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TECHNICAL ASSISTANCE COLLABORATIVE

Housing and services strategies *that work for people*.

September 22, 2023

Senator Durbin, Chair
United States Senate Committee on the Judiciary
Email: record@judiciary-dem.senate.gov

Re: August 26, 2022 questions from Subcommittee on Criminal Justice and Counterterrorism hearing entitled "Behavioral Health and Policing: Interactions and Solutions" on Thursday, April 22, 2021

Dear Senator Durbin,

Thank you for the questions submitted by Senators Booker and Whitehouse in response to the testimony that I provided at the Senate Committee on the Judiciary, Subcommittee on Criminal Justice and Counterterrorism, hearing entitled "Behavioral Health and Policing: Interactions and Solutions" on Thursday, April 22, 2021. Please accept my response to the questions from Senator Booker and Senator Whitehouse into the record in addition to my original testimony.

If I can be of further assistance to the Committee regarding the behavioral health system and related issues, please do not hesitate to contact me.

Sincerely,

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Subcommittee on Criminal Justice and Counterterrorism
Behavioral Health and Policing: Interactions and Solutions
Submitted April 29, 2021
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QUESTIONS FROM SENATOR BOOKER

1. What are the basic components of a behavioral health system, and the critical services that a city, town, or county would need to have in place to provide basic services to people with mental illness, or those who are in crisis, or people with substance disorders?

   a. What function does each of these components serve?

Background

Mental illnesses and substance use disorders, commonly known together as behavioral health conditions, affect roughly 25% of the U.S. population and are among the most common causes of disability.[1] Neuropsychiatric disorders are the leading cause of disability in the United States, accounting for 18.7% of all years of life lost to disability and premature mortality.[2,3] Recent data suggests that roughly 56% of young adults and 40% of adults in the U.S. have reported symptoms of anxiety or depression during the COVID pandemic.[4]

The severity, chronicity, and recovery from these health conditions varies widely across the population, and is also influenced by a number of other factors, including, but not limited to, social determinants of health such as economic stability, access to affordable housing, education, and employment, and the impact of racism and other forms of discrimination on health equity.

Estimating the full costs of untreated mental illness and the criminalization of people with mental illness are difficult. The National Alliance on Mental Illness estimates that untreated mental illness already costs us up to $300 billion annually due to lost productivity and associated costs due to absenteeism, employee turnover and increases in medical and disability expenses.[5]

[1] National Institute of Mental Health. https://www.nimh.nih.gov/health/statistics/mental-illness
[2] US Burden of Disease Collaborators. The state of US health, 1990-2010: burden of diseases, injuries, and risk factors. JAMA, 310(6): 591-608, 2013.
[3] Neuropsychiatric disorders include behavioral health conditions, but also encompass a broader range of disorders (e.g. seizures, migraine headaches).
[4] Twenge JM, Joiner TE. U.S. Census Bureau-assessed prevalence of anxiety and depressive symptoms in 2019 and during the 2020 COVID-19 pandemic. Depress Anxiety. 2020 Oct;37(10):954-956. doi: 10.1002/da.23077. Epub 2020 Jul 15. PMID: 32667081; PMCID: PMC7405486.
[5] National Alliance on Mental Illness. https://www.nami.org/Press-Media/In-The-News/2021/2020-devastated-US-mental-health-%E2%80%94-healing-must-be-a-priority?feed=In-the-news#:~:text=The%20National%20Alliance%20on%20Mental,in%20medical%20and%20disability%20expenses.

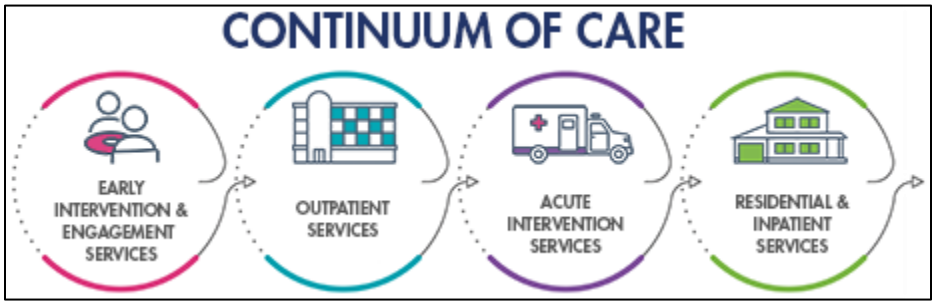
Estimates of the added impact of the coronavirus pandemic on mental health in the United States could reach approximately $1.6 trillion.[6]

Accordingly, behavioral health is a public health issue that requires multidimensional approaches to the prevention, early intervention, treatment, and recovery from behavioral health conditions, as well as, interbudgetary strategies to more appropriately allocate and align resources.

