The Rapid Evolution of Crisis Mental Health Services in Utah: Opportunities and Challenges as a Result of the Global Pandemic

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Our country is facing a resurgence of behavioral health crises from over the past 30 years, further illuminated and exacerbated by the global COVID-19 pandemic. Increasing suicide crises among youths over recent decades, untreated anxiety and depression, and serious mental illness are signs of the need for improvements in accessible, affordable, timely, and comprehensive behavioral health services. Against the backdrop of high suicide rates and low behavioral health services in Utah, statewide collaborators aligned with a common goal: deliver crisis services to anyone, anytime, and anywhere. After its initiation in 2011, the integrated behavioral health crisis response system continued to expand and excel, ultimately improving access and referral to services, flattening suicide rates, and reducing stigma. The global pandemic further motivated the expansion of Utah's crisis response system. This review focuses on the unique experiences of the Huntsman Mental Health Institute as a catalyst and partner in these changes. Our goals are to: inform about unique Utah partnerships and actions in the crisis mental health space, describe initial steps and outcomes, highlight continuing challenges, discuss pandemic-specific barriers and opportunities, and explore the long-term vision to improve quality and access to mental health resources.

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THE NATIONWIDE NEED FOR AN INTEGRATED BEHAVIORAL HEALTH CRISIS RESPONSE SYSTEM

"Our country is in the midst of a mental health crisis. Increasing suicide rates, untreated anxiety and depression among our youth, traumatic brain injuries, and serious mental illness are all signs of the need for accessible, affordable, and comprehensive mental health services. Utah is not exempt from this crisis. Utah has a high rate of adults with mental illness, but a shortage of mental health providers" (1).

This is a recent summary of the Kem C. Gardner Institute report on the state of brain health care in the State of Utah. Although Utah is not markedly different from other Mountain West states, or even from states in the South, in rates of suicide or brain health delivery systems, Utah was recently ranked 51st among states and territories in the capacity for mental health services.

In response to the Gardner Institute analysis (1), a discussion group of participants agreed that an ideal mental health system would: provide integrated mental and physical health services in a timely manner; consistently use mental health screenings to assess individuals and identify risk, allowing for early intervention; ensure that people have the resources to access necessary mental health services as well as safe, acuity-appropriate places to seek treatment. As a result of this analysis, multiple stakeholders across the state have come together to respond to this plea—including social policy analysts, public and private health care representation, state and local officials, and many others—engaging in significant efforts to further enhance and develop Utah's ideal behavioral health care system.

As reported in a 2021 progress report on Utah's mental health system: "Based on the Gardner Institute's report, the workgroup's collective knowledge of the mental health system, and additional assessments from researchers and industry stakeholders, UHA [the Utah Hospital Association] developed a proposed Roadmap for Improving Utah's Behavioral Health System in 2019" (2).

According to the Utah Hospital Association: "Because of the need for an organized approach to system improvement, UHA's Roadmap includes a set of tiered recommendations. The following is an evaluation of the progress made to date on the Roadmap's recommendations that require legislative action. Note, the Roadmap's recommendations that do not clearly require legislative action are not included below, but additional study of those recommendations may lead to legislative action in the future" (2).

The Need for Expanded Crisis Services in Utah—Gaps Observed

It is notable that Utah has had a unique and increased collaboration between both public and commercial systems of care that have been an impetus to bringing multiple

stakeholders together in alignment with a common goal: crisis services to anyone, anytime, and anywhere.

Traditionally, the public mental health system was operated by various local mental health authorities across the State of Utah. They have operated on a population health model of reimbursement and developed effective and extraordinary crisis response systems for their communities. It is interesting to note that local mental health authorities were early adopters of utilization and evaluation of social determinants of health.

In 2011, Salt Lake County, the largest metropolitan area in Utah, experienced a change in model of care, moving to expand providers within the network serving the Medicaid and unfunded clientele for behavioral health needs. Huntsman Mental Health Institute (HMHI)—formerly the University Neuropsychiatric Institute (or UNI)—joined with Salt Lake County and Optum Health SL County in March 2011 to develop a continuum of crisis response programs to all Salt Lake County residents at no cost to those served. The Crisis Line was the first program rolled out.

