Addressing Teen Mental Health Crises

A National Policy Playbook

Prepared by AcademyHealth
In partnership with ACT for Health

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This report summarizes views expressed at the National Summit for Policy & Action on Teen Mental Health Crises. The views expressed herein do not necessarily represent the views of AcademyHealth or Adolescents and Children Together for Health (ACT for Health).

Executive Summary

Our teenagers are not OK.

When our teens face a potentially dangerous emotional crisis, the systems that are meant to protect them are failing. The consequences are grim.

For a shocking number of our teenagers, America's foundational promise of "life, liberty and the pursuit of happiness" represents nothing more than an empty catchphrase. Suicide is now one of the top two causes of death for adolescents. Hospital emergency departments are overwhelmed by teens in psychological distress. Only two out of five teens seeking treatment are able to get it, and even fewer if a young person is a racial, ethnic, or sexual minority, trapped in the child welfare or criminal justice system, or using drugs and alcohol. Parents send their kids off to school every day wondering if they will come home. One out of three high school students experiences persistent sadness and hopelessness. Responses to teen crisis situations vary widely among different communities, and there is no national model of effective care to guide improvement. This situation is unacceptable.

National Summit Conclusions
- A fresh approach to financing and funding is essential.
- New models of care must cover all the sectors engaged in crisis response.
- These models must be teen-centered and engage families.
- Models should take advantage of digitial health information and communications technology.
- Value-based payment approaches should be tailored to teen mental health.

In response, 45 national and local advocates and policy experts met in Washington, D.C. on June 5, 2019, for a National Summit for Policy and Action on Teen Mental Health Crises. The goal was to identify high-priority policy activities aimed at fixing gaping holes in the safety net for teens in crisis.

This National Policy Playbook is not just about the angst of unmet needs; it is deliberately intended to help guide action.

Policies and Priorities

Although National Summit participants strongly agreed that teen mental health systems require a full-scale overhaul, the Summit's focus was on teens in crisis; i.e., youth at high risk of suicide, a drug overdose or perpetration of violence. One theme emerged above all others: families, schools, local community groups and others

Seven Domains of Focus
- Financing & Funding
- Teen-Centerdness & Family Engagement
- Models of Care
- Building the Workforce
- Information & Communications Technology
- Research & Evaluation
- Performance Improvement

that are trying to cope with teen mental health crises desperately need more dedicated resources. A well-resourced national model of teen crisis response could provide much-needed direction so we can effectively cope with a growing problem that often threatens to overwhelm teens and those who care for them.

In breakout sessions, National Summit participants proposed policy priorities in each of seven domains and suggested advocacy strategies for achieving them. Detailed policy recommendations in each domain, as well as the advocacy strategies, are laid out in the full Playbook publication.

The National Summit's conclusions can be briefly summarized as follows:

The persistently unmet mental health service needs of teens and other children are broad and deep, making a fresh approach to financing and funding essential. This new approach should be based on new models of care that cover all the sectors engaged in crisis response, are teen-centered and engage families, while also taking advantage of digitial health information and communications technology, and value-based payment approaches tailored to teen mental health.

The one recommendation that all participants strongly agreed would constitute a major step in the direction of meeting all of these requirements was the establishment of a crisis response system with 24/7 integrated teen-friendly capability. This system would be accessible anywhere in the country via a three-digit call number that would quickly connect callers to local response centers that would perform triage; dispatch in-person help; and coordinate care that is effective, safe and guarantees a path to recovery[1] and a more stable environment.

In its online presence, the system would feature a teen-friendly user interface and user experience. This type of comprehensive crisis

response system would not obviate the need for providing more resources to local organizations dealing with teen mental health crises and for building a robust infrastructure enabling ongoing teen mental health support. That infrastructure requires:

- A workforce of professionals and peer specialists with greater expertise in working with teens;

- Teen-led organizations to ensure that teens themselves create a coordinated Federal and state policy agenda and direct policy and program development and evaluation.

- A new "floor" for teen mental health benefits with a focus on increasing accessibility and quality;

- Accelerated research on and evaluation of teen-specific models of care and value-based payment models, with particular attention to diversity, equity, and inclusion.

- Evidence-based, cross-sectoral, continuous performance improvement.

- Considering schools across all policy changes.

- Using the crisis in crisis care to bring attention to the full mental health and substance use ecosystem for adolescents.

Put simply, no teen considering suicide or any other harmful act to themselves or to others should ever be more than a text or three-digit phone call away from teen-focused help. It is the minimum we owe our children and, in these unstable times, the minimum we owe ourselves.

Advocacy Strategies

As might be expected, advocacy strategies to achieve the goals in each policy domain invariably included local, state and/or federal officials. The exact target audience, however, varied from Congress and governors, in the case of financing and funding, to the National Institute of Mental Health and the Substance Abuse and Mental Health Services Administration (SAMHSA), in the case of research and evaluation.

The strategies themselves ranged from conventional educational efforts, such as showing legislators the consequences of not having a teen mental health benefits floor, to partnering with law enforcement, first responders and hospital emergency departments on designs for teen crisis text and phone lines.

There was also a wide range of potential partners for teen mental health crisis advocacy. Primary among these allies are teens themselves, preferably in leadership roles. In addition to families and established mental health organizations, these included private foundations, college and university leaders, law enforcement, youth groups, and health care and other professional societies.

Summary and Next Steps

The unmet mental health service needs of teens and other children are broad and deep, whether in mental health promotion or in treatment and recovery.[2,3] Our tolerance of that persistent and shameful gap costs money and lives and reflects on who we are as a society.

The National Summit was designed to focus on teens in crisis; i.e., youth at high and imminent risk of suicide, a drug overdose or perpetration of violence. Teens in crisis are a group whose needs have been overlooked. Crisis care itself is not a national priority. Multiple local and national systems—emergency and crisis line operators, law enforcement, juvenile justice, child welfare, education, mental health and substance use disorder services – are an integral part of crisis care and a comprehensive continuum of care that must become far more robust and responsive to the needs of our teens.

The new adolescent "brain science," in the context of increasingly sophisticated knowledge of social determinants of health and well-being; and rapid developments in information and communications technologies, are among the societal advances that can help make crisis services more responsive to the needs of teens on the brink of death or injury of themselves or others.

This National Policy Playbook is not just about the angst of unmet needs; it is deliberately intended to help guide action. National Summit participants have been asked to use it to advocate for policy change at the federal and local levels. In addition, AcademyHealth and ACT for Health will disseminate the Playbook through their websites and direct distribution to national and local organizations.

Given the wide-ranging and complex nature of this challenge, there are advocacy leadership and support roles for every sector, including public and private funders; health and social services providers; law enforcement; state and local leaders in K-12 education; college and university officials; employers; health plans; researchers; advocates for adolescent wellbeing; and federal legislative and executive branch leadership.

Too many of our teens are suffering. Though we too often look away from the consequences, the anguish of our children is affecting all of American society. Their voices call out to us. They deserve no less an answer than a concerted effort on our part to help them avoid the devastating effects of a mental health crisis.

Introduction

Adolescence is a maturational period of tremendous learning, exploration, and opportunity.[4,5] Behavioral and psychiatric problems can emerge or worsen, especially when nature—changes in the adolescent brain—and nurture—teens' social environments—are not aligned.

Today's teens are experiencing unprecedented and growing levels of mental health crises – defined as situations involving suicide, psychiatric symptoms, drug and alcohol use, and violence that are highly and imminently likely to cause teens to harm themselves or others. Data on these trends are compelling. Suicide, formerly the third most common cause of death for older adolescents now ranks second.[6] Suicide rates among teen girls are rising more quickly than among boys, and racial and ethnic minorities continue to fall victim to homicide at high rates.[7,8] Moreover, nearly 8,000 adolescents ages 15 through 24 died from opioid use over the course of 2016 and 2017.[9]

In addition to rising death rates, emergency room visits for mental health problems have doubled.[10] Teens are self-medicating in dangerous ways.[11,12,13] Even teens who are not hurting themselves or others are subject to pressures that may lead them to injure themselves or others in the future.[14] Teens face new burdens occasioned by waves of mass shooting in schools and elsewhere, anxiety about their economic futures, and alarm as they see the increasing effects of climate change.[15] Teens report higher stress levels than adults do.[16,17,18] Up to 47 percent of high school students regularly experience serious psychological distress that affects their daily productivity, and the rate is rising.[19,20]

Teens are desperate for adults to take action, asking that adults go where the teens are, and warning "… [they] will be shocked by the alarming thoughts students have, the lack of help they are currently getting…"[21] Some teens are taking to the streets and statehouses, saying they "have had enough of sitting around while adults do nothing."[22]

An economic case for greater attention is also clear. Globally, mental disorders are the leading cause of lost economic output across non-communicable diseases, accounting for 35 percent.[23] Most mental disorders begin in adolescence.

Working with the Jewish Healthcare Foundation and under the guidance of a National Advisory Panel, AcademyHealth partnered with Adolescents and Children Together for Health (ACT for Health) to identify best practices, barriers, and policy priorities for creating a teen mental health safety net. This work culminated in the National Summit for Policy and Action on Teen Mental Health Crises (National Summit), which brought together 45 researchers, health system leaders, policymakers, advocates, and other thought

Figure 1. Drug overdose death rates for adolescents aged 15–19, by sex: United States, 1999–2015
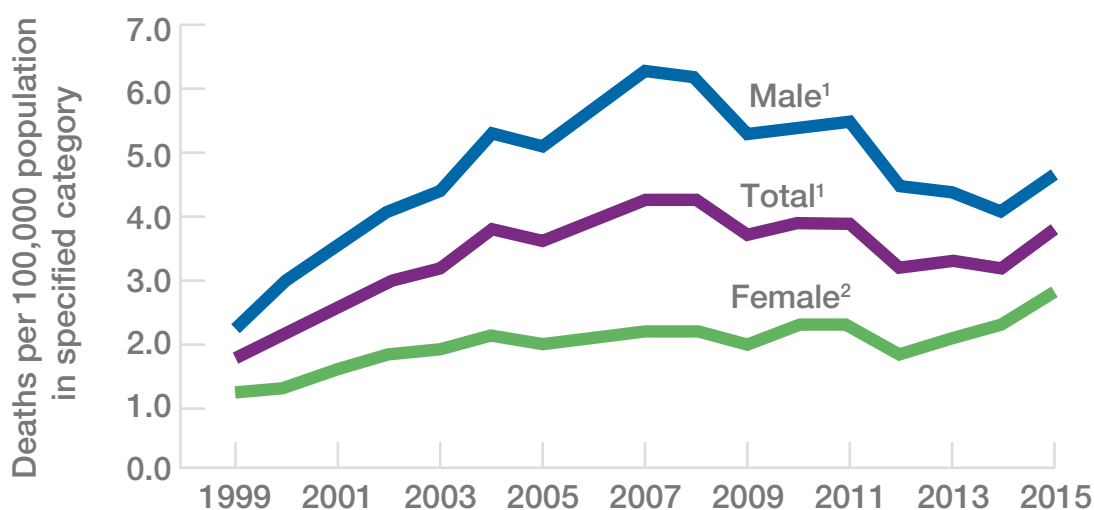
[1]Significant increasing trend for 1999-2007; significant decreasing trend for 2007-2014; rate for 2015 significantly higher than for 2014; *p < 0.05*.
[2]Significant increasing trend for 1999-2004; stable trend for 2004-2013; significant increasing trend for 2013-2015; *p < 0.05*.

Notes: Drug overdose deaths are identified with *International Classification of Diseases, Tenth Revision* underlying cause-of-death codes X40-X44, X60-X64, X85, and Y10-Y14. In 2015, there were 772 total drug overdose deaths: 494 for males and 278 for females. Access data table for Figure 1 at: https://www.cdc.gov/nchs/data/databriefs/db282_table.pdf#1.
Source: NCHS, National Vital Statistics System, Mortality.

leaders to develop a national policy and advocacy strategy to create a safety net for teen mental health crises.

This Policy Playbook presents the results of the National Summit, identifying the top policy priorities recommended by the participants across seven policy domains: financing and funding; teen-centeredness and family engagement; models of care; building the workforce; information and communications technology; research and evaluation; performance improvement. In addition, the Policy Playbook outlines advocacy approaches that National Summit participants argued could effectively advance the top policy priority within each domain.

A supplement of methods used over the course of the initiative will be made available on the AcademyHealth website (www.AcademyHealth.org).

Financing & Funding

Background

Increasing and rationalizing funding across all participating sectors is a linchpin for improving the crisis response system for teens. The current system is emphatically recognized as both under-resourced and having a dangerously fragmented approach to funding, and, as a consequence, organization.[24,25,26,27,28]

The mental health service system, which forms the underpinning of the crisis response system once a teen or teen supporter identifies a crisis in progress, provides a case in point. Despite the large percentages of young people and adults with mental and substance use disorders, mental health and substance use disorder treatment accounts for a small and decreasing percentage of overall health spending: a projected 6.5 percent by 2020.[29,30] In law enforcement, a chief officer recently reported that he had to seek funds from the private sector in order to provide teen-mental-health-crisis-focused training for his deputies; he was able to raise only $35,000.[28]

Fragmentation is evident in the jumble of sources that may be called on to support teen crisis response—private insurance, Medicaid, federal mental health and substance abuse block grants, other federal grants, local funds (small for mental health treatment, large [23%] for substance use disorder treatment), limited amounts from philanthropies, and consumer out of pocket costs.[31,32,33,34,35] Each source has its own coverage rules and other constraints. New guidance for integrating mental health care across all system levels could help the nation move toward there being "no wrong door for a person presenting with a mental health problem."[36]

Proposed legislation in the current Congress suggests some windows of opportunity for increasing funding for teen crisis response.

