
- From Harm to Health: Centering Racial Equity and Lived Experience in Mental Health Crisis Response (2021)
- Consensus Approach and Recommendations for the Creation of a Comprehensive Crisis Response System (2021)
- A Guidebook to Reimagining America's Crisis Response Systems (2020)
- Crisis Residential Best Practices Handbook (2018)

There has been an effort to develop formulas for estimating the number who might be expected to need crisis services based on population size. These efforts are simply guides,

²¹ The National Council for Wellbeing, 2021. Roadmap to the Ideal Crisis System, https://www.thenationalcouncil.org/wp-content/uploads/2022/02/042721_GAP_CrisisReport.pdf

while need for crisis services depends on many complex factors such as social determinants of health and the availability, accessibility, and quality of services and supports in the community to support wellbeing. The National Alliance for Suicide Prevention developed the crisis system flow depicted in [Figure 7](#) to estimate the number expected to need crisis services based on population size.²² Based on data from Maricopa County, Ariz., the model suggests 200 people per 100,000 per month can be expected to experience a behavioral health crisis that requires more than a typical outpatient or phone intervention. Based on Wake County's population size, this ratio translates to 2,259 people per month, or 27,106 annually expected to need crisis care.

Figure 7. National Action Alliance for Suicide Prevention Crisis System Flow



²² National Association of State Mental Health Program Directors, 2018. A Comprehensive Crisis System: Ending Unnecessary Emergency Room Admissions and Jail Bookings Associated with Mental Illness. https://www.nasmhpd.org/sites/default/files/TACPaper5_ComprehensiveCrisisSystem_508C.pdf

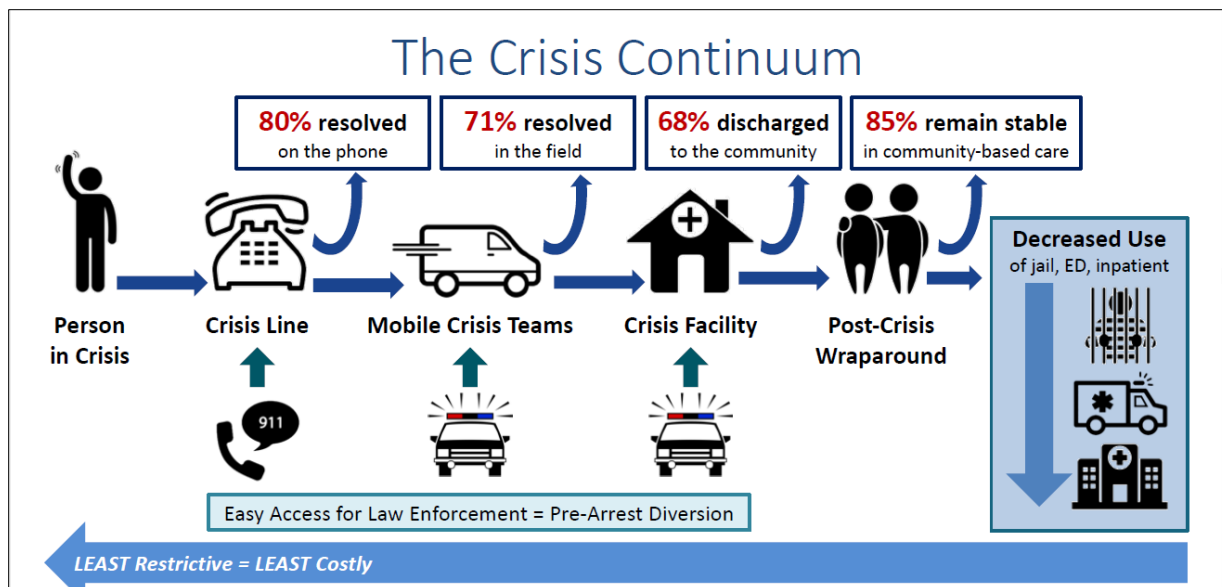
The figure also suggests an expected distribution of level of care needs based on data analysis from the state of Georgia using the Level of Care Utilization System (LOCUS), a tool widely used to assess level of care needs for people with behavioral health conditions. The following distribution, cited in SAMHSA’s national guidelines, is suggested to inform optimal referral pathways for individuals in crisis:

- 32% LOCUS Levels 1-4: Evaluation by mobile crisis team with referral to care as needed
- 54% LOCUS Level 5: Referral to crisis receiving and stabilization facility
- 14% LOCUS Level 6: Direct referral to acute care hospital

Levels of care determined by LOCUS are: Level I Recovery maintenance and health management; Level II Low Intensity Community-Based; Level III High Intensity Community-Based; Level IV Medically monitored non-residential; Level V Medically monitored residential; and Level VI Medically managed residential. This distribution offers benchmarks for what might be expected with a high-quality crisis system.

Another graphic ([Figure 8](#)) depicting crisis system flow with associated benchmarks based on data from southern Arizona is the following from Connections Health Solutions.

Figure 8. Connections Health Solutions Crisis System Flow



Source: Schematic designed by Margie Balfour, Connections Health Solutions. Data courtesy Johnnie Gaspar, Arizona Complete Health and applies to southern Arizona geographical service area.

Crisis Now is an effort led by the National Association of State Mental Health Program Directors (NASMHPD) to bring together best practices and resources to support crisis system transformation. It has a [Crisis Resource Need Calculator](#) that enables users to consider

potential system capacity and costs of various scenarios. It cannot estimate capacity needs or cost, but rather facilitates consideration of how expansion of certain services, such as mobile crisis or inpatient could impact costs to the overall system.

In Appendix B we have included as reference the Crisis Now model projections for Wake County based on its population size, which, as stated on the Crisis Now webpage, can serve to compare costs of various configurations, such as reliance solely on hospital emergency departments versus a continuum of crisis services.

Overview of Wake County Behavioral Health and Crisis Service System

Medicaid Managed Care

In North Carolina, publicly funded behavioral health services are financed and administered through a combination of Medicaid and state-funded services, managed by six regional Local Management Entity/Managed Care Organizations (LME/MCOs). Alliance Health is the LME/MCO serving Wake County as well as Cumberland, Durham, Johnston, Orange, and Mecklenburg counties, having assumed responsibility for the latter two in 2021. Alliance is administratively funded through a combination of the Medicaid waiver, state LME/MCO allocation, and county administrative contribution. There are roughly 30,000 Alliance members in Wake County. The focus of this report is on publicly funded crisis services, though it should be noted that some number of individuals with private insurance are also served by crisis services in Wake County.

As part of the state's Medicaid transformation, beginning in 2021 and continuing into 2023, Medicaid services are administered through one of four types of health plans:

1. **Standard Plan** – provides integrated physical health, behavioral health, pharmacy, and long-term services and supports to the majority of Medicaid beneficiaries, as well as programs and services that address other unmet health-related resource needs
2. **Behavioral Health I/DD Tailored Plan** – provides the same integrated services as Standard Plans, as well as additional specialized services for individuals with significant behavioral health conditions, intellectual and/or developmental disabilities (I/DDs), and traumatic brain injury (TBI), including Assertive Community Treatment (ACT) and home and community-based services (HCBS) provided under the state's 1915(i) and 1915(c) waivers. The Tailored Plan also administers state-funded services for behavioral health and I/DD.
3. **Specialized Plan for Children in Foster Care** – available to children in foster care and will cover full range of physical health, behavioral health, and pharmacy services
4. **Eastern Band of Cherokee Indians (EBCI) Tribal Option** – available to tribal members and their families and managed by the Cherokee Indian Hospital Authority

Eligibility for the behavioral health “Tailored Plan” is determined through a process that considers frequent use of behavioral health crisis services as well as other information about

diagnoses, services use, and waiver membership. The Tailored Plan was expected to roll out in late 2022, but as of the writing of this report (March 2023), the transition was pushed back to an anticipated date of Oct. 1, 2023. Tailored Care Management (TCM) is a program through which Tailored Plan beneficiaries will have a single designated care manager supported by a multidisciplinary care team to provide integrated care management.²³

County Oversight and Financing

In Wake County, behavioral health is a focus area, not a department, overseen by the Assistant County Manager. This structure reflects that in North Carolina LME/MCOs are the authority charged with oversight of the behavioral health delivery system. In Wake County, in addition to the Assistant County Manager there is an internal Behavioral Health Committee comprised of the county's Chief Medical Officer, Deputy County Managers, and leadership from the departments of Health & Human Services, Finance, Legal, Budget, Internal Audit, and General Services Administration (GSA), who help to support planning and oversight of the system.

In 2015, leaders from across Wake County, including representatives from local governments, hospitals, criminal justice, education representatives, and other advocates concerned about behavioral health came together to form the Wake "Directors" group. Based on feedback from community members and agency leaders, the group articulated a vision statement to guide the county's behavioral health system planning:

"The dignity and well-being of every person is paramount. To that end, we support accessible, high-quality healthcare to address the physical and behavioral needs of all Wake County residents. Services must be delivered in the least restrictive manner possible, with clear communication and a firm commitment to personal privacy. Access to sound care must not depend on individual resources or payment source. Continuous improvement must be a core goal in all of our efforts."

The group identified five priority areas for the county's behavioral health system. A Behavioral Health Plan, updated in 2021 for FY 2022-23, outlines the context, priority objectives, and progress measures across these five focus areas:

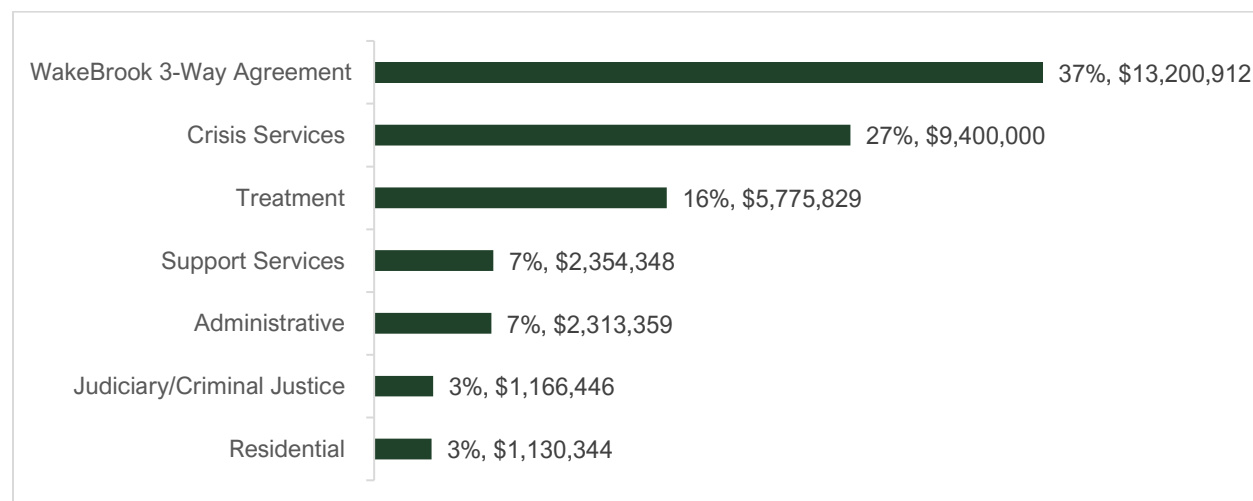
1. **Crisis services** – Act early and manage crisis in an appropriate setting.
2. **Access and coordination** – Get accessible, coordinated care when needed.

²³ <https://medicaid.ncdhhs.gov/Behavioral-Health-IDD%20Tailored-Plans>

3. **Criminal justice** – Reduce interactions of individuals with mental illness and substance use disorders with criminal justice system.
4. **Housing** – Provide a continuum of housing resources to allow individuals to focus on recovery and wellbeing.
5. **Familiar Faces** – Stabilize frequent users of crisis services.

Wake County commits over \$30 million annually to support the behavioral health needs of its residents. Figure 9 shows the behavioral health budget allocation for this funding for FY 2022. The largest share of funding, roughly \$14 million, goes to support services at WakeBrook, of which the funds are primarily dedicated to assessment, facility-based crisis, and detox services for uninsured individuals. Wake County owns the WakeBrook building, so additional county funds also go towards maintenance and operations of the building and grounds. Nearly \$10 million of county funding supports other crisis services, of which most is allocated to inpatient services for uninsured residents. The remaining funds go to community-based services and supports including outpatient treatment, housing, and other supports. Of the \$35 million budgeted in FY22, \$9 million was unspent, representing an opportunity to target dollars where they have the greatest impact for the coming year.

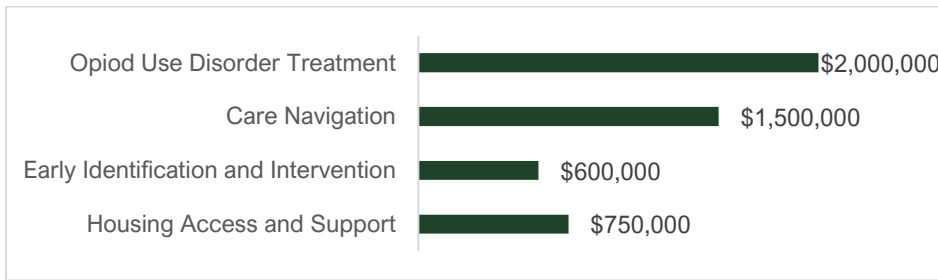
Figure 9. Wake County FY22 Behavioral Health Budget (\$35,341,238 Total)



Source: Wake County

In 2022, Wake County Board of Commissioners approved a plan putting \$4.85 million of the state’s Opioid Settlement dollars toward four county-wide initiatives through 2024. [Figure 10](#) shows the allocation of these dollars.

Figure 10. Wake County Plans for Opioid Settlement Allocation (\$4.85 million)



Source: <https://www.wakegov.com/news/wake-county-approves-plan-battle-opioid-epidemic>. The funding amount for these initiatives is planned through June 2024.

Wake County Crisis Services Continuum

Below, [Figure 11](#) shows an overview of the service continuum in Wake County, followed by a map in [Figure 12](#). These services are discussed in the sections that follow in the context of national guidelines, with findings from qualitative and quantitative data.

Figure 11. Overview of Wake County Crisis Services Continuum

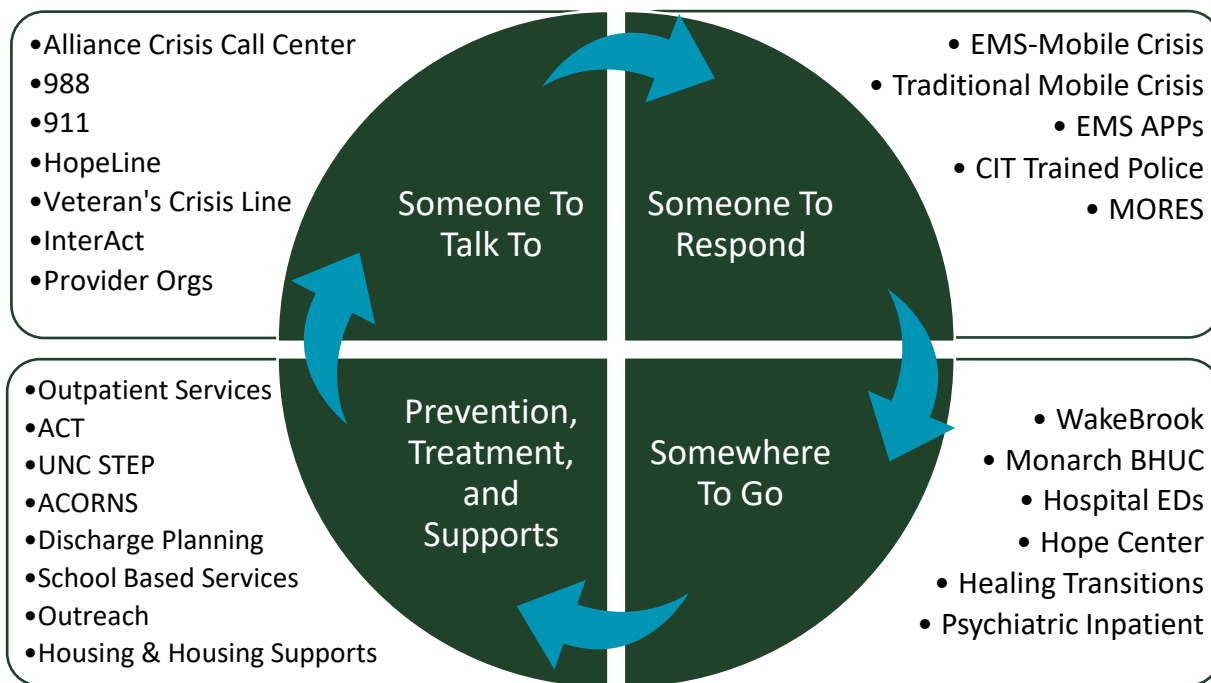
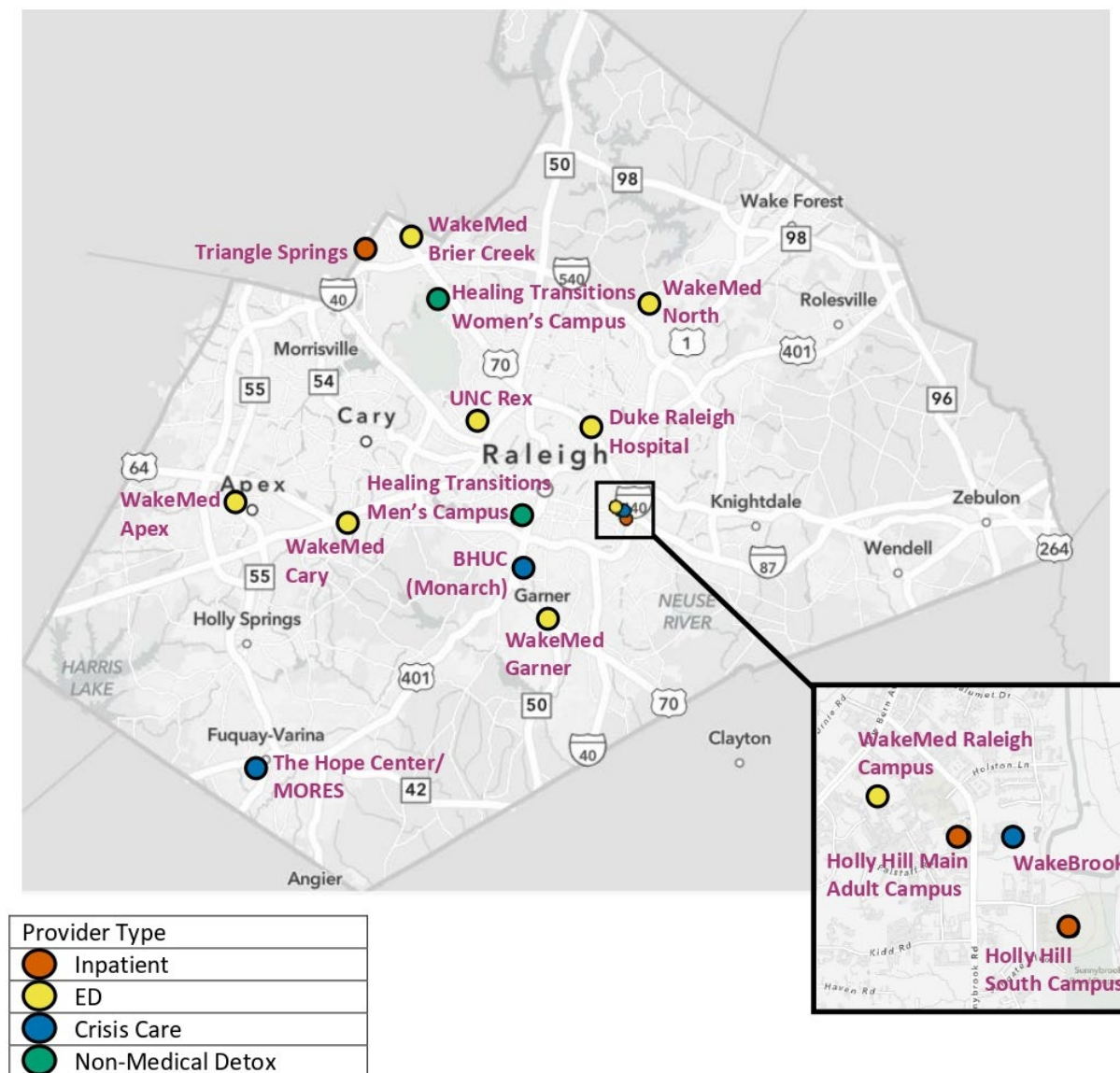


Figure 12. Map of Crisis Services in Wake County



Core Element — Someone to Talk To

Crisis Call Lines

As outlined in SAMHSA’s national guidelines for behavioral health crisis care, a clinically staffed, 24/7 regional crisis call hub/center is the first of three essential core elements of a crisis system. In Wake County, there are numerous crisis call lines, the central of which, **Alliance Access and Information Center** (800-510-9132 or 877-223-4617), serves as the centralized call hub. The call center serves as both a crisis line and information center to connect individuals with a range of services in the community and coordinate follow-up. The

call center has a staff of roughly 70 serving the six counties in Alliance's catchment area. The call center receives approximately 6,000 calls monthly, with Wake County accounting for 20-25%, or roughly 1,200 to 1,500 calls per month. Of total calls, approximately 6% are crisis referrals: 5% urgent (connected to mobile crisis or walk-in crisis) and 1% emergent (connected to 911).²⁴ Based on these numbers, we can estimate the center receives approximately 70-90 urgent or emergent crisis calls monthly for Wake County. In contrast, the average number of calls per month for Emergency Services to 911 for mental health (via the CAD system) was 364 in 2021,²⁵ over four times as many. This difference reflects an overreliance on 911, which was also identified through discussions with key informants who reported that 911 is typically who community members call for a behavioral health crisis. In an ideal crisis system, 911 calls for behavioral health without a life-threatening emergency should be triaged to the crisis call center as if the person had called that number in the first place.