This created a unique opportunity for bridging the public and commercial providers and payors. Individuals with commercial insurance now had an opportunity to utilize the behavioral health crisis response system. In other counties across the state, other local mental health authorities have offered and continue to offer varied crisis services to their local communities at their discretion using their designated funding.

Utah's 2018 legislative general session passed House Bill (H.B.) 41 (Mental Health Crisis Line Amendments) to create a statewide crisis line, in affiliation with the National Suicide Prevention Lifeline, and outlined professional education and training requirements for crisis workers answering the telephone as well as outlined the standards and scope for high-quality services. UNI, now HMHI, was selected to manage the calls. As of today, local mental health authorities are routing callers to the statewide number, in addition to advertising one number to call. In short, 20 disparate crisis lines throughout the state have been consolidated.

The forethought of our Division of Substance Abuse and Mental Health with the Department of Human Services (now the Utah Department of Health and Human Services) is remarkable in developing standards of care for the Behavioral Health Crisis Response System. Rule R523-17 outlines the Behavioral Health Crisis Response System Standards of care and practice for statewide behavioral health crisis response system crisis line services and certification for crisis workers: https://rules.utah.gov/publicat/code/r523/r523-017.htm.

In addition, key legislative champions have been instrumental in the creation and development of our behavioral health crisis response system. In fact, the National Suicide Hotline Designation Act of 2019 originated in Utah and was sponsored by Utah Representative Chris Stewart. The key purpose was to amend the Communications Act of 1934 to direct the Federal Communications Commission to designate 988 as the universal three-digit telephone number for the purpose of the national suicide prevention and mental health crisis hotline system operating through the National Suicide Prevention Lifeline and through the Veterans Crisis Line.

KEY ELEMENTS AND SERVICES PROVIDED IN CRISIS SERVICES

HMHI is providing many of the key services for our Behavioral Health Crisis Response System of Care, which is fully aligned with Substance Abuse and Mental Health Services Administration (SAMHSA) National Guidelines for Behavioral Health Crisis Care (3). "The following represent the *National Guidelines for Crisis Care* essential elements within a **no-wrong-door** [bold in original] integrated crisis system:

- **Regional** [and statewide] **Crisis Call Center**: Regional 24/7 clinically staffed hub/crisis call center that provides crisis intervention capabilities (telephonic, text, and chat). Such a service should meet National Suicide Prevention Lifeline [. . .] standards for risk assessment and engagement of individuals at imminent risk of suicide and offer air traffic control [. . .] - quality coordination of crisis care in real-time;
- **Crisis Mobile Team Response**: Mobile crisis teams available to reach any person in the service area in his or her home, workplace, or any other community-based location of the individual in crisis in a timely manner; *and*
- **Crisis Receiving and Stabilization Facilities**: Crisis stabilization facilities providing short-term (under 24 hours) observation and crisis stabilization services to all referrals in a home-like, non-hospital environment" (3). These facilities are currently slated to expand with joint partnership funds from private philanthropic and state resources.

The Utah Crisis Line, in association with the National Suicide Prevention Lifeline, provides statewide services by certified crisis workers 24 hours a day, 7 days a week. In fiscal year 2021 (July 1, 2020–June 30, 2021), the Utah Crisis Line team received more than 92,000 calls for help—a 32% yearly increase in calls from fiscal year 2020 (July 1, 2019–June 30, 2020). Staff are highly trained and skilled at de-escalating crisis situations over the telephone, with 86% of concerns resolved over the course of the telephone call. In 8% of calls, Mobile Crisis Outreach Teams (MCOTs) were engaged to provide in-person support for higher acuity crisis concerns. In 4% of calls, staff referred callers to a higher level of care (e.g., the emergency department, crisis receiving center, or inpatient hospitalization) and engaged in collaborative crisis response and safety planning. In 2% of calls, staff collaborated with law enforcement or emergency medical services (or both) to initiate a welfare check or

life-saving intervention. In fiscal year 2021 alone, the Utah Crisis Line team initiated 1,353 life-saving interventions (or "active rescues") for callers who were at imminent risk of suicide.