> **Priority Policy Recommendations for Financing & Funding**
>
> 1. Fund Schools-as-Hubs
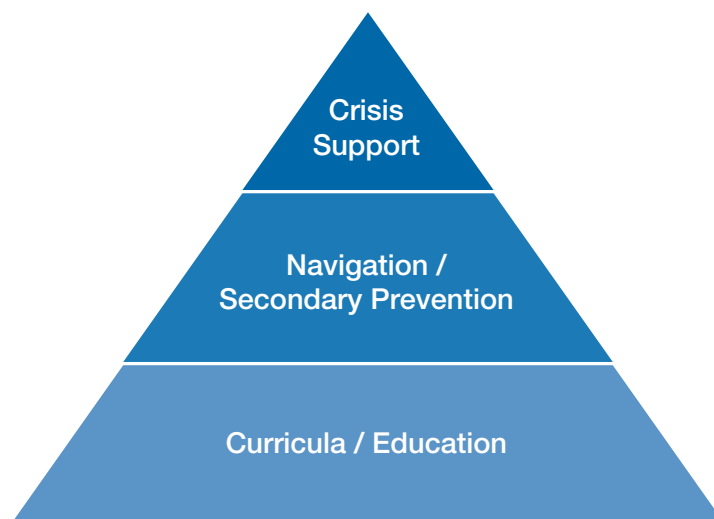> 2. Develop a "floor of services" to inform innovative new financing designs.

For example, a $35 million block-grant set aside for crisis response services is under consideration as part of the House of Representatives' Fiscal Year 2020 Labor, Education, Health and Human Services Appropriations bill.[37] Training of law enforcement officers for behavioral health crisis response would be supported under two Senate bills and one House bill.[38,39,40] Community partnerships led by state education agencies and school mental health programs would be supported under House and Senate bills, for total authorization of $200 million.[41,42,43] Awardees would also have to focus on suicide prevention and provide mechanisms for students to report threats of violence by peers.

In summary, the system needs both more money and a systematic, coordinated approach for using the increased funding to serve the needs of teens in crisis. National Summit participants prioritized a set of policy recommendations that, if implemented, could help meet these needs.

Priority Policy Recommendations

1. Align private foundations to work simultaneously at the federal, state, and local levels to coordinate public-private partnerships that would fund schools as hubs for a three-tiered mental health system for students, with crisis response as the top tier (Figure 2).

Figure 2. Schools-as-Hubs for Teen Mental Health

Source: National Summit for Policy and Action on Teen Mental Health Crises, Funding Breakout Group. (2019, June 5). Washington DC: AcademyHealth.

2. Develop an innovative financing approach based on a freshly identified floor of services for teen mental health, across crisis response sectors.

Advocacy Strategies for Selected Policy Recommendations

For each recommendation, National Summit participants first developed a force field analysis to identify forces for and against increasing funding for teen crisis response, and then created a step-wise advocacy strategy.

Priority Policy Recommendation 1: Fund Schools-as-Hubs

The funding group prioritized enhancing financial support for a new model of crisis response undergirded by secondary prevention efforts for students at risk of a crisis, including resources that would help students, schools, families and others in the community navigate the mental health system; and mental health promotion and primary prevention resources such as those focused on enhancing students' social and emotional competence and eliminating stigma related to psychological distress and mental illness.

Positive Forces. Forces in favor of enhanced funding include the pressures to improve teen mental health, and reduce drug crises and violent events faced by multiple sectors: schools and school districts, law enforcement, crisis phone lines, emergency medical services, emergency departments, and federal agencies. Colleges and universities feel overwhelmed by the numbers of teens coming to them with mental health issues, and want better programs at the high school level. Moreover, as federal provider reimbursement models change to value-based payment models such as bundled payments for episodes of care, there is greater receptivity by the health care system to become involved in mental health and crisis response. All of these entities would likely welcome increased financing.

Negative Forces. Forces working against crisis response funding with schools as hubs include a paucity of knowledge about what works best and a lack of alignment among foundations, including territoriality. Schools may also hesitate to adopt programs that could disrupt their curriculum and put them at a disadvantage in the current context of testing and publicizing results.

Strategy for Targeted Action: Engaging Private Foundations in Schools-as-Hubs Strategy

Messengers
- AcademyHealth
- Grantmakers in Health
- National Association of Community Foundations

Target Audience
- Group of private foundations, initially convened by Messengers listed above.
  - Government funders could also participate, but convening the meeting as a private initiative would allow foundations to talk candidly and would keep the meeting relatively small.
  - A recent example of private funders coming together to support work around adolescents is the Funding Adolescent Science Translation (FAST) projecct,[44] which supported research to identify contemporary views of teens with an eye toward creating and leveraging "reframing" messages.[45]
- Eventually, target messages to government funders including[46]:
  - Congress
  - Medicaid
  - SAMHSA
  - Health Resources and Services Administration (HRSA)

Strategy for Targeted Action: Engaging Private Foundations in Schools-as-Hubs Strategy (cont'd)

Activities/Messages

- Participants recommended a series of 4 steps:
    - o Start by convening the private sector (foundations) via AcademyHealth, Grantmakers in Health, and/or the National Associations of Community Foundations to:
        - Educate foundations about social and emotional competence for teens,[47]
        - Get private philanthropists to collaboratively fund creative, school-based, approaches to teen mental health crisis response,
        - Develop a framework outlining a robust package of school-based services at all 3 tiers (Figure 2),
        - Create common standards for evaluating schools-as-hubs models and,
        - Support a learning network to provide technical assistance.
    - o Second, invite the right people from among federal government funders (Centers for Disease Control and Prevention; HRSA; SAMHSA; National Institute of Mental Health; Center for Medicare and Medicaid Innovation) to identify:
        - Available funding streams
        - Specific purposes of each funding stream
        - Mechanisms for schools to bill for mental health resources and fund mental health services
    - o Third, identify a specific advocacy plan, message, and ask;
    - o Fourth, advocate by:
        - Making a case to schools with a focus on effects on attendance, test scores, and school connectedness,
        - Increasing awareness of the available resources and supports for schools, including guidance on how to implement the framework (Figure 2) and standards,
        - Using personal stories plus data to make the issue salient,
        - Helping schools to fulfill their roles as hubs through linkages between schools and the mainstream health care delivery system, community programs, law enforcement, and other sectors.

Priority Policy Recommendation 2: Develop a "floor of services" to inform innovative new financing designs.

For this recommendation, National Summit participants concentrated on creating advocacy strategies for identifying and advocating for a floor of services that "cross-cuts benefit regulations with new enforcement methods."

Positive Forces. Forces identified in favor of creating such a floor include: growing awareness of the teen mental health crisis; decreasing stigma around mental health and substance use, school shootings, and associated increasing health care costs, good regulations such as parity, growing local innovation and opportunity, and activated and engaged youth ready to be mobilized.

Negative Forces. Forces against include: an Administration tending toward deregulation; complexities of regulation enforcement; perceptions of expense and infeasibility; a push for "skinny benefits" in healthcare; lagging politics in the mental health and substance use fields; and lack of capacity to provide the benefits once a floor is established.

Two targeted actions were chosen:

1. Approach consensus on a floor of benefits, and
2. Illustrate the consequences of the missing floor of benefits.

Strategies for each are shown on the next page.

Strategy for Targeted Action 1: Illustrate the Consequences

Messengers
- Families and youth at risk of crisis

Target Audience
- Congress
- Governors
- State and local policymakers

Allies/Partners
- State and local leadership
- Family organizations
- College and university leaders
- Law enforcement

Allies/Partners
- State and local leadership
- Family organizations
- College and university leaders
- Law enforcement

Activities/Messages
- Tailored, tested and effective messages
- Human and financial costs of lacking a minimum set of benefits

The Modern Medicaid Alliance was suggested as a model for this activity.[48]

Strategy for Targeted Action 2: Approach Consensus

Messengers
- The mental health stakeholder ecosystem (i.e., payers, providers, teens).

Target Audience
- Congress
- Governors
- Other policymakers (e.g., state Departments of Insurance)

Allies/Partners
- Neutral convener such as the Bipartisan Policy Conference, Brookings Institution, the American Enterprise Institute, or law enforcement as allies and partners.

Activities/Messages
- Assemble and build consensus on the floor of benefits
- Communicate the message, "We all agree on the approach, so we should do it."

Teen-Centeredness & Family Engagement

Background

The world's view of teens and their families is due for a "refresh." Adolescent brain science[49] and other fields of research,[50,51,52] are painting a new picture of adolescence as a time of unique developmental changes and of opportunity rather than trouble. Teens are newly politically active,[53,54] and the importance of families to teens is increasingly recognized.[55]

Teen-centeredness. Throughout this Policy Playbook, we emphasize the need for teen-specific crisis response approaches. This focus on teens in crisis response is one, to the best of our knowledge, no one else has taken, which is not surprising. It is not unusual for teens to be omitted from policy and program considerations.[56,52] But now teens, claiming that adults have failed them,[57,58] have created new social movements. Examples include Black Lives Matter[59] and March for Our Lives.[60] Black Lives Matter and the March for Our Lives have met together. Youth MOVE national is a youth-driven, chapter-based organization dedicated to uniting the voices of youth nationwide; it has grown to 60 chapters.[61]

Family Engagement. Except for help from health professionals, schools, and organizations such as the National Federation of Families for Children's Mental Health,[62,63] families often struggle individually with their teens' mental health crises. Families of children with other conditions have found family support groups to be helpful. At the National Summit participants observed that the activism and organization among families of adolescents facing mental health problems pales next to the activism of organizations like Family Voices, a support and advocacy organization focused on children with special needs (traditionally those who have a disability or chronic physical disease).[64,65] Family Voices now has access to support that has allowed the organization to grow and become more forceful as educators of policymakers."[66]

National Summit participants addressed these issues in their top priority policy recommendations.

Priority Policy Recommendations

1. Fund adolescent-led organizations to design, implement, and evaluate teen crisis response systems.

2. Require youth engagement as part of all funding applications to pursue work in teen mental health.

3. Support teen- and family-led organizations to develop a coordinated state and federal policy agenda for youth mental health.

4. Conduct a social marketing campaign to educate the public and policymakers about youth development with a focus on mental health.

Priority Policy Recommendations for Teen-Centeredness & Family Engagement

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2. Require youth engagement as part of all funding applications to pursue work in teen mental health.

3. Support teen- and family-led organizations to develop a coordinated state and federal policy agenda for youth mental health.

4. Conduct a social marketing campaign to educate the public and policymakers about youth development with a focus on mental health.

Advocacy Strategy for Selected Policy Recommendation

National Summit participants focused on the highest priority policy recommendation: fund adolescent-led organizations to design, implement, and evaluate teen crisis response systems and require youth engagement as part of all funding applications pursuing work in teen mental health.

Positive Forces. In their force-field analysis, participants identified a number of forces they believed would support a move toward this policy recommendation. First, they suggested that existing strong, family-parent groups have the political will to support this approach to funding system design. Second, they noted that teen crises and concerns about unresponsive systems are true across every class, race, socioeconomic level, and other teen characteristic. Third, they combined recommendation 1 and 3, suggesting that social marketing strategies could serve as a catalyst for action. Fourth, only a limited number of service models require youth design leadership; these include SAMHSA's Systems of Care, teen pregnancy prevention, and participatory research. Fifth, the recommendation fits with movements toward more human-centered, participatory design in programs and research.[67] Finally, the ability of teens to lead is being demonstrated by teens leading movements for climate change,[68] gun legislation,[69] police restraint,[61] voter registration,[71] and student mental health days.[70]

Negative Forces. Participants also noted a number of forces that could impede policy change. Principally, there remains a deep stigma toward both teens and mental illness. Second, many prospective teen leaders will need technical assistance, which can be resource intensive and needs to be part of funding considerations. Third, political will toward teen needs, teen leadership, and teen causes, is lacking in the U.S. Fourth, participants noted a paucity of evidence of the value of teen engagement and leadership, although there is some, for both teens and the broader community. Numerous

resources now exist for creating and managing adolescent-led organizations, and for how adult-led organizations can meaningfully integrate teens as shared decisionmakers at the highest levels.[71,72,73] Rigorous research on how to make services more teen-friendly is beginning, although it may not always be led by teens.[74]

Based on the force field analysis, participants recommended two targeted actions:

1. Build the business case for youth leadership of organizations and strategies.

2. Scale existing models of youth-led organizations (e.g., Youth MOVE) so that every youth has access to leadership opportunities.

Strategy for Targeted Action 1: Build the Business Case

Messengers
- Youth MOVE
- Family-led organizations

Target Audience
- Public and private research funders, including foundations and federal agencies.

Allies/Partners
- Providers
- Families
- Researchers
- Other established youth organizations such as Boy Scouts and Girl Scouts

Activities/Messages
- Conduct an environmental scan to:
    - o Examine the business case of youth engagement;
    - o Identify innovative ways to build the evidence and develop measures of engagement and effectiveness; and
    - o Identify clearly the components that would need to be funded.