Basic Components of a Behavioral Health System

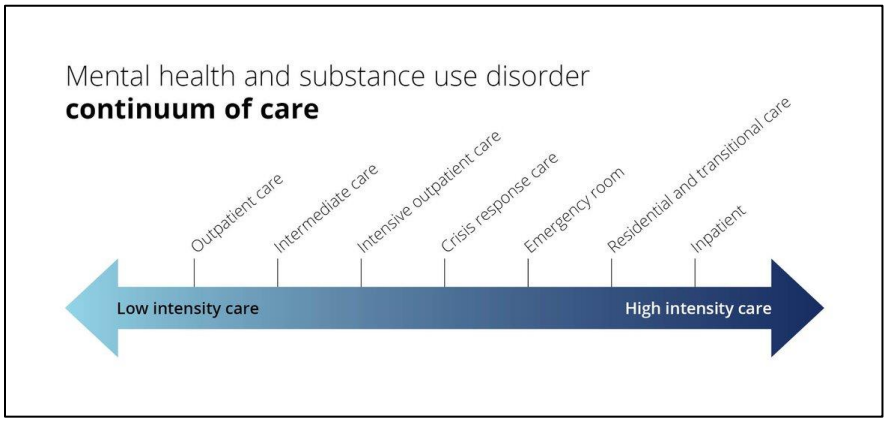
A well-functioning behavioral health system should be built on a public health framework (as opposed to a public safety approach) that includes prevention, early intervention, treatment, and recovery supports. A range of evidence-based, best, and promising treatment and support services must be available in communities to meet the diverse needs of people who are at risk for or are experiencing behavioral health conditions. The following two graphics demonstrate examples of the basic components of services that should be available to people in all communities, including urban, suburban, rural, and frontier areas.

Table 1:



Source: Alaska Division of Behavioral Health

Table 2:



Source: UCare

[6] Cutler DM, Summers LH. The COVID-19 Pandemic and the $16 Trillion Virus. JAMA. 2020;324(15):1495–1496. doi:10.1001/jama.2020.19759

Functions of Core Services

Using Table 1 as a framework, the core functions of these basic components are described below.

Early Intervention and Engagement Services: Mental illnesses and substance use disorders can emerge at any time across the age span, and prevention and early intervention services should be basic components of all systems.[7] These services are designed to prevent the development of behavioral health conditions, identify early warning signals, and provide early interventions that can prevent or reduce the severity of behavioral health conditions. Early intervention and engagement services can begin as early as infancy and carry through older adulthood, and may be delivered through programs and services in pediatric and primary care settings, schools (i.e. primary, secondary, and post-secondary), employment, and behavioral health providers.

Outpatient Services: Community-based outpatient services include a broad range of face-to-face and tele-health treatment and service delivery options designed to provide ongoing treatment and recovery supports for mental illnesses and/or substance use disorders. These may include traditional appointments for medication management and individual and group psychotherapy. They also include program-based services designed to support individuals with more complex needs. These programs may include permanent supportive housing (PSH), Assertive Community Treatment (ACT), intensive case management, and supported employment. Services should be person-centered, range in intensity, and be provided daily, weekly, or monthly depending on a person and/or family's needs. Provider types may include Community Mental Health Centers (CMHCs), Certified Community Behavioral Health Clinics (CCBHCs), Federally Qualified Healthcare Centers (FQHCs), private practitioners, and organizations run by persons with lived experience.