The most critical development for crisis lines across the country is the passage of The National Suicide Hotline Designation Act, the federal law passed in 2020 that designates 988 as the three-digit code to access the National Suicide Prevention Lifeline network, launching in July 2022. The new three-digit telephone number will allow callers in emotional crisis to more easily remember and access potentially life-saving services, which makes a critical step toward parity for mental health services with medical services accessed by calling 911. It is challenging to anticipate what the impact for utilization of crisis lines across the country will be with the transition from a 10-digit to a three-digit number, with national estimates of volume increases ranging from 200% to 700%. Utah appears to be on the forefront of preparation for this transition with a consolidated, statewide Crisis Line already existing and robust investments made by the State of Utah (through key legislation such as the the Utah H.B. 32 in 2020 and the Utah Senate Bill 155 in 2021) to support workforce expansion, quality measures, and technology enhancements to build capacity for utilization of services.

Although there are many other services that will be incorporated into the continuum of a comprehensive system of care, these three programmatic components represent the three true crisis service elements when delivered to the fidelity of the Crisis Service Best Practice guidelines defined in the SAMHSA toolkit (3). However, crisis systems must not operate in isolation, instead striving to fully incorporate within the broader system of care so seamless transitions evolve to connect people in crisis to care based on the assessed need of the individual.

ADDITIONAL SERVICES IN THE INTEGRATED CRISIS RESPONSE CONTINUUM

In addition to the three key services described earlier, Utah has further expanded its integrated system to include the Utah Warm Line, SafeUT, the Safe Care Transition Follow-Up Program, the HMHI-Unified Police Department (UPD) Mental Health Unit and West Valley City Police Department (WVCPD) Partnership, and the Crisis Intervention Team (CIT).

Utah Warm Line

HMHI, formerly the University of Utah Neuropsychiatric Institute, joined with Salt Lake County and Optum Health SL County in June 2012 to form the Warm Line. In 2020, the services expanded to cover the entire state. The Utah Warm Line is staffed by certified peer support specialists who provide telephone-based help to individuals, families, agencies, professionals, and others across Utah with support, engagement, encouragement, and empathetic listening. Certified peer support specialists connect and empower callers to resolve problems by fostering a sense of hope, dignity, and self-respect through the recovery model—a holistic, person-centered approach to mental health and substance dependence disorders—using their own lived experience to share perspectives and hope in ways other clinical staff may not be able to.

SafeUT

The SafeUT Crisis Chat and Tip Line is a statewide service that provides real-time crisis intervention to users through live chat, a confidential tip program, or a telephone call—right from their smartphone. SafeUT can help anyone with emotional crises, bullying, relationship problems, mental health issues, suicide-related issues, or any other challenges that the user is facing. Licensed clinicians in our 24-7 integrated crisis call center respond to all incoming chats, tips, and calls by providing support or crisis counseling, suicide prevention, and referral services.

Unfortunately, suicide is the leading cause of death for youths (ages 10–24) in Utah (4). In 2015, the School Safety and Crisis Line legislation (SB175), sponsored by Senator Daniel Thatcher and Representative Steve Eliason, passed the Utah State Legislature, creating an active commission, chaired out of the Attorney General's office to address this public health crisis. HMHI was designated as the crisis provider, and the University of Utah's IT department developed an app available for download at no cost and a custom backend platform for HMHI staff to operate. The SafeUT Commission plays a critical role in bringing key stakeholders from across the state together to collaborate on systemic solutions and advocate for expanded resources to reduce youth suicide. Voting members of the Commission include representatives from the Utah Attorney General's Office, Utah State House of Representatives, Utah State Senate, Utah State Board of Education, Utah System of Higher Education, Utah Department of Health, Utah Department of Human Services, Law Enforcement and Emergency Response, and HMHI, as well as members of the public.

The SafeUT app began rolling out to Utah public middle and high schools in early 2016, eventually expanding to elementary and charter schools. SafeUT advanced to Utah higher education institutions and Utah technical colleges in 2019. By 2021, more than 850,000 students across Utah had access to SafeUT, as well as their parents/guardians and educators at enrolled schools. SafeUTNG for the Utah National Guard was launched December of 2019, and SafeUT Frontline was launched in December 2020 to support frontline workers, specifically, law enforcement, fire and emergency medical services, and health care professionals. These service expansions follow a gradual progressive model to expand crisis services to all individuals throughout the state. As crises are not limited to individuals, access to SafeUT is also available to family members of students, Utah National Guard members, and frontline workers.