Strategy for Targeted Action 2: Scale Existing Models of Youth-led Organizations

Messengers
- Youth MOVE
- Other youth-led organizations
- System leaders who can speak to past successes
- Family-led organizations

Target Audience
- Public and private funders

Allies/Partners
- Providers
- Families
- Researchers
- Other established youth organizations such as Boy Scouts and Girl Scouts

Activities/Messages
- Meet with Youth MOVE to develop a strategy.
- Prioritize teen needs such as communication plans, governance.
- Provide technical assistance to current groups.
- Create opportunities for links across other youth-serving groups.
- Identify and meet with potential funding sources, with a focus on obtaining resources for sustainable funding models.

Models of Care

Background

Observers of overall systems of mental health services in the U.S. and globally continue to express opinions similar to this:

> "Existing models of care …fail to adequately address the global crisis of mental health care."[75]

For the crisis response component, which is typically more complicated by engagement of other social sectors, observers have the same concerns.[76,77]

Given this problem, work is under way to develop new models of mental health care, with attention to multiple levels of policy and action, such as: more effective leadership and governance; integrated mental health and social care services; community-based (i.e., non-residential) care settings; strengthened information systems;[78] and new delivery platforms (e.g., social media, social networks to scale interventions[79]). National Summit participants also noted the urgent need to integrate substance use disorder prevention and treatment into the mental health and primary care physical health systems.[80] Models also exist to integrate physical and mental health care.[81] Some proposals focus specifically on the unique needs of young people.[85,82]

Not all of the emerging mental health service models specifically include crisis response as a component.[83,77] Proposed models of crisis response systems typically include integration with the overall

mental health system, as well as the components outlined in Box 1 and summarized in the Figure 3. By achieving more effective crisis response models, proponents hope to achieve the benefits outlined in Box 2.

These resources can provide inspiration for a national vision and concrete examples of innovation for children and the general public. The children's model continuum published by the National Association of state Mental Health Program Directors includes examples of state and locally-reported cost savings achieved by leveraging Mobile Crisis and Stabilization Systems.[84] The Crisis
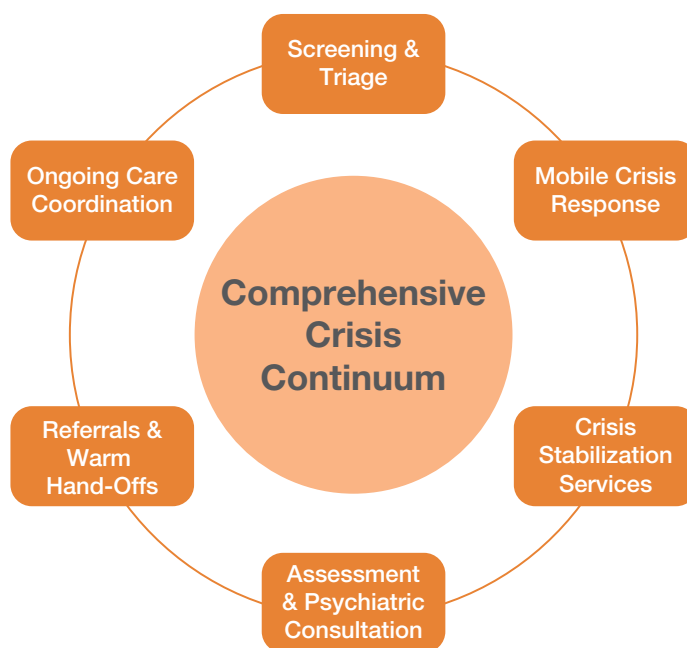
Priority Policy Recommendations for Models of Care

1. A new approach to financing and funding is essential.

2. A national vision of comprehensive crisis response for teens is vital in order to fashion a system with at least the following key elements: a 3-digit national crisis call number, a nationwide call and dispatch system that is tied into a crisis call number; crisis functions and facilities with clear-cut responsibilities for teens; adequate capacity to respond 24 hours a day, 7 days a week, every week.

3. All components of the comprehensive crisis response system must include integrated teen-friendly capabilities that ensure responsiveness and effectiveness in addressing the unique needs of adolescents.

Figure 3. Components of a Teen Crisis Response System

Source: Zabel M. 2019, June 5. Presentation at National Summit for Policy and Action on Teen Menal Health Crises. Washington DC: AcademyHealth.

Now report includes multiple examples of state implementation of innovative crisis care components.[78] None of these models focus on the needs of teens specifically, or explicitly invoke substance use or violence perpetration crises. Nonetheless, some states and communities are making progress toward better systems, and the identification of key components and principles, combined with greater efforts at teen-centeredness and family engagement, could help to inform designs of more effective models of teen crisis response care. An implicit challenge in envisioning and effecting a national model is that no federal agency or group of agencies provides dedicated financial support for local crisis response within the framework of a comprehensive system.

Priority Policy Recommendations

1. A new approach to financing and funding is essential.

2. A national vision of comprehensive crisis response for teens is vital in order to fashion a system with at least the following key elements: a 3-digit national crisis call number, a nationwide call and dispatch system that is tied into a crisis call number; crisis functions and facilities with clear-cut responsibilities for teens; adequate capacity to respond 24 hours a day, 7 days a week, every week.

3. All components of the comprehensive crisis response system must include integrated teen-friendly capabilities that ensure responsiveness and effectiveness in addressing the unique needs of adolescents.

Box 1. Common Components of Model Crisis Response Continua

- **Physical/technical Components**
    - Pre-crisis service availability/Integration into overall comprehensive mental health service system
    - Crisis hotline (phone or text; preferably simple and nation-wide)
    - Triage
- Assessment (financial, mental health, using standardized instruments)
- Residential crisis stabilization
    - Air Traffic Control-like capabilities
    - Electronic Health Records
    - Web-based forms
    - Electronically scheduled appointments and referrals
- Performance measurement and dashboards in real time

- **Principles Across Components**
    - No "wrong door"
    - Family- and person-centered (e.g., person and family define crisis)
    - Mobile teams (go where the child is)
    - Warm handoffs
    - Coordination and collaboration across sectors and with the community, including:
        - Law enforcement
        - Community-based paraprofessionals for peer support, including cultural understanding
    - Trauma-informed (avoid re-traumatization)
    - Least restrictive environment.
    - Recovery and reintegration focus
    - Safety for people in crisis and staff as a strong commitment
    - Suicide prevention principles (Zero Suicide, National Suicide Prevention hot Line)

Sources: National Action Alliance for Suicide Prevention. Crisis Services Task Force. 201678; National Association of State Mental Health Program Directors. 2018, August. https://www.nasmhpd.org/content/ta-coalition-assessment-working-paper-making-case-comprehensive-children's-crisis; Paton, F., Wright, K., Ayre, N., et al. 2016. http://openaccess.city.ac.uk/id/eprint/14163/

Box 2. Anticipated Benefits of Model Comprehensive Crisis Response System

- More sense of possibility for people contemplating suicide
- Fewer suicides, potentially zero
- Diversion from costly and inappropriate services (emergency department, inpatient psychiatric, juvenile justice, prison, out-of-home placement)
- Diversion-associated cost-savings
- Fewer wasted resources
- Reductions in unspeakable pain for teens, families, schools, communities, and the nation
- More police attention to crime reduction

Advocacy Strategy for Selected Policy Recommendations

National Summit participants recommended a set of advocacy actions aimed at advancing a national vision, and establishing annual federal appropriations for mental health crisis care that requires accountability for teen responsiveness. Thus, they addressed all 3 high priority recommendations.

Positive Forces. Forces in favor of a change to increased funding include, for the first time in the history of the Mental Health and Substance Abuse Block Grants, a $35 million (5 percent set-aside) "down payment" to support evidence-based crisis care programs addressing the needs of individuals with severe mental illness and children with serious mental and emotional disturbances."[85] Nonetheless, National Summit participants also warned that funding should "go beyond the Block Grant" mechanism. As noted in the Financing and Funding Domain section of this Playbook, other bills in the current Congress would also help enhance crisis response in general (funds for training of law enforcement officers in behavioral health) and youth-focused crisis response (funds for state Education agencies to support schools as leaders of mental health, in coordination with community partners). The workgroup did not identify any negative forces.

Strategy for Targeted Action: Advance a National Vision and Establish Federal Appropriations

Messengers
- A coalition of existing and new organizations and champions with robust engagement by teen and family organizations
- Activated researchers and other experts to provide evidence to support implementation, monitoring, and evaluation of the model system

Target Audience
- Congressional leaders and staff

Allies/Partners
- Health systems
- Existing emergency providers across sectors (e.g., crisis hotlines, law enforcement, schools, emergency departments, hospitals, other aspects of the health systems, and employers)

Activities/Messages
- Recommending Congressional action that could bring multi-sectoral funding streams (and possibly others) together
- Dedicated source of federal funds that could help promote creation of a national vision

Building the Workforce

Background

Teens in crisis need expert help. The level of teen-related expertise among crisis response workers is not known, but schools, families, and health care facilities have long experienced shortages of mental health professionals skilled at, and willing to work with, adolescents.[86,87] For example, no child and adolescent psychiatrists are available in three out of four U.S. counties. The implication for teens is that, in any given year, about 60 percent of teens 12-17 with a major depressive episode are unable to get the care they need. Even contemporary crisis call lines are not fully able to respond to need, a situation worsened when suicides are heavily publicized.[88] SAMHSA and HRSA support efforts to identify supply and demand for mental health professionals and also support some grant programs;[89,90] however, National Summit participants remarked that federal support for training new mental health professionals has declined since the late 1980s. Crisis response training is available for professionals in some sectors (e.g. law enforcement) but resources to support the actual training may not be sufficient. In one county where the opioid epidemic is one of the country's worst, the county Sheriff had to seek private funds in order to establish and maintain a trained cadre of deputies able to deal with mental health and substance abuse emergencies in teens.[91,92]

Proposed legislation in the current Congress would provide loan repayment opportunities for child and adolescent mental health professional training,[93] and behavioral training for law enforcement officers.[94,95,96] The fields of school psychology, school social work, and school counseling would all be able to make trainees eligible for favorable loan repayment opportunities under the proposed legislation.

Priority Policy Recommendations

1. Make greater use of grants and loan forgiveness to attract more professionals and peer specialists to the field of crisis response.

2. Support communities to develop and implement retention strategies, including by changing culture.

> ## Priority Policy Recommendations for Building the Workforce
>
> 1. Make greater use of grants and loan forgiveness to attract more professionals and peer specialists to the field of crisis response.
> 2. Support communities to develop and implement retention strategies, including by changing culture.
> 3. Include schools in all workforce initiatives to improve access.

3. Include schools in all workforce initiatives to improve access.

Advocacy Strategy for Selected Policy Recommendation

In this domain, National Summit participants focused on the top and second highest priority policy recommendations: increasing the availability of grants and loan forgiveness, and supporting communities to implement more effective retention strategies.

Positive Forces. Given the frequent media attention to teen suicide, self-harm, and growing rates of depression National Participants believe that there is increasing understanding that mental health crises can happen to anyone, and that this can be a force for change. As more and more teens experience crises, so do a widening circle of families, schools, and communities. In addition, there are now visible national leaders.

Negative Forces. As in advocacy strategies for other domains, stigma and lack of data and financial resources counted as forces against change.

Two messages were targeted for advocacy action

1. Teens are resources; we should not let them die.

2. There comes a point when a teen needs a new door: "It's a point in time; not a lifetime" could be a slogan.

Strategy for Targeted Action 1: Teens as Resources

Messengers
- Families and legislators

Allies/Partners
- Families and legislators should form a coalition

Strategy for Targeted Action 2: Teens Need a New Door

Messengers
- Teens

Allies/Partners
- Professional organizations
- Mental Health America
- National Alliance for Mental Illness

Activities/Messages
- Adolescent mental wellness

Information & Communications Technology

Background

Innovations in information and communications technology (ICT) are revolutionizing all aspects of our lives. Early experiences with ICT approaches appear promising for use during all phases of responses to teens in crisis, from identification and recognition[97] through professional assessment and triage[98] to helping teens on the path to recovery.

As of December 2017 (the latest data available), the United States had 5,783 primary and secondary public service answering points (PSAPs; aka 9-1-1 numbers) in 3,135 jurisdictions (counties, parishes, independent cities, boroughs, and Census areas).[99] In addition, there are multiple crisis hotlines, perhaps the most prominent being the National Suicide Prevention Lifeline. PsychCentral.com, the internet's largest and oldest independent mental health online resource, lists multiple crisis hotlines by crisis type (e.g., AIDS, domestic violence, runaways), including at least five for suicide, some oriented toward specific populations at risk.[100] Simplification to one nationwide 3-digit code is one essential step toward improved crisis response, according to many in the crisis and suicide prevention communities. As ordered by the National Suicide Hotline Improvement Act of 2018, a Federal Communications Commission (FCC) report found that:

> (1) designating a 3-digit code dedicated solely for the purpose of a national suicide prevention and mental health hotline would likely make it easier for Americans in crisis to access potentially life-saving resources; and

> (2) the Commission should initiate a rulemaking proceeding to consider designating 988 as the 3-digit code to be used for this purpose.[101]

Crisis Now also proposes combining crisis line operator expertise with "Air Traffic Control" capabilities.[102] For example, the Georgia Crisis and Access Line uses technology and secure Web interfaces to bring big data to crisis care and provide the ability of real-time coordination across the crisis response continuum. Crisis Now notes that this capability could not have been envisioned a generation ago, but should now be considered an essential component of crisis care.