Active Intervention Services: Active intervention services are those designed to identify, respond to, and resolve emerging or active behavioral health emergencies. These "safety net" services typically include a range of: 1) behavioral health crisis call centers (e.g. the new national 988 Suicide & Crisis Lifeline); 2) behavioral health mobile response teams; and 3) crisis stabilization services, designed to ensure safety, resolve a crisis, and promote recovery. Crisis respite and crisis residential services are also important components that can help provide extended support to help resolve a crisis.

Ideally, acute intervention services are the responsibility of the behavioral health system and led by designated behavioral health providers, but will likely include coordination with other first responders, such as law enforcement, EMS, and Fire, depending on the nature of the call, clinical assessment, and any public safety concerns. Additional information regarding crisis services is discussed below.

While the availability of 24/7/365 crisis services must be a safety net component of the behavioral health system, it is critical to ensure access to preventative, early intervention, and "upstream" services that can help prevent behavioral health emergencies that require acute intervention services.

[7] Mental Health America. Prevention and Early Intervention in Mental Health.

Residential and Inpatient Services: Residential and psychiatric inpatient services are designed to meet the needs of people with mental illnesses and substance use disorders with more complex, chronic conditions, as well as, acute care needs due to a behavioral health emergency. Most people who experience behavioral health conditions do not need these intensive, more supervised and restrictive services with access to upstream, community-based options, but the need for capacity to exist as a safety net function is an important component of a comprehensive system. These services are the most intensive and costly, and tend to be designed for short term use.

Access to Social Determinants of Health

Access to Social Determinants of Health (SDOH) are also critically important functions necessary to support people with behavioral health conditions, and are non-medical factors that influence behavioral health outcomes. Addressing social determinants of health is a primary approach to achieving health equity.[8] Among these include access to affordable housing, education and employment, as well as, programs and services that address racism and discrimination and food security.

All people need access to safe, decent affordable housing. However, a significant number of people with mental illness and substance use disorders experience homelessness or live in segregated settings.[9,10] Most people with mental illness and substance use disorders can benefit from, and prefer, to live in integrated housing in their communities.[11] While supervised residential treatment settings described above may have a short term role in treatment and recovery, most people with behavioral health conditions do not need to live in supervised housing. Access to housing is not a behavioral health system issue; it is an issue that is the result of a shortage of affordable housing that exists nationally.[12] Unfortunately, a significant number of people with behavioral health conditions experience poverty and are unable to afford housing. In fact, for people with serious mental illness living on Supplemental Security Income (SSI), there is not a single housing market in the United States where a person on SSI can afford housing at the HUD established Fair Market Rent (FMR).[13]

Many people with behavioral health conditions are unemployed/under-employed, but are interested in working and furthering their education. Supported employment and supported education are important services that should be basic components of a behavioral health system.

Funding Behavioral Health Services

Federal, state, and local government agencies, as well as, health insurers have roles in ensuring equitable access to behavioral health services and related SDOH and other supports. Because the

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[8] Centers for Disease Control and Prevention. https://www.cdc.gov/nchhstp/socialdeterminants/faq.html

[9] National League of Cities. Mental Illness, Substance Use, and Homelessness: Advancing coordinated solutions through local leadership.

[10] Mental Health America. Position Statement 25: Community Inclusion after Olmstead.

[11] Tsai J, Bond GR, Salyers MP, Godfrey JL, Davis KE. Housing preferences and choices among adults with mental illness and substance use disorders: a qualitative study. Community Ment Health J. 2010 Aug;46(4):381-8. doi: 10.1007/s10597-009-9268-6. Epub 2009 Nov 7. PMID: 19898935; PMCID: PMC2891397.

[12] Martone, K. The Impact of Failed Housing Policy on the Public Behavioral Health System. Psychiatric Services. March 2014 Vol. 65 No. 3

[13] Technical Assistance Collaborative. Priced Out: The Housing Crisis for People with Disabilities

basic behavioral health components do not always fit neatly into a single payer, treatment and services are often paid for through braided or blended funding strategies.[14] Other supports are paid for by non-behavioral health agencies (e.g. housing assistance through HUD or state housing agencies; employment assistance Vocational Rehabilitation agencies) and should be coordinated with behavioral health funds.