The Alliance call center reports seven seconds as the average answer time for a call, which is well within expectations.²⁶ In addition to Alliance's call center, there are other crisis lines available in Wake County, which Alliance's call center coordinates with. We did not hear feedback that multiple call lines pose confusion to community members. The following are other crisis line resources. In addition to these, many provider organizations, such as SouthLight, have crisis lines available to their clients.

- **HopeLine** 24/7 (919-231-4525 or 877-235-4525)
- **WakeBrook** 24/7 crisis line (984-974-4800)
- **Therapeutic Alternatives** 24/7 crisis line (877-626-1772)
- **Veteran's Crisis Line** (800-273-8255)
- **InterAct** has a 24/7 crisis call line for domestic violence and sexual assault, including a call number for Spanish speaking crisis response

988 is the federal crisis call and text line, now in conjunction with the National Suicide Prevention Hotline (800-273-TALK), rolled out in July 2022. In North Carolina, 988 is operated by REAL Crisis Intervention, Inc. that operates the call center for all 100 counties. According to early data, 988 received 810 calls from Wake County in April through June of 2022, and 1,141 calls in July through September—a 41% increase. Calls to 988 are transferred to Alliance's call center as the access hub. Feedback from some interviewed for this study reported

²⁴ Numbers provided upon request in March 2023 by Alliance Call Center.

²⁵ Data provided by Wake County.

²⁶ Crisis Call Center Metrics, Part 1: Service and Efficiency, 2019. Accessed April 2023 from: https://988lifeline.org/wp-content/uploads/2019/02/CallCenterMetrics_final.pdf

communication on the rollout of 988 from the state has not been good. Mobile crisis reported issues with connection from 988, with people getting disconnected and not knowing who to call back. Working out these issues, and promoting public awareness of 988, will be important for Wake County moving forward.

The following table shows how Alliance’s crisis call center aligns with SAMHSA’s minimum expectations and best practices for the service. The service in Wake County meets all minimum expectations. There are two best practices involving advanced technology that the Alliance call center is not yet fully meeting, though many states/communities have yet to implement these features so this is not unexpected. With regard to a real-time regional bed registry, the state recently launched a new tool, BH SCAN,²⁷ to serve this function that is promising to fill this gap. Since it is only recently rolled out, it is not yet fully utilized in Wake County. The call center noted it does use such statewide resources including BH SCAN, the Behavioral Health Crisis Referral System (BH-CRSys) and NC CARE360, but thus far at a high level and not integrated to the extent described in the best practice model.

²⁷ <https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-abuse/crisis-services/behavioral-health-statewide-central-availability-navigator>

Table 5. Comparison of Wake to National Expectations for Crisis Call Services

Minimum Expectations to Operate Regional Crisis Call Service	Wake Meets Criteria?
1. Operate every moment of every day (24/7/365)	Yes
2. Be staffed with clinicians overseeing clinical triage and other trained team members to respond to all calls received	Yes
3. Answer every call or coordinate overflow coverage with a resource that also meets minimum crisis call expectations defined in SAMHSA toolkit	Yes
4. Assess risk of suicide in a manner that meets NSPL standards and danger to others within each call	Yes
5. Coordinate connections to crisis mobile team services in the region	Yes
6. Connect individuals to facility-based care through warm hand-offs and coordination of transportation as needed	Yes
Best Practices to Operate Regional Crisis Call Service	
1. Incorporate Caller ID functioning	Yes
2. Implement GPS-enabled technology in collaboration with partner crisis mobile teams to more efficiently dispatch care to those in need	No
3. Utilize real-time regional bed registry technology to support efficient connection to needed resources	Insufficient
4. Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff to support connection to ongoing care following a crisis episode	Yes

Core Element — Someone to Respond

Mobile Crisis

Centrally deployed, 24/7 mobile crisis response is the second core element of SAMHSA’s guidelines for a crisis system. Wake County has, at the time of this study, three mobile crisis resources. The first is a mobile crisis service contracted through Alliance to Therapeutic Alternatives; in Wake County, this is referred to as “traditional” mobile crisis. The second is a pilot partnership between Wake County EMS and Therapeutic Alternatives, referred to as “EMS enhanced” mobile crisis. Through this partnership, EMS Advanced Practice Paramedics (APPs) collaborate with mobile crisis clinicians on crisis responses. The pilot is funded with roughly \$900,000 of county behavioral health dollars annually. The third mobile crisis resource, Mobile Outreach Response Engagement and Stabilization (MORES), is operated out of The Hope Center in Fuquay-Varina to serve youth and their families; it began operating in May of 2022. Each of these services is described further in the section below.

Table 6 shows the number of mobile crisis encounters for Wake County residents, totaling 1,358 in FY 2021. The drop in encounters in FY 2022 was reported by EMS to be due to staffing shortages. Even before this dip, these numbers are lower than what could be expected if mobile crisis were a more robust service in Wake County. For example, the Crisis Now Crisis System Calculator estimates an optimally functioning mobile crisis service comprised of eight or nine mobile teams could serve over 8,000 per year in a county the size of Wake.

Table 6. Number of Mobile Crisis Service Encounters for Wake County Residents

	FY19	FY20	FY21	FY22
Traditional mobile crisis	324	292	400	286
EMS enhanced mobile crisis	N/A	468	958	490
TOTAL	324	760	1,358	776

Source: Alliance Health. Notes: Traditional mobile crisis data are based on Alliance claims data. EMS Enhanced Mobile Crisis data are from EMS database data reported to Alliance. N/A=Not applicable.

Traditional Mobile Crisis

Mobile crisis in Wake County is contracted through Alliance to Therapeutic Alternatives, which also serves Durham, Cumberland, and Johnston counties with Alliance and additional counties through contracts with Sandhills and Vaya, two of the state's other LME/MCOs. The mobile crisis service has a staff of ten when fully staffed, but as of the end of 2022, they were operating understaffed; the team includes one peer support specialist who is not always present for mobile responses. Therapeutic Alternatives reported having trouble recruiting peer staff. Mobile crisis responders deploy from different locations depending on the staff.

Tables 7 and 8 and Figure 13 show the referral sources, time from request to face-to-face contact, and disposition (outcome) of traditional mobile crisis responses (not exclusive to Wake County). Nearly two-thirds of referrals in FY 2022 were from families of individuals self-referred; 16% of referrals were from the Alliance crisis call line and only a small number from schools, law enforcement, or hospital emergency departments. Response time is typically between one and two hours (Figure 13)—which meets the state's requirement for response within two hours but reflects what community members say is too long to wait in crisis situations. According to best practice, mobile teams should arrive on-site within an hour of request—preferably sooner.²⁸ Only 6% of Therapeutic Alternative's mobile crisis face-to-face encounters had a response time of less than one hour in 2022. In Arizona, which is considered

²⁸ National Council for Mental Wellbeing, 2021. Roadmap to an Ideal Crisis System.

a model for its robust crisis system, mobile crisis teams respond in an average of 30 to 40 minutes anywhere in the state, including rural areas,²⁹ showing there is much room for improvement in mobile crisis response time in Wake County. To achieve this quick response, mobile teams in Arizona are often co-located in 911 centers, police departments, and areas that receive a high volume of calls.

As shown in Table 8, 61% of responses result in disposition to community setting, 19% to emergency department, and 8% to facility-based crisis. According to SAMHSA, a survey of high-performing mobile crisis teams shows that approximately 70% of engagements result in community stabilization with the remaining 30% connected to facility-based care.³⁰ As shown in Table 8, Therapeutic Alternatives' service has a lower percentage stabilized in the community (61% vs. 70%) and 19.2% are referred to hospital emergency departments. Ideally the percentage referred to hospital EDs would be lower in place of referrals to crisis stabilization facilities. It is important to note the data in Table 8 are for all counties served by Therapeutic Alternatives, not just Wake County, but still provides an overall sense of the outcome of mobile crisis encounters in Wake County.

Themes that arose from interviews for this study were that mobile crisis is not widely used for issues of reliability, quality, and response time. Informants said they called 911 over mobile crisis in order to have a faster response, citing two hours being too long to wait for response to an acute crisis. Informants also said Therapeutic Alternative's policy to require consent from the individual in crisis over the phone before responding was a significant barrier, and that individuals would be more likely to accept the service if the clinician was there in-person to obtain consent. The long assessment form was also cited as a barrier.

In July 2021, Alliance engaged a consultant, RI International, to review and provide assessment, analysis, and recommendations for mobile crisis in Wake County. The study found there is significant opportunity for improvement toward higher fidelity to SAMHSA's national guidelines for mobile crisis. Among the consultant's 11 recommendations are a new assessment tool and process, incorporation of peers, purchasing vans for transport to stabilization when necessary, uniforms for responders, trainings, and a review of funding. We endorse all of the recommendations put forth.

²⁹ <https://nashp.org/the-rural-behavioral-health-crisis-continuum-considerations-and-emerging-state-strategies/>

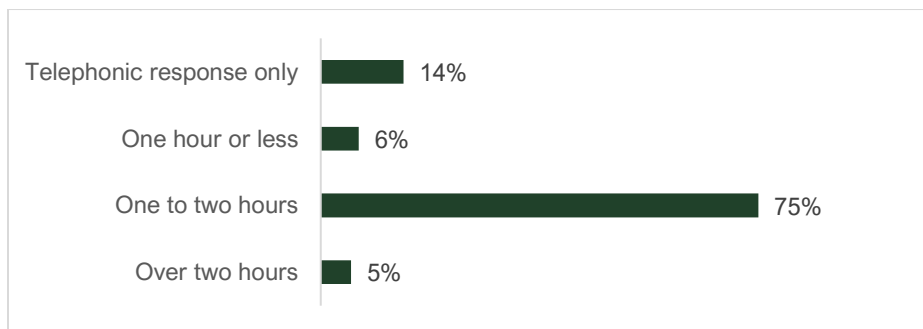
³⁰ SAMHSA National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit. 2020.

Table 7. Referral Source for Traditional Mobile Crisis Responses (FY22)

Referral Source	# of Requests	% of Requests
Family / support system	233	37.6%
Self	166	26.8%
LME STR / Crisis Line	98	15.8%
Other provider agency	55	8.9%
School	15	2.4%
Other public agency	15	2.4%
First Responder / Clinical Home	13	2.1%
Law Enforcement	9	1.5%
Other / Unknown	9	1.5%
Hospital emergency department	3	0.5%
Social Services Department	2	0.3%
Justice System	1	0.2%
Total	619	100%

Source: Therapeutic Alternatives, data provided upon request. Note: these data are not restricted to Wake County residents, they include all responses for the three counties covered by Therapeutic Alternatives.

Figure 13. Time from Request to Face-to-Face Contact (FY22)



Source: Therapeutic Alternatives. Note: these data are not restricted to Wake County residents, they include all responses for the counties covered by Therapeutic Alternatives.

Table 8. Disposition of Traditional Mobile Crisis Responses (FY22)

Disposition	Number of Crisis Responses	Percent of Crisis Responses
Community Setting	380	61.4%
Medical/Emergency Dept.	119	19.2%
Crisis Respite	55	8.9%
Facility-Based Crisis	49	7.9%
Community Hospital (psych unit)	7	1.1%
Other	4	0.6%
Community Detox	2	0.3%
Alternative/Natural Support	1	0.2%
START Team	1	0.2%
State Psychiatric Hospital	1	0.2%
State ADATC	0	0.0%
Jail or Detention	0	0.0%
Total	619	100%

Source: Therapeutic Alternatives. Note: these data are not restricted to Wake County residents, they include all responses for the counties covered by Therapeutic Alternatives.

EMS Enhanced Mobile Crisis

EMS Enhanced Mobile Crisis is a partnership between Wake County EMS, Alliance, and the Alliance-contracted mobile crisis provider, Therapeutic Alternatives. The pilot program began in 2019 with an investment from Wake County's behavioral health budget. A mobile crisis clinician responds with Wake EMS Advanced Practice Paramedics (APPs) to provide on-scene risk assessment, provider referrals, linkages to long-term community resources, and 30-day follow-up for people receiving EMS response with mental health crisis as the primary complaint³¹. The program made 490 responses in FY 2022. Expected response time is within 30 minutes of request, faster than traditional mobile crisis that has a window of two hours for emergent calls. [Table 9](#) shows the disposition of EMS Enhanced Mobile Crisis responses in FY 2022. In nearly half of responses (44%), individuals were transported to a hospital ED, compared to only 5% transported to WakeBrook and 2% linked to care at the BHUC.

Feedback from EMS responders indicates the low numbers transported to WakeBrook are due to accessibility. This is supported by data showing WakeBrook was on diversion an average of

³¹ Alliance FY2021 Annual Report.

8 hours per day in 2022. EMS noted that some individuals who could remain in the community with supports request to go to the hospital.

Table 9. Disposition of EMS Enhanced Mobile Crisis Responses (FY22)

Disposition	Number of Crisis Responses	Percent of Crisis Responses
Transported to ED	215	45.3%
Refused Services	168	35.4%
Transport to WakeBrook	24	5.1%
Linked to current provider	17	3.6%
Linked to new provider	13	2.7%
Required Involuntary Commitment	13	2.7%
Transport to Triangle Springs	11	2.3%
Linked to Monarch BHUC	7	1.5%
Transport to Holly Hill	3	0.6%
Transport to Healing Transitions	2	0.4%
Transported to Monarch	2	0.4%
Total	475	100%

Source: Alliance Health, based on EMS database. There were 15 blanks disposition for EMS Enhanced Mobile Crisis, which were left out of the percentage calculations and totals presented here.

Mobile Outreach Response Engagement and Stabilization (MORES)

MORES is part of a joint venture by KidsPeace and Alliance Health known as The Hope Center for Youth and Family Crisis (The Hope Center), operated out of Fuquay-Varina. MORES was the first service to launch out of The Hope Center and began operating in May 2022. MORES is a mobile crisis response program designed specifically for youth and their families. It provides immediate assessment by trained crisis responders to meet psychiatric, developmental, and behavioral needs, and provides follow-up and supports for up to eight weeks after the crisis. These supports range from extensive case management to skills training for parents. Each MORES team has a qualified professional and a family partner, which is someone with lived experience being the parent or primary caregiver of a child or adolescent with behavioral health needs. They currently have four family partners who work with qualified professionals, and they receive training so that they can not only understand how other parents feel, but they can also be a coach and teacher.

As of the writing of this report, MORES operates from 10 a.m. to 10:30 p.m. seven days a week with two teams, with the intention of recruiting more teams starting in early 2023. From the time MORES started operating in May 2022 through mid-November 2022, they reported having approximately 25 youth on their census.

Table 10, below, shows how Wake County's mobile crisis options align with the expectations and best practices set forth in SAMHSA's national guidelines. As discussed, although the minimum elements are in place, the traditional mobile crisis service is currently insufficient to serve the role outlined in the guidelines. The relatively low numbers served are a reflection of this. Importantly, incorporation of peers into mobile crisis response is a best practice and not sufficiently available in Wake County.

Table 10. Comparison of Wake to National Expectations for Mobile Crisis Services

Minimum Expectations to Operate Mobile Crisis Team Services	Wake Meets Criteria?
1. Include a licensed and/or credentialed clinician capable to assessing the needs of individuals within the region of operation	Yes
2. Respond where the person is (home, work, park, etc.) and not restrict services to select locations within the region or particular days/times	Yes/ Insufficient*
3. Connect individuals to facility-based care as needed through warm hand-offs and coordinating transportation when and only if situations warrant transition to other locations	Insufficient*
Best Practices to Operate Mobile Crisis Team Services	
1. Incorporate peers within the mobile crisis team	No
2. Respond without law enforcement accompaniment unless special circumstances warrant inclusion in order to support true justice system diversion	Yes
3. Implement real-time GPS technology in partnership with the region's crisis call center hub to support efficient connection to needed resources and tracking of engagement	No
4. Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff in order to support connection to ongoing care	Yes

*While these elements are present, their capacity in Wake County is insufficient to meet expectations outlined in SAMHSA's national guidelines.

Core Element – Somewhere to Go

Crisis Receiving and Stabilization Services

WakeBrook

WakeBrook is a 24/7 crisis services facility operated by UNC Health with four main units, described below, plus a primary care clinic. WakeBrook's clinical model is a patient-centered, team-based approach to mental health and substance use treatment, staffed by a multidisciplinary team that includes physicians, nurses, social workers, addiction counselors, occupational therapists, and others, all on a single campus in East Raleigh. WakeBrook coordinates with hospitals, community-based organizations, law enforcement, housing providers, and others to support ongoing care. A summary table of capacity and utilization across the four units is presented in Table 11, below.