Given the imbalance between supply and demand for teen mental health services, and the widespread recognition of the convenience of online consumer services, many have proposed broad expansion of TeleMental Health (TMH) services.[103] Alan E. Kazdin, a prominent clinical and research psychologist, has proposed novel models of delivering psychosocial interventions to children and adolescents, with special attention to the use of social media, socially assistive robots, and social networks.[104] A recent Roadmap for Action outlines steps schools can take to advance the adoption of telehealth

in schools.[105] Advantages include greater efficiency and the capacity for higher and more equitable volume.

However, multiple technical, regulatory, financial, and ethical challenges remain, including for teens.[99,105,106] The interoperability of electronic health data in the mainstream health care delivery system is still a work in progress. Noting that significant challenges have been repeatedly identified, Scholten and Granic walk through using three key principles of design thinking to address the current limitations of digital mental health interventions for youth.[107,108]

Priority Policy Recommendations

1. Create and support a multidisciplinary innovation team to develop, prototype, and test a range of technology user-interface (UI) and user-experience (UX) designs for teen crisis text and phone lines.

2. Support management of digital mental health approaches such as interoperable electronic health records, and support efforts to explicitly address specific teen issues.

3. Implement a nationwide universal three-digit crisis number, with texting incorporated.

Advocacy Strategy for Selected Policy Recommendation

National Summit participants focused on the top priority policy recommendation as a platform for advocacy: create and support a multidisciplinary innovation team to develop, prototype, and test a range of technology user-interface (UI) and user-experience (UX) designs for teen crisis text and phone lines.

Positive Forces. They identified several forces for change, including rising suicide rates, challenges with access to care, overburdened first responders (e.g., time spent locating people in crisis situations; time doing wellness checks), overburdened emergency departments, and the advantage of potential simplified handoffs to public safety answering points (PSAPs).

Negative Forces. Forces that could impede implementation of the policy changes include the potential for an exponential increase in call and text volume; capacity issues in the first response and crisis service delivery systems; the challenge of getting a good, memorable, simple code; cost and funding; and the presence of other players in this space.

Participants recommended two foci, or targeted actions, for advocacy:

1. Form and sustain partnerships with law enforcement, first responders, and emergency departments.

2. Work with other players in the space.

Strategy for Targeted Action 1: Partnerships with Law Enforcement, First Responders, Emergency Departments

Messengers
- National Emergency Number Association (NENA)
- Hospital associations
- Professional organizations that represent these groups

Target Audience
- Legislators
- Other policymakers
- Other politicians

Activities/Messages
- Distribute data
- Advocate using lobbying efforts such as advocacy, or "Hill" days. These are one day or more events during which an organized group of constituents and other advocates visit members of Congress and their staffs, including relevant Committees and personal offices

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Strategy for Targeted Action 2: Working with Other Players

Messengers
- Crisis Text Line
- The Trevor Project (a suicide prevention group for LGBTQ youth)
- Lifeline
- RAINN (the nation's largest anti-sexual violence organization)
- Local crisis centers

Target Audience
- Legislators
- Other policymakers
- Other politicians

Activities/Messages
- Form a coalition of crisis lines
- Distribute data to policy makers and other stakeholders so that they can more effectively tailor their advocacy strategies and interventions.
- Advocate using lobbying efforts such as advocacy, or "Hill" days. These are one day or more events during which an organized group of constituents and other advocates visit members of Congress and their staffs, including relevant Committees and personal offices

Research & Evaluation

Background

Many aspects of the crisis response system could benefit from additional research and evaluation,[109,110,111,112,113,114] especially when it comes to efforts to become teen-centered and family-engaged.[115] National Summit participants focused on urgent needs to evaluate innovative models of financing and delivery of crisis response systems for teens and rapidly disseminate results. Participants also emphasized testing value-based payment models using hybrid effectiveness-implementation study designs, as well as developing research-based quality measures, an essential component of value-based payment.[116,117]

While there is some preliminary research,[118] value-based payment has been understudied in mental health and substance use care, in child and adolescent services, and for multi-sector service systems such as crisis response, and experts urge that more investment in research is needed.[119,120,121,122]

To be more useful to policymakers and advocates within their preferred time frames, different approaches to research and evaluation are needed, such as hybrid effectiveness-implementation study designs. These designs blend design components of clinical effectiveness and implementation research[123] and have been used extensively in large, complex systems[124,125] and in public health.[126]

Value-based payment relies heavily on having valid performance measures. Except for the Pediatric Quality Measures Program (PQMP), research investment in quality measures is relatively rare.[127] PQMP researchers have developed measures relevant to mental health crisis care, such as emergency department services. PQMP researchers could be challenged to develop measures across the multiple sectors of crisis response, including patient-reported outcome measures (PROMs).[128]

Challenges to building the research and evaluation base for teen crisis response services include recent trends in child mental health services research funding.[129]

National Summit participants emphasized the importance of including a diversity of teens in any research and evaluation efforts, given the rapidly changing demographics and culture of the teen population. While meaningful inclusion of children and adolescents (0-21), female, and racially and ethnically diverse populations in research is a requirement at the National Institutes of Health (NIH),[130,131] the success of the policy remains unknown.[132,133,134]

Policy Priority Recommendations for Research & Evaluation

1. Accelerate research, evaluation, and dissemination of findings on provider payment models, financing strategies, and value-based payment approaches that support high-quality comprehensive crisis response care for teens.
2. Support hybrid effectiveness-implementation study designs development of new models for policy, program, and practice, being sure to embed diversity, equity, and inclusion in the designs.
3. Expand the PQMP to conduct research developing additional teen mental health measures, including crisis care measures and measures specific to quality for the teen population.

Priority Policy Recommendations

1. Accelerate research, evaluation, and dissemination of findings on provider payment models, financing strategies, and value-based payment approaches that support high-quality comprehensive crisis response care for teens.

2. Support hybrid effectiveness-implementation study designs development of new models for policy, program, and practice, being sure to embed diversity, equity, and inclusion in the designs. Examples include: youth and family peer specialist models of care; on-ramps to new workforce ladders; use of digital technology for service delivery; and family support.

3. Expand the PQMP to conduct research developing additional teen mental health measures, including crisis care measures and measures specific to quality for the teen population.

Advocacy Strategy for Selected Policy Recommendation

For this policy domain, National Summit participants focused their discussion of advocacy strategies on the highest priority policy recommendation: accelerating research and dissemination of findings on provider payment models, financing strategies, and value-based payment approaches that support high-quality comprehensive crisis response care for teens.

Positive Forces. Participants identified several forces in favor of policymakers adopting this recommendation. They noted the bipartisan support for reducing health care costs, and extensive testing of strategies to decrease the cost of physical care. Employers, insurance companies, and the National Institute of Mental Health (NIMH) focus extensively on the economics of health care. Family advocates are on board for making change, and can push Congress

for research and evaluation funding. Funder collaborations have shown success in the current policy environment, for example, by saving some federal datasets. Finally, expanding insights from adult-focused-care-model research can be thoughtfully applied to teen mental health care, and the variety of funding models provides a basis for comparative research.

Negative Forces. Advocates should be aware of forces against adopting the policy recommendation. National Summit participants pointed out that, while NIMH has an economics funding portfolio, it is not focused on adolescents or children. Policymakers lack a life course perspective, a research-based outlook that informs how investing in young people can change their health trajectories and enhance their contributions to society. Data limitations can also inhibit financing model research. It is difficult to get the data on system models for financing, and there is no repository of knowledge for different funding models. A centralized bank of learning from different funding models is needed, so that policy-

makers and researchers can learn from past failures and successes. Knowing which variations in payment have and have not been implemented, and which have a limited research base, is also important for efficiently moving forward on teen crisis response payment model research and evaluation. Finally, as also noted with respect to the financing and funding policy domain, a review is needed of the hodgepodge of current financing and funding strategies.

Participants recommended two targeted actions for advocacy:

1. Use the collaborative funding models of First Episode Psychosis and suicidality to study funding strategies for implementation of new models of care.

2. The second targeted action focused on initial research questions as an advocacy focus. These should include: how is teen mental health currently being funded? How does it track to disparities? What are the variations across states, and do they link to state financing models?

Strategy for Targeted Actions 1 & 2

Messengers
- Researchers
- Youth
- Providers
- Purchasers
- Advocates

Target Audience
- National Institute of Mental Health (NIMH)
- SAMHSA
- Centers for Medicare & Medicaid Services
- Employers
- Health Plans

Allies/Partners
- Family-run organizations such as the National Alliance on Mental Illness
- American Pediatric Association, which has funding for a state scan of psychotropic use
- American Board of Pediatrics Foundation (Dr. Laurel Leslie), which has expressed deep concern about the emergency mental health system for children and adolescents[135]

Activities/Messages
National Summit participants recommended taking two preliminary steps toward an eventual messaging campaign:
- Get funders to conduct research to build the evidence base
- Embed financing questions into other crisis response research

Key activities:
- Scan the field to assess current research
- Understand the health systems innovations currently under way, and the overlap in data of young adults resulting from the expansion of dependent coverage to age 26
- Understand current gaps
- Get support to conduct research similar to the First Episode Psychosis model of integrated care

Performance Improvement

Background

Continuous performance improvement is a widely recognized system imperative.[136] Many of today's not-for-profit and commercial entities aim to be learning systems – bodies or associations that unceasingly conduct their own research, set standards, continuously measure performance, and move carefully vetted evidence into practice and policy.[137,138] In health care and public health, the health services research community aims to understand and rapidly disseminate the lessons of learning systems in the interest of rapid diffusion and continuous improvement in the health and well-being of the nation.[139,140,141,142]

The nation's crisis response systems are making progress toward dissemination of best practices, for example by sharing resources through federally supported Technical Assistance Centers. However, National Summit participants believed that crisis response could benefit from a more systematic approach to performance improvement – becoming a nationwide learning system. Participants recommended the development of evidence-informed performance standards as a necessary starting point. Standards would be translated into performance measures. Measures would be used to assess crisis response access and quality, and, with federal support, states and localities could field evidence-based improvement initiatives, building upon the fields of quality improvement and implementation science.[143,144,145] As in health more generally, crisis response could move toward the triple aim of better health (e.g., fewer preventable deaths and self-inflicted injuries), better services (e.g., more person-centered, more timely and coordinated), and lower cost.[146]

> ## Priority Policy Recommendations for Performance Improvement
>
> 1. Develop standards specific to a multisectoral, comprehensive, evidence-informed, teen- and family-centered crisis response system, to serve as a foundation for future performance measures and performance improvement initiatives.
> 2. Develop and implement incentives (both carrots and sticks) to motivate and accelerate system adoption of performance standards.

Priority Policy Recommendations

1. Develop standards specific to a multisectoral, evidence-informed, teen- and family-centered crisis response system, to serve as a foundation for future performance measures and performance improvement initiatives.

2. Develop and implement incentives (both carrots and sticks) to motivate and accelerate system adoption of performance standards.

Advocacy Strategy for Selected Policy Recommendations

In this domain, National Summit participants developed an advocacy strategy that would target both priority policy recommendations.

Strategy for Targeted Action: Advance Political, Social, and Evidence Support for Comprehensive Standards

Messengers
- Coalition of stakeholders

Target Audience
- Congress

Activities/Messages
- Work to create broader political and social support for performance improvement in the context of teen mental health crisis response
- Ask the U.S. Congress to have the Centers for Disease Control and Prevention-led Community Preventive Services Task Force conduct a review that would lead to creation of evidence-informed performance standards for multi-sector community adoption

- The Community Preventive Services Task Force should ask federal agencies across sectors to provide evidence
  o For example, within the U.S. Department of Health and Human Services:
    - Agency for Healthcare Research and Quality (AHRQ),
    - SAMHSA,
    - National Institute of Mental Health (NIMH),
    - National Institute on Drug Abuse (NIDA),
    - National Institute on Alcohol and Alcohol Abuse (NIAAA).
- Ask the U.S. Congress to include funding for:
  o Developing the standards,
  o Development and implementation of incentives to accelerate implementation of the standards across the nation,
  o Development and use of evidence-informed quality measures,
  o Development and use of multi-level improvement strategies.

Summary and Next Steps

The unmet mental health service needs of teens and other children are broad and deep, whether in mental health promotion or in treatment and recovery.[147,148] Our tolerance of that persistent and shameful gap costs money and lives and reflects on who we are as a society.

The National Summit was designed to focus on teens in crisis; i.e., youth at high and imminent risk of suicide, a drug overdose or perpetration of violence. Teens in crisis are a group whose needs have been overlooked. Crisis care itself is not a national priority. Multiple local and national systems – emergency and crisis line operators, law enforcement, juvenile justice, child welfare, education, mental health and substance use disorder services – are an integral part of crisis care and a comprehensive continuum of services that must become far more robust and responsive to the needs of our teens.