However, chronic underfunding and the patchwork of paying for services results in barriers to access, workforce shortages, and red tape that interfere with a person's ability to engage in and remain in services. In addition, the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA) was passed by congress to create more equitable access to behavioral health treatment and services, but, over ten years later, there is continued and increased disparities between behavioral health care and physical health care coverage, indicating possible evidence of noncompliant insurance practices.[15]

2. After a 911 call is made involving a person in crisis, or with mental health disabilities, or with a substance use disorder, if the person dispatched was a mental health professional rather than a law enforcement officer, how would the outcome differ?

    a. Why is the difference significant?

In many communities, 911 and police are the default response for behavioral health emergencies due to a lack of behavioral health crisis services, and 911 will dispatch police, even if a response is unnecessary. Depending on the capacity of the behavioral health system, the skills of police, and level of coordination between law enforcement and behavioral health providers, the outcomes can vary significantly. When 911 is called for a behavioral health emergency, the range of outcomes when police are dispatched may include use of force, arrest and incarceration, drop-off at the emergency department/hospital, or transportation to an outpatient behavioral health provider.

The less involved behavioral health professionals are, the more likely that the disposition by law enforcement will be a more restrictive, forceful, and clinically unnecessary intervention. Compared to the general population, individuals with mental illness are three times more likely to interact with police and are more likely to be arrested.[16] People with untreated mental illness are sixteen times more likely to be killed during a police encounter than other civilians approached or stopped by law enforcement.[17] Numbering fewer than 1 in 50 U.S. adults,

[14] Urban Institute. Examples of braiding and blending to support community health: a compendium of resources. October 2018.
[15] Davenport, S., Gray, T., and Melek, S. Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement. November 2019.
[16] Magee, L.A., Fortenberry, J.D., Rosenman, M. *et al.* Two-year prevalence rates of mental health and substance use disorder diagnoses among repeat arrestees. *Health Justice* **9**, 2 (2021). https://doi.org/10.1186/s40352-020-00126-2
[17] Treatment Advocacy Center. Overlooked in the Undercounted: The Role of Mental Illness in Fatal Law Enforcement Encounters. December 2015

individuals with untreated severe mental illness are involved in at least 1 in 4 and as many as half of all fatal police shootings.[18]

It is also widely known that people with mental illness are overrepresented in the criminal justice system and disproportionately Black.[19] Nationally, approximately 20% of inmates in jails and 15% of inmates in state prisons are now estimated to have a serious mental illness.[20] There is evidence that people who are Black are less likely to be identified as having a mental health problem,[21] and they are less likely to receive access to treatment once incarcerated.[22]

The potential outcomes of a behavioral health led response instead of, or in coordination with law enforcement, are significant. In better-developed behavioral health systems, the 988 national crisis hotline or a similar crisis hotline and warm lines exist, the call is fielded by a behavioral health specialist, and the response is triaged based on the individual situation and need. In places where 988 and crisis hotlines are used, the majority of crises are deescalated on the phone with referrals or warm handoffs made to the appropriate provider. Approximately 98% of answered 988/Lifeline calls do not require an emergency response,[23] and it is estimated that 80% of mental health calls to 911 are resolved without the need for police involvement when diverted to a crisis line.[24] The ability of crisis lines to de-escalate calls enable police resources to be directed to legitimate policing activities, and reduces the likelihood of negative police encounters that involve use of force, arrests and incarceration, and costly and unnecessary emergency department and inpatient hospital stays.

Behavioral health led mobile crisis response teams (MCRTs) may be dispatched by 988 or 911 to engage an individual if, based on assessment, there is minimal public safety risk. MCRTs add another level of diversion or deflection from law enforcement and associated outcomes. Many MCRT encounters result in a de-escalation, a voluntary transport to the hospital or a crisis stabilization program, or referral and follow-up to outpatient services. Referral and follow-up are critical services not typically provided by law enforcement that can help mitigate a crisis and prevent it from escalating further. The CAHOOT team in Eugene, Oregon, for example, handles about 60 calls per day and request police assistance less than once a day. For 911 calls, the CAHOOTS team diverts an estimated 5–8 percent of calls to 911 that would otherwise have been dispatched to police officers, estimating over 6,000 avoided police calls.[25]

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[18] Treatment Advocacy Center.