- **Crisis and Assessment (CAS)** – 16 space walk-in and receiving unit provides assessment services to ages 5 and up to determine level of care needs; is the primary source of admissions to the other units at WakeBrook. Accepts voluntary and involuntary referrals and has a designated law-enforcement drop-off area. Licensed as an outpatient clinic. Serves primarily Wake County residents with roughly 40% uninsured. Multidisciplinary team intervention and treatment begins in CAS.
- **Facility-Based Crisis (FBC)** – 16 beds, licensed as a Residential Unit, serves adults age 18+ with acute mental health and dual diagnosis conditions. Voluntary and involuntary. Serves as a step-down from the inpatient unit when needed. In FY22 64% served were uninsured. Occupancy rate 90-98%. Average length of stay (LOS) 7-10 days, 8.5 days in FY22. Diverse distribution of diagnoses (psychosis, crisis, mood disorders, dual diagnosis).
- **Addiction Detox Unit (ADU)** – 16 beds, licensed as Residential Unit, addiction detox (primarily alcohol and opioids) for adults age 18+. Voluntary and involuntary. Provides SUD treatment, education, and assessment for medication assisted treatment (MAT); MAT can begin in ADU and transfer to outpatient community provider. Occupancy rate 87-100%. ~80% uninsured with rest primarily Medicaid. Average LOS 5 days.
- **Inpatient Unit (IPU)** – 28 beds, psychiatric inpatient, for individuals who would have been referred to state hospitals. Voluntary and involuntary, serving adults ages 18+. Serves a lower percentage of uninsured (35-40%) compared to FBC and ADU. Roughly 60% have psychotic illness.

Table 11. Summary of WakeBrook Capacity and Utilization by Unit (FY22)

	# Beds/ Chairs	% Beds Utilized	Total Encounters FY22	Estimated % Uninsured*	Estimated # Uninsured*	Average LOS (days)
Crisis & Assessment (CAS)	16	N/A	4,690	45%	2,111	<1
Facility-Based Crisis (FBC)	16	92%	731	64%	468	8.5
Addiction Detox Unit (ADU)	16	87%	950	80%	760	5.5
Inpatient Unit (IPU)	28	95%	560	40%	224	27

Sources: The data in this table have multiple sources. % Beds utilized is from WakeBrook FY22 Q4 Report; Total encounters is from data provided by WakeBrook; *The % uninsured is an estimate from slides provided by WakeBrook in September 2022, except for FBC which is based on the % of individuals served who were uninsured across quarters in FY22; Average LOS is from data provided by WakeBrook.

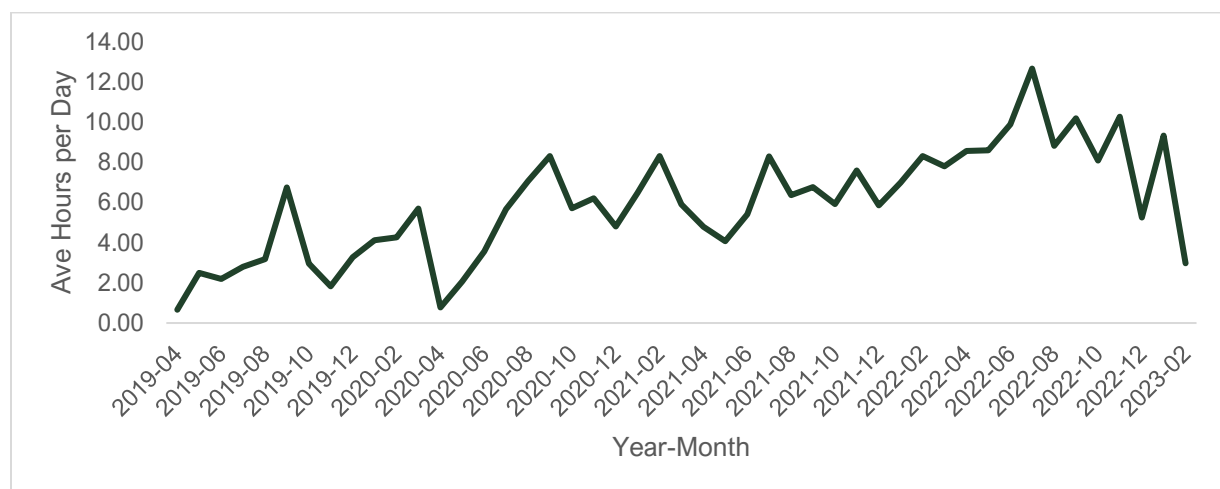
Notes: N/A= not available.

We were not able to obtain data on insurance breakdown for all individuals served at WakeBrook, though we received some data for the CAS unit. In the CAS unit, which has the highest volume of encounters at WakeBrook, Medicaid accounted for roughly 30% of admissions in FYs 2019 and 2020, or 744 people in 2019 and 1,361 in 2020.³² The number served who are Medicaid enrollees would be smaller in the FBC and ADU units which serve a higher percentage of uninsured.

Feedback from service users, EMS, and community providers about WakeBrook was positive regarding quality care, responsiveness, and coordination for discharge planning. However, accessibility of WakeBrook services was a primary concern. [Figure 14](#) shows the average number of hours per day WakeBrook was on diversion, meaning it could not accept referrals from hospitals, law enforcement, and EMS. The average ranges from 3.4 hours per day pre-COVID to 8.8 hours per day in 2022. COVID-19 was a driver of increased time on diversion. SAMHSA's best practice guidelines stipulate that a crisis-receiving and stabilization facility should be able to accept referrals at least 90% of the time, an area that future planning for WakeBrook should address.

³² Data provided by Alliance Health.

Figure 14. Average Hours per Day on Diversion at WakeBrook



Source: WakeBrook

The following tables and figures show the numbers served, average LOS, demographic characteristics and disposition of individuals served at WakeBrook. We compare these data to benchmarks to the extent possible, though it is important to note that crisis facilities such as WakeBrook operate in the context of a broader system for which there is much variation across communities and service systems.

In terms of capacity, WakeBrook's time on diversion suggests a need for expanded capacity in the CAS service, which currently has 16 observation chairs. We found examples of crisis stabilization facilities in other localities that have a greater number of chairs. For example, the Crisis Response Center in Tucson, Ariz., which has a similar population size to Raleigh, has 34 chairs for 23-hour observation for adults and 10 observation chairs for children/adolescents. As we discuss later in this section, many crisis systems incorporate a "living room" model for crisis assessment and observation, which have couches and reclining chairs in a homelike, non-clinical environment that can be largely staffed by peer staff. Wake County's lack of such a service option puts more pressure on WakeBrook's CAS unit even when some people could be assessed and deescalated in a less clinical setting. In Utah, which is in the process of developing additional community-based crisis stabilization units (CSUs) around the state, a facility based in Salt Lake County,³³ which has a similar population size to Wake County, will have 30 receiving chairs attached to a 24-bed inpatient unit and plans to have 12,000–14,000 annual admissions, more than double WakeBrook's roughly 5,000.

³³ <https://healthcare.utah.edu/hmhi/programs/crisis-diversion/crisis-care-center>

Table 12. WakeBrook Total and Unique Encounters for Fiscal Years 2020-2022

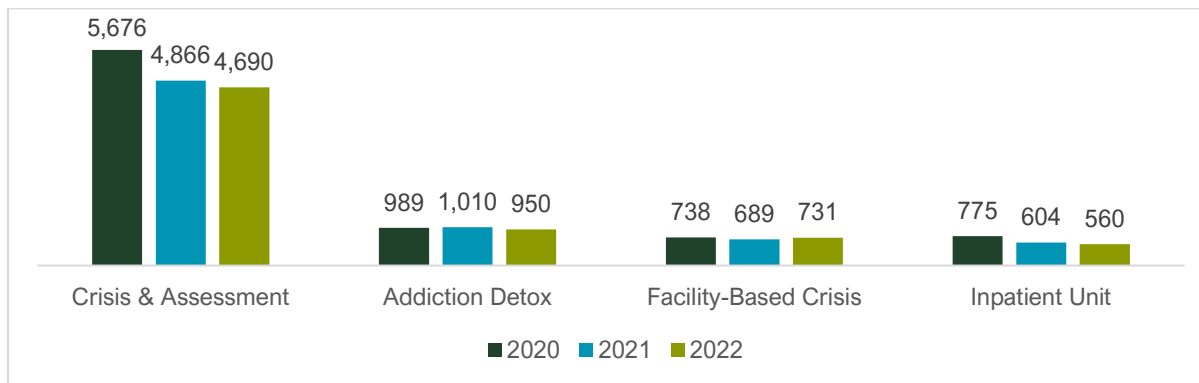
	Crisis & Assessment		Alcohol Detox Unit		Facility-Based Crisis		Inpatient Unit	
	Total Encounters	Unique Encounters	Total Encounters	Unique Encounters	Total Encounters	Unique Encounters	Total Encounters	Unique Encounters
2020	5,676	5,156	989	675	738	548	775	597
2021	4,866	4,367	1,010	689	689	494	604	501
2022	4,690	4,283	950	670	731	537	560	437

Source: WakeBrook

Table 13. Percentage of Unique Encounters for Fiscal Years 2020-2022

Unit	2020	2021	2022
Crisis & Assessment	91%	90%	91%
Alcohol Detox Unit	68%	68%	71%
Facility-Based Crisis	74%	72%	73%
Inpatient Unit	77%	83%	78%

Source: WakeBrook

Figure 15. WakeBrook Total Encounters by Unit 2020-2021

Source: WakeBrook

Regarding length of stay (LOS), a 2018 report surveyed Crisis Residential Programs across the country to identify characteristics and best practices.³⁴ It found in facilities around the country the average LOS ranges from 3 to 28 days. At WakeBrook, the average LOS for facility-based crisis is 8.5 days, around the middle of this range, though this is longer than can be expected for short-term crisis stabilization. For example, the Recovery Response Center in

³⁴ TBD Solutions, LLC. Crisis Residential Best Practices Handbook (2018). <https://crisisnow.com/wp-content/uploads/2020/02/CrisisResidential-BestPracticesHandbook.pdf>

Durham, operated through Alliance, says it provides 3 to 5 days of stabilization in its facility-based crisis service,³⁵ which is shorter than the average at WakeBrook.

Table 14. Average Length of Stay by Unit for Fiscal Year 2022

Unit	Average LOS	% Under 24 Hours
Crisis & Assessment	17 Hours	80%
Alcohol Detox Unit	5.5 Days	--
Facility-Based Crisis	8.5 Days	--
Inpatient Unit	27 Days	--

Source: WakeBrook. Note: LOS is based on all discharges and not specific to Wake County residents.

Table 15 shows the number of percentage of persons who present to CAS but whose acuity level is not able to be managed in the unit. This includes situations where a person is acting aggressively, does not respond to de-escalation interventions, and refuses medications. WakeBrook staff work to avoid the need to request transfer but are not able to perform restrictive interventions or force medications due to CAS's licensing as an outpatient clinic. These numbers are not unexpected. For example, data from Georgia referenced in SAMHSA's national guidelines found up to 14% of people presenting with crisis had direct referral to acute hospitalization based on their Level of Care Utilization System (LOCUS) score.

Table 15. CAS Diversion Rates for Fiscal Years 2020-2022

	Total Diversions	Number of Admissions	Diversion Rate
2020	295	5,676	5.2%
2021	410	4,866	8.4%
2022	348	4,690	7.4%
Total	1,053	15,232	6.9%

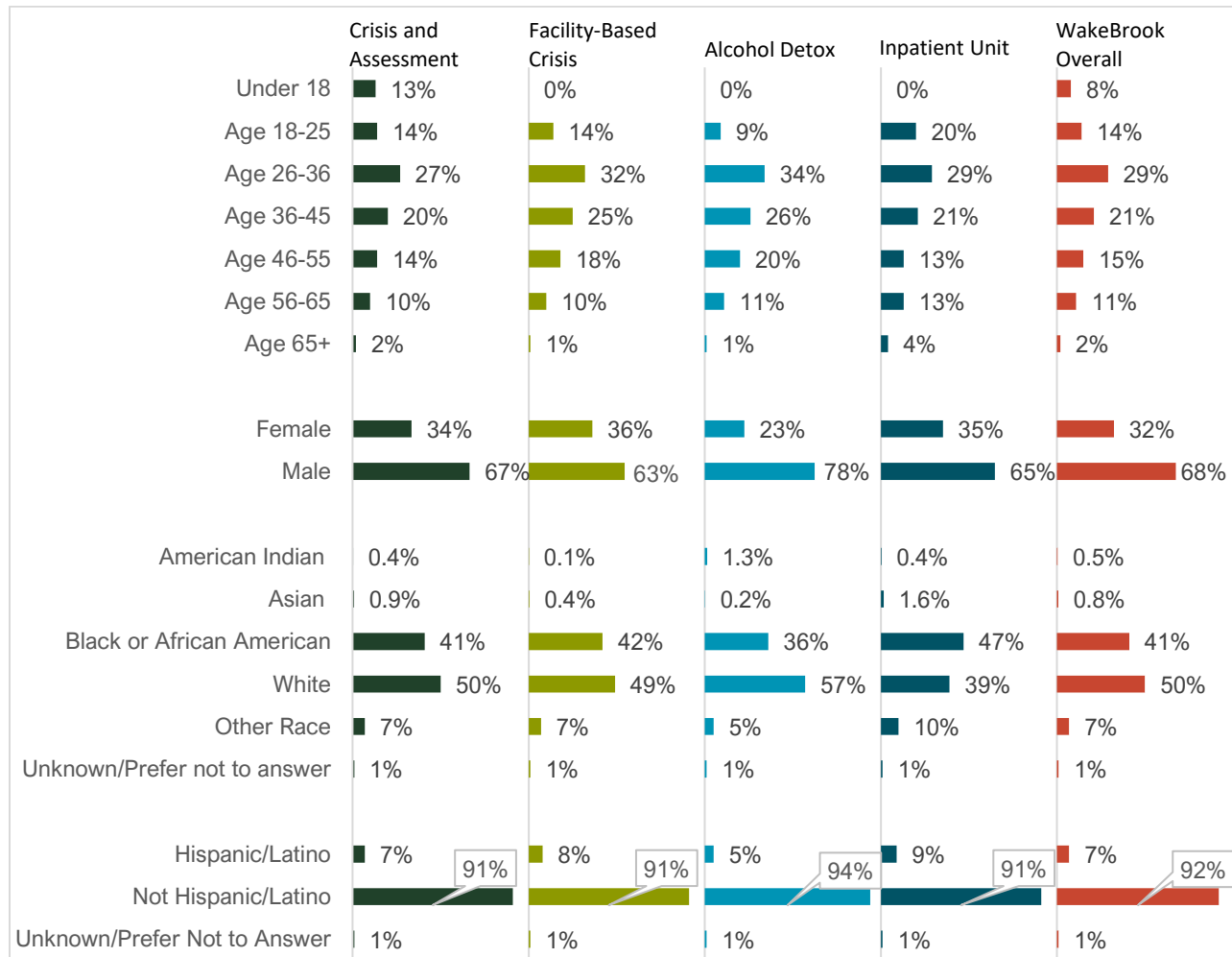
Source: WakeBrook

Figure 16 shows the demographic characteristics of persons served at WakeBrook by unit. Roughly two-thirds are male. In terms of race, 41% are Black or African American, which is higher than the distribution of this group in the general population in Wake County (22%), but similar to the proportion of Alliance members who are Black (38%). The inpatient unit has a higher proportion of people served who are Black, nearly half (47%). This is consistent with

³⁵ <https://riinternational.com/listing/recovery-response-center-durham/>

research showing Black people are overrepresented in psychiatric inpatient settings³⁶. Overall, half of people served at WakeBrook are White, and the proportion of White people served is higher in the addiction detox unit (57%).

Figure 16. WakeBrook Demographics by Service Type FY22



Source: WakeBrook

³⁶ Snowden R. et al. Overrepresentation of Black Americans in Psychiatric Inpatient Care. *Psychiatric Services* (2009).

Table 16. WakeBrook Average Age and Median Age by Unit FY22

	Average Age	Median Age
CAS	35	34
ADU	40	37
FBC	39	37
IPU	39	36
WakeBrook	38	36

Source: WakeBrook

Table 17 shows the disposition of discharges for the FBC and Detox units. These data are from Alliance for its members and the uninsured, not WakeBrook overall. Also of note are the large number of records for which disposition was not available, noted beneath the table. These are limitations, but the data nonetheless provide insight on the dispositions of discharges from the FBC and ADU units. Over 85% of discharges from FBC and nearly 80% from Detox are back to the community, with less than 10% referred to a higher level of care. This is in line with benchmarks from other communities. It will be important to understand the disposition of encounters to CAS when planning short-term and long-term for the crisis system. We sought to obtain data on disposition for all WakeBrook units, but there were quality issues with the Alliance data we were unable to resolve at the time of report. The data on disposition for CAS we received were for 1,465 encounters and represented final disposition for those who were referred to other WakeBrook units. The county should request from WakeBrook data on disposition for CAS encounters to better understand the flow of the roughly 5,000 annual encounters. According to WakeBrook's quarterly reporting, all patients seen at CAS had a listed disposition in FY22.

Table 17. Number and Percent of Discharges from WakeBrook by Disposition - data from Alliance Health for uninsured and Alliance members (FY22)

Disposition	Facility-Based Crisis #	Facility-Based Crisis %	Addiction Detox #	Addiction Detox %
Acute Care Hospital	36	5.7%	75	8.4%
ED Dismiss – Diverted	8	1.3%	1	0.1%
Home with Self Care	558	88.6%	709	79.8%
Inpatient Rehabilitation Facility	4	0.6%	0	0.0%
Psychiatric Hospital	11	1.7%	10	1.1%
READMIT planned: Psychiatric Hospital	4	0.6%	1	0.1%
Home or Assisted Living with Home Health	6	1.0%	0	0.0%
Left Against Medical Advice or discontinued care	3	0.5%	93	10.5%
Total	630	100.0%	889	100.0%

Sources: Alliance Health. Data are for uninsured individuals and Alliance members.

Notes: There were 98 blanks disposition for Facility-Based Crisis and 72 blanks for Alcohol Detox Unit, which were left out of the percentage calculations and totals presented here.

Overall, UNC WakeBrook has been a critical asset to Wake County, providing a continuum of crisis services in one location with strong clinical expertise and leadership. WakeBrook’s service model and physical structure is more clinically oriented than models that center a more recovery-oriented approach. For example, SAMSHA describes crisis receiving and stabilization facilities as providing “short-term observation and crisis stabilization to all referrals in a home-like, non-hospital environment.” In a recovery-oriented setting, the environment is as free from barriers as possible—including Plexiglas barriers between staff and those being served—to support stronger connections. Many crisis facilities around the country are centered around a “living room” model that conjoins the presence of a home-like, no-force-first environment that is highly staffed with peers and has adjacent clinical capabilities. While WakeBrook’s physical structure has some limitations with respect to its ability to be “home-like,” UNC Health operates its services with a recovery focus and emphasis on proving a calm and comfortable environment. WakeBrook employs some peer staff, but peer specialists are not fully integrated into each of its units in line with the best practice principle of “significant role for peers.”

