Top Level Findings

pp. 5-11 of full Community Engagement Committee Report

Based on an inductive analysis of what we heard from community members, the qualitative analysis working group of the CEC developed a series of hypotheses and design recommendations relevant to crisis response systems in Jackson County. Those ideas and recommendations are listed briefly here, followed by detailed analysis. The evidence supporting that analysis is in the pages below.

Hypothesis 1: Involuntary Commitment

Families and caregivers are sometimes stymied by a lack of options when a person in crisis does not meet criteria for involuntary commitment.

Design recommendations:

a. **FAMILY SUPPORTS**

   Involving family members and other informal caretakers can be an integral element of successful care when a person is in crisis. This is especially the case when an individual is oppositional to treatment. Family members and caretakers deserve appreciation and respect for the significant benefits that they provide. Therefore, consideration and supports for family members, and as much transparency in communication and information sharing as legally permissible is of vital importance.

b. **WELFARE CHECKS**

   Sending someone to check on the welfare or wellbeing of a person who may be in crisis serves an important function. At present, such “welfare checks” are conducted by law enforcement, but law enforcement officers are unlikely to be well equipped to this task. To be effective and to build community trust, welfare checks should involve clear, compassionate communication, and should include an analysis of the individual’s overall situation beyond basic assessment of suicidality and capacity to care for self. Therefore, welfare checks should be conducted by non-police mobile crisis responders.

c. **NO WRONG DOOR / COORDINATION**

Gaining the trust and informed consent of individuals in crisis may be extremely challenging at times, particularly if the individual has had past negative experiences attempting to navigate the system, is a "complex" case, or is oppositional. Implementing a "no wrong door" approach across crisis services, to ensure that no one is turned away without help or otherwise left to navigate the system alone while in crisis, is a core component of building trust and consent. "No wrong door" is achieved through a system change which involves both cross-provider collaboration and frontline dedication to ensuring that everyone who seeks services is connected with appropriate care, and will often involve coordination via a crisis stabilization center.

Hypothesis 2: Housing

Having a safe place to reside, such as stable housing, is intimately connected with behavioral health and wellbeing:

- **when people do not have a safe place to reside, they often experience crisis,**
- **those who experience crisis often find themselves without a safe place to reside,**
- **those who deal with these overlapping struggles are disproportionately likely to also struggle with substance use disorders,**
- **and those attempting to recover from crisis struggle with finding safe and stable places to live.**

Design recommendations:

a. **REMOVING BARRIERS AFFECTING HOUSING AND/OR CARE**

The harms and negative outcomes associated with not having a safe and stable place to live are reinforced by policies which criminalize homelessness and which make it more difficult to access housing or to recover from crisis, increasing the demands on acute care. When possible, and in keeping with state and federal guidance, crisis services should reduce or mitigate these harms by actively removing barriers to physical safety, stable housing, and dignified care.

b. ASSESS CLIENT HOUSING NEEDS

Service providers should take the housing needs of individuals who are in crisis into consideration as part of any assessment. Because housing is often complex and dependent on community or familial connections, such assessments should go beyond a determination of whether the individual can access shelter, and be geared toward connecting the individual and, where acceptable, family members of the individual, with housing resources and supports. This may also include creating supports for families that provide housing to those in crisis, and offer trainings for families to address housing needs for loved ones when parents are gone.

c. NO WRONG DOOR HOUSING RESOURCES

Unhoused individuals are at high risk for a variety of mental and behavioral health crises, and find it very difficult to navigate systems which are intended to help them secure shelter and stable housing, as well as the systems which are intended to help them access care. Crisis services could be crucial in helping navigate those systems and removing barriers. To achieve this, a “no wrong door” approach to housing and emergency shelter should be implemented across crisis services, just as there will be a “no wrong door” approach to accessing care.

Hypothesis 3: Values

Interviewees shared the values that they would like enacted through crisis services, as well as their ideas for how those values might be operationalized in that system. The values described are parallel to those described in current best practices for behavioral health, such as concepts described under the framework of trauma informed care.