[19] NAMI. Racial Disparities in Mental Health and Criminal Justice.

[20] Treatment Advocacy Center. Serious Mental Illness Prevalence in Jails and Prisons. September 2016.

[21] US Department of Justice, Bureau of Justice Statistics. Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12. June 2017.

[22] Kaba F, Solimo A, Graves J, Glowa-Kollisch S, Vise A, MacDonald R, Waters A, Rosner Z, Dickey N, Angell S, Venters H. Disparities in Mental Health Referral and Diagnosis in the New York City Jail Mental Health Service. Am J Public Health. 2015 Sep;105(9):1911-6. doi: 10.2105/AJPH.2015.302699. Epub 2015 Jul 16. PMID: 26180985; PMCID: PMC4539829.

[23] Vibrant Emotional Health. FAQ for Understanding 988 and How It Can Help with Behavioral Health Crises.

[24] Substance Abuse and Mental Health Services Administration (2020). *National guidelines for behavioral health crisis care – a best practice toolkit*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[25] Congressional Budget Office. Estimated budgetary effects of the American Rescue Plan Act [Internet]. Washington (DC): CBO; 2021. Table 9, Estimated budgetary effects of Title 9 (Committee on Finance) of the amendment in the nature of a substitute to H.R. 1319 (KIN21174) as posted on the Senate Budget Committee's

Unfortunately, a comprehensive and coordinated set of services does not exist locally in most communities, particularly in rural and remote areas. Furthermore, the lack of "upstream" services often results in preventable behavioral health emergencies that lead to encounters with law enforcement, arrest and incarceration, unnecessary emergency department and inpatient hospital use, suicide, and other negative outcomes such as loss of employment and homelessness.

QUESTIONS FROM SENATOR WHITEHOUSE

1. This hearing highlighted the difficulties that arise when police officers are called upon to respond to mental health, substance use, and other behavioral health crises, and alternative approaches to these situations.

    a. Based on your experience, what are the most promising models to handle these situations?
    b. What are the biggest obstacles these programs face?
    c. How can the federal government encourage and support these programs?
    d. How have cities and states created sustainable funding for these programs? What can the federal government do to help other jurisdictions do the same?

In many communities throughout the United States, the default system in place to respond to behavioral health emergencies is 911 and law enforcement dispatch. As discussed above, the default system often leads to negative outcomes for people with behavioral health conditions who are experiencing a behavioral health emergency, as well as, the misappropriation of police and criminal justice system resources.

Access to a comprehensive set of behavioral health crisis services are essential to effective response for people experiencing behavioral health emergencies. Based on my nearly thirty years in behavioral health as a direct clinician, agency administrator, state mental health commissioner, national consultant, and family member of a person living with mental illness, the following are promising models that federal, state and local systems should support and ensure access to.

<u>Crisis Hotline and Warm Lines</u>
As discussed above, crisis hotlines and warmlines staffed by trained mental health professionals and para-professionals (e.g. trained peer support workers) perform a critical first line intervention for people who may be experiencing a behavioral health crisis, and are effective at de-escalating the crisis, providing immediate support, and reducing the need for mobile crisis or law enforcement response. Generally, crisis lines are designed to take calls from, or regarding, individuals who may be experiencing a behavioral health crisis, whereas warmlines are used as an important early intervention support function to help prevent a crisis.[26]

website on March 4, 2021 (see Subtitle J, section 9813 in tab labeled "Title 9"); [cited 2021 Apr 26]. Available for download from: https://www.cbo.gov/system/files/2021-03/Reconciliation_Detailed_Tables.xlsx Google Scholar

[26] American Psychiatric Association. Warm Lines: Providing Help Before a Crisis Develops.

Signed into law on October, 17, 2020 and effective July 2022, the national 988 Suicide & Crisis Lifeline provides an easy to remember number to call that can provide immediate support, link with local mobile crisis providers, refer to treatment services, and triage to 911 and law enforcement if needed. Congress has provided financial assistance to support states in this transition through various federal agencies (e.g. SAMHSA), and the authorizing legislation enabled states to establish fees on telecommunication companies to support development and operation of local 988 call centers. Several states are actively working to identify resources through legislation and state appropriations. Colorado, Nevada, Washington, and Virginia, for example, have passed fees on telecom to support 988 operations and service.