The [table below](#) shows the minimum expectations and best practices for a crisis receiving and stabilization facility according to SAMHSA’s national guidelines. WakeBrook meets most of these, with three areas needing strengthening:

- Be staffed with a multidisciplinary team that includes peer specialists

- Be structured in a manner to accept all referrals 90% of the time
- Include beds within real-time bed registry operated by a crisis hub

Table 18. Comparison of Wake to National Expectations for Crisis Facilities

Minimum Expectations for Crisis Receiving and Stabilization Service	Wake Meets Criteria?
1. Accept all referrals	Yes
2. Not require medical clearance prior to admission but rather assessment and support for medical stability while in the program	Yes
3. Design their services to address mental health and substance use crisis issues	Yes
4. Employ the capacity to assess physical health needs and deliver care for most minor physical health challenges with an identified pathway in order to transfer the individual to more medically staffed services if needed	Yes
5. Be staffed at all times (24/7/365) with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community; including: psychiatrists or nurse practitioners (telehealth may be used), nurses, licensed and/or credentialed clinicians capable of completing assessments, and peers with lived experience	Yes/ Insufficient with respect to peers*
6. Offer walk-in and first responder drop-off options	Yes
7. Be structured in a manner that offers capacity to accept all referrals at least 90% of the time with a no rejection policy for first responders	Insufficient*
8. Screen for suicide risk and complete comprehensive suicide risk assessments and planning when clinically indicated	Yes
9. Screen for violence risk and complete more comprehensive violence risk assessments and planning when clinically indicated	Yes
Best Practices for Crisis Receiving and Stabilization Service	
1. Function as a 24 hour or less crisis receiving and stabilization facility	Yes
2. Offer a dedicated first responder drop-off area	Yes
3. Incorporate some form of intensive support beds into a partner program (could be within the services' own program or within another provider) to support flow for individuals who need additional support;	Yes
4. Include beds within the real-time regional bed registry system operated by the crisis call center hub to support efficient connection to resources	Insufficient*
5. Coordinate connection to ongoing care	Yes

*While these elements are present at WakeBrook, they are insufficient in capacity

Behavioral Health Urgent Care (Monarch)

In North Carolina, BHUC is a designated service for individuals ages four and older experiencing a behavioral health crisis related to SUD, mental health disorder, and/or I/DD.

BHUCs are designed to provide triage, crisis risk assessment, evaluation and intervention for those whose crisis response is deemed to be urgent or emergent.³⁷

In Wake County, Monarch operates the one BHUC, which is open 8 a.m. to 8 p.m. Monday through Thursday, 8 a.m. to 3 p.m. on Friday, and 8 a.m. to 1 p.m. on Saturday. The BHUC served over 1,300 people in FY22, primarily Medicaid and uninsured. In addition to walk-ins, the BHUC also serves as a connection point for discharges from inpatient and ED, notably Holly Hill and WakeMed have arrangements to meet the required 7-day follow-up window. WakeMed has a shared scheduling platform to facilitate scheduling. Unlike WakeBrook, the BHUC only sees individuals who are voluntary and medically stable. It can initiate the IVC process, which it reports occurs about six times per week.

Feedback from interviews suggested wait times at the BHUC can be very long, especially for those who show up later than first thing in the morning, with individuals sometimes waiting all day to be seen. According to its contract with Alliance and Wake County, all emergent individuals should be triaged within 20 minutes and receive a billable service, or if indicated coordination with a higher level care, within two hours of walking in. The contract stipulates that most individuals served should receive their first billable service within two hours. Data were not available to review the average wait time, but feedback from interviews suggests there may be a need for increased staff capacity to reduce wait times. Monarch reports its assessment process takes about 2.5 to 3 hours per person. The BHUC is staffed by a therapist, a nurse, and a prescriber. It does not incorporate peer staff. It is located about three blocks from the closest bus line, which was cited as inconvenient for some. According to Alliance's FY22 performance reporting, the BHUC met its target of less than 5% of individuals with Medicaid having an ED service within 30 days of BHUC visit. It did not meet its target of 70% of individuals having a follow-up behavioral health service within 30 days of BHUC visit.

³⁷ NC DHHS: <https://files.nc.gov/ncdhhs/documents/files/State-Funded-Behavioral-Health-Urgent-Care--BHUC---effective-2-1-2020.pdf>

Table 19. FY22 Number of People Served at Monarch BHUC by Demographics

	Number	%
Age Group		
Youth-Under 18	70	5.2%
Adults-18+	1,264	94.8%
Gender		
Female	596	44.7%
Male	738	55.3%
Region		
Wake County	1,208	90.6%
Other County	126	9.4%
Total	1,334	100%

Source: Alliance Health. Notes: Data is based on provider submitted DHHS reports. Age Group is reported as Youth or Adult, and Race and Ethnicity are not reported.

Table 20. FY22 Monarch BHUC Primary Disposition

Disposition	Number	%
Outpatient/Community Services or Supports	1,307	98.0%
Requires higher level of care	27	2.0%

Source: Alliance Health

The Hope Center/KidsPeace

The Hope Center for Youth and Family Crisis in Fuquay-Varina, N.C., is contracted by Alliance and operated by KidsPeace, an organization with other locations in Pennsylvania, Maine, and Georgia. Fuquay-Varina is located in the southern part of the county about 30 minutes southwest of Raleigh.

The Hope Center, planned to open in 2023, will be a 24-hour, seven days a week, 365-days-a-year program designed to provide crisis assessments, observation, and short-term support to youth. The center has a behavioral health urgent care (BHUC) and facility-based crisis. There will be six chairs in the urgent care, with some overflow capability, and 16 beds in the facility-based crisis with six beds for youth ages 6-12 and ten beds for youth ages 13-17.

Under the BHUC model, a youth in crisis can be referred to The Hope Center where they and their family can meet and work with a team of admission specialists, parent partners, qualified professionals, licensed clinicians, nurses, mental health technicians and providers who are all caring and trained to support the needs of the youth and their family at a difficult time. The focus is on providing a therapeutic, least restrictive, comforting experience.

The facility-based crisis will provide an alternative to emergency departments and provide a place for 24/7 inpatient therapeutic programming designed specifically for youth experiencing a behavioral health crisis.

The opening of the Hope Center will be a needed addition to the continuum of services in Wake County and excitement for it was expressed during interviews for this study. The MORES mobile crisis service was the first service to launch from the Hope Center in May of 2022. It provides mobile crisis and ongoing support and follow-up for up to eight weeks.

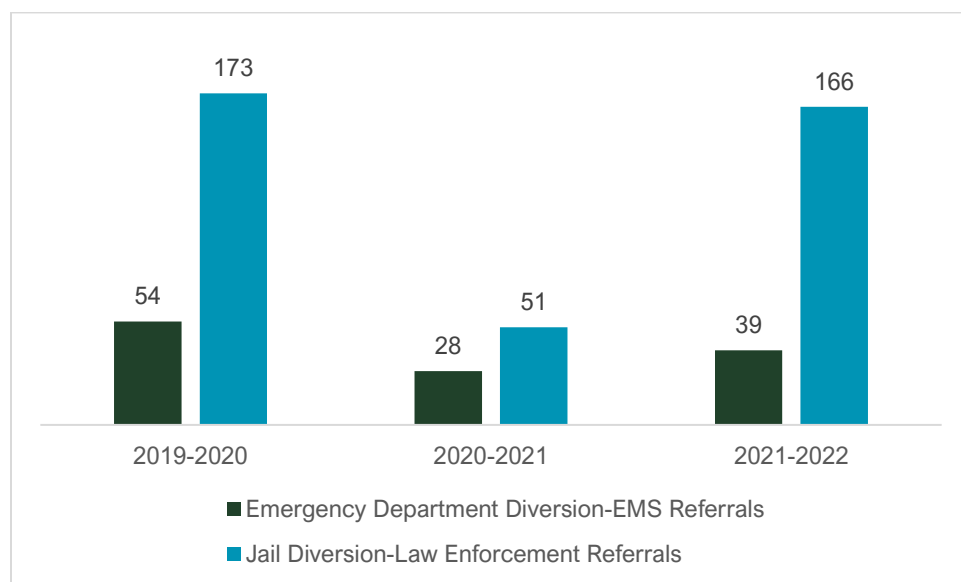
Non-Medical Detox (Healing Transitions)

Healing Transitions is a SUD recovery center providing long-term recovery programming, overnight shelter, non-medical detox, and family services. It serves around 2,000 individuals annually, with an average daily census of 222 in 2021, down from 317 in 2019 pre-COVID. The organization is currently expanding, with planned expansion to 290 beds on its men's campus and 210 beds on its women's campus.

Healing Transitions is highly regarded in the community, with its effective open-door policy and quick law enforcement and EMS drop-off arrangements cited as major assets to the continuum. Its staff includes many peers in recovery, though not all are certified peer support specialists. In 2018, Healing Transitions established the Rapid Responder Program, which sends peers in recovery out with Wake County EMS APPs to visit individuals in the community who have overdosed in the past 24 hours. Rapid Responders are trained to evaluate an individual's readiness for recovery, provide linkages to harm reduction services and provide harm reduction supplies, and follow-up to provide ongoing recovery support. In 2021, there were 660 new referrals to the program. This program is an innovative and exciting asset in Wake County.

Figure 17 shows ED and jail diversions from Healing Transitions, with the drop due to the COVID pandemic. There are more jail than ED diversions. While Jail Diversions saw a larger drop during COVID-19, these diversions have since rebounded.

Figure 17. Healing Transitions Emergency Department and Jail Diversions



Hospital Emergency Departments

Historically, hospital emergency departments (EDs) were the primary locus of default care for a person experiencing an emotional crisis. By now, however, the use of EDs for behavioral health crisis is widely recognized as having unsatisfactory and even harmful consequences, and a variety of alternatives have been implemented around the county, several of which are described below. In general, as exemplified by the Crisis Now model, these consist of various community-based services designed for diversion from EDs and inpatient treatment. It is likely, however, that EDs will continue to have some role in crisis service systems, in particular for individuals in crisis who are also medically unstable. There are also a number of challenges to developing alternatives to the ED involving financing, policy, and regulations. In Wake County some of these ED alternatives have been implemented, notably at WakeBrook; however, hospital EDs continue to serve a considerable proportion of individuals experiencing crises.

There are three acute care hospitals in Wake County: UNC Rex, Duke Raleigh Hospital, and WakeMed, which has seven ED locations throughout the county. As shown in [Table 21](#), there were over 17,000 ED encounters in these hospitals in FY 2022 where the primary diagnosis was behavioral health, an increase of 40% since 2018, while total ED encounters increased less than 1% during the same period. Although these numbers are high, they are in line with trends across the country. Nationally, the rate of ED encounters for behavioral health was

1,875 per 100,000 people;³⁸ in Wake County, it was lower at 1,181 per 100,000.³⁹ Similarly, state data for North Carolina show the crude per capita rate of ED encounters for mental health is lower in Wake County compared to the state rate and Mecklenburg County ([Figure 22](#)).

WakeMed, which sees by far the largest volume of ED encounters in Wake County overall and for behavioral health, has developed a 21-bed crisis stabilization unit in its Raleigh ED to create a better environment for people admitted for behavioral health reasons. The unit has 10 pediatric and 11 adult beds. WakeMed's staff includes clinicians specializing in behavioral health who work closely with patients in the ED and liaise with case managers and social workers from other organizations. Informants interviewed for this study spoke positively about WakeMed's case management and liaison services, as well as its leadership around coordination efforts, such as the Network for Advancing Behavioral Health.

[Figures 20](#) and [21](#) show the distribution of ED encounters for behavioral health by demographic characteristics in FY 2022. Fourteen percent of encounters (n=2,331) were for youth under age 18. Black people are overrepresented in ED encounters for behavioral health; for example, 22% of the Wake County population is Black or African American, but this group makes up 38% of ED encounters for behavioral health.

About one quarter (24%) of ED encounters for behavioral health were for people without health insurance ([Figure 19](#)). [Table 22](#) shows the average length of stay for ED encounters in Wake County for behavioral health; 96% of those had a stay less than 48 hours. However, ED "boarding" is defined as more than four hours in the ED waiting for the next appropriate service. Thus, these data do not capture the extent of ED boarding, as the goal should be to eliminate unnecessary wait time. When WakeBrook is on diversion (not able to accept admissions), a system for backup care places the three hospitals on rotation. However, we were told that this system is not followed and does not make sense. For example, UNC Rex and Duke Raleigh don't have pediatric ED services, but through this rotation end up receiving pediatric patients who can end up waiting for extended periods in the ED.

³⁸ National Center for Health Statistics. (2020). *National Hospital Ambulatory Medical Care Survey: 2020 Emergency Department Summary Tables*. https://www.cdc.gov/nchs/data/nhamcs/web_tables/2020-nhamcs-ed-web-tables-508.pdf. The population for the denominator to turn into a rate is from U.S. Census Bureau. (2020). Decennial Census, 2020. Retrieved Sept. 16, 2022, from https://data.census.gov/cedsci/table?q=p2&g=0100000US_0400000US37_0500000US37183&tid=DECENNIALPL2020.P2

³⁹ Data provided by WakeMed, UNC Rex, and Duke Raleigh Hospital. The population for the denominator to turn into a rate is from U.S. Census Bureau. (2020). Decennial Census, 2020. Retrieved Sept. 16, 2022, from https://data.census.gov/cedsci/table?q=p2&g=0100000US_0400000US37_0500000US37183&tid=DECENNIALPL2020.P2

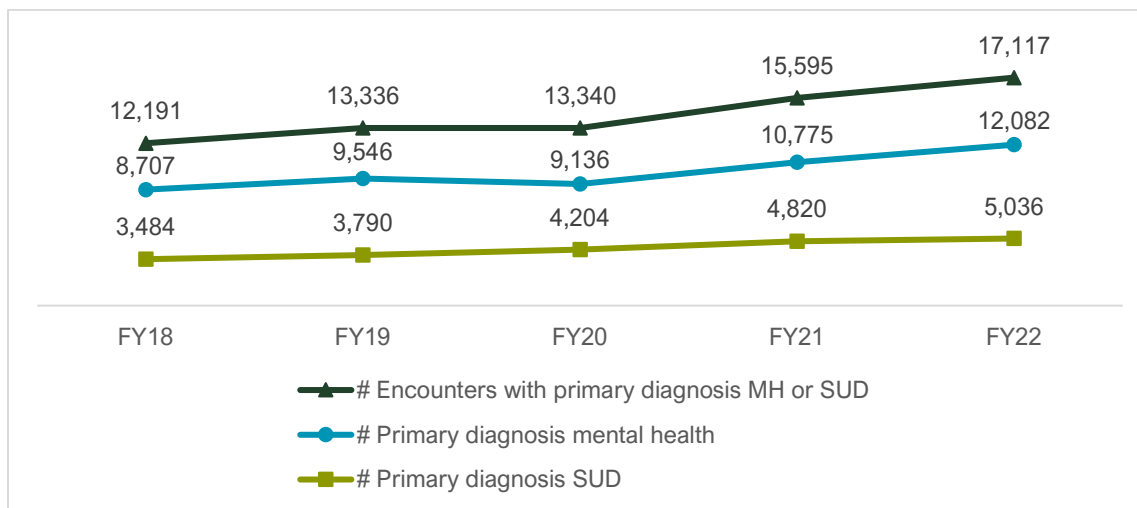
Table 21. Emergency Department (ED) Encounters in Wake County

	FY18	FY19	FY20	FY21	FY22	% Change FY18 to FY22
# Total ED encounters (all diagnoses)	670,664	681,863	602,088	619,775	671,727	0.2%
# Encounters with primary diagnosis MH or SUD	12,191	13,336	13,340	15,595	17,117	40.4%
# Primary diagnosis mental health	8,707	9,546	9,136	10,775	12,082	38.8%
# Primary diagnosis SUD	3,484	3,790	4,204	4,820	5,036	44.5%
% of ED Encounters for Behavioral Health	1.8%	2.0%	2.2%	2.5%	2.5%	40.2%
# Unique persons with primary dx MH or SUD	9,974	10,566	10,273	12,022	13,155	31.9%

Sources: WakeMed, UNC Rex, and Duke Raleigh Hospital. Numbers include non-Wake County residents.

Notes: MH=mental health; SUD=substance use disorder; dx=diagnosis. The first row in this table shows the overall total of ED encounters for all causes; all other rows are focused on behavioral health.

Figure 18. Trend in ED Encounters for Behavioral Health in Wake County



Sources: WakeMed, UNC Rex, and Duke Raleigh Hospital.

Table 22. Length of Stay in ED for Behavioral Health (FY22)

	Youth (Age <18)		Adults (Age 18+)		Total	
	#	%	#	%	#	%
Number with LOS less than 48 hours	2,182	93.6%	14,298	96.7%	16,480	96.3%
Number with LOS > 48 hours*	149	6.4%	488	3.3%	637	3.7%
Number with LOS > 1 week	21	0.9%	68	0.5%	89	0.5%
Number with LOS > 2 weeks	9	0.4%	27	0.2%	36	0.2%
Number with LOS 30+ days	3	0.1%	7	0.0%	10	0.1%

Sources: WakeMed, UNC Rex, and Duke Raleigh Hospital. Numbers include non-Wake County residents.

*Notes: Each category indented below the >48 hours row is included within this count, and the indented categories are not mutually exclusive. For example, “Number with LOS > 48 hours” includes the numbers counted in “Number with LOS > 1 week”, “Number with LOS > 2 weeks”, and “Number with LOS 30+ days”.