The new adolescent "brain science," in the context of increasingly sophisticated knowledge of social determinants of health and well-being; and rapid developments in information and communications technologies are among the societal advances that can help make crisis services more responsive to the needs of teens on the brink of death or injury of themselves or others.

This National Policy Playbook is not just about the angst of unmet needs; it is deliberately intended to help guide action. National Summit participants have been asked to use it to advocate for policy change at the federal and local levels. In addition, AcademyHealth and ACT for Health will disseminate the Playbook through their websites and direct distribution to national and local organizations.

Given the wide-ranging and complex nature of this challenge, there are advocacy leadership and support roles for every sector, including public and private funders; health and social services providers; law enforcement; state and local leaders in K-12 education; college and university officials; employers; health plans; researchers; advocates for adolescent wellbeing; and federal legislative and executive branch leadership.

Too many of our teens are suffering. Though we too often look away from the consequences, the anguish of our children is affecting all of American society. Their voices call out to us. They deserve no less an answer than a concerted effort on our part to help them avoid the devastating effects of a mental health crisis.

Endnotes

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Appendix A. National Summit Methods

National Summit for Policy & Action on Teen Mental Health Crises
National Summit Planning Methods

AcademyHealth & ACT for Health
September 30, 2019

National Summit Planning Methods

The National Summit for Policy and Action for Teen Mental Health Crises was a collaborative effort by AcademyHealth, Adolescents and Children Together for Health (ACT for Health), and the Jewish Healthcare Foundation to address gaps in the teen mental health crisis (TMHC) delivery system. The work surrounding this effort included the following:

- Convening a National Advisory Panel (NAP) to provide overall guidance for the project;

- Conducting a series of key informant interviews (KIIs) better understand current system limitations and potential policy opportunities;

- Scanning databases and the literature to identify an initial list of policy recommendations;

- Convening a group of policy experts, advocacy leaders, and key stakeholders to review the policy recommendations, prioritize them, and identify advocacy strategies for the highest priorities;

- Developing a Policy Playbook based on the deliberations from the National Summit for broad dissemination.

The following report provides an overview of the methods for each of these activities.

National Advisory Panel

A National Advisory Panel (NAP) was appointed to provide overall guidance to the project. A list of members is provided in Table 1. Panel members had expertise in adolescent health policy, state government issues, clinical and digital teen mental health care, and provision of federally funded technical assistance for crisis response. The panel was engaged through a series of virtual convenings and email communications between January and April 2019. Panel members provided review and comment on policy recommendation lists, a script for key

Table 1. National Advisory Panel (NAP) for the National Summit on Policy & Action for Teen Mental Health Crises

Name	Title	Affiliation
Nicholas B. Allen, PhD	Director, Center for Digital Mental Health	University of Oregon
Alfiee Breland-Noble, PhD, MHSc	Chief Executive Officer	The AAKOMA Center, PLLC
Claire Brindis, DrPH	Professor and Director, Philip R. Lee Institute for Health Policy Studies Co-Project Director, Adolescent and Young Adult Health National Resource Center	University of California, San Francisco
Nathanial Counts, JD	Associate Vice President of Policy	Mental Health America
Wayne Lindstrom, PhD	Director, Business Development	RI International
Jill Ryan, MPH	Executive Director	Colorado Department of Health and the Environment
Michelle Zabel, MSS	Assistant Dean and Director, The Institute for Innovation and Implementation School of Social Work	University of Maryland, Baltimore

*Affiliations current at time of National Summit.

informant interviews (KIIs), potential interviewees, National Summit invitees, and the National Summit agenda. All panel members participated in the National Summit, providing: critical background information about teen crises, a model of a contemporary crisis response system, guidance for developing advocacy strategies, facilitation of domain-specific breakout groups, active participation throughout the National Summit, and review of the Policy Playbook.

Key Informant Interviews

The purpose of the KIIs was to better understand the gaps in delivery and policy that hinder the implementation of a comprehensive TMHC response system and to obtain from key stakeholders potential policy opportunities for building such a system. To identify potential interviewees, the project team first determined five categories of TMHC-relevant perspectives: advocacy, health and related services and providers, state and local government, people with lived experience, and federal government. An initial list of organizations for each of the five categories was developed and shared with the NAP for feedback, including additions. Each NAP member was invited to rank his or her top three individuals/organizations within each category; four NAP members responded with their rankings. Based on these rankings, the project team determined the top three individuals/organizations in each category, and identified a person in a leadership position for each one. We sent an invitation to participate to each of these 15 individuals; 10 of the invitees agreed to take part in a KII. All ten interviews were conducted in March, 2019 and captured each of the stakeholder perspectives, including: advocacy (2), service organizations and providers (3), lived experience (1), state and local government (1), and federal government (2). A listing of interviewees is provided in Table 2.

Table 2. Participants Serving as Key Informants

Name	Title	Affiliation
Johanna Bergan	Executive Director	Youth MOVE National
Gary Blau, PhD	Chief, Child, Adolescent and Family Branch, Center for Mental Health Services	SAMHSA
Alex Briscoe, MA	Principal	California Children's Trust
Gabrielle Carlson, MD	President	American Academy of Child and Adolescent Psychiatry
Scott Dziengelski	Director, Policy and Regulatory Affairs	National Association for Behavioral Healthcare
Evelyn Kappeler	Director	Office of Adolescent Health
Deborah Klein-Walker, EdD	Past President	Global Alliance for Behavioral Health and Social Justice
Joseph Parks, MD	Medical Director	National Council for Behavioral Health
John Tharp	Sheriff	Lucas County, Ohio
Kathy Williams	Lead North Carolina Community Liaison	The AAKOMA Center, PLLC

Interviews were semi-structured, 45 minutes in duration, conducted over the telephone, and recorded. Participants were asked to (1) describe an ideal TMHC delivery system; (2) describe gaps in the current system; and (3) identify opportunities and barriers for enacting policies to improve the TMHC system. Participants were asked to base their answers on their personal/professional cumulative experience and expertise rather than as an official representative of their affiliated organization. Appendix B presents a summary of the interviews, and Appendix C presents the interview guide used during discussion.

Development of Policy Recommendations

Between January and May 2019, the project team worked with NAP members to identify, categorize, and refine a set of draft policy recommendations that would be presented for consideration at the National Summit. For purposes of gathering and refining policy recommendations, the project team developed the following definition of a teen mental health crisis (TMHC):

- A situation in which a teen experiences a moderate to severe psychiatric or mood disorder, substance use emergency, or violence-related event that is highly and imminently likely to harm the teen or another person.

Crisis response was defined as typically lasting from 4-8 weeks and comprising identification or recognition of the crisis situation, connection to immediate services for crisis stabilization, and services that can lead to effective recovery, including ensuring that the teen does not return to a dangerous or unsuitable environment.

All policy recommendations were developed for the federal government and focused on federal assistance to states and local communities to facilitate implementation of a crisis response system for teens in crisis.

Sources of the policy recommendations identified prior to the National Summit included:

- Published and grey literature on crisis response, prioritizing policies specific to teens
  - o Published: PubMed, Google Scholar, Health Evidence.
  - o Grey: Key think tanks, policy organizations, advocacy organizations.
  - o Searches focused on 2018-2019, but went back as far as 2015.
- Key informant interviews
- NAP members

Policies were categorized according to the following seven policy domains:

- Models of care;
- Information and communication technology;
- Building the workforce;
- Performance improvement;
- Financing and funding;
- Teen centeredness and family engagement; and
- Research and evaluation.

Tables were developed for each domain; each domain included between five and 20 policy recommendations plus the following components:

- Overall rationale(s) for the policy recommendations
- Responsibility (within the federal government)
- Feasibility forecast, and
- National Summit participant feedback (blank column for participants' use)

Policy recommendations were revised iteratively with guidance from NAP members in advance of sharing them with National Summit participants prior to the in-person meeting. The extensive list formed the foundation of the policy discussions planned for the National Summit on June 5, where participants were asked to recommend additions or changes, and to prioritize the list, taking into consideration the effectiveness and feasibility of the policies. The full list of policy recommendations is provided in Appendix D.

National Summit

The National Summit was held on June 5, 2019, from 7:30 a.m. to 4:30 p.m. at the offices of AcademyHealth, 1666 K St NW, Suite 1100, Washington DC 20006. The aim was to identify a near term agenda of policy plays to enhance care for teens experiencing mental health crises. The agenda and participant list are provided in Appendix E and Appendix F, respectively. The National Summit brought together 45 national and local advocates and policy experts for a mix of large group presentations and small group working sessions. The meeting resulted in a set of priority policy recommendations coupled with advocacy strategies for advancing them.

Policy Prioritization. Participants were assigned to breakout groups by policy domain (Appendix G), each with an assigned facilitator from the NAP or project team. Breakout group composition was designed to have a balance of domain-specific expertise, multiple stakeholder types, and NAP members in each group. Using the master list developed in advance of the meeting (Appendix D), morning breakout groups were asked to prioritize a set of no more than two to three policy recommendations for their assigned domain and write them on a flip chart. Designated spokespersons then presented the results of these deliberations to the large group. Following this, National Summit participants were asked to further refine the prioritized policies by placing a red dot sticker next to the policy recommendation they considered to be the highest priority for each domain.

Advocacy Strategies. In the afternoon, participants were asked to reconvene with their same breakout groups to focus on developing advocacy strategies for the policy recommendation that ranked highest following the red dot voting exercise. Groups were charged with conducting a Force Field Analysis[1], noting factors in support of and against the change that came to mind for the breakout group. The purpose of force field analysis is to identify drivers and barriers to change, so it is a helpful tool for clarifying priority levers for advocacy attention. Once the groups carried out their Force Field Analyses, they were asked to develop strategies for bolstering or mitigating the priority forces using structured worksheets and considering objectives, target audiences, messengers, allies/partners, activities, and messages (Appendix H). National Summit participants again reconvened, submitted their worksheets, and reported on breakout group discussions.

Policy Playbook Development

The project team developed the Policy Playbook by describing the policy recommendations and related advocacy strategies identified at the National Summit (using the documents provided by National Summit participants); and writing background sections for each domain, an Executive Summary and an Introduction section. The draft Policy Playbook was reviewed by National Summit participants between the end of August and early September, 2019. The revised Playbook incorporated their feedback and was finalized for submission to JHF by September 30, 2019.

[1]Lewin K. (1951) 'Field Theory in Social Science', Harper and Row, New York.

Appendix B. National Summit Key Informant Interviews Summary

National Summit for Policy & Action on Teen Mental Health Crises
Key Informant Interview Summary

AcademyHealth & ACT for Health
April 23, 2019

Introduction

AcademyHealth, in partnership with Adolescents and Children Together for Health (ACT for Health) and Jewish Healthcare Foundation (JHF), is convening a National Summit for Policy and Action on Teen Mental Health Crises (TMHC) in June, 2019, which aims to identify a near term agenda of policy plays to enhance care for teens experiencing mental health crises. The planning, preparatory work, and subsequent Policy Playbook development were all overseen by a National Advisory Panel (NAP) of experts and key stakeholders in the field. In preparation for this event, the project team conducted a series of key informant interviews (KIIs) with individuals whose work was relevant to the field of teen mental health crisis response. The purpose of these KIIs was to better understand the gaps in delivery and policy that hinder the implementation of a comprehensive TMHC response system and to obtain from key stakeholders potential policy opportunities for building such a system. The following report summarizes the results of those interviews.

Methods

To identify potential interviewees, the project team first determined five categories of TMHC-relevant perspectives: advocacy, health and related services and providers, state and local government, people with lived experience, and federal government. An initial list of organizations for each of the five categories was developed and shared with the NAP for feedback, including additions. Each NAP member was invited to rank his or her top three individuals/organizations within each category; four NAP members responded with their rankings. Based on these rankings, the project team determined the top three individuals/organizations in each category, and identified a person in a leadership position for each one. We sent an invitation to participate to each of these 15 individuals; 10 of the invitees agreed to take part in a KII. All ten interviews were conducted in March, 2019 and captured each of the stakeholder perspectives, including: advocacy (2), service organizations and providers (3), lived experience (1), state and local government (1), and federal government (2). A listing of interviewees is provided in Table 1.

Table 1. Participants Serving as Key Informants

Name	Title	Affiliation
Johanna Bergan	Executive Director	Youth MOVE National
Gary Blau, PhD	Chief, Child, Adolescent and Family Branch, Center for Mental Health Services	SAMHSA
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Scott Dziengelski	Director, Policy and Regulatory Affairs	National Association for Behavioral Healthcare
Evelyn Kappeler	Director	Office of Adolescent Health
Deborah Klein-Walker, EdD	Past President	Global Alliance for Behavioral Health and Social Justice
Joseph Parks, MD	Medical Director	National Council for Behavioral Health
John Tharp	Sheriff	Lucas County, Ohio
Kathy Williams	Lead North Carolina Community Liaison	The AAKOMA Center, PLLC

Interviews were semi-structured, 45 minutes in duration, conducted over the telephone, and recorded. Appendix C presents the interview guide used during discussion. Specifically, participants were asked to (1) describe an ideal TMHC delivery system; (2) describe gaps in the current system; and (3) identify opportunities and barriers for enacting policies to improve the TMHC system. Participants were asked to base their answers on their personal/professional cumulative experience and expertise rather than as an official representative of their affiliated organization.