Many systems also have their own state, regional, or local crisis lines that are operated by 988 centers or other providers. As state and local systems work to develop their crisis hotline systems, they will need to ensure that crisis lines, as well as 911, work together to manage and triage calls, minimize police and provider confusion, ensure coordination, and make calling for help easier for potential callers.

Mobile Crisis Response Teams

It is important to understand that there is not a universal mobile response model that is applicable across all jurisdictions in the United States. Among the reasons for this include population density and geography (i.e. urban/suburban/rural/frontier), behavioral health system capacity, funding streams, and system structure. Nevertheless, leading mobile crisis response team (MCRT) models are run by community behavioral health organizations, led and staffed by behavioral health professionals and para-professionals (e.g. peer support specialists) that respond and provide needed assessment, intervention, and disposition, including transportation when possible. Since linkage to ongoing, upstream community-based services may not be immediate, MCRTs should have capacity to provide short-term, interim crisis case management to help bridge any time between the crisis and needed services. In some jurisdictions, especially in rural communities, MCRTs are part of the local police department and dispatched as a co-response with police or alone depending on the nature of the call.

If a decision has been made that there is not a public safety risk based on the initial evaluation by 988, another crisis line, or 911, the response must be driven by the individual's need, and not based on what or who is available. When needed, a MCRT should be dispatched by 988 or other crisis hotlines, or 911. MCRTs need to have the capacity to respond quickly to a location; otherwise, the crisis could escalate necessitating police response. There may be times when there is a potential safety risk or medical concern that warrants a co-response by police and/or EMS. If the situation warrants it, EMS and police should assist if there is a potential medical need or safety risk. These first responder dispatches could be requested by the MCRT, or sent as a co-response to the location to provide support and help ensure safety.

Well known MCRT programs and model examples include: CAHOOTs in Eugene, Oregon; RIGHT Care in Dallas, Texas; the STAR program in Denver, Colorado; Community Bridges teams in Arizona; and New Jersey's Mobile Response and Stabilization Services program and Connecticut's Mobile Crisis Intervention Services program for children and youth.

While more calls will be handled by behavioral health systems as crisis systems develop nationally, it is likely that many calls will continue to go to 911 resulting in police dispatches, even if unnecessary. CIT trained officers will still be an important response when an MCRT is unavailable, or in coordination with an MCRT response.[27]

Behavioral health led MCRTs face various obstacles. Lack of funding for design, start-up, infrastructure and technology, staffing, and ongoing training is a major barrier. MCRTs need 24/7/365 capacity to respond to one or more emergencies simultaneously, but funding is often insufficient to meet demand, not well coordinated, and vulnerable to budget cuts. In order for MCRTs, as well as other crisis services, to be viable and sustainable, they cannot rely solely on a fee-for-service model of reimbursement or variations in annual budget cycles. MCRTs should be considered essential services with mandatory funding support. Medicaid does not pay for all types of services, and other federal, state, and local funds should be braided with Medicaid to pay for ongoing services and infrastructure (e.g. technology; vehicles, training, planning). Unfortunately, many non-Medicaid commercial insurers do not pay for crisis services utilized by their members. Because MCRTs need to respond to individuals who may have health insurance through Medicaid, non-Medicaid commercial insurers, Medicare, or be uninsured, multiple sources must have a role in supporting MCRT capacity. However, in most systems where MCRTs exist, a patchwork of funding exists and typically does not include Medicare or commercial insurers.

In addition, significant challenges with recruitment and retention have resulted in severe workforce shortages in behavioral health. This is due to a combination of near-poverty level salaries, lack of training and supervision, and burnout. Funding for livable salaries, as well as, training and supervision need to be built in to grants and/or insurance rates.

In some communities, resistance by police to coordinate with MCRTs is an issue due to the belief that behavioral health emergencies are public safety issues requiring a public safety response. Lack of coordination and collaboration between MCRTs, law enforcement, and other systems providers are barriers to successful implementation and operations. Also, poor communication and marketing publicly about behavioral health resources, including alternatives to 911 (i.e. 988 and other crisis hotlines/warmlines) results in far too many behavioral health calls going to 911 and police dispatch that could be handled by MCRTs.