Figure 19. Percent of ED Encounters for Behavioral Health by Payer Source (FY22)

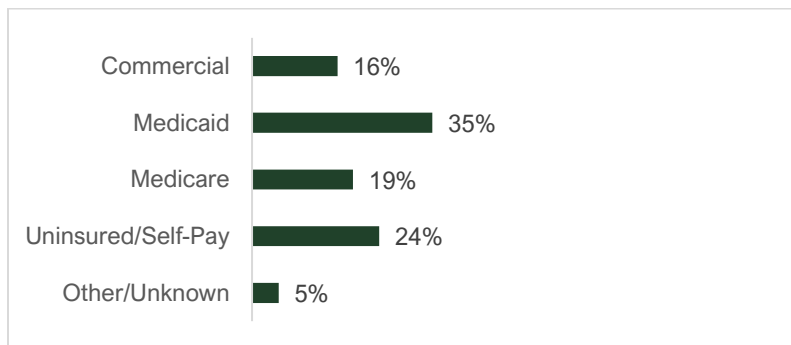


Figure 20. Percent of ED Encounters for Behavioral Health by Age and Gender (FY22)

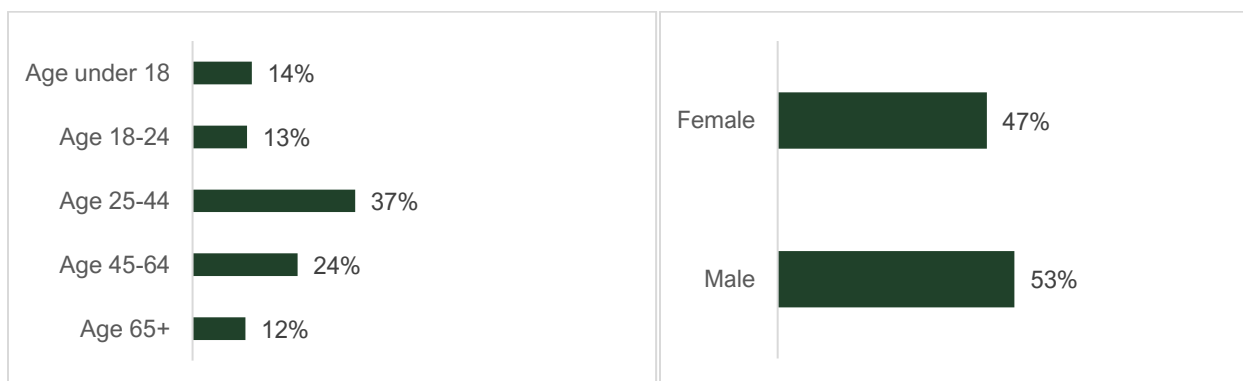
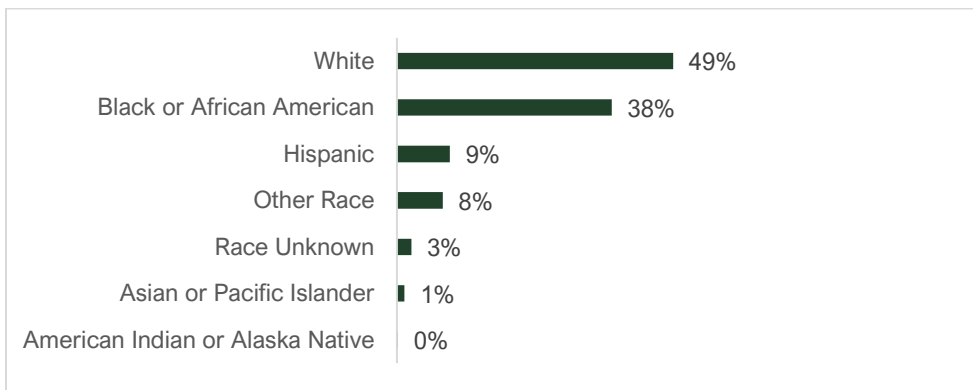
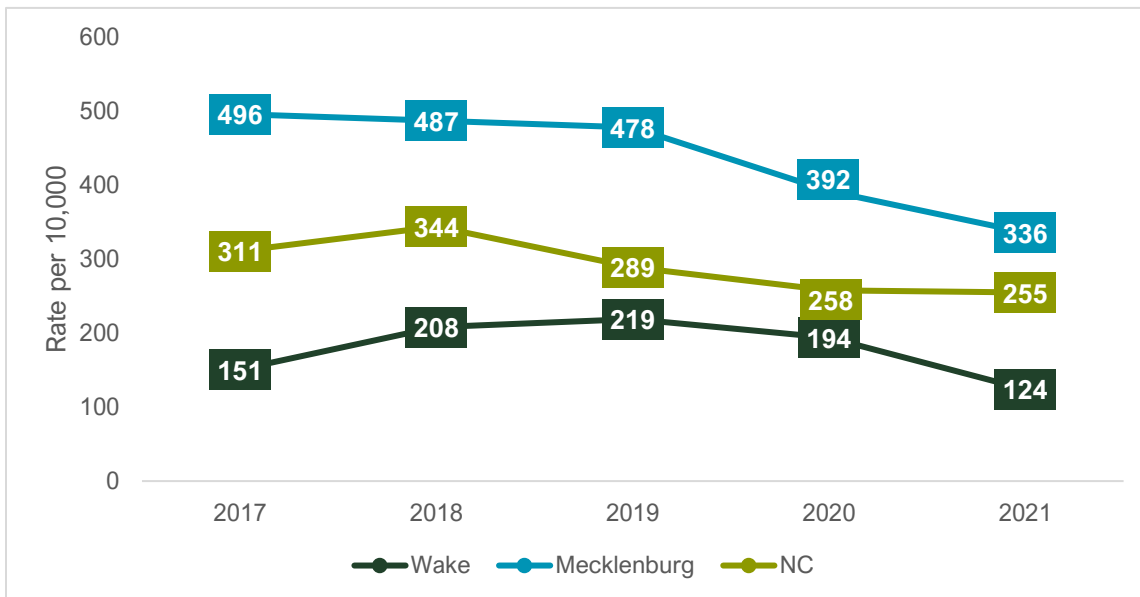


Figure 21. Percent of ED Encounters for Behavioral Health by Race and Ethnicity (FY22)



Note: One hospital is not included in the Hispanic calculations because it did not have data for Ethnicity

Figure 22. Crude rate for ED visits for mental health conditions is lower in Wake County compared to Mecklenburg County and North Carolina average



Source: NC Detect. (2021). *Mental Health Dashboard*. Retrieved 9/26/22, from <https://ncdetect.org/mental-health-dashboard/>

Psychiatric Inpatient Services

In addition to inpatient services at WakeBrook described previously, there are two psychiatric hospitals in Wake County: Holly Hill and Triangle Springs.

- Holly Hill, located in east Raleigh, is licensed for 296 beds, with an average daily census of around 230. It has 17 units across multiple campuses, with 28 beds for SUD, 71 beds for children and adolescents, and 197 for adult psychiatric. The hospital serves people from all over the U.S., estimating roughly 16% of its 26,000 annual referrals are from Wake County. Through Alliance, the county contracted with Holly Hill for care for uninsured (“indigent”) residents and in 2022 shifted this funding to Triangle Springs.

- Triangle Springs, located on the west side of the county, has 77 beds for adults. In August 2022, Wake County began contracting through Alliance for care for uninsured residents. The county's investment equates to an average daily census of seven (7) people a day; it was reported on a given day it could be four, or up to ten. Triangle Springs reports having no waitlist and that it can typically admit people the next day.

There are also three state psychiatric hospitals in North Carolina—Broughton Hospital (Morganton), Central Regional Hospital (Butner), and Cherry Hospital (Goldsboro). The Dorothea Dix Hospital, which was located in Raleigh, closed in 2012.

Though it is often asked what is the appropriate number of beds per capita, there is no single answer because it depends on many community-specific factors, especially the availability and quality of community support and crisis services, as well as characteristics of the population. ED boarding is often considered an indication of a need for more beds, but it may instead be due to inefficiency or lack of community alternatives. Additionally, the number of beds in a community is determined by market factors as well as policy.

A perceived need for more inpatient psychiatric beds was expressed by many of those interviewed for this study. The three acute care hospital systems reported long wait times for individuals awaiting inpatient care. Some reasons cited for delays in patients being accepted for inpatient care were insurance status, chronic medical conditions, and options for elderly patients, children, and youth.

Another theme that arose from informants and focus group participants was dissatisfaction with the quality of inpatient services, with WakeBrook being one noted exception. In particular, discharge planning from the psychiatric hospitals was reported to be poor, sometimes resulting in individuals being dropped off at Oak City Cares or day shelters with no notice or communication to the organizations, requiring staff to scramble to find options. Post-discharge follow-up was also raised as inadequate.

Table 23. Inpatient Admissions for Behavioral Health

	FY19	FY20	FY21	FY22
Holly Hill	998	949	1,238	1,312
Triangle Springs	31	55	185	213
Other	534	520	888	846

Sources: Alliance Health

Table 24. Average (mean) length of stay in psychiatric inpatient in Wake County

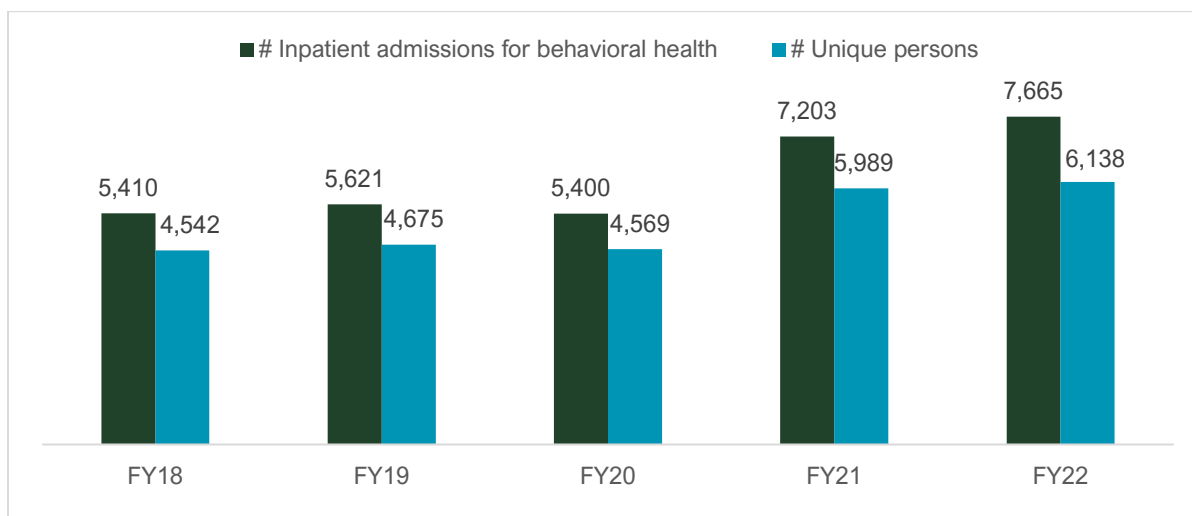
FY2022 Provider	Average LOS (days)
Holly Hill Hospital, LLC	9
Triangle Springs LLC	9
WakeBrook - IPU	12
Acute Care Hospitals	5.4

Sources: Alliance Health; WakeMed, and UNC Rex provided data for acute care hospitals

Notes: LOS is based on all discharges and is not specific to Wake County residents.

Although not psychiatric hospitals, WakeMed and UNC Rex admit individuals whose primary diagnosis is a mental health or substance use disorder. [Figure 23](#) shows the number of inpatient admissions and number of unduplicated individuals across these two hospital systems where the primary admitting diagnosis was behavioral health. WakeMed, which sees the largest volume of encounters for behavioral health, has established an inpatient consultation liaison service that offers psychiatric consultative care to inpatients and observation patients at the Raleigh campus who are either admitted for medical problems but have significant psychiatric co-morbidities, or who are awaiting bed availability and transfer to an appropriate psychiatric hospital.⁴⁰

Figure 23. Inpatient Admissions for Behavioral Health to Acute Care Hospitals



Sources: WakeMed and UNC Rex Hospitals. Numbers include non-Wake County residents.

⁴⁰ <https://www.wakemed.org/assets/documents/community/2019-chna-initiatives.pdf>

Note: The number of unique (unduplicated) individuals is the sum of unduplicated persons across the two hospital systems (WakeMed and UNC Rex); a person would be duplicated if they were admitted to both hospital systems with a primary diagnosis of behavioral health during the given year.

Prevention, Treatment, and Supports

Outpatient Behavioral Health Services

While the national effort to improve behavioral health crisis services is an extremely valuable development, it is important to keep in mind that the best approach for dealing with crises is to prevent them from occurring in the first place. As discussed in the Approach and Methods section above, we emphasize that crisis services are a part of a broader continuum of care, and even the best crisis service system will not compensate for inadequate routine community-based care. For this reason, although the focus of this needs assessment is on Wake County's crisis service system, we also consider the upstream factors that either alleviate or contribute to the need for crisis services.

The following are themes from interviews regarding outpatient services:

- Not enough outpatient capacity, particularly therapists and medication management, with long wait lists for some services; some providers turn people away due to capacity.
- Need for better prevention and early intervention and programs to prevent crises generally, and especially for youth and families engaged in foster system.
- At the same time, reports of community options being underutilized; Alliance has invested in preventative services such as in-home models that are often underutilized.
- ACT teams are not effective at keeping people out of EDs or very engaged with patients discharged from ED; variable quality across ACT teams with a perceived need for better training for staff; a need for more ACT teams and for forensic ACT.
- Planning for crises and ensuring safety, particularly for youth, is limited throughout the system.
- Transportation is a challenge for people getting to appointments, and it is hard for working people to take time during working hours for appointments
- Telehealth has expanded, but not necessarily engaging people effectively
- Some cited the major provider organizations as difficult to get ahold of by phone
- Lack of capacity to serve children with complex needs

School-Based Services and Services for Youth

Youth behavioral health is a national crisis exacerbated by the pandemic. In Wake County, an acute manifestation of the failures to meet youth and families' needs for a comprehensive and coordinated system of care is youth in the foster system sleeping the county's Swinburne

building for days or weeks for lack of alternatives. In response to this, Alliance is in the process of developing three short-term transitional group homes for youth ages 12 to 17 in Wake County DHHS custody, for which Wake County put up capital to fund start-up costs for these homes. One will be devoted to youth with I/DD, and the other two for youth with behavioral health needs. Youth must meet criteria for therapeutic residential level of care and need intensive, active therapeutic intervention to qualify. This will help address the immediate crisis, but there is need to strengthen comprehensive services for youth and families to prevent such crises, as outlined in SAMHSA's National Guidelines for Child and Youth Behavioral Health Crisis Care. In particular, the Wraparound model of intensive care coordination implemented by many states and localities. High-fidelity wraparound services take intentional steps to build a youth "system of care," which create networks of meaningful partnerships to enhance success and community thriving for youth and families. These networks should include non-traditional partners such as faith-based programs, school systems, and housing. Systems of Care (SOC) are effective in crisis prevention and early mitigation to defer from need for hospitalizations. Alliance Health has a foundation for System of Care, though it was outside of the scope of this assessment to fully assess the quality and capacity of these services.

Themes from interviews emphasized lack of options for pediatric crisis, including lack of provider capacity to serve youth with complex needs, lack of post-discharge options, and youth getting stuck in EDs for lack of available options. Staff from MORES noted that a central barrier after engaging with youth and families is access to appropriate providers that accept clients' insurance, adding it can be a two-week to six-month wait time. Informants also cited a need for more prevention and early intervention for youth, naming schools as an important place for this.

Alliance has several innovative programs aimed to prevent crisis and coordinate crisis care for youth, notably its School Based Team (SBT), a partnership with Wake County Public School System (WCPSS) to identify and connect WCPSS students to behavioral health services. It served over 600 youth in 2021/22 year. The initiative has six core programs:

- Traditional program connects students referred through the schools to behavioral health providers for assessment and connection to services
- Traditional I/DD program to connect students referred through special education
- Crisis Program supports students referred from crisis facilities including EDs to transition back to school. In the past two years, it notes having seen a significant increase in volume of crisis admissions along with higher acuity.
- Psychiatric Residential Treatment Facility (PRTF) program helps coordinate re-enrollment and transition for kids leaving PRTFs

- Justice Liaison program helps divert high school and middle school students who commit non-violent offenses at school from getting charges in the court system
- Alternative School program assists Longview School students transitioning in and out of crisis facilities

The SBT program is an effective partnership highly valued in the community. One limitation of the SBT is it only operates with WCPSS. Success from the program could be used to identify opportunities to extend the service to private schools in the county.

Law Enforcement and Criminal Legal System Resources

Crisis Intervention Teams (CIT) Training

Crisis Intervention Team (CIT) training teaches police and other first responders how to recognize and respond to individuals in a behavioral health crisis, de-escalating crises and referring individuals to treatment instead of jail or EDs whenever possible.

CIT training began in Wake County in 2005 and was the first CIT program in the state. Alliance holds the 40-hour trainings which combine classroom hours with on-site visits to organizations providing crisis diversion. [Figure 24](#) shows the number of participants in CIT training in Wake County between 2017 and 2022. The COVID pandemic limited the capacity for trainings in 2020. All municipalities in Wake County have some representation in CIT trainings. In addition to municipal police departments, other entities participating in Wake County include the Wake County Sheriff's Office, adult probation and parole, Wake County EMS, and police departments from universities, Raleigh Durham Airport, and the State Capitol.

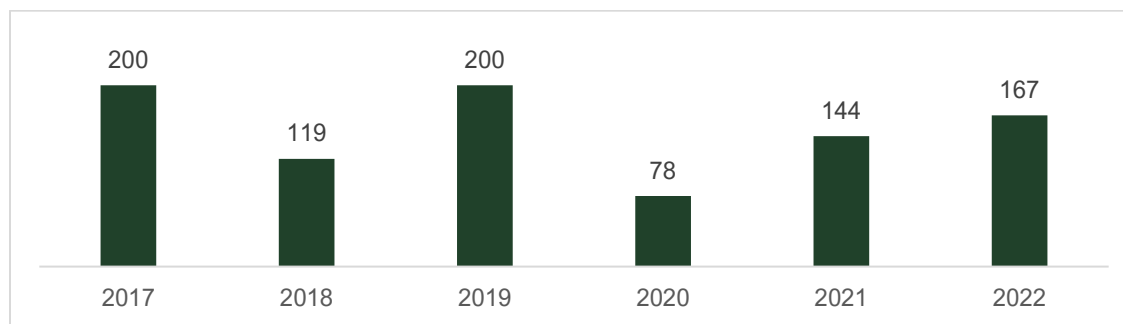
Feedback from individuals interviewed for this study was generally positive on the effectiveness of CIT training for law enforcement. Numerous providers noted when calling 911 for an individual in crisis they ask dispatch for a CIT trained officer and the request is honored, when possible. Interviewees reported variability in competencies handling behavioral health crises among officers. One comment suggested need for police training for domestic issues involving youth. Though feedback we received was generally positive about the skills of CIT trained police, it must be acknowledged that interactions with law enforcement can be traumatic, especially for Black Americans who are disproportionately represented among victims of fatal and nonfatal police violence compared to White Americans.⁴¹

No data were available on outcomes or quality of interactions with CIT trained responders. CIT is about community responses to mental health and should include cross sector partnership and collaboration with the behavioral health system to strengthen behavioral health-led

⁴¹ Mubarak E, et al. 2022. Promoting Antiracist Mental Health Crisis Responses. AMA Journal of Ethics. Retrieved 4/13/23 at: <https://journalofethics.ama-assn.org/article/promoting-antiracist-mental-health-crisis-responses/2022-08>

responses to crisis situations. The CIT coordinator should monitor program for adherence to CIT model and effectiveness including regular review of CIT forms and dispositions. CIT programs should evaluate the core elements of CIT. SAMHSA has a [guidance document](#) on establishing data collection processes for CIT training data reporting. This is an area for Alliance to monitor for continuous quality improvement of the CIT program.

Figure 24. Number of CIT Training Participants in Wake County, 2017-2022



Source: Data provided by Alliance. Note: some officers seek CIT Training outside of Wake County. These data represent the number who participate in CIT training delivered in Wake County.

ACORNS

Raleigh's [Addressing Crises through Outreach, Referrals, Networking, and Service \(ACORNS\)](#) team, comprised of four RPD personnel and three social workers, connects with individuals in crisis and provides outreach, education, case management, referrals to services, and assistance with transportation and other basic needs.

Thus far the ACORNS team is only serving Raleigh but has plans to expand to other regions of Wake County. Since the program is new there was little outcome data available on its impact, but reception from community partners is highly positive. Between August 2021 and August 2022, ACORNS had 795 calls from the CAD system, 488 requests for follow-up, and 89 requests for service. The program's data tracking activities should include tracking connections to services by type of service. The program is innovative on the part of law enforcement to meet individuals needs to prevent crises and to partner with community organizations including those addressing housing, homelessness, behavioral health, and other social determinants of health. We did not have the opportunity to hear feedback from people who have been served by the ACORNS program, which is something the county to solicit input on moving forward.

Recovery Court

The Recovery Court is an adult drug treatment court open to clients involved in the criminal justice system mainly due to a substance use disorder. It provides an alternative to jail or prison for non-violent individuals with goals of reducing the chances that people will return to the criminal justice system and to support recovery. The program is a minimum of one year

with a maximum of two years in which time people receive probation supervision, substance use disorder treatment, mental health treatment, drug and alcohol testing, case management, and bi-monthly court sessions with the recovery court judge and team.

Reentry Council

The Reentry Council is the first stop for people leaving incarceration and returning to live in Wake County. They first look to understand the immediate needs of people returning to Wake County and identify any direct services that would help to address those needs. Then people are connected to a partner who is part of their larger reentry council network and address the broad spectrum of needs; these include the probation and parole department, medical practitioners, behavioral health providers, transitional housing providers, and individuals with lived experience.

Staff includes a behavioral health case manager, a detention center case manager, an employer engagement consultant, and a resource consultant. The behavioral health case manager serves as a system navigator. The case manager is able to walk through the options and resources with someone until they are more stable and self-sufficient.

A suggestion that arose in interviews was a need for SOAR case managers for reentry specifically since when entering the criminal legal system, people lose their benefits. Having a SOAR case manager housed at the Reentry Council could facilitate this.