Results

Ideal System to Provide Care for Teens Experiencing a Crisis

The participants were asked, in accordance with question 4 in Appendix 2, to describe what they believed an ideal system for providing care to teens experiencing a mental health crisis would be. Several themes arose in the responses to this question: teen- and family-centeredness, integration, accessibility, workforce competence, acceptability, and the importance of the teen's social environment.

First, an ideal TMHC response system should be teen-centered. Teens experiencing a mental health crisis, along with their families, should not have to navigate a confusing network of services to obtain the care they need. Additionally, definitions of "crisis" and "trauma" should be defined by teens and their families. The crisis care that teens receive should also be appropriate to their level of development and be as unrestrictive as possible. The wellbeing of the teen should be prioritized at every level of care, and any transition between services should be a warm handoff, in which the teen's family and representatives from all care services are present.

Crisis services should be integrated into non-healthcare settings, as well. Many respondents stressed that mental health services should be included in educational settings; one participant said that, in their ideal system, teens would receive physical and mental health care in the same school facility. Workplaces and religious institutions should have the tools necessary to respond to teens in crisis, too. Law enforcement should be able to identify a TMHC as a medical emergency and refer teens in crisis to mental health services, not jail.

In an ideal system, crisis care would be accessible and affordable. Crisis response centers, hotlines, and "warmlines" should always be available. Mental health and addiction services should also be covered in parity to other medical services. Teens would also have resources available to connect them with services if they wanted to seek help but did not know where to go.

Furthermore, the workforce should be able to adequately respond to TMHCs. Mental health care providers should utilize standardized assessment tools (in the vein of CASII or LOCUS) to determine the appropriate level of care for a teen in crisis. They should also have the skills necessary to evaluate and stabilize teens in crisis and debrief them and their family members, and should understand how a teen's mental development informs the care they need. Additionally, the non-medical workforce should be trained to recognize, refer, and respond to TMHCs.

Also, in an ideal crisis response system, there would be no stigma around receiving mental health care. Teens would feel safe and secure seeking help for their mental health needs. Their care providers, in turn, would make sure that the teens understand that there is nothing wrong with receiving mental health care: teens are not "bad" because they are experiencing a crisis.

Finally, two respondents cautioned that a good crisis response system would make sure to not send the teen back to environments that may have contributed to the crisis in the first place.

Gaps in the Delivery of the Ideal Crisis Response System

The participants were next asked to describe the current gaps in the delivery of their ideal crisis response system (see Appendix 2, question 5). As before, there were several themes in their responses: lack of integration, workforce shortage, inadequate insurance coverage, lack of family involvement, and insufficient focus on prevention.

First, the current mental health care system in the U.S. is not well-integrated. In educational settings, for example, physical and mental health centers are generally separate. Because of different systems for keeping health and other personal records, it is also difficult to obtain or transmit patient details or intervention histories across different systems.

Respondents also pointed to the mental health workforce shortage as a major obstacle to the delivery of their ideal TMHC response system, noting that three-fourths of the country's counties have a shortage of mental health professionals. Current mental health professionals, including child psychiatrists, are also not compensated enough for their services. The youth support and law enforcement workforce were pointed to as other TMHC-relevant fields that needed more support. Additionally, the workforce requires training to effectively treat adolescents; adolescence is a unique developmental period, and adult or child-oriented care does not adequately address teens' mental health needs.

Furthermore, some children lack insurance that will adequately cover mental health services, or they and their families have difficulty understanding which services their insurance covers. For instance, not all mental health care providers accept Medicaid, and even if they do, their service might not be the best fit for every teen. One respondent pointed out that, while 60% of low-income children in California received the MMR vaccine, only 4% received mental health services, despite Medicaid's comprehensive coverage of mental health services.

Inadequate family involvement was described as a current gap in the current crisis system, as well. When a teen goes through a mental health crisis, their parents may suffer, too. Parents may feel overwhelmed by the time necessary for their child to recover from a crisis, or will deny that their teen is experiencing a mental health crisis in the first place. Several respondents stressed that a teen's family should be involved at every possible step of the crisis response.

While the project's primary focus is on the response to TMHCs, it is worth noting that many participants stated that there is not enough work done to prevent crises from occurring in the first place. One respondent said that a crisis is often the end result of an underlying mental health issue, and the crisis could be avoided if the teen's mental health was adequately cared for. Another pointed out that it is challenging to implement preventive practices because it is difficult to determine the extent of prevention necessary to prevent crises. They then said, however, that investing "upstream" from a crisis would improve teen health and save money.

Policy Barriers

Next, the participants described the barriers in existing policies and difficulties in enacting policies that contributed to the gap between the current and ideal TMHC response system, as further described in Appendix 2, question 6. In particular, they reported emergency department resources, financing gaps, disruptions in different levels of care, communication difficulties, and uninformed administrative decisions as barriers to administering an effective TMHC response system.

Emergency departments were generally described as ineffective in responding to teens facing a mental health crisis. Many insurance plans will only cover emergency treatment that arises from a TMHC but not the necessary outpatient rehabilitation services. However, many emergency departments do not contain staff that are trained in adolescent psychiatry or are equipped to respond to TMHCs. Consequently, teenagers with mental health crises use up significant resources when they visit EDs.

The respondents also pointed to various insurance gaps as policy barriers in the mental health system. For instance, Medicaid same-day billing restrictions on mental and physical health services restrict the ability of low-income teens to receive mental health care. Inadequate or inflexible contract language in managed care arrangements may prevent the implementation of desired modifications that would help teens from receiving the appropriate level of mental health care when a crisis occurs. Additionally, mental health parity requirements do not apply to fee-for-service Medicaid, although it does apply to managed care plans that pay FFS for mental health and substance use benefits. Even when teens' insurance is required by law to cover mental health in parity with physical health, the parity requirements may not be well-enforced.

Limits on funding were also described as policy barriers. Schools have limited budgets, so they are unable to consistently provide extensive mental health services to teens. Also, funding restrictions for one level of care were described as affecting other levels of care. For example, the establishment of qualified residential treatment programs under the Family First Prevention Services Act increased the bureaucratic and administrative burden on residential treatment facilities without increasing their funding; this limited the number of teens they could treat, diverting them to higher and lower levels of care.

Additionally, obstacles to communicating patient information serve as policy barriers. Law enforcement, for example, generally only receives personal health information from health care providers when that information (like a stabbing or gunshot wound) arises from

a crime. This can make it difficult for law enforcement to be conscious of a teen's mental illness when interacting with them. Even within health care, different systems of care may use different health record systems, making it hard to share information between providers.

Participants indicated that uninformed or unhelpful policies and programs could act as policy barriers, as well. This applied to service provision as well as efforts to provide Federal support.

The amount of time teens can spend in inpatient settings can be limited arbitrarily: one participant stated that limits on inpatient stays in a child and adolescent psychiatric ward they were familiar with were changed by the hospital administrator from thirty days on average to seven days on average. However, they pointed out, mental health care takes time, and a week is not necessarily enough time for teens to recover adequately from a mental health crisis. With a longer length of stay, according to this interviewee, kids can try out going back to their home and school environments and return to the hospital if they need to. This participant attributed these arbitrary decisions to a lack of an evidence base for adolescent inpatient psychiatric care activities, and recommended that more research be done.

One community-level respondent remarked on the Federal grant-finding and grant-writing processes. For local people not connected to a university, the activities are cumbersome and inefficient, which could limit their ability to get assistance with local programs. In addition, this interview said that Federal support in the form of sending pamphlets to disseminate is not helpful and a waste of resources.

Policy Opportunities

Finally, the participants described opportunities to advance and enact policies to adequately respond to TMHCs (see Appendix 1, question 7). They listed the current focus on health care in politics, the opioid crisis, interest in integrated care, parents' concerns, the recent activist stance of youth themselves, and funds available for research.

First, teen behavioral health should be part of the discussion on health issues facing the country. The shifting politics of health care reform may introduce opportunities to advocate for the expansion of mental health coverage. The opioid crisis may be an opportunity to bring attention to teen substance abuse, as well, and advocate for more efficient delivery of behavioral health services. One respondent believed that a White House conference on health issues facing teenagers could be helpful.

Additionally, the increasing Federal focus on integrated care at several levels could serve as a policy opportunity. For example, the Centers for Medicaid and Medicare Services recently signaled to the states that they would support efforts to reform mental health services, including as part of an integrated system. One respondent indicated that the focus on integrating primary care with mental health care could make it easier for schools to include mental health services. Another participant talked about the integration of services within the crisis continuum and was optimistic regarding the future of teen mental health, saying that the money for an efficient child safety net exists, but the different pieces of the safety net need to be better integrated to develop a feasible financial strategy.

Respondents also explained that teens and their parents themselves are policy opportunities. Parents and teens should be informed of the gaps in their coverage and the existence of parity laws so that they know what care that they are entitled to receive. Similarly, policymakers should listen to teenagers and their families to learn about deficiencies in mental health care and possible solutions. One respondent believed that current teen advocates should work with mental health players to push for improvements to policies regarding teen mental health.

Lastly, research should be conducted on a number of topics to inform the policymaking process. Research on adolescent brain development should continue so that mental health providers can respond to a youth in crisis in a manner appropriate to their developmental stage. The current state of teen mental health in the country, especially with regard to their relatively high levels of anxiety, should be researched. Additionally, telemedicine should be investigated to determine the best practices for integrating it into the current child and adolescent mental health system.

Appendix C. National Summit Key Informant Interview Script

National Summit for Policy & Action on Teen Mental Health Crises
Questions for Key Informant Interviews

AcademyHealth & ACT for Health
March 6, 2019
NOTE: Questions may vary somewhat depending on interviewee.

Introduction

A. Thank you for taking the time to participate in this interview.

- To ensure we have accurate notes stemming from these conversations, we would like to record this interview. Please note that your name and organization will not be connected with any of your responses in any reports stemming from this effort. Is it ok with you for us to record?

- As you know, we are working to develop a set of prioritized and actionable policy recommendations to improve care for U.S. teens experiencing mental health crises.

- This small set of semi-structured key informant interviews with you and others will contribute to the development of a Policy Playbook that will be disseminated to key policymakers and other stakeholders.

- Please note that in this interview we are looking for responses based on your expertise and experience, and not the official policy views of any organization you may be affiliated with.

- Do you have any questions so far?

B. May I get your full name, the organization(s) you work for (if any), and what positions you hold in those organizations.

C. Background:

- Let me start with giving you our working definitions of teens, teen mental health crises, and the goals of mental health crisis services and supports:

    o A Teen is an individual of any age 13 through 19.

    o A Teen Mental Health Crisis is a situation in which a teen experiences acute symptoms such as an acute disturbance in their normal patterns of thought, mood, behavior, or social relations that are highly and imminently likely to cause harm to the teen or others. For purposes of this initiative, mental health may include psychiatric symptoms, disturbances or disorders, as well as substance use- and aggression-related thoughts and behaviors.

    o The kinds of services and supports that we are considering typical crisis interventions for teen mental health emergencies include those aimed at:

        ▪ identifying or recognizing the teen's situation as a crisis

        ▪ arranging for and/or providing stabilization and treatment for the immediate crisis

        ▪ arranging for and/or providing longer-term follow-up care and supportive environments through recovery, including avoidance of a repeat crisis

Interview Questions

1. Based on our definitions, can you briefly give us your vision of an ideal system that would provide care and enhance social and built environments for U.S. teens experiencing mental health crises?

   a. Please be sure to include what, if anything, makes your vision teen-specific?

2. Now, given that ideal vision, what would you say are the gaps in delivery, social or built environments, and public policies that would have to be addressed for the ideal system to be in place? Here, we are thinking about areas such as the following. Feel free to address as many as you wish or to identify additional themes:

   a. Leadership and planning

   b. Coordination and integration across components and social and health sectors

   c. Financing

   d. Workforce

   e. Health and other services (e.g., child welfare, juvenile justice, police/sheriff)

   f. Social and built environments to address societal factors related to mental health crises

   g. Person-centeredness, including teen-friendliness and cultural acceptability

3. What do you see as the major policy barriers and challenges to closing the gaps you identified above to achieve your ideal vision of a teen-friendly mental health crisis system?

   a. Please think about the same areas as in the previous question, and identify additional matters if necessary.

4. What do you see as the major opportunities for policies for achieving the ideal crisis mental health system tailored to adolescents?

   a. Policy opportunities may include the following:

      i. Existing laws, programs, and appropriations that can be expanded to cover additional foci

      ii. Policy "windows" - a scenario in which the ground is fertile for the uptake of an idea

      iii. New technological innovations

      iv. New advocacy organizations

   b. Please think about the areas we discussed previously, and identify additional areas if necessary.

5. We have reached the end of our interview. Thank you very much for responding to our questions. Is there anything else you would like to add?

6. Finally, would you like to receive a copy of the Policy Playbook when it is published later this year?

   a. If YES, confirm contact information.

Appendix D. National Summit Policy Recommendations: Full List

Teen Mental Health Crises: National Summit for Policy & Action

A National Policy Playbook

Prepared by AcademyHealth & ACT for Health

In partnership with the Jewish Healthcare Foundation

May 29, 2019

Table of Contents

Guide to Reading & Reviewing This Document

This document contains a draft list of policy recommendations, organized into seven categories. Below we provide some guidance that may be helpful as you read this document.