The federal government should encourage and support these programs in various ways. The U.S. Department of Health and Human Services (HHS) should continue to inform policy and best practices in mobile response. SAMHSA and key partners, such as the National Association of State Mental Health Program Directors and others, are working together on these issues. Identifying best practices, minimum core standards, roles, coordination, identification of key outcome measures are important for state and local communities to use in the development of policy, standards, funding, and overall design, implementation, and sustainable operations. The federal government can support training and technical assistance in best practices, and consideration should be given to the development of a national training and technical assistance

[27] CIT International. https://www.citinternational.org/What-is-CIT

center that can provide training and TA to state behavioral health and Medicaid agencies, behavioral health providers, local police departments, and others.

States and cities have developed some funding strategies for these programs. Medicaid is a potential sustainable funding source to pay for crisis services that leverages state and federal funding. Several states do use Medicaid to pay for some crisis services, and the American Rescue Plan created a new mobile crisis team state plan option through Medicaid to pay for services. Many states are in the process of designing their state plans for approval by CMS, and Congress should continue to explore incentives for states to expand and sustain crisis and upstream services through, for example, additional enhanced match and broadening coverable services. While most non-Medicaid commercial insurers do not pay for crisis services utilized by their members, Washington and Massachusetts have recently required commercial health insurers to contribute to crisis services which will be helpful in sustaining crisis capacity for non-Medicaid members who utilize crisis services.

2. Even when jurisdictions have alternate responder programs, police may still respond to situations where people are experiencing mental health or substance use crises or have disabilities (whether because of inaccurate dispatching, to support behavioral health professionals, or because a serious crime is in progress).

    a. What should police departments do to better prepare their officers to respond safely and effectively to these situations?
    b. How can the federal government support these efforts—i.e., by providing funding, developing best practices, etc.?

Training for police on behavioral health should be mandatory for all officers. This should be part of basic training provided at the academy, as well as, made available periodically for all officers. Topics should include an understanding of mental illness and the types of symptoms that people may experience and behaviors they may display, particularly if they are experiencing a crisis, the impact of trauma, and how racial and other disparities affect mental health conditions, access to services, and responses. Training on substance use disorders and other conditions, such as intellectual and developmental disabilities, is important since these alone or co-occurring with mental illness can complicate the situation. Advanced Crisis Intervention Team (CIT) training should also be made available so that police departments can also have officers with more advanced training respond to behavioral health emergencies when needed. CIT is well known model with specific training and protocols.[28]

Advance coordination and collaboration with local behavioral health, social service, and homeless providers, not just hospital emergency departments, is important for police departments to engage in. Officers will be more capable of making an appropriate intervention and disposition the more aware they are of the behavioral health provider system and capabilities. Police should be aware of 988 and local crisis and warmlines, mobile crisis response teams, and a range of community-based alternatives. A drop-off at a crisis stabilization program or walk-in

[28] CIT International. https://www.citinternational.org/What-is-CIT

behavioral health urgent care may be more appropriate than the local emergency department, and officers should know about these resources in advance and have pre-established protocols for working with them.