Transportation

Transportation is an important and often overlooked component of the crisis services continuum and a gap in Wake County. A major theme from interviews with key informants and focus group participants is lack of transportation—both non-law enforcement emergency transportation, and non-emergency transportation to appointments. RPD’s policy to handcuff individuals for transportation to treatment contributes to trauma, can exacerbate crises, and is especially harmful to people of color. As we were writing this report, RPD announced plan to stop providing transportation from WakeBrook to hospitals. County Sheriff’s offices around the state and in Wake County are not staffed to provide transport and do not want this role. Transportation is a major gap in the crisis continuum in Wake County. According to best practice systems, transportation should maximize transport in the least restrictive setting and minimize use of law enforcement and EMS for routine transport. A comprehensive system should have defined capacity and roles for:⁴²

- Private vehicles (driven by family members, peers, or volunteers)

⁴² National Council, 2022. Roadmap to an Ideal Crisis System.

- Taxis
- Specialty taxis
- Specialty mental health transportation services/vans
- Mobile crisis transport
- Emergency medical transportation
- Law enforcement transportation

Wake County previously contracted a transportation vendor, but problems with the vendor resulted in termination of the service. Expansion of mobile crisis in Wake County, including the purchase of vans, as was recommended by a consultant engaged to evaluate mobile crisis services in Wake County in 2021, and potential deployment of mobile crisis out of WakeBrook as discussed in the recommendations sections of this report, would help address transportation for behavioral health crises. At the time of this report, Alliance was working on a transportation plan for the county.

There is also a strong need to support transportation to behavioral health appointments as an upstream means to prevent crises. As part of its Tailored Plan, Alliance Health is rolling out a Non-Emergency Medical Transportation (NEMT) service. This will be an important addition to the service array for Alliance members.

Housing and Housing Supports

Housing was frequently cited as a critical gap and a need in Wake County to reduce pressure on the crisis system. The lack of low barrier, 24-hour drop-in emergency shelter is a notable gap in the county's continuum. Housing was a central barrier cited for discharges out of WakeBrook.

Wake County has numerous programs and initiatives through its department of Housing Affordability & Community Revitalization, the Homeless and Prevention Services Division and the Permanent Housing and Services Division are most relevant to this assessment. The Homeless and Prevention Division funds the homeless services providers (shelter, homeless outreach, and other homeless service providers). The Permanent Housing and Services Division manages the county's local voucher program, which primarily services individuals with behavioral health conditions. They directly provide the supportive housing case management or contract for case management. Access to these permanent supportive housing (PSH) resources are allocated through coordinated entry and the Continuum of Care, whose lead agency is the Raleigh Wake Partnership.

Some barriers cited by informants for stable housing are requirements for medication compliance, and services associated with permanent supportive housing (PSH) or Housing

First models being lacking or insufficient. The Housing Affordability and Community Revitalization has recently taken steps to ensure any agency funded through them is adhering to housing first models. They have incentivized low barrier and housing first principles through additional funding, capacity building, and data supports.⁴³ Continued support and oversight to ensure housing first principles will support individuals with behavioral health conditions in more effectively accessing housing supports.

The county's Cornerstone Service Center is currently undergoing renovations and when it opens will be an important resource for residents in need of PSH, serving as a PSH "front door." It will have 20 units of bridge housing for clients prioritized for PSH services, as well as street outreach, intensive case management, SOAR benefits assistance, vocational counseling, peer support, life skills training, and supported employment programs.

Alliance has a number of housing initiatives in Wake County, including Wake Healthy at Home, two bridge housing programs, and Coming Home, a justice-involved housing program for people with behavioral health needs. Informants interviewed spoke positively about Alliance's housing programs, supports, and coordination.

Key informant interviews cited concerns around accessing housing services through the access hub and crisis providers identified potential knowledge gaps around the continuum of care's housing process. Enhancing coordination between the behavioral health system and the housing support system at all levels would aid in more effective utilization of and prioritization for housing.

Comparison of Wake County's Continuum to National Models

The National Council for Mental Wellbeing's 2021 "Roadmap to an Ideal Crisis System" report describes the continuum of services in a model crisis system. In an ideal system, people have access to a broad continuum of settings, with emphasis on the least restrictive, and fluid movement in both directions along the array (e.g., from least to most restrictive and resource-intensive) based on the individual's needs and preferences⁴⁴. The following services are put forth to describe the ideal continuum:

- Crisis hub
- 24-hour call center/crisis line- Alliance Call Center
- Deployed crisis trained first responders

⁴³ L. McDowell. Personal Communication

⁴⁴ National Council for Mental Wellbeing, 2021. Roadmap to an Ideal Crisis System: <https://www.thenationalcouncil.org/resources/roadmap-to-the-ideal-crisis-system/>

- Medical triage/screening (non-ER and ER)
- Mobile crisis teams
- Behavioral health urgent care
- Intensive community based continuing crisis intervention services
- 23-hour observation and extended evaluation
- Residential crisis program continuum, including peer crisis respite and sobering support
- Peer respite and sobering services
- Hospitals: ERs, psychiatric consultation, psychiatric emergency services
- Psychiatric hospitalization
- Intensive outpatient continuing crisis intervention services
- EMS and non-EMS transport

Overall, Wake County has many of the key services in the continuum in place. As discussed in the previous sections of this report, there are areas in need of strengthening to reduce reliance on hospital emergency departments, notably enhancement of mobile crisis and reduced reliance on 911 for crisis response. One component missing in Wake County's service continuum is residential services including a peer crisis respite. Residential services are extremely limited in Wake County and interviewees identified a need for residential options, particularly for substance use disorder and for youth. WakeBrook's FBC and ADU units are licensed as residential but are not the ideal setting for residential care. Healing Transitions provides sobering support, overnight shelter, a long-term recovery program, and has many peers on staff, thus having features of respite but is not a traditional crisis respite. A crisis respite is a voluntary, short-term, overnight program that provides community-based, non-clinical support to help people find new understanding and ways to move forward, operating 24 hours per day in a homelike environment.⁴⁵ Peer respites are staffed by peers who have experienced mental health or substance use problems themselves and have also received professional training in providing crisis support. Peer respites are rapidly expanding throughout the U.S. and have been shown to be effective in reducing inpatient and emergency room stays and to create positive experience for guests.⁴⁶ The unit cost varies but is comparatively low cost compared to other residential services.

Another part of the continuum listed above where there is need for enhancement in Wake County is intensive community-based and outpatient continuing crisis intervention services. A

⁴⁵ Live & Learn, Inc: <https://livelearninc.net/peer-respites>

⁴⁶ <https://www.nasmhpd.org/sites/default/files/Peer%20Run%20Respite%20slides.revised.pdf>

behavioral health crisis is not a single event and typically requires ongoing intensive follow-up support for some period of time (such as two weeks to three months), to regain stability, prevent recurrence of crises and plan for return to less intensive community-based care. These services may consist of evidence-based practices such as critical time intervention or, for families, multisystemic therapy or functional family therapy.⁴⁷ A smaller number will need ongoing intensive support, such as ACT, to prevent recurrence of crises. The need for enhancement of intensive services to prevent crises was a theme from interviews conducted for this study.

⁴⁷ National Council for Mental Wellbeing, 2021. Roadmap to the Ideal Crisis System.

Other System Considerations

Coordination and Collaboration

Mental health systems in the past tended to function in isolation from other service systems, but this has been gradually changing in the past few decades. This process began with a widespread recognition of the need to integrate mental health and substance use treatment followed by the yet to be completed integration of behavioral health and primary care. Most recently, and still at a nascent stage, the recognition of the importance of social determinants of mental health has resulted in efforts to integrate behavioral health with a range of sectors and service systems including housing, education, child and family services, and criminal justice, with an emphasis on promoting equity. In Wake County, there is strong commitment to collaboration, and informants spoke of collaboration as a strength in the community, with good partnerships across the county, service providers, hospitals, law enforcement, and Alliance. There are notable collaborative efforts to support high utilizers and those with complex needs including needs related to SDOH, several of which are noted below. Informants also acknowledged opportunity for improvement, and feelings of silos in Wake County.

Areas identified as needing improved coordination are post crisis and transition from inpatient (same day appointments, transportation, reminders); formalized communication mechanisms between UNC programs and non-UNC hospitals (for example, UNC STEP reported it does not find out if one of its clients are admitted to a non-UNC hospital); and ideally a centralized medical platform or data system to facilitate referrals and data sharing across providers.

- **Wake County Familiar Faces Health Collaborative** is a collaboration by the Robert Wood Johnson Foundation Clinical Scholar Program to improve coordination across medical and social services providers for individuals with multiple, complex needs who are frequent users of emergency, medical, law enforcement, and other social services. Members include Wake County's three area hospital systems, Alliance Health, Wake EMS, the Raleigh Police Department, the county Manager's Office and housing division, WakeBrook, SouthLight, and other provider and social service organizations. WakeMed's Center for Community Health, Innovation, and Equity also focuses on coordinating with area resources to meet the diverse and complex needs of individuals suffering from behavioral health conditions, chronic medical issues, and health-related SDOH.
- **Alliance Crisis Collaborative** brings together community partners including hospitals, provider organizations, ACORNS, and many others every other month, facilitated by Alliance. Alliance also has Wake Community Collaborative for Children.
- WakeMed's **Network to Advance Behavioral Health (NABH)** is a multi-disciplinary network of 17 outpatient and community-based organizations focused on enhancing care coordination and

reducing access barriers for individuals with behavioral health needs. The network has a referral platform to help facilitate referrals and the ability to match patients to providers based on location, payor, clinical symptoms, and other factors. Providers in the network are expected to respond within two hours if they are able to accept the referral and to provide appointments the next day for urgent cases or within a week for routine needs. The network incorporates performance metrics for monitoring performance and WakeMed reports the collaboration has led to quantifiable reduction in avoidable bed days, inpatient length of stay, and referrals to state psychiatric hospitals. The network doesn't yet have the ability to refer to housing, which remains a major challenge for meeting needs. WakeMed's Connected Community also provides accelerated access to services to social service organizations working to address SDOH.

- **Oak City Cares** is a hub for connecting individuals and families who are experiencing, or at risk of experiencing, homelessness to services including medical care, social services, meals, and housing services. The group has a medical and mental health committee that meets monthly to coordinate across partners and providers.
- **Wake Network of Care** is an online Service Directory designed to increase access to all services and supports in Wake County. The Wake Network of Care launched on October 15, 2016. The site has had over 1 million users since launch. It hosts a database of 2,200 listings of Wake services and resources of 30 unique Categories (each with multiple Subcategories) of Social Determinants of Health across the Wake System of Care.

Workforce

A dominant theme in key informant interviews is the system-wide behavioral health workforce shortage. Exacerbated by the pandemic and not unique to Wake County, the workforce shortage is widely considered to be a national crisis. Key informants identified a variety of ways in which this has had a negative impact on the availability of services. Notably, it has had the effect of reducing the availability of inpatient beds, as hospitals have had to limit the number to meet staff ratio requirements. Providers described the impact of workforce shortages on most service types including ACT, mobile crisis, peer support, and outpatient therapy and on services for special populations such as the unhoused and children with complex needs. Providers expressed that it was more difficult to hire certain types of practitioners, including nurses (especially those with mental health expertise), behavioral health clinicians, and psychiatrists. It was noted that Medicaid reimbursement rates are too low to compete with health plans, thus leaving certain organizations struggling to fill positions. The only public data on behavioral health workforce available, shown in Table 25, shows the population-to-mental-health-provider ratio in Wake County is more favorable than the state average.

Strategies to address behavioral health workforce shortages include leveraging funding opportunities to increase rates and to incentivize recruitment and retention. Partnership with

colleges and universities and supporting loan forgiveness can help develop a workforce pipeline.

Table 25. The ratio of population to mental health providers in Wake County is similar to Mecklenburg County and more favorable than the statewide average

Wake County	Mecklenburg County	North Carolina
298:1	301:1	363:1

Source: County Health Rankings, 2022. Mental health providers are defined as psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, mental health providers that treat alcohol and other drug abuse, and advanced practice nurses specializing in mental health care.

Cultural and Linguistic Responsiveness

Wake County is an increasingly diverse and international community, with many different languages spoken and cultures. Themes from interviews noted language to be a barrier to behavioral health care in Wake County and a need for more providers that are bicultural and bilingual, particularly Spanish speaking. The county allocates funds to support behavioral health services in Spanish at the Fernandez Community Center, and access points such as the Alliance call center have some Spanish-speaking staff. Some informants noted there are efforts to provide materials and websites in Spanish, and providers noted having access to and using telephonic interpretation services.

However, many community members feel there is a need for more resources that are better tailored to a person’s cultural identity. Most service providers lack a sufficient bilingual workforce, and because of increasing international diversity, it is challenging to meet all the language needs. Access to interpretation services alone is not enough, while there is a broader need for increased cultural humility and awareness throughout providers and first responders.

Spanish is the most common language spoken at home other than English in Wake County and the Hispanic population is expected to have high growth over the next 30 years, thus the need for services in Spanish will also likely increase. The high rates of mental health and suicide attempts among Hispanic youth in Wake County is of notable concern and highlights the need for more culturally competent care for this population. 988 has an associated text line and WhatsApp in Spanish that should be promoted in Wake County.

Language and cultural barriers were also noted for members of the Asian community, particularly refugee communities. As the Asian population is expected to grow substantially over the next 30 years in Wake County, it will be important to build cultural competence and language resources for the diverse Asian community.

Multiple participants noted the cultural barriers that exist in people accessing crisis services, such as communities not recognizing mental health, the notion of “just get over it,” and the stigma of reaching out for help. While these cultural barriers may lead to people not seeking services, as one interviewee noted, it is still worth the effort to reach out. Concerns around deportation is another barrier that was cited for immigrant communities.

In regard to culturally competent care, interviewees noted that while providers will say they are culturally competent, it is questionable what actionable steps they are taking to ensure cultural competency. It is reported that some therapists believe in a one-size-fits-all approach, not taking into consideration cultural differences or trauma that individuals have faced, including refugee communities. One suggestion that was raised is when a provider is utilizing an interpreter, they should continue to maintain eye contact and speak with the patient as they would normally, not looking at the interpreter or phone.

Another theme was that different communities might not seek out care from providers first, rather they might reach out to their religious community or families. Informants suggested that it was important to partner with faith-based organizations and in creative ways in the community to do better health promotion and prevention.

It was also noted the LGBTQ+ community in Wake County does not have a good relationship with law enforcement, and a need for the provider and social services community more broadly, as well as law enforcement, to work to build trust.

Peer Support Services

Peer support is an evidence-based practice that supports recovery. Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse.⁴⁸ Peer support has been shown to reduce hospital length of stay and re-hospitalization, lower overall service costs, and improve quality of life outcomes. In its national guidelines for crisis care, SAMHSA outlines a significant role for peers as one of six core principles of an effective crisis system. This is a gap in Wake County.

According to state data, as of February 2023 there are 4,342 Certified Peer Support Specialists (CPSS) North Carolina, with 337 in Wake County.⁴⁹ Durham County has a similar number of

⁴⁸ SAMHSA, <https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers>

⁴⁹North Carolina's Certified Peer Support Specialist Program website, accessed 02/17/2022: <https://pss.unc.edu/data>

CPSS (321) for a population less than half the size of Wake's, and Mecklenburg County has 437, considerably more than Wake County.

Peer support services are available in Wake County, notably through SouthLight, Healing Transitions, Carolina Outreach, Fellowship Health Resources, and ACT programs. However, a need for more peer-based services was a theme that arose during interviews and focus groups. A particular need for peer support for young adults and for individuals without Medicaid was noted.

There was some apprehension and misconception about the role of peer support among those interviewed, highlighting the need for more awareness and training for the broader provider community and peer specialists. For example, some reported the quality of peer support in Wake County to be inconsistent and sometimes harmful; another said peer support has historically been viewed in Wake County as a volunteer position and is only recently starting to be recognized; others expressed a need for better training and credentialing for peer support workers. At least one provider organization reported challenges recruiting and retaining peer specialist staff due to the low pay rates. Efforts to expand the role of peer support in Wake County should consider this and supplement low reimbursement rates. Implementation guidance in SAMHSA's guidelines includes:

- Hire credentialed peers with lived experience that reflect the characteristics of the community served as much as possible. Peer should be hired with attention to common characteristics such as gender, race, primary language, ethnicity, religion, veteran status, lived experience and age.
- Develop support and supervision that aligns with the needs of your program's team members.
- Emphasize engagement as a fundamental pillar of care that includes peers as a vital part of a crisis program's service delivery system. This should include:
 - Integrating peer within available crisis line operations
 - Having peers served as one of two mobile team members
 - Ensuring a peer is one of the first individuals to greet an individual admitted to a crisis stabilization facility

Feedback from People with Lived Experience

We conducted four focus groups in January 2023 to hear about the crisis system from individuals who had experience with crisis services in Wake County. Feedback from users of crisis services emphasized not feeling listened to, heard, or respected in interactions with the behavioral health system. Individuals reported that they were not often treated with empathy by the people they encountered, or that they would be treated differently once their behavioral health histories were known. Youth participants reported feeling like they were not listened to

during encounters with law enforcement or behavioral health providers, with preference given to their parents or guardians.

Focus group participants reported the quality of care they received and how they were treated varied widely, largely dependent on the individual providers they were interacting with. Overall, feedback on experiences with WakeBrook and EMS services were reported to be positive, while experiences with psychiatric inpatient, emergency departments, law enforcement, mobile crisis, and BHUC varied more. It was suggested that a true embracing of person-centered care by the system would help address some of the challenges encountered currently within the system. Those interviewed reported people with lived experience generally have little role in planning, providing feedback, and implementing services in Wake County, at both an individual and a systems level.

In terms of recommendations from service users to improve the experience with behavioral health and crisis services, the benefit of and need for more peer support services was widely endorsed. Some suggested that peer support services be generally available and not tied to a specific program; it was thought that this would result in a more genuine peer to peer connection without interference by agency policies and procedures. Participants also stressed the need for more housing and housing support services. Specifically mentioned were youth shelter options, more recovery-oriented housing, rental assistance, low barrier options (no background checks, credit, work history, etc.), landlord educational programs, and transitional housing options. Education and employment support services were also indicated as being a need.

Data and Performance Measures

A key to improving the behavioral health crisis continuum is the measuring and monitoring of data related to crisis services and supports. According to SAMHSA's national guidelines, "funders, system administrators and crisis service providers should continuously evaluate performance through the use of shared data systems."⁵⁰ Having a real-time perspective along with trends over time of how the crisis system is operating is crucial to continuous quality improvement. Sharing data with system partners as well as the general public also improves accountability and transparency. When data and performance measures are captured and utilized effectively, needed improvements in the system can be identified quickly. When changes are made, the data can be monitored to understand how these changes are impacting the system.