Design recommendations:

a. TRAUMA-INFORMED CARE

Incorporate all six guiding principles of Trauma-Informed Care at all levels of organizations involved in crisis services: 1. Safety, 2. Trustworthiness and Transparency, 3. Peer Support, 4. Collaboration, 5. Empowerment, and 6. Humility and Responsiveness.

b. LISTEN TO COMMUNITY MEMBERS

Many of the guiding principles of Trauma-Informed Care can be fortified by listening to community members and incorporating their feedback into the practices and communication strategies of service providers. The Community Engagement Committee recognizes our role in this work, and is especially committed to ensuring that perspectives of historically marginalized communities are integrated into the planning of crisis services and the continuous improvement of such services.

c. WELCOME PEOPLE

Making people feel welcome, included, and that they belong is a central value of crisis services which is crucial to the task of providing dignified care based on informed consent to those in crisis. Crisis services can be welcoming in the way that they communicate with individuals and communities, and through the presence of individuals in the system with lived experiences of crisis, such as peer support specialists.

Hypothesis 4: Bias and Discrimination

People who have lived through crises have experienced barriers to care based on whether they have money, whether they have insurance, whether they have stable housing, or whether they have presented with the same symptoms previously, etc. These barriers run the gamut from implicit biases or microaggressions to discriminatory behaviors.

Design recommendations:

a. ELIMINATE BIAS

Staff and clinicians play a key role in eliminating discrimination in crisis services. In particular, biases regarding low socio-economic status, homelessness, and disability have been mentioned in testimony we collected. Crisis services have a responsibility to examine and eliminate such biases internally and develop strategies to help people who have been harmed by these biases to be met with equity, dignity, and respect. Progress on this goal should be specific, actionable, and measurable.

b. FREE AND ACCESSIBLE SERVICES

For a “no wrong door” ethos to be meaningfully incorporated into crisis services, all members of our communities need to know and trust that if they seek help, they will not be turned away due to lack of insurance or ability to pay for services. Unlike many aspects of our healthcare system, crisis services are designed to be free of charge. Providers should work to communicate to the public in general and to high-risk populations in particular that crisis services are free.

c. **DUAL DIAGNOSIS**

Individuals with mental or behavioral health challenges have experienced barriers to receiving care, including being told that they do not meet criteria for care or that they are not eligible due to co-morbidities or a dual-diagnosis. A key example of this is when someone self-medicates with substances to deal with crisis, and is therefore disqualified from accessing needed services. Crisis service providers should take every step possible to ensure that health status or substance use history does not function as a barrier or bias for those seeking services.

Hypothesis 5: Law Enforcement

People we spoke with feel that non-police mobile crisis response would enable greater trust from community members and be helpful in de-escalating crisis situations. This perspective was broadly shared by those who have had both positive and negative past experiences with law enforcement in moments of crisis.

Design recommendations:

a. NON-POLICE MOBILE CRISIS

Mobile crisis response teams can be highly effective at building trust with individuals in crisis and de-escalating tense situations without the involvement of police. In designing the policies and procedures which stipulate how mobile crisis response teams will work with law enforcement and under what circumstances, the community mental health provider should ensure that law enforcement officers are involved only when absolutely necessary, such as when an individual is an immediate danger to themselves or others.

Therefore, the community mental health provider should develop these policies and agreements in consultation with community members with lived experience of crisis.

b. MOBILE CRISIS PROTOCOLS

When individuals in crisis are subjected to citations, physical coercion, arrest, or incarceration, it makes things worse for them. This undermines public trust and may lead to lasting harms, including traumatization of the individual and family members as well as increased barriers to recovery such as loss of all personal belongings, personal documents, necessary prescription medications, and psycho-social supports. Crisis service providers should design mobile crisis response policies and procedures so as to avoid these sorts of outcomes whenever possible, given state and federal laws and the safety of all concerned.

c. LAW ENFORCEMENT COLLABORATION

Individuals in crisis and their families and caregivers need to know that if they call for help that it will not put them at risk for physical violence. Mobile crisis response can be a solution to that need. To do this effectively, mobile crisis must work in close collaboration with law enforcement agencies and must be designed to have the scale and capacity to respond to the large percentage of calls for service which do not require a police response.

In addition to these recommendations, the CEC received testimony from many participants which reinforced steps which are already in the works, such as the intent to set up a crisis stabilization center, the creation of non-police mobile crisis response, the involvement of more peers and peer support specialists in crisis care, and the expansion of community education focused on de-stigmatization. Finally, testimony also acknowledged the importance of identifying adequate and sustainable funding sources for the services recommended.