Safe Care Transition Follow-Up Program
The program launched in January 2018 for adults ages 25 and older who presented with suicidal ideation in the University of Utah Hospital emergency department, or in the South Jordan Health Center emergency department, and were discharged from HMHI. The HMHI team performs a series of four follow-up calls, or caring contacts, over the course of 90 days postdischarge during the highest risk period for suicidal ideation and postdischarge suicide attempts. In January 2020, expansion included individuals ages 10–24.

HMHI-UPD Mental Health Unit and WVCPD Partnership
A licensed mental health therapist housed within the UPD offices corresponds with law enforcement to mental health crises within the community and provides individualized follow-up. The objectives of this program are to: assist with the de-escalation of volatile situations, reducing the potential for violence during police contacts; provide mental health consumers and their families with linkages to services and supports; serve consumers in the least restrictive setting, diverting from jail and hospitalization as appropriate; reduce repeated law enforcement responses to the same location; and free up patrol officers to respond to other calls. The program was implemented in the UPD in July 2018 and in the WVCPD in October 2018.

CIT Training Program
CIT was developed in partnership with Salt Lake County and Optum Health SL County in July of 2014. CIT Utah is a program of the State of Utah. The CIT Utah program develops and sustains partnerships between criminal justice services, behavioral health care services, and community members. These partnerships provide three basic services: training law enforcement officers and other first responders in proper methods of crisis response and resolution; developing effective crisis response systems; and advocating for accessible behavioral health services and programming.

SAFEUT: ADDRESSING YOUTH SUICIDE THROUGH A TECHNOLOGY-BASED SYSTEM OF CARE

SafeUT is much more than a smartphone app. It is a comprehensive system of care that delivers best practices in behavioral health and public safety by providing real-time access to master's-level mental health clinicians for users in crisis and allows for collaboration with school administrators and law enforcement officials across the State of Utah. Whereas other tip lines across the country are often triaged and responded to by law enforcement, SafeUT is differentiated by a mental health–first approach, recognizing that even school safety concerns often have an underlying behavioral health component that requires a collaborative response with mental health professionals; school administrators; and, at times, law enforcement.

In fiscal year 2021, the SafeUT team received 30,527 unique chats and tips (24,253 chats and 6,274 tips) (https://safeut.org/about-us). Of the 6,274 tips submitted for K-12 and higher education institutions, the top 10 categories of concern were suicide (21%), bullying (9%), depression (8%), crisis (7%), other (6%), mental health (6%), cutting/self-harm (5%), drugs (5%), cyberbullying (3%), and harassment (3%). There were 256 tips received about threats of violence in schools in which SafeUT counselors were able to coordinate with school administrators and, if needed, law enforcement officers, to respond appropriately and ensure student safety. Although the vast majority of suicide-related concerns are supported and de-escalated through the real-time chat process, SafeUT clinicians initiated 298 life-saving interventions for users that were actively attempting or at imminent risk of suicide.

A COMMITMENT TO CONTINUOUS QUALITY IMPROVEMENT

With HMHI as part of the University of Utah's academic medical center, there is a commitment to continuous quality improvement facilitated through ongoing end user and stakeholder feedback, as well as bidirectional integration of evidence-based practice and practice-based evidence. These improvements range from technological enhancements to refinement of clinical operations to strengthened relationships with community partners. With dedicated University of Utah IT staff supporting SafeUT, there have been iterative improvements made to the clinician and school administrator backend dashboards that have made the product more user friendly, improved communication between both parties, and reduced the emotional toll on school administrators from receiving mental health and suicide concerns about their students. These improvements include embedded training modules, customizable contact list prioritization and notification preferences, tracking of school-specific operating hours and break schedules, enhanced outcomes reporting, and coordinated emergency response protocols.

The 2019 passage of Utah H.B. 373 provided funding to create a dedicated SafeUT-Utah State Board of Education dual report full-time equivalent (FTE) to act as a liaison between both agencies. This embedded and collaborative staffing model has allowed SafeUT to participate on the Utah School Safety Commission and has improved integration of the Utah State Board of Education school safety and mental health curriculum and protocols into SafeUT's clinical operations. The bill also provided funding for a SafeUT SuperUser grant program in which local education agencies can apply for stipends to create school safety advisory committees that incorporate an evidence-based mental health curriculum and promote awareness and utilization of SafeUT to create a safer school environment.