Purpose. This list will form the foundation of the policy discussions planned for the National Summit on June 5, where participants will be asked to recommend additions or changes, and to prioritize the list, taking into consideration the effectiveness and feasibility of the policies.

Definition: For the purposes of the National Summit, a teen mental health crisis (TMHC) is being defined as a situation in which a teen experiences a moderate to severe psychiatric or mood disorder, substance use emergency, or violence-related event that is highly and imminently likely to harm the teen or another person. Based on guidance from the National Advisory Panel, crisis response is defined as typically lasting from 4-8 weeks and comprising identification or recognition of the crisis situation, connection to immediate services for crisis stabilization, and services that can lead to effective recovery, including ensuring that the teen does not return to a dangerous or unsuitable environment.

It is important to note that the needs of teens for improved environments and services to enhance mental health and substance use and violence-related services exist across the entire ecological framework of social determinants and care types. While the crisis period is part of this overall continuum and may have implications for other services andactions, is only the crisis period that is the focus of this initiative and National Summit.

Recommendation Focus: All policy recommendations are for the Federal government and focused on Federal assistance to States and local communities to facilitate implementation of a crisis response system for teens in crisis.

Recommendation Sources:
- Published and grey literature on crisis response, prioritizing policies specific to teens.
    - o Published: Pubmed, Google Scholar, Health Evidence.
    - o Grey: Key think tanks, policy organizations, advocacy organizations.
    - o Searches focused on 2018-2019, but went back as far as 2015.
- Key informant interviews
- NAP members

Recommendation Ordering:
- *Models of Care* is first, because these recommendations address the overall crisis continuum and thus provide a roadmap for many of the other recommendation topics.
- *Information & Communications Technology* through *Teen-Centeredness & Family Engagement* comprise policies intended to contribute to making the overall system and its components work, especially for teens. These are in no particular order.
- *Research & Evaluation* is last. The purpose of the project was not to develop a set of research recommendations, and we did not conduct a systematic evidence review to this end. Rather, these capture the needs for research or evaluation identified during our scanning of the literature.

Table Structure:

- Following the topic heading and overall rationale(s) for the policy recommendations, each table has 4 columns:

    o   Policy Recommendations,

    o   Responsibility (within the Federal Government)

    o   Feasibility Forecast, and

    o   Summit Participant Feedback (blank column for Summit participants' use before and/or during the Summit on June 5.).

Feasibility Forecasts: Weather icons are used to provide a qualitative assessment of the relative difficulty of a recommendation being implemented in the current policy environment.

Icon	Qualitative Assessment of Implementation Feasibility
☀	Least difficult
⛅	Somewhat difficult
☁	Difficult
☁☁	Most difficult

List of Acronyms

Acronym	Term
ACF	Administration for Children and Families (DHHS)
AHRQ	Agency for Healthcare Research and Quality
CDC	Centers for Disease Control and Prevention
CMHS	Center for Mental Health Services
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare and Medicaid Services
DASH	Division of Adolescent and School Health (CDC)
DHHS	Department of Health and Human Services
DOJ	Department of Justice
DOL	Department of Labor
ED	Department of Education
EHB	Essential Health Benefits
FTC	Federal Trade Commission
HRSA	Health Resources and Services Administration
HUD	U.S. Department of Housing and Urban Development
MAT	Medication-assisted treatment
NIAAA	National Institute on Alcohol Abuse and Alcoholism (NIH)
NICHD	National Institute on Child Health and Human Development
NIDA	National Institute on Drug Abuse (NIH)
NIH	National Institutes of Health
NIMH	National Institute of Mental Health (NIMH)
ONC	Office of the National Coordinator for Health Information Technology (DHHS)
OS	Office of the Secretary (DHHS)
SAMHSA	Substance Abuse and Mental Health Services Administration (DHHS)
TA	Technical Assistance
TMHC	Teen mental health crises
USDA	U.S. Department of Agriculture
VBP	Value-Based Payment

1. Models of Care

Rationale: Crisis mental health and related responses should exist along a highly integrated, stepped care, integrated continuum, from identification and recognition of a crisis situation, through ensuring that the teen is on the way to recovery through access to evidence-based services and modifications to the teen's environment, as needed. These cross-sectoral models, and many of their components, are well described in general and to some extent for children, but not for teens.

Components can include 911-type crisis call centers and roles for law enforcement, child welfare systems, schools, hospital emergency departments, and traditional mental health and substance abuse treatment systems. Cross-sectoral integration is essential because teens in crisis can be recognized in many different places, by a broad range of actors, and with different acute symptoms.

Policy Recommendations	Responsibility	Feasibility	Summit Feedback
Support the development of a comprehensive matrix of integrated cross-sectoral teen mental health crisis system components for States and local communities to use to identify and implement missing components and multisector connections. (*Also see Financing and Funding category.*)	• DHHS • DOJ • ED	(partly sunny)	
Provide evidence-informed guidelines, technical assistance, and financial support to school districts and associated communities for crisis responses and teen-focused recovery plans.	• ED	(sunny) [Guidelines] (partly sunny) [TA, funding]	
Assist Emergency Departments and other entities with teens as patients or potential clients to create linkages to behavioral health and crisis services.	• DHHS • DOL • DOJ • ED	(cloudy)	
Continue to help support and create mental health and related drop-in wellness and service centers, and include attention to TMHC as a requirement of support.	• DHHS • DOJ • ED	(partly sunny)	
Support the education of adolescents in mental health and related crises and how to help as peer counselors.	• SAMHSA • DOJ • ED	(partly sunny)	
Support effective TMHC training for all adults with responsibilities for teens, including parents, families, school staffs, recreational and athletic staff, employers, juvenile justice, law enforcement, and child welfare.	• DHHS • DOJ • ED	(partly sunny)	
Provide support to all States and, communities, and youth-serving organizations to meaningfully engage young people with lived experience of TMHC in the design, implementation, and evaluation of all TMHC-related initiatives and programming.	• DHHS • DOJ • ED	(partly sunny)	
Provide support and technical assistance directly to teens or groups of teens to design, implement, and evaluate TMHC-responsive initiatives.	• DHHS • DOJ • ED	(cloudy)	

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2. Information & Communications Technology

Rationale: Innovations in information and communications technology (ICT) appear promising for use during all phases of responses to teens in crisis, from identification and recognition through getting teens on the path to recovery. Effectiveness research specific to teens is limited, although there are recommendations for enhancing the evidence base.

Examples of ICT in TMHC include using voice data, text messages, and other social media as screening tools; games; internet-based self-help tools; EHR-embedded risk calculators to identify teens at risk of psychosis and improve outcomes of first episode psychosis; video-conferencing and other tele-mental health tools to assess and stabilize teens and have ongoing connections as they get on the path to recovery; and text-messaging to engage court-involved non-incarcerated youth in behavioral treatment.

Policy Recommendations	Responsibility	Feasibility	Summit Feedback
• Implement and actively disseminate a national 3-digit number for "no wrong door" access to a teen-friendly crisis response continuum of care.	• SAMHSA		
• Support expansion of digital mental health approaches to identification and recognition, immediate crisis response, evaluation and stabilization, through follow-up designed to ensure a path to recovery.	• NIH • ONC		
• Push information technology companies to account for TMHC in their designs and services.	• FTC • FDA • New Regulatory Entity		

3. Building The Workforce

Rationale: The professional behavioral health workforce is very limited, especially when child and adolescent expertise and racial and ethnic diversity are considered. In addition, the extent of knowledge and capacity for TMHC crisis work among key professionals and laypeople who could be trained as peer counselors appears to be low. Several challenges contribute to the low engagement in behavioral health and adolescent mental health, including low reimbursement rates and high burdens for credentialing and insurance paperwork. Further, work in crisis response can be demanding, resulting in reductions in professional and peer well-being with consequences such as burnout.

Policy Recommendations	Responsibility	Feasibility	Summit Feedback
• Design or redesign workforce development and organizational capacity initiatives so that the racial, ethnic, gender, and socioeconomic characteristics of the professional and peer specialist TMHC-relevant workforces and delivery organizations correspond to that of the teen population.	• DHHS • DOJ		
• In order to create demand for adolescent-specific mental health providers, enforce provisions of the ACA that "[require] that insurers maintain an adequate network of behavioral health providers to ensure that all services are accessible without unreasonable delay."	• DOL		
• To reduce administrative burden and encourage provider insurance participation, support States to implement centralized provider credentialing processes for service professionals and peer specialists relevant to TMHC response.	• DHHS • DOL • DOJ		
• Include in all workforce enhancement initiatives support for the educational workforce and secondary school organizations.	• DHHS • DOJ • ED		
• Enhance or establish loan forgiveness or repayment programs to provide incentives specifically for TMHC-related service providers.	• DHHS • DOJ • ED		
• Provide funding and training for peer specialists to act as support partners for parents and youth to help them navigate the TMHC continuum.	• DHHS • DOJ • ED		
• Support adolescent-specific training for relevant professionals, peer specialists, and others engaged in crisis response across all sectors.	• DHHS • ED • DOJ		
• Support communities to provide wellbeing assistance to the professionals, peer specialists, other personnel, and organizations that provide crisis response to teens across all sectors.	• DHHS • DOL • DOJ • ED		

4. Performance Improvement

Rationale: In addition to informed critiques of the performance of mental health care delivery systems, many observers have observed a need for performance improvement across the mental health, substance abuse, juvenile justice, and child welfare delivery systems, including needs for improvement in the crisis response system. Recent reviews of quality improvement and implementation strategies suggest both the promise of selected current improvement strategies as well as the need for further enhancement and evaluation. National and international observers also note a need for additional performance measures suitable for crisis care and its components.

Policy Recommendations	Responsibility	Feasibility	Summit Feedback
Collect and publicly report data using existing performance measures, adapted to reflect performance for teens, by including measures in national and local performance measurement systems. • Examples include: quality measures in the Medicaid/CHIP Child Core Set, others endorsed by the National Quality Forum, and measures developed within the Pediatric Quality Measures Program (PQMP). PQMP measures include caregiver counseling on lethal means restriction for suicidal patients; documentation of communication with an outside provider for admitted suicidal patients; and screening for comorbid substance abuse in ED patients with psychosis.	• DHHS • ED		
Build on the Pediatric Quality Measures Program to develop and implement additional crisis-related performance measures relevant to care for teens in crisis. Examples include: • Access, including timing, and use of crisis services by teens, including but not limited to, medication-assisted treatment (MAT). • School policies and programs related to opioid use, violence perpetration, and other mental health emergencies. • Measures of diversion away from restrictive and costly settings of care. • Parity implementation for aspects of care most relevant to teens in crisis.	• DHHS • ED • DOJ • DOL		
Build on CMMI value-based payment demonstration models such as InCK and Accountable Health Communities to increase opportunities for cross-sectoral performance improvement, with specific requirements for attention to TMHC-related needs.	• CMS • DOJ • ED • HUD • USDA		
Increase support for States, communities, and settings to use and evaluate promising quality improvement and implementation strategies for cross-sectoral models and their specific components to enhance access, effectiveness, client-centeredness, and safety for teens, and publicly report the processes and outcomes. • For example, use funding thresholds to ensure that relevant funded entities use evidence to provide care. • Set a minimum percentage of expenditures for mental health, substance abuse, and violence-related performance improvement.	• DHHS • ED • DOJ		

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5. Financing & Funding

Rationale: Financing and funding for mental health, substance use, and aggression-related treatment services has long been a challenge that impedes access to care and its quality. Specific to crisis response, the National Action Alliance for Suicide Prevention Crisis Now Task Force found that "the absence of consistent expectations for crisis care functioning and funding is problematic. Among other issues: The method of financing crisis mental health services varies from state to state. In many cases, it is cobbled together, inconsistently supported, and inadequate."

Policy Recommendations	Responsibility	Feasibility	Summit Feedback
Financing			
Continue to expand public and private insurance coverage for teens for crisis intervention, including treatment of mental health and substance use crises and disorders.	• DHHS • DOL	☁️	
• Standardize across States and insurance plans the ACA Essential Health Benefits (EHB) requirements for mental health and substance use, and for those benefits within the pediatric EHB.	• DHHS	☁️	
• Enforce parity laws and regulations specifically with respect to the teen crisis services continuum.	• DHHS • DOL	☁️	
• Require public and private health insurers, including self-funded employers, to cover comprehensive crisis services or provide incentives for State insurance commissioners to so require.	• DHHS	☁️	
• Enhance Federal match for Medicaid for teen mental health and related crisis response continua.	• DHHS	☁️	
• Fully enforce the Early and Periodic Screening, Detection, and Treatment (EPSDT) benefit under Medicaid, beginning with mental health requirements.	• DHHS	☁️	
• Develop value-based payment models for cross-sectoral teen-focused Crisis Response Episodes of Care.	• DHHS • DOJ • ED	🌤️	
Funding			
Fund States and Local Communities to ensure that a full continuum of evidence-based teen mental health and related crisis response care is available.	• DHHS • DOJ • ED	☁️	
• Establish an independent panel to determine how much, for whom, in what contexts, and through what mechanisms crisis response funds should be increased, and how they can be combined to serve teens in crisis situations.	• DHHS • DOJ • ED	🌤️	

5. Financing & Funding (cont'd)

• Provide support to States and local communities to develop and implement ways to expand their funding capacity (e.g., through SAMHSA Block Grant recommendations or requirements; switch to evidence-based strategies).	• DHHS • DOJ • ED		
• Provide federal funding to develop and sustain programs directly to organizations representing and led by adolescents.	• All Federal agenices		
• Include funding and directives for school-based mental health services crisis response readiness in federally funded health, mental health, and education programs.	• DHHS • ED		
• Add generous TMHC-relevant set-asides and similar requirements in discretionary Congressional authorizations and appropriations, and in Executive Branch program planning, for generic discretionary funding sources such as the 21st Century Cures Act, the SUPPORT Act, and future initiatives.	• U.S.Congress • DHHS • DOJ • ED		
• Mandate that funding recipients such as States and Systems of Care grantees embed TMHC crisis response in their service models.	• DHHS • DOJ • ED		
• Provide technical assistance to States and local communities to help them develop sustainable funding models out of current patchworks.	• DHHS • DOJ • ED		
• Develop funding partnerships with private philanthropy to support innovative models for the teen mental health and related crisis response continuum.	• DHHS • DOJ • ED		

6. Teen-Centeredness & Family Engagement

Rationale: Policies and programs in health and other social systems do not reflect what we now know about how adolescents develop and grow as they transition from childhood to adulthood. Adolescents continue to be seen as bundles of risk-taking behaviors.