⁵⁰ SAMHSA, 2020. National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit. <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>

Wake County has the following reporting of data currently in place:

- **Wake County Outcomes and Analysis Quarterly Reports:** Alliance provides quarterly reports to the county for services that the county funds. Data include numbers referred and served by each service, in addition to outcome measures specific to each service.
- **WakeBrook Outcomes and Analysis Quarterly Reports:** Similar to the above reports, WakeBrook provides quarterly reports to the county and to Alliance with various metrics and performance targets. These reports, however, have not been meeting the county's needs for performance monitoring and understanding how its funds are utilized.
- **WakeMed** has its own performance monitoring related to behavioral health, but this isn't available to the county on a regular basis nor is there required reporting to the county.
- **North Carolina LME-MCO Quarterly Reporting Measures:** Each LME-MCO in North Carolina is required to report to the state on behavioral health crisis measures. This infrastructure could be leveraged in making a system-wide dashboard for the county.
- The state of North Carolina has invested in various dashboards and data tools. The North Carolina Disease Event Tracking and Epidemiologic Collection Tool (NC DETECT) was created for early event detection and timely surveillance. Of particular importance to behavioral health is the **NC DETECT Mental Health Dashboard**,⁵¹ which provides mental health data at the state and county level since 2017. It shows ED visit trends for five mental health conditions which can also be looked at by demographics, insurance status, and zip code. Another resource is the **Opioid and Substance Use Action Plan Data Dashboard**.⁵² This dashboard includes data since 2000, showing trends for measures related to opioid and substance use. Data can be broken down by county or district, and the overdose death rate can be viewed by race and ethnicity. This dashboard also helps to visualize and track progress towards reaching the goals of the North Carolina Opioid and Substance Use Action Plan.
- **Live Well Wake** is a collaborative in Wake County that brings together agencies and organizations to improve the health and well-being of the Wake community. As part of Live Well Wake, they led the **Community Health Needs Assessment**⁵³ (CHNA) process which gathered and utilized both quantitative and qualitative data. Mental Health/Substance Use Disorders were identified as a top priority in the 2019 CHNA, with various measures identified to track over time. In the 2022 CHNA, these data measures, along with other measures related to behavioral health, are reported, and again, mental health was identified as a top priority. Live Well Wake also developed the **Live Well Wake Data Dashboard**.⁵⁴ The dashboard includes demographics,

⁵¹ NC Detect. (2023). *Mental Health Dashboard*. <https://ncdetect.org/mental-health-dashboard/>

⁵² NCDHHS. (2023). *Opioid and Substance Use Action Plan Data Dashboard*. <https://www.ncdhhs.gov/opioid-and-substance-use-action-plan-data-dashboard>

⁵³ Live Well Wake. (2022, April). *Wake County Community Health Needs Assessment*. https://livewellwake.org/wp-content/uploads/2022/09/LWW_CHNA-2022-FINAL.pdf

⁵⁴ The North Carolina Institute for Public Health at UNC-Chapel Hill (2022, April 29). *2022 Live Well Wake Data Dashboard*. <https://livewellwake.org/priorities/>

various measures related to social determinants of health, and of particular interest, data pertaining to mental health and substance use. Presented in this section are depression prevalence rates, mental health ED visit rates, substance use hospitalizations, drug overdose deaths, suicide mortality rates, and findings from surveys and focus groups.

- **Familiar Faces** has a central focus on utilizing whole-person analytic models to identify and support the most frequent users of crisis services, medical, social, law enforcement, homeless, and other public services. Familiar Faces is still in the early phase of identifying data needs and infrastructure. With this initiative comes the complexities of sharing data between hospitals, law enforcement, community organizations, and more.
- The **Wake County Behavioral Health Plan** outlines progress measures for the five priorities that it has identified; however, there isn't a regular repository or structure for reporting and monitoring. It would also be helpful to identify parties responsible for each action measure and available data sources.

Wake County, in partnership with Alliance and the hospitals, has a good foundation for improving data and performance monitoring for its behavioral health system. The county has been considering building a data dashboard which is something we recommend. Below are key performance measures as indicated by NASMHPD and SAMHSA for the three core elements of crisis systems.⁵⁵

Performance measures for **crisis call lines**:

- | | |
|-----------------------------|--|
| • Abandonment rate | • Result/outcome of call |
| • Answer rates | • Service level |
| • Average handle time | • Number of follow-up calls made (including chats and texts) |
| • Average speed of answer | • Presenting concern |
| • Caller acuity | • Referral source |
| • Caller disposition | • # of referrals made for follow-up |
| • Call volume | • Calls dropped |
| • Connection to resources | • Number of warm handoffs made/declined |
| • Demographic information | • After-call work time |
| • First time/repeat callers | • Blockage |
| • Location of caller | |

⁵⁵ NASMHPH, 2022. Telling the Story: Data, Dashboards, and the Mental Health Crisis Continuum. https://www.nasmhpd.org/sites/default/files/2022-11/Data-Dashboards-and-the-Mental-Health-Crisis-Continuum_NASMHPD-3.pdf and SAMHSA, 2020. National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit. <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>

Performance measures for **mobile crisis response**:

- Assessments completed
- Case review completion within 30 days
- Disposition of mobile dispatch
- Diversion rate
- Follow-up service connections
- Response time
- Client satisfaction
- Demographics
- Diagnosis
- Duration of service
- Insurance status
- Living arrangement
- Method of response
- Number of dispatches
- Referral source
- Service location
- Client satisfaction

Performance measures for **crisis stabilization facilities**:

- Number of admissions & discharges
- Change in acuity
- Diagnoses
- Disposition at discharge
- Diversion rate
- ED utilization
- Length of stay
- Occupancy rate
- Readmission rate
- Referral source
- Response time
- Client satisfaction
- Treatment follow-up
- Triage assessment
- Waitlist
- Commitment status
- Denial rate
- Insurance status
- Mode of arrival
- Living arrangement

Additionally, the National Council for Mental Wellbeing⁵⁶ adds that quality metrics should use customer-oriented metrics about experience and performance, with some examples including:

- Percent of crisis customers who have welcoming hopeful customer experience.
- Percent of customers who receive “no force first” engagement.
- Percent of crisis calls that are resolved without having to dispatch police.
- Percent of mobile crisis team encounters resolved in the field without ER or police transport.
- Percent of individuals discharged safely to non-hospital settings.
- Percent of individuals who receive crisis follow-up care within 48 hours.
- Percent of families engaged collaboratively in the crisis intervention process.
- Percent of crisis encounters resolved successfully within two hours.

Displaying and disseminating data in a dashboard makes the data more readily available and is useful in showing a range of measures and trends over time. As recommended best practice measures should be “aggregated into system-wide quality dashboard that is routinely and transparently disseminated to relevant stakeholders.”

We conducted a scan to identify examples of county or state dashboards that could serve as helpful examples to Wake County. The following are some examples:

- **Arizona’s Crisis Response Network Performance Dashboard:**⁵⁷ This dashboard displays data related to call lines in conjunction with mobile crisis. Includes measures of monthly volume for crisis calls and mobile crisis, as well as answer rate, speed of answer, stabilization rate, reasons for calling, top referral sources, and collaboration with law enforcement. Most data are updated daily and can be viewed by region.
- **Maryland Behavioral Health Hospital Coordination Dashboard:**⁵⁸ Includes psychiatric bed availability, crisis bed facilities, and behavioral health walk-in and urgent care centers. The psychiatric bed availability tab shows the types of beds that are available (child, adult, co-occurring, etc.) and that the crisis beds tab shows if walk-ins and referrals are accepted, if there are addiction beds, and if uninsured, Medicaid, Medicare, and commercial insurance are accepted.

⁵⁶ Roadmap to the Ideal Crisis System, https://www.thenationalcouncil.org/wp-content/uploads/2022/02/042721_GAP_CrisisReport.pdf

⁵⁷ Solari Crisis and Human Services. (2023, Mar. 5). *Crisis Response Network Performance Dashboard*. Retrieved Mar. 6, 2023, from: <https://public.tableau.com/app/profile/crisis.network/viz/AZ600StatewideDashboard/AZ600StatewideDashboard>

⁵⁸ Maryland Department of Health: Behavioral Health Administration. (2023, Mar. 6). *Behavioral Health Hospital Coordination Dashboard*. Retrieved Mar. 6, 2023, from: <https://health.maryland.gov/bha/Pages/hospitalcoordination.aspx>

- **New York State Office of Mental Health County Planning Profiles:**⁵⁹ Provides data on inpatient and outpatient capacity in New York state, can be viewed at the county and regional levels, and can be broken down by age group. The four components of the dashboard are Medicaid utilization, inpatient use, outpatient capacity, and readmissions.
- **Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) Dashboards:**⁶⁰ ODMHSAS has developed three comprehensive dashboards as follows: Mental Health Based Dashboard, Substance Abuse Based Dashboard, and Treatment Admission Dashboard. All three dashboards provide admission numbers and rates and geographic distribution and rates by county. The mental health and treatment admissions dashboards also provide information on demographics and primary problem, with the substance abuse dashboard providing data on most common drug choices and frequency. The mental health dashboard additionally shows referral source and discharge information. While not covering all components of the crisis system, this dashboard includes a good range of the metrics listed above. Much like Arizona, Oklahoma also has a 988 dashboard with key metrics for call lines.
- **Utah's Mobile Crisis Response Team (MCOT) Services Dashboard:**⁶¹ This dashboard is focused on mobile crisis, providing numbers of people who received mobile response, non-mobile response, and follow-up services. Other measures include insurance status, age group, county of residence, primary concern, service setting, caller, response time, duration of service, and outcomes, including location of client at the end of the service and law enforcement involvement.
- **Wisconsin's County Services - Mental Health Dashboard and County Services - Substance Abuse Dashboard:**⁶² These two dashboards provide an overall perspective on services used across the behavioral health system continuum. Includes trend data and data can be filtered by demographics and by county.

⁵⁹ The New York State Office of Mental Health. (2020, Dec.). *New York State Office of Mental Health County Planning Profiles*. Retrieved Mar. 6, 2023, from: <https://omh.ny.gov/omhweb/tableau/county-profiles.html>

⁶⁰ Oklahoma Department of Mental Health and Substance Abuse Services. (2023). *Dashboards: Agency Statistic Dashboards*. Retrieved Mar. 6, 2023, from: <https://oklahoma.gov/odmhsas/research/statistics-and-data/dashboards.html>

⁶¹ DHS Reports. (2023, Mar. 1). *Mobile Crisis Response Team (MCOT) Services*. Retrieved Mar. 6, 2023, from: <https://public.tableau.com/app/profile/dhs.reports/viz/MCOTDASH/Dashboard1>

⁶² Wisconsin Department of Health Services. (2022, Dec. 11). *County Services - Mental Health*. Retrieved Mar. 6, 2023, from: <https://dhs.wisconsin.gov/mh/county-services-dashboard.htm> and Wisconsin Department of Health Services. (2022, Dec. 13). *County Services – Substance Abuse*. Retrieved Mar. 6, 2023, from: <https://dhs.wisconsin.gov/mh/county-services-dashboard.htm>

Summary of Key Findings

System Strengths and Assets

- Overall, many of the core services in an ideal crisis continuum are in place
- Commitment to behavioral health from county leaders
- Relative to similar communities around the country a good array of resources and funding opportunities
- UNC Health at WakeBrook provides a continuum of high-quality services in one location
- Overall good health of the population
- Innovative approaches, initiatives, and partnerships, such as the Familiar Faces initiative, ACORNS, peer-led Rapid Responders program, EMS enhanced mobile crisis, and WakeMed's behavioral health outreach and coordination initiatives, among others
- Community providers across sectors are committed to collaboration to address challenges, though coordination efforts could be improved

System Gaps

- The mobile crisis service does not have the capacity to fulfill its potential to significantly divert individuals from emergency departments.
- There is an overreliance on calling 911 for behavioral health
- Lack of coordination with the new 988 crisis call line
- WakeBrook's crisis and assessment (CAS) unit is too often full and unable to accept referrals
- No transportation options beyond police and EMS is a critical gap in the continuum
- The county lacks a crisis respite or peer crisis respite
- There is lack of residential service capacity
- There is no clearly defined crisis system coordinator (at the county or Alliance)
- No 24-hour emergency shelter for adults
- Lack of system-wide capacity to serve children and youth with complex needs
- Assertive Community Treatment (ACT) and other community-based intensive services could be improved to prevent unnecessary emergency department and psychiatric inpatient stays

Recommendations

This section presents 12 priority recommendations based on our assessment of the Wake County crisis services system. The recommendations are arranged into four categories: crisis services continuum, systemwide needs, social supports, and quality and coordination.

Crisis Services Continuum

1) Continue investment in the WakeBrook facility as a centralized crisis “hub.”

WakeBrook is a highly regarded and central component of the crisis service system in Wake County, providing a continuum of integrated, high-quality services in one location. Late in this project, during the drafting the final report, UNC Health announced plans to end its operation of services at the facility and negotiations between the County and UNC about the specifics of this plan are still underway.⁶³ When planning for the future of WakeBrook, regardless of the provider, we recommend the following:

- a) Because of the county’s ownership of the facility, proximity to WakeMed’s Raleigh campus that sees the largest volume of ED visits for behavioral health, proximity to a bus route, and community satisfaction with the current configuration of services at WakeBrook, we recommend the county continue to invest in the facility as the crisis “hub” for Wake County.
- b) There is a need to expand capacity for the crisis and assessment service, which in 2022 was too full to accept referrals an average of 8 hours per day. This service should be able to accept all referrals at least 90% of the time according to national standards.
- c) Access to short-term (2-5 day) crisis stabilization beds is a key component for a crisis facility. It is advantageous, though not essential, that such beds be available on site. If short-term stabilization beds are not offered within WakeBrook, there will be a need to establish them elsewhere and to provide transportation.
- d) Serving as the crisis hub, there should be more coordination between mobile crisis and services at WakeBrook. The county and Alliance should consider deployment of mobile crisis out of WakeBrook or otherwise how to facilitate coordination between the two.
- e) There should more peer staff involved in all services at the WakeBrook facility.

⁶³ <https://www.wral.com/story/unc-wakebrook-awarded-federal-grant-funding-for-expansion/20774276/>

- f) Long-term planning for the 28 inpatient bed unit at WakeBrook should take into consideration the impact of additional inpatient capacity being developed by WakeMed and other locations proximate to Wake County.

2) Expand and invest more in mobile crisis.

In model crisis service systems, mobile crisis teams effectively divert crises from emergency departments and EMS/law enforcement response. In Wake County, however, the quality and capacity of mobile crisis is inadequate to fulfill the potential for significantly reducing emergency room encounters and improving coordination with short-term crisis stabilization; in addition, there needs to be much more awareness of mobile crisis throughout the community. EMS Enhanced Mobile Crisis is highly valued and reported by service users to be compassionate and person-centered.

- a) We endorse the recommendations from the RI International Report, which are consistent with our findings for needed improvement to mobile crisis services. We acknowledge implementing these recommendations will take coordination with the state, for example, allowable assessments to reduce the length of the assessment.
- b) Get clarification from the state on minimum assessment threshold for Medicaid to ensure contracting for mobile crisis uses as streamlined an assessment as allowable.
- c) Consider deployment of mobile crisis out of provider locations. For example, deployment of mobile crisis out of WakeBrook could improve coordination, emphasize stabilization in the community, and streamline the intake/referral processes.
- d) As part of its CCBHC grant award, SouthLight will be developing a mobile crisis service; the county should coordinate with this effort.
- e) Continue to fund the EMS Enhanced Mobile Crisis service, ideally with a peer specialist as part of the response.

Once capacity is established, the county should promote awareness of mobile crisis as an alternative to 911 response for behavioral health.

3) Establish a peer-run crisis respite in Wake County.

A crisis respite is a part of the crisis continuum and is a gap in Wake County. Peer-run crisis respites have become increasingly popular as an alternative to traditional crisis services. A peer respite is a voluntary, short-term, overnight program that provides community-based, non-clinical crisis support to help people find new understanding and ways to move forward, operating 24 hours per day in a homelike environment⁶⁴. A peer respite is staffed by people with lived experience of extreme states and/or the behavioral health system. It is either operated by a peer-run organization or has an

⁶⁴ Live & Learn, Inc: <https://livelearninc.net/peer-respites>

advisory group with 50% or more members having lived experience with the behavioral health system⁶⁵. Research studies have shown peer respites guests are less likely to use inpatient or emergency services, have improved feelings of healing, empowerment, and satisfaction, and are much less costly than inpatient care⁶⁶. A 2018 study showed peer-staffed crisis respite services resulted in lowered rates of Medicaid-funded hospitalizations and health expenditures for participants⁶⁷. The county should identify funding opportunities to establish one or more crisis respites within the county.

- a) A peer respite recently opened in Charlotte, Retreat at the Plaza, operated by Promises Resource Network. County staff should review this respite model as it could serve as an example for Wake County: <https://www.northcarolinahealthnews.org/2021/08/18/first-peer-run-respite-opens-as-alternative-to-hospitalization-for-people-in-mental-health-distress/>. Another good example is the Karaya Peer Respite in Massachusetts: <https://kivacenters.org/karaya-peer-respite/>
- b) The following SAMHSA presentation includes evidence of effectiveness and examples of peer respites from around the country, including start-up costs: <https://www.nasmhpd.org/sites/default/files/Peer%20Run%20Respite%20slides.revised.pdf>

4) Establish residential treatment options outside of WakeBrook.

Options for residential treatment for mental health or substance use disorders are very limited outside of WakeBrook. Key informants identified a need for more residential treatment options, particularly for youth and for individuals with severe addiction. While WakeBrook's facility-based crisis and detox units are licensed as residential, WakeBrook is not an ideal setting for residential care and furthermore these services at WakeBrook are currently operating at a higher, inpatient level of care. The need for residential treatment options will become more immediate if UNC Health discontinues facility-based crisis and detox services at WakeBrook. While there is an advantage to having a step-down residential treatment connected to the continuum of services at WakeBrook, the county should explore the possibility of establishing a residential service option in the community, specifically for substance use disorder.

5) Invest in transportation options to minimize use of law enforcement for transportation.

Transportation is an important and often overlooked component of the crisis services continuum. A major theme from interviews and focus groups with service users is lack of

⁶⁵ Live and Learn, Inc. Consensus definitions of peer respites, <https://kivacenters.org/karaya-peer-respite/>

⁶⁶ Live and Learn, Inc. Peer respite published research, <https://livelearninc.net/respite-research>

⁶⁷ Bouchery E, et al. 2018. The effectiveness of a peer-staffed crisis respite program as an alternative to hospitalization. *Psychiatric Services*. Available at: <https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201700451>

transportation—both non-law enforcement emergency transportation, and non-emergency transportation to appointments. Handcuffing individuals for transportation to treatment, as is RPD’s policy, contributes to trauma, can exacerbate crises, and can be especially harmful for people of color. Furthermore, RPD is seeking to end providing transportation from WakeBrook to hospitals. Law enforcement should be a last resort for transportation for individuals experiencing a behavioral health crisis and only in situations in which there is a threat to public safety. Lack of alternative transportation is a critical gap in the county’s continuum of crisis services.

- a) County and Alliance should develop a comprehensive transportation plan that maximizes transportation in the least restrictive safe setting and minimizes utilization of law enforcement and EMS for routine transport. The transportation plan should include defined capacity and roles for: private vehicles, taxis, specialty taxis, specialty mental health transportation services, mobile crisis transport, emergency medical transportation, and law enforcement transportation.
- b) Use county funds to establish an alternative to police transportation for crisis. The expansion of mobile crisis, including purchase of vans, would help significantly to reduce reliance on police for transportation.
- c) One good example to highlight is Oklahoma’s RideCARE program, which provides regionally based alternative transportation in partnership with local vendors. This could be operated in coordination with mobile crisis.

Systemwide Needs

6) Expand the role of peer support throughout the behavioral health system.

Feedback from service users emphasized not feeling listened to, heard, or respected in interactions with the behavioral health system. Peer support is an evidence-based practice that supports recovery and has been shown to be cost effective. Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse.⁶⁸ A significant role for peers is also a core principle of a model crisis system⁶⁹ and one that is lacking in Wake County. There is hesitancy and misconception about the role of peers in the provider and social services community. Wake County and Alliance should plan for and work to expand peer services in partnership with local and state peer leaders and in alignment with best practice in peer support implementation.