Additionally, H.B. 373 provided short-term funding for research led by a team in the University of Utah's Department of Psychiatry to evaluate the impact and efficacy of

SafeUT over time. Some highlights of their institutional review board–approved research has included a geospatial time study analyzing the rates of youth suicide compared with when regions of the state had access to SafeUT, the impacts of COVID-19 infection rates on mental health and utilization of SafeUT, and more. The research team has become a collaborative part of the ongoing quality improvement process, working closely with SafeUT's clinicians, administrators, and Commission to improve data integrity, disposition and outcomes reporting, and even refine SafeUT's marketing and communications tactics.

We also have in place quality improvement contacts for post-acute care, but funding limitations have restricted the number and types of quality control steps that can be implemented. Thankfully, our legislative partners in the Utah House and Senate continue to work to provide resources to increase the breadth and scope of our follow-up interactions.

OUTCOMES OF UTAH'S INTEGRATED CRISIS SYSTEM

As part of an academic medical center, HMHI is leading the way in integrating research, education, and clinical services that result in positive outcomes for Utah—both qualitative and quantitative. According to the Utah Suicide Death Surveillance Report, Utah has seen flattening or declining suicide rates over the past 3 years. Unofficial Utah numbers from 2021 suggest a 20% decline in deaths by suicide among youths relative to 2020. Numbers in 2020 and 2019 were similar to those in 2018, suggesting a flattening curve and relative increase in the effectiveness of concerted efforts at enhancing and integrating crisis services and implementing other prevention steps. Key programs and initiatives that have supported these efforts include expanding the Statewide Crisis Line, Statewide Warm Line, and MCOTs in each county; expanding SafeUT; increasing access to care; expanding Medicaid; promoting safe gun handling and storage; and passing meaningful legislation to codify standards of care and fund many of these services so they can be offered at no cost to the client.

Over the past 4 years of crisis service expansion and integration, we have noticed some welcome changes, with opportunities for additional improvements. These changes and programs have been timely as the COVID-19 health pandemic, and adjustments made for public health safety, have led to changes in academic and social contexts for our youths. Our youths do not have a lifetime of experience to draw on to understand just how unique and temporary the COVID-19 health crisis has been. Moreover, the inability of disparate groups to marshal community resources and strategies to mitigate the COVID-19 crisis has led to additional deaths, as well as financial and medical complications. There is also a broader message that our youths have received: that, potentially, science and health care are not to be trusted and may be used as tools of political subversion. Together, many messages have combined to send a message of instability and unpredictability to our youths.

In our quality improvement initiatives, one result is striking: 31% of our users report SafeUT as their first exposure to a mental health professional. Ongoing work is targeting whether a SafeUT interaction increases the likelihood of follow-up with traditional and nontraditional forms of care. Many users report that SafeUT is helpful and supportive. In one trial of this data, we asked SafeUT clinicians to ask SafeUT texters about the support provided by SafeUT and its relative usefulness in February 2021. Of the 92 individuals who were queried, over 80 gave a response to at least one item. The average ratings suggested that most users found the clinician support and intervention through the app useful. Supportiveness was somewhat lower. In a review of the lower ratings, SafeUT users sometimes made stipulations that overall supportiveness was rated 3 (possible scores ranged from 1 [low] to 5 [high]), which included high levels of support from the SafeUT clinician but relative lack of support from school, family, and community.

SafeUT continues to have high usage in most urban and suburban school settings. Some of the lowest settings for utilization are in rural and frontier areas of Utah. One concern raised in evaluating these data is whether, in smaller community settings, the use of SafeUT can truly be anonymous. Rural and frontier communities in Utah tend to be multigenerational in nature, and individuals are often in tight-knit communities in which teachers, administrators, and counselors may also be family members and parents of students. It is possible that rural and frontier users are more likely to leave school district designations blank and to turn off location services because of these fears around anonymity, although only future inquiries will tell us this for sure. Efforts continue to increase use in rural areas, including involvement of super-user groups, advertising, and direct outreach by our marketing teams.