Family engagement is also critical in TMHC. Considerable research finds that teens want their families involved in their lives, as long as they can be involved using productive approaches (e.g., authoritative parenting). A smaller body of research finds associations between such positive parenting and good teen mental health. Very few studies have evaluated the effectiveness of interventions to enhance families' relationships with teens. There are more studies of interventions to enhance family engagement in teens' mental health and substance abuse treatment care.

Policy Recommendations	Responsibility	Feasibility	Summit Feedback
Teen-Centeredness			
• Mount an evidence-based social marketing campaign to acquaint the public and policymakers with current, scientifically valid information about the nature of contemporary adolescence.	• SAMHSA • DOJ • ED		
• Hold a White House or Surgeon General's Conference on Adolescence to share the latest science and develop guidance for implementation.	• Office of the President • DHHS • DOJ • DOL • ED		
• Provide grants to adolescent-led organizations to design, implement, and evaluate TMHC response systems.	• DHHS • DOJ • ED		
Family Engagement			
• Build on models such as the HRSA Family to Family Health Information Centers and the SAMHSA CMHS Statewide Family Network grant program to develop more effective initiatives to provide parents with practical strategies to understand and address TMHC and to increase parental engagement in service design, implementation, and evaluation. For example: create models for educating and supporting parents of teens who have attempted suicide.	• DHHS • DOJ • ED		

7. Research & Evaluation

Rationale: Research in pediatrics, child mental health and violence is limited. For example, between 2007 and 2015, child health services research (CHSR) funding by the National Institute of Mental Health declined by 42%. Only substance abuse research is increasing, in response to the opioid crisis. The results of NIH inclusion policies are uncertain.

- Funding for criminal justice health research via NIH is minimal.
- A few foundations have funded research, including implementation evaluation research, on vulnerable teens.
- Research in child welfare is said to require an infrastructure.
- Research in pediatrics declined after the NIH doubling period.
- No studies appear to have estimated spending levels and trends for adolescent-specific research.

Policy Recommendations	Responsibility	Feasibility	Summit Feedback
• Address equity: Across all research and evaluation efforts, address the needs of the most vulnerable teens, which may include: youths of color; LGBTQ adolescents; males and females, depending on the symptoms; and, for substance use, adolescents from more affluent families.	• DHHS • DOJ • ED	(cloudy)	
• Expand funding for research in teen mental health services, substance use clinical effectiveness and services, and violence prevention treatment and services.	• DHHS • DOJ • ED	(cloudy)	

• In the implementation evaluations recommended in "Performance Improvement," support hybrid effectiveness-implementation study approaches, given that questions remain about the clinical effectiveness of crisis models and their components.
  o Either separately or within a hybrid effectiveness implementation design, conduct clinical and organizational effectiveness research on the range of interventions embedded in the TMHC crisis response continuum. Examples include:
    ▪ Crisis Call Centers
    ▪ Emergency Department
    ▪ Warm handoff approaches
    ▪ Tele-mental health assessment
    ▪ Tele-mental health models (e.g., Child Psychiatric Access Programs)
    ▪ Mobile Response Teams
    ▪ Interventions with teens with immediate suicidal intent (acute suicidal crisis)
    ▪ Suicide relapse prevention
    ▪ Acute non-suicidal self-harm interventions
    ▪ Acute Overdose interventions
    ▪ Models for Emergency Department responses to TMHC.
    ▪ Step down units
    ▪ Tele-mental healthcare for crisis situations
    ▪ Follow-up after all TMHC care experiences, including inpatient psychiatric hospital care
    ▪ Home-based relapse prevention
	• AHRQ
	• DOJ
	• ED
	• NIAAA
	• NIDA
	• NIMH
		(sunny/cloudy)	

• Develop and test new models for creating and sustaining widespread teen and adult actionable awareness of teens at acute risk of suicide, non-suicidal self-harm, homicide and drug and alcohol overdoses.	• DHHS • ED • DOJ	(sunny/cloudy)	
• Reconsider the funding and delivery models for Youth and Teen Mental Health First Aid to enhance the evidence base and make the modified program more accessible to more communities.	• SAMHSA • NIMH	(sunny/cloudy)	

7. Research & Evaluation (cont'd)

• More expansively and rigorously study substance abuse interventions for teens to identify effective treatments, especially those combined with mental health treatments.	• NIDA • NIMH		
• Conduct research testing the effectiveness of interventions at the time of teen self-harm.	• AHRQ • ED • HRSA • NIMH		
• Support collaborative research across secondary schools that would work to identify evidence-based interventions during active shooter experiences.	• ED • NIMH • DOJ		
• Fund research to rapidly identify provider payment models that would draw more people to adolescent-specific psychiatry and related professions and increase the numbers of adolescent-centered professionals in other sectors.	• CMS/CMMI • HRSA • NIMH • NIDA • NIAAA		

Appendix E. National Summit Agenda

National Summit for Policy & Action on Teen Mental Health Crises

June 5, 2019
7:30 AM – 4:30 PM ET

AcademyHealth
1666 K. St. NW, Suite 1100
Washington, DC 20006

Agenda

Meeting Objective: *To identify a near term agenda of policy plays to enhance care for teens experiencing mental health crises, focusing on the following target areas:*

- *Models of care;*
- *Information and communication technology;*
- *Building the workforce;*
- *Performance improvement;*
- *Financing and funding;*
- *Teen centeredness and family engagement; and*
- *Research and evaluation.*

7:30 – 8:00 AM   **Breakfast & Networking**

8:00 – 8:20 AM   **Welcome, Introductions, & Objectives**
Lisa Simpson, President & CEO, AcademyHealth
Karen Feinstein, President & CEO, Jewish Healthcare Foundation
Richard Wittenberg, President & CEO, ACT for Health

8:20 – 9:10 AM   **Understanding the Challenge**

8:20 – 8:30 AM – Using Case Studies of Teen Crisis as Lived Experience
Alfiee Breland-Noble, CEO, The AAKOMA Center

8:30 – 8:40 AM – Contemporary Crisis Intervention Systems for Teens
Michelle Zabel, Assistant Dean & Director, The Institute for Innovation and Implementation, School of Social Work, University of Maryland, Baltimore

8:40 – 9:10 AM – Large Group Discussion
Alfiee Breland-Noble, CEO, The AAKOMA Center
Michelle Zabel, Assistant Dean & Director, The Institute for Innovation and Implementation, School of Social Work, University of Maryland, Baltimore

9:10 – 9:40 AM   **Exploring Policy Options for Teen Mental Health Crises**
Denise Dougherty, Senior Scholar in Residence, AcademyHealth

9:40 – 9:50 AM   **Break & Move to Small Groups**

9:50 – 10:50 AM   **Small Group Policy Prioritization Discussion**
Each breakout group will focus on a different target area. Groups are tasked with prioritizing policy actions taking into account feasibility and potential for impact.

10:50 – 11:00 AM   **Break & Reconvene**

11:00 – 11:45 AM   **Small Group Discussion Report Out & Information Sharing**
Small groups share recommendations discussed in their group discussions.

11:45 – 12:15 PM   **Policy Prioritization**
Red-dot voting for policy priorities based on recommendations from small groups.

12:15 – 12:45 PM   **Lunch**

12:45 – 1:15 PM   **Fireside Chat**
Herminia Palacio, Deputy Mayor for Health and Human Services, City of New York
Lisa Simpson, President & CEO, AcademyHealth

1:15 – 1:45 PM   **Moving to Action & Advocacy**

                 1:15 – 1:35 PM – Elements of an Effective Advocacy Strategy
                 Claire Brindis, Professor of Pediatrics & Health Policy, University of California, San Francisco

                 1:35 – 1:45 PM – Policy Priorities & Advocacy Strategy Design
                 Elizabeth Cope, Senior Director, AcademyHealth

1:45 – 2:00 PM   **Break & Move to Small Groups**

2:00 – 3:00 PM   **Small Group Advocacy Strategy Discussion**
Each breakout group will focus on a different priority policy action. Groups are tasked with developing an advocacy strategy to include consideration of: objectives, specific activities, sympathetic and influential policymakers, compelling messages, and action timing.

3:00 – 3:15 PM   **Break & Reconvene**

3:15 – 4:15 PM   **Small Group Discussion Report Out & Information Sharing**
Small groups share recommendations discussed in their group discussions

4:15 – 4:30 PM   **Closing Remarks & Adjourn**
Lisa Simpson, President & CEO, AcademyHealth
Karen Feinstein, President & CEO, Jewish Healthcare Foundation
Richard Wittenberg, President & CEO, ACT for Health

Appendix F. National Summit Participant List

Policy & Action on Teen Mental Health Crises
National Summit Participant List

Summit Participants

Rachel Bonesteel
Specialist, Policy Analysis
Children's Hospital Association

Gabrielle de la Gueronniere, JD
Policy Director
Legal Action Center

Kathleen Delaney, PhD, PMH-NP, FAAN
Professor
Director, PMH-NP Program
Rush College of Nursing

Susan Duffy, MD, MPH
Director of Pediatric Special Projects
Department of Emergency Medicine
Brown University
Hasbro Children's Hospital

Kimberly DuMont, PhD
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Appendix G. National Summit Breakout Group Assignments

Breakout Group	Room	Participant	Breakout Group	Room	Participant
Models of Care	Connect (Huddle)	Claire Brindis	Funding	Engage II	Karen Feinstein
		Caitlin Gillooley			Robert Ferguson
		*Wayne Lindstrom**			Justine Larson
		Ron Manderscheid			*Michael Millenson**
		Kalpana Ramiah			Benjamin Miller
		Michelle Zabel			Joni Schwager
Information & Communications Technology	Connect (Huddle)	*Nicholas Allen**			Jonathan Webb
		Gabrielle de la Gueronniere	Financing	Skyline	Rachel Bonesteel
		Wendy Farmer			*Nathaniel Counts**
		Devin Jopp			Sinsi Hernández-Cancio
		Caroline Miller			Herminia Palacio
		Matthew Olego			Cecilia Oregon Echeverria
		Maria Trent			John Schlitt
Workforce	Connect (Huddle)	Alfiee Breland-Noble	Teen-Centeredness	Reception	*Elizabeth Cope**
		Kathleen Delaney			Dana Gold
		Denise Macerelli			Evelyn Kappeler
		Kathleen Minke			Deborah Klein Walker
		*Richard Wittenberg**			Katrina Mariategue
Performance Improvement	Develop	*Denise Dougherty**			Maria Rodriguez
		Susan Duffy	Research & Evaluation	Advance	Kimberly DuMont
		Kathleen Ethier			Kimberly Hoagwood
		Todd Krieger			Michael Hogan
		Jonathan Purtle			*Deborah Murdoch**

*Facilitator

Appendix H. National Summit Advocacy Breakout Worksheets

Advocacy Strategy Breakout Groups

Activity Instructions

Force Field Analysis

Use the worksheets provided to perform a Force Field Analysis for your policy priority:

1. Write your policy objective in the center box.

2. List all of the factors in support of change in the column on the left.

3. List all of the factors acting against change in the column on the right.

4. Score each factor according to its relative impact (1 = weak impact; 5 = strong impact).

5. Add up the total scores for each column.

Strategy Outline

Once you have carried out the Force Field Analysis consider the following questions:

1. Does your policy objective need to be amended in light of this analysis?

2. What strategies do you need to employ to strengthen the forces for and weaken the forces acting against the change that you have identified?

3. Given limited resources, which forces should be priority targets for an advocacy strategy? Identify 2 targeted actions for either strengthening or weakening one or more of the forces and outline a strategy in the worksheets provided. Consider objectives, target audiences, messengers, allies/partners, activities, and messages.

Score							
Forces AGAINST Change							**TOTAL**

Policy Change							

Score							
Forces FOR Change							**TOTAL**

	Targeted Action 1		Targeted Action 2
Advocacy Focus			
Messengers			
Target Audience (Level, etc.)			
Allies/Partners			
Activities & Messages			