⁶⁸ SAMHSA, <https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers>

⁶⁹ Crisis Now, <https://i0.wp.com/crisisnow.com/wp-content/uploads/2020/02/CrisisNow-HowYourSystemRate.jpg?fit=1024%2C768&ssl=1>

- a) Expand peer support services in and from WakeBrook and allow “bridging” services to ensure upstream connections
- b) Alliance to sponsor trainings for certified peer support that meets state standards
- c) Enhance understanding and supervision of peer support staff through targeted supervisory training. Supervisors and community partners should be familiar with national practice guidelines for peer specialists and supervisors:
<https://www.peersupportworks.org/wp-content/uploads/2021/07/National-Practice-Guidelines-for-Peer-Specialists-and-Supervisors-1.pdf>
- d) County funds could be used to create financial incentives for recruitment and retention
- e) SAMHSA has a short document outlining the role of peer in crisis care, including a table on page 7 showing peer support services across intensity of need:
<https://store.samhsa.gov/sites/default/files/pep22-06-04-001.pdf>
- f) Consider a leadership role on county staff for someone with lived experience who will lead community engagement, with a focus on engaging groups that are historically underrepresented as well as youth and families; or consider establishment of an advisory/steering committee with this function that receives compensation and is involved with the directors groups for behavioral health system planning. Partner with local peer-run organizations to oversee peer roles and ensure aligned with peer values.

7) Focus on enhancing culturally and linguistically accessible services and supports.

Wake County is a rapidly growing and increasingly diverse and international community. The Asian community is expected to grow 354% between 2020 and 2050, the most of any racial or ethnic group. The Hispanic population is also expected to grow at a rate higher than the average, and prevalence data show Hispanic or Latino high school students in Wake County are more likely to report feeling sad or hopeless or to have attempted suicide than White students.

- a) Behavioral health system leaders at the county and Alliance should intentionally work to involve and build trust with culturally diverse communities, including new immigrants and refugees. This will involve more outreach and partnerships with faith-based organizations in these communities. There is also a need to engage and build trust with the LGBTQ+ community.
- b) Examine the makeup of existing community advisory boards, including Alliance’s Consumer and Family Advisory Committee and participants involved in developing the county’s Behavioral Health Plan and create a plan to increase representation of underrepresented racial, ethnic, gender, and cultural groups.
- c) If not previously undertaken, conduct an audit of county programs and practices to determine language access need and develop a plan to align programs and practices with standards for linguistic accessibility. National CLAS Standards:
<https://thinkculturalhealth.hhs.gov/clas/standards>. There is also a Behavioral Health

Implementation Guide for CLAS standards:

https://www.minorityhealth.hhs.gov/Assets/PDF/clas%20standards%20doc_v06.28.21.pdf

- d) Promote awareness of 988 in Spanish-speaking communities. SAMHSA has a Spanish version of the 988 promotion poster designed to be placed in community settings:
https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP22-08-03-008.pdf

Social Supports to Prevent Crisis

8) Continue to prioritize housing for people with mental health and SUD and enhance coordination and cross-sector collaboration to streamline access.

A lack of safe discharge options for individuals experiencing homelessness contributes to the length of stay in crisis care settings. With Cornerstone closed for renovations, South Wilmington Street Center no longer offering overnight stays, and the lack of a low barrier 24-hour drop-in emergency shelter, there is a critical gap in Wake County's service continuum. Housing is a central barrier for discharges out of WakeBrook. Enhancing coordination between the behavioral health system and the housing support system at all levels would aid in more effective utilization of and prioritization for housing.

- a) Evaluate prioritization of housing subsidies and housing supports funded through county dollars, particularly related to individuals with co-occurring mental health and substance use disorders.
- b) Coordinate with CoC Board to ensure individuals with co-occurring mental health and SUD obtain access to housing supports.
- c) Consider allocating SOR funding towards CTI Rapid Rehousing (RRH) program or landlord incentives to support targeted placements for individuals with behavioral health needs. The county should collaborate to establish eligibility criteria.
- d) Ensure housing providers/CoC providers engage in crisis collaboratives to enhance coordination.
- e) Expand 24-hour access to homeless services through drop-in emergency shelter and drop-in center access (e.g., Cornerstone) and coordinate to identify prioritization of bridge housing.
- f) Create a universal [data sharing agreements](#) to create routine data sharing opportunities between EHRs/Medicaid and HMIS.
- g) Make housing a priority for the Familiar Faces initiative.

9) Ensure access to comprehensive services for youth and families.



The need for enhanced capacity to serve youth in crisis was expressed by many interviewed for this study. There is an acute crisis of youth engaged in the foster care system with behavioral health needs sheltering in the county's Swinburne building for lack of other options. Wake County is funding the startup costs for three short-term transitional group homes for youth to meet this gap that will be contracted through Alliance. These group homes will help to address immediate needs for youth in DHHS custody, however, there is a need to strengthen comprehensive services to youth and families to prevent crises escalating to this level.

- a) Review capacity and quality of Alliance's intensive home- and community-based services for youth and families, such as the Community Inclusion Planning service. If this service is underutilized there should be more community education and awareness eligibility of this and other intensive services to avoid placement of youth in congregate care settings.
- b) If not already in existence, establish a mentoring support network for foster parents.
- c) Including specific language in contracts with providers, such as the three transitional group homes being developed by Alliance, to ensure youth with complex needs are accepted.

Quality and Coordination

10) Expand county capacity for behavioral health system coordination and oversight.

Best practice for a crisis system entails a clearly identified accountable entity and defined role for a crisis system coordinator⁷⁰. In Wake County, although Alliance is responsible for service delivery, there is lack of clarity on which entities—Alliance or the County—are accountable for oversight of which pieces, and there is currently no defined crisis system coordinator. County leaders have strong commitment to behavioral health, but lack staffing capacity to support system coordination, oversight, and quality improvement. Given its population size and financial investment, Wake County should have in-house behavioral health capacity and expertise to oversee and help coordinate the system, and to foster a culture of person-centered care, something service users report is lacking. This will be even more important with Medicaid expansion to keep track of changes and their implications, engage the community, and identify additional opportunities for funding.

⁷⁰ National Council Roadmap to an Ideal Crisis System (2021). https://www.thenationalcouncil.org/wp-content/uploads/2022/02/042721_GAP_CrisisReport.pdf

- a) Establish an additional leadership position at the county to oversee and coordinate the behavioral health and crisis system. Characteristics of coordinator: experience with behavioral health quality and performance improvement, cross-system collaboration, and ideally lived experience.
- b) The coordinator should be responsible for establishing a forum for robust and ongoing dialog between community leaders and people who use services and their families, with a focus on engaging historically underrepresented voices and perspectives. The county should compensate people with lived experience for their participation.
- Consider adding a county-funded SOAR case management position in anticipation of Medicaid expansion and specifically targeting re-entry population; the NC Works Career Center could be a good place to house this position.

11) Promote awareness of 988 in the community and coordination between 988, 911 dispatch, and Alliance’s crisis call center.

There is lack of awareness in the community about 988, and there has been little communication or support from the state in coordinating around 988, which rolled out in the summer of 2022. In addition, there is an overreliance on 911 for behavioral health.

- a) Identify funding opportunities to enhance communications around 988. For example, there may be federal or state funding opportunities to engage a communications firm to develop communications strategies to promote 988.
- b) Place promotional materials around the county in public spaces including libraries, places of worship, bus stops, social services providers, county offices, etc. SAMHSA has a toolkit with promotional materials in English and Spanish: <https://www.samhsa.gov/find-help/988/partner-toolkit>
- c) Add 988 prominently to the list of crisis resources on the county’s behavioral health website: <https://www.wake.gov/living-visiting/behavioral-health>
- d) Initiate discussions with the state to better understand how 988 is coordinating with Wake County, identify any barriers, and how counties can promote awareness.

12) Expand/develop measures for performance monitoring for the crisis system.

In a model crisis system, quality standards are identified, formalized, measured, and continuously monitored⁷¹. Wake County should work with Alliance and its community partners to develop and expand the performance metrics identified in the Behavioral Health Plan and to have a shared data dashboard that is reviewed regularly by partners throughout the system to support system and quality improvement efforts.

⁷¹ National Council for Behavioral Health. Roadmap to the Ideal Crisis System, 2021. https://www.thenationalcouncil.org/wp-content/uploads/2022/02/042721_GAP_CrisisReport.pdf

- a) In the section “Data and Performance Measures” of this report we provided a list of performance measures across the three domains as suggested in national models: https://www.nasmhpd.org/sites/default/files/2022-11/Data-Dashboards-and-the-Mental-Health-Crisis-Continuum_NASMHPD-3.pdf . The county should review these measures and in partnership with Alliance select those that best meeting needs for performance monitoring and align with the priorities in county’s Behavioral Health Plan. There is opportunity to leverage metrics already tracked by Alliance for state reporting.
- b) Selected performance measures should be included in county contracts for services.
- c) Client satisfaction is an important measure to track and should be considered for future contracting with providers operating services at WakeBrook.
- d) Contracts should also be specific in defining the data necessary to quantify a unit of service so the county can better understand how its funding is being spent.
- e) Develop a public-facing data dashboard; we provided links to other state/jurisdiction public-facing dashboards for reference.
- f) Performance monitoring data should be regularly shared and reviewed at Alliance’s crisis collaborative meetings.

Limitations

There are limitations with this crisis system assessment that are important to acknowledge. First, it can be challenging to obtain all desired data in a timely manner given that data managers typically have multiple priorities. There was a delay in receiving data from our primary data source (Alliance) that prevented time to request follow-up analyses to address questions that arose during the assessment and to vet data findings with providers to better understand the data and its implications.

In addition, the primary focus of this project was to compare Wake County's crisis service system with national models and to make recommendations where improvements were indicated. The county was also interested in cost-effectiveness and return on investment for services at WakeBrook, but it was not within the scope of this project to conduct an actuarial cost-effective analysis. Instead, we sought to identify benchmarks for cost from high functioning systems, however, it was difficult to provide precise benchmarks that would consider differences between Wake County and other locales in population characteristics, funding mechanisms, geographical factors, etc. What is known, however, based on extensive body of cost effectiveness research, that implementation of high-quality prevention and crisis services, such as those we have recommended, produce a positive return on investment.^{72,73}

The capacity and quality of community-based and outpatient behavioral health services impact on the crisis system, but we did not obtain data on behavioral health services outside of crisis services. For example, we did not obtain data on intensive community-based services such as ACT. This was also true for child and family services, which are important to prevent the need for higher levels of care for youth in crisis.

We aimed to engage community members broadly representative of the diversity in Wake County and in particular groups that have been historically marginalized or underrepresented. Appendix A shows the demographic characteristics of interview and focus group participants. While we had representation across most demographic

⁷² Le, L. K., Esturas, A. C., Mihalopoulos, C., Chiotelis, O., Bucholc, J., Chatterton, M. L., & Engel, L. (2021). Cost-effectiveness evidence of mental health prevention and promotion interventions: A systematic review of economic evaluations. *PLoS medicine*, 18(5), e1003606. <https://doi.org/10.1371/journal.pmed.1003606>.

⁷³ Substance Abuse and Mental Health Services Administration. Crisis Services: Effectiveness, CostEffectiveness, and Funding Strategies. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014

groups, we could have done better reaching groups most impacted by crisis services. For example, in Wake County Black people make up 38% of emergency department visits for behavioral health and 41% of those served at WakeBrook, but only 28% of those who provided input to this study. In addition, most who participated in interview and focus groups were from Raleigh, with less representation from other municipalities.

We also acknowledge there are many organizations and community members in Wake County that did not have the opportunity to give input to this study. A list of the organizations/roles we engaged is in Appendix A, and we recognize this list is not comprehensive of all those with important perspectives on crisis services in the county.

Finally, the news of UNC Health's decision to change its long-term plans for services at WakeBrook came too late in the study for us to intentionally explore the impacts of changes to the service array and considerations for alternative uses for the space, as our recommendations sought to build on the strengths and optimize the current service array. Addressing this new development will require a more extended planning process, for which the findings and recommendations of this study should be useful.

Appendix A: Interview and Focus Group Participations

Figure A1. Demographic Characteristics of Participants

Characteristic	Responses	(n=79)
	N	%
Gender Identity (check all that apply)		
Woman	49	62%
Man	28	35%
Transgender	2	3%
Non-binary	1	1%
Genderqueer	1	1%
Prefer not to say	0	0%
Prefer to self-describe	1	1%
Age		
18-24 years old	9	11%
25-34 years old	12	15%
35-44 years old	25	32%
45-54 years old	18	23%
55-64 years old	13	16%
65-74 years old	2	3%
75 years or older	0	0%
Prefer not to say	0	0%
Hispanic or Latino		
No, not Hispanic or Latino	69	87%
Yes, Hispanic or Latino	7	9%
Skipped or prefer not to say	3	4%
Race (check all that apply)		
American Indian or Alaska Native	5	6%
Asian	1	1%
Black or African American	22	28%
Native Hawaiian or other Pacific Islander	0	0%

White	54	68%
Prefer not to say	1	1%
Other (please specify)	4	5%
Region		
Apex	3	4%
Cary	4	5%
Fuquay-Varina	4	5%
Garner	1	1%
Holly Springs	5	6%
Knightdale	3	4%
Morrisville	1	1%
Raleigh	38	48%
Rolesville	1	1%
Wake Forest	4	5%
Wendell	1	1%
Zebulon	1	1%
Other (please specify)	12	15%
Skipped	1	1%

Note: Of the 12 'other' responses to region, most noted they work but do not live in Wake County.

List of Organizations/Roles Included in Interviews

- Alliance
 - Leadership
 - Consumer and Family Advisory Committee
 - Crisis Call Center
 - CIT Training
 - Community Health and Well-Being
- Behavioral Health Urgent Care (Monarch)
- Duke Raleigh Hospital
- Fellowship Health Resources Peer Drop-In Center
- Haven House
- Healing Transitions
- Holly Hill Hospital

- KCSSU
- KidsPeace/The Hope Center
- NAMI Wake County
- Oak City Cares
- Wake/Raleigh Partnership to End Homelessness
- Raleigh Police Department, ACORNS
- South Wilmington Street Center
- SouthLight
- North Carolina DHHS
- North Carolina Asian Americans Together (NCAA Together)
- Therapeutic Alternatives
- Triangle Family Services
- Triangle Springs Hospital
- UNC (Administration)
- UNC STEP
- Wake County
 - EMS
 - Human Services
 - Housing Affordability & Community Revitalization
 - Internal Behavioral Health Committee
 - Recovery Court
- Wake Local Reentry Council
- WakeBrook (various roles)
- WakeMed (various roles)

Appendix B: Crisis Now Model Projections

As noted in the report, Crisis Now is an effort led by the National Association State Mental Health Program Directors (NASMHPD) to bring together best practices and resources to support crisis system transformation. The effort has developed several tools for examining how expansion of certain services, such as mobile crisis or inpatient, can impact costs to the overall system. The formulas used in these tools are based on: (a) population size (with an assumption that 200 persons out of 100,000 population will require more than a typical outpatient or phone intervention per month); (b) average length of stay (ALOS) of acute inpatient based on state data; and (c) average cost of an acute bed per day. The following table shows the model's projections for Wake County. As stated on the [Crisis Now](#) website, proper use of the model is to compare the costs of various crisis systems configurations, and it is not to be used for developing detailed budgets or estimating one-time capital investments, therefore we present these projections only for the purpose of consideration in planning. It does not factor in all the local community variables required to predict detailed resources or costs.

Figure B1. Crisis Now System Calculator Results for Wake County

Crisis Now Crisis System Calculator		
	No Crisis Care	Crisis Now
Number of Crisis Episodes Annually (200/100,000 Monthly)	27,106	27,106
Number Initially Served by Acute Inpatient	18,432	3,795
Number Referred to Acute Inpatient from Crisis Facility	-	1,508
Total Number of Episodes in Acute Inpatient	18,432	5,303
Number of Acute Inpatient Beds Needed	460	132
Total Cost of Acute Inpatient Beds	\$176,685,190	\$50,835,967
# Referred to Crisis Bed From Stabilization Chair	-	6,034
# of Short-Term Beds Needed	-	46
Total Cost of Short-Term Beds	-	\$17,633,664
# Initially Served by Crisis Stabilization Facility	-	14,637
# Referred to Crisis Facility by Mobile Team	-	2,602
Total # of Episodes in Crisis Facility	-	17,239
# of Crisis Receiving Chairs Needed	-	54
Total Cost of Crisis Receiving Chairs	-	\$25,190,948
# Served Per Mobile Team Daily	4	4
# of Mobile Teams Needed	-	9
Total # of Episodes with Mobile Team	-	8,674
Total Cost of Mobile Teams	-	\$2,439,526
Number of Unique Individuals Served	18,432	27,106
TOTAL Inpatient and Crisis Cost	\$176,685,190	\$96,100,104
ED Costs (\$520 Per Acute Admit)	\$9,584,625	\$2,757,694
TOTAL Cost	\$186,269,815	\$98,857,798
TOTAL Change in Cost		-47%

Source: <https://crisisnow.com/tools/> (found under "Crisis Resource Need Calculator"). Assumptions: (a) population size= 1,129,410; (b) ALOS of acute inpatient: 8.2; (c) average cost of acute bed/day: \$1,169.

Appendix C: Acronyms

ACORNS-Addressing Crisis through Outreach, Referrals, Networking and Service

ACT-Assertive Community Treatment

ADU-Addiction Detox Unit (WakeBrook)

AI/AN-American Indian or Alaska Native

APPs-Advance-Practice Paramedics

ATC-Air Traffic Control

BHUC-Behavioral Health Urgent Care

CAD System-Computer-Aided Dispatch System

CAS-Crisis & Assessment Unit (WakeBrook)

CCBHC-Certified Community Behavioral Health Clinic

CIT-Crisis Intervention Training (for first responders)

CoC-Continuum of Care

CON-Certificate of Need

ED-Emergency Department

EMS-Emergency Medical Services

FBC-Facility Based Crisis

FQHC-Federally Qualified Health Center

FY-Fiscal Year

HMIS-Homeless Management Information System

HSRI-Human Services Research Institute

I/DD-Intellectual and Developmental Disabilities

IMD-Institute for Mental Disease

IPU-Inpatient Unit (WakeBrook)

LME/MCOs-Local Management Entity/Managed Care Organizations

LOCUS-Level of Care Utilization System

LOS-Length of Stay

MCM-Mobile Crisis Management

MH-Mental Health

MORES-Mobile Outreach Response Engagement Stabilization (for youth ages 5-17)

NABH-Network to Advance Behavioral Health

NAMI-National Alliance on Mental Illness

NASMHPD-National Association of State Mental Health Program Directors

NCDHHS-North Carolina Department of Health and Human Services

PRTF-Psychiatric Residential Treatment Facility

PSH-Permanent Supportive Housing

RPD-Raleigh Police Department

RRH-Rapid Rehousing

SAMHSA-Substance Abuse and Mental Health Services Administration

SBT-School-Based Team

SDOH-Social Determinants of Health

SDOMH-Social Determinants of Mental Health

SOAR-SSI/SSDI Outreach Access and Recovery

SOR-State Opioid Response grant

State ADATC- Alcohol and Drug Abuse Treatment Centers

SUD-Substance Use Disorder

TAC-Technical Assistance Collaborative

TBI-Traumatic Brain Injury

TCM-Tailored Care Management benefit

UNC Health-University of North Carolina Health System

YRBS- Youth Risk Behavior Survey