SafeUT has also allowed us to conduct a deeper evaluation of access and quality of acute crisis services. For example, in 2020, there were 298 active rescue chats and tips in which the SafeUT team "broke the glass" of anonymity in working to secure the safety of a user. Sometimes this included contacting the school or parents (or both) to conduct a well-child check. In 60% of these cases, there was a contact to emergency service personnel within minutes after the contact was initiated by the user. This is a reassuring example of how quickly danger can be assessed, the likelihood that users will access SafeUT when in crisis, and the rapidity with which such systems can engage active rescues and well-child checks. One source to consider in evaluating these systems is the outcomes that are observed. In about 47% of these active rescue cases, there is not a known disposition about the safety of the user. Future improvements can allow for feedback systems for SafeUT and

crisis services to enable evaluation of effectiveness of services.

BARRIERS TO CARE

Provision of mental health services to children and adolescents comes with unique challenges given their age, their legal rights and protections, and their current stage in cognitive and emotional development. Although there has been evidence for reduced stigma toward mental health among younger generations over time, there is still progress to be made. Every 2 years, students in the sixth, eighth, 10th, and 12th grades in the State of Utah complete the Student Health and Risk Prevention (SHARP) Prevention Needs and Assessment Survey. This is coordinated by a number of organizations, including the Utah Department of Human Services, the State Board of Education, and Division of Substance Abuse and Mental Health. In 2021, approximately 71,000 students completed at least part of the survey, a decrease relative to over 86,000 students in 2019, a reduction that is attributed to the COVID-19 pandemic. The SHARP survey includes several items to assess mental health and attitudes toward mental health treatment. In the 2021 survey, of students who indicated feeling very sad, hopeless, or suicidal in the past 30 days, 40.9% indicated that although they felt this way, they did not talk to anyone about it. This is in contrast to 33.6% in the 2019 survey. Students were also asked, "Do you think it is OK to seek help and talk to a professional counselor, therapist, or doctor if you've been feeling very sad, hopeless, or suicidal?" Eighty-five percent of students in 2019 and 83.2% in 2021 indicated "yes." Another 12%–14% indicated, "I think it's OK for other people to seek help but not for me to seek help." These percentages may seem promising, but there is still room for growth, particularly when it comes to self-stigma or the belief that it is acceptable for someone to ask for help for themselves.

An additional challenge in child and adolescent mental health is the disparity between need and availability of service providers. Among the students in Utah who completed the SHARP survey in 2021, approximately 75% endorsed moderate to severe depressive symptoms. Rates of suicidal ideation, suicide attempts, and nonsuicidal self-injury were 17.5%, 7%, and 17.9%, respectively, which are fairly close to national estimates. Despite high rates of depressive symptoms, the Kem C. Gardner Policy Institute at the University of Utah released a report in 2019, which found that 60% of adolescents in Utah experiencing depression did not receive treatment. Utah has fewer mental health providers per 100,000 people relative to the national average, per a 2016 report by the Utah Medical Education Council on Utah's mental health workforce, and most counties within the state do not have a child and adolescent psychiatrist (5). This shortage is particularly pronounced in rural and frontier regions, where it is difficult to recruit therapists, psychiatrists, social workers, and other mental health professionals.

Although not a sufficient solution, accessible youth mental health services, such as SafeUT, fill a critical gap in providing support to adolescents experiencing mental health crises. The availability of telehealth options, which has been facilitated by the COVID-19 pandemic, also allows for at least some improved accessibility, as youths in rural areas may be able to connect with mental health providers in more populous areas of the state. Unfortunately, Utah will ultimately require a significant increase in providers to meet this demand, as even urban areas such as Salt Lake City do not have sufficient mental health providers, per the County Health Rankings and Roadmap data (6).

As availability and accessibility of mental health options are, in themselves, a significant limiting factor in acquiring services, an additional barrier for youths that is often less discussed is the role of parents in seeking care. In an ideal situation, an adolescent experiencing mental health challenges would approach their parent (or the parent would approach the youth) and discuss these concerns and seek treatment options. However, this is not always the case, as over half of SafeUT users who completed a mental health service utilization survey indicated parent-related barriers, including not wanting to talk to a parent or guardian (52%) or that their parent or guardian is aware but will not help (11%). In Utah, the parent has decision-making authority over the adolescent for inpatient or outpatient substance use treatment. Although there is no specific law regarding consent for mental health treatment, Utah law requires that a parent consents to medical care, except in very few circumstances (e.g., legal emancipation, homeless minors, minors who are lawfully married). In this case, mental health treatment may be considered a form of medical care, meaning that youths are unable to obtain mental health services without the consent of a parent or guardian.

LESSONS LEARNED FROM COVID-19

Although the scope and long-term impact of the COVID-19 global pandemic are yet to be realized, the integrated crisis programs operated by HMHI have been forced to adapt to the individual and public health concerns presented to maintain the integrity of 24-7 life-saving services. Before the pandemic, the crisis services workforce operated in a large office that allowed for in-person collaboration between service lines. Remote and hybrid work was rapidly adopted in March 2020, requiring identification of equipment needs, training protocols, measurable productivity and quality standards, expansion of telephone and internal chat-based software capabilities, and structured staff support and mental and emotional well-being processes to keep our workforce healthy, engaged, and able to safely and effectively perform their crucial work.

In-office staff adopted personal protective equipment (PPE) and health measures, such as social distancing and increased sanitation protocols, in alignment with the broader University of Utah Hospital system to maintain the

health and safety of team members. Additionally, Salt Lake County MCOTs expanded tele-MCOT options for patients who tested positive for COVID-19 or exhibited symptoms of COVID-19 (or both) to maintain the health and well-being of both clients and staff members. MCOT staff utilized iPads supported by mobile hotspots that were purchased with allocated CARES (Coronavirus Aid, Relief, and Economic Security) Act funding to expand services during the pandemic.

Since early 2020, the hybrid workforce model has proven to be highly effective in delivering quality patient care and in improving employee engagement and workplace satisfaction, has expanded the candidate pool to recruit more staff across the State of Utah, and is a critical element to the long-term growth strategy of crisis intervention and support services that continue to expand to support the needs of our community. Additional workforce expansion measures include partnering with the Division of Substance Abuse and Mental Health to offer the State Crisis Worker curriculum and certification, which qualifies recipients to work on the Utah Crisis Line and in other crisis services, in the Weber State University and University of Utah Masters of Social Work course offerings.

Although mental health crisis services are starting to receive more financial support, as well as implement more transitional care from crisis to postcrisis and more long-term care, recovery and secondary prevention are imperative in reducing instances in which individuals experience repeated crises. Caring Contacts is a suicide prevention initiative that includes repeated follow-up contact after a patient has been discharged from an emergency department or inpatient unit in which suicide was a concern. Although HMHI is already implementing this strategy, as described earlier, postcrisis care is in need of continued development. Currently, youths transitioning from inpatient to outpatient care experience challenges in the availability of outpatient therapists, day treatment programs, or intensive outpatient programs. When these resources are available, there are important considerations that are critical to facilitating the most optimal transition. Youths, in particular, may derive significant benefit from programming that occurs either outside of school hours or for only part of the school day. This would allow youths to have a more gradual transition back to their precrisis context and possibly relieve some added stress and anxiety that youths may have regarding school progress and participation in school-related events.

CONCLUSIONS

Existing and emerging resources in Utah, such as SafeUT, can allow for continued growth of quality mental health services and access. Currently, these services provide a continuum of care in times of mental health crises and include availability of call centers, mobile crisis outreach teams, and receiving and stabilization centers. Additionally, the availability of a Warm Line provides an important resource for individuals who may not consider themselves in crisis but who still require support. With regard to youth services in particular, SafeUT allows for an accessible first point of contact for youths in need of mental health services by reducing barriers unique to this population. Additional services in Utah work in concert. There are many areas in which we still need to continue to create a continuum of care in our services. In particular, there are remaining challenges around parity and number of available service providers. Our goal is to build the integrated web of crisis services, to enable bridging to short- and long-term care, and to reduce the burden of mental health challenges in Utah. As we move to collaborative partnerships at national, state, and local levels; robust legislative efforts; and implementation of evidence-based systems of care, Utah is pioneering best-in-class mental health services that are making an impact.

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Dr. Langenecker reports that his spouse is the owner of Secondary Triad, Inc., in which he holds a share. The other authors report no financial relationships with commercial interests.

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