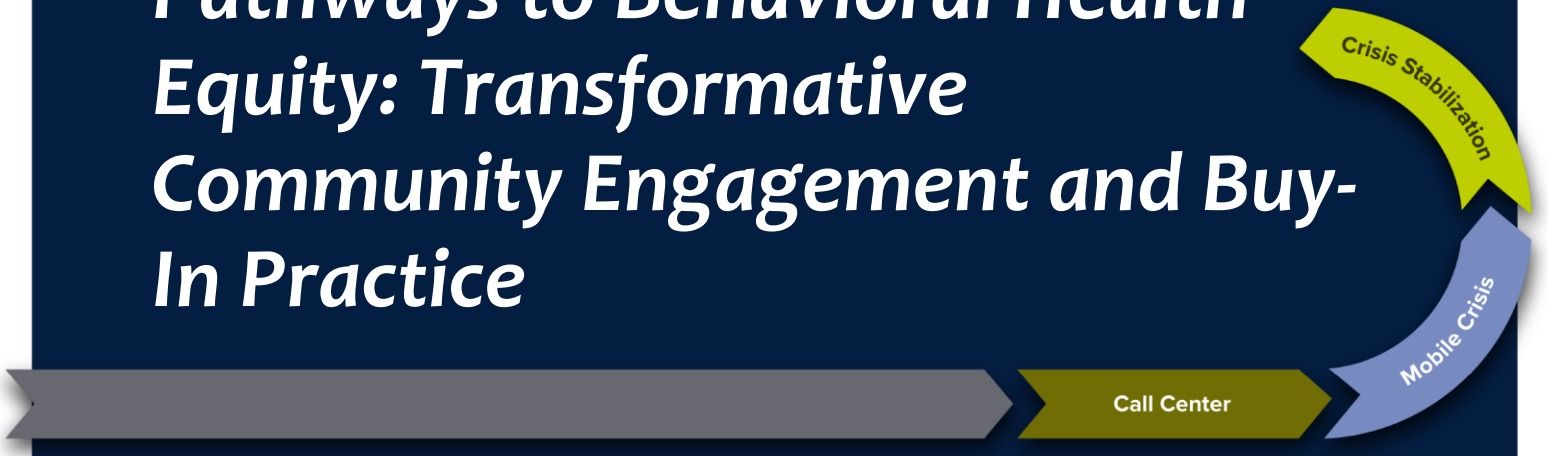
The federal government can support these efforts in various ways. Funding made available to states and local jurisdictions for police training, as well as, cross system capacity building, training, and coordination are important. This includes funding opportunities for cross system partners to come together for ongoing planning and implementation. Sustainable funding is important due to the complexity of these cross system issues, as well as, the need to ensure continued coordination due to staff turnover in systems. These funds are often hard to come by and not generally covered by Medicaid or other insurers, but are critical to successful crisis response. Funding for performance monitoring and evaluation of outcomes should be built in.

3. Reforming how law enforcement responds to mental and behavioral health crises also requires working with other stakeholders at the state and local levels, such as health departments and behavioral health providers.

    a. Are there any jurisdictions successfully coordinating various state and local stakeholders? If so, which ones?
    b. What suggestions do you have to better coordinate funding, training, and resources among stakeholders?

Attached is a report prepared by the Technical Assistance Collaborative (TAC) and Meadows Mental Health Policy Institute (MMHPI), *Pathways to Behavioral Health Equity: Transformative Community Engagement and Buy-In Practice.* The report identifies the importance of community stakeholder engagement. In addition to engaging state health departments and behavioral health providers, the report identifies the importance of engaging individuals served in these systems, identifies examples of jurisdictions who are doing good work in this area, and shares recommendations for coordination of funding, training, and other resources at the federal, state, and local level.

Pathways to Behavioral Health Equity: Transformative Community Engagement and Buy-In Practice



TAC

MEADOWS MENTAL HEALTH POLICY INSTITUTE

Technical Assistance Collaborative • Meadows Mental Health Policy Institute

Table of Contents

This brief was developed by the Technical Assistance Collaborative, Inc. (TAC) and the Meadows Mental Health Policy Institute (MMHPI) for a time-limited collaborative of philanthropic organizations initially consisting of The Pew Charitable Trusts, Ballmer Group, Blue Meridian Partners, Peg's Foundation, the MacArthur Foundation, and the Charles Koch Institute, a part of the Stand Together community. These organizations came together in a joint learning process to explore the potential for lasting change and innovation in behavioral health emergency response. The collaborative's goal is to develop a common understanding of the key steps necessary to advance an effective, equitable system in which people with mental health and substance-use-related emergencies have access to a continuum of targeted crisis response services. This brief was developed to support the collaborative's learning process; it does not represent the formal position of TAC, MMHPI, the collaborative, or its individual members. The brief is being shared informally as a resource to the field.

Executive Summary

This is a pivotal moment for behavioral health crisis response systems. Our current crisis response system is flawed, is rooted in racism, continues to perpetuate the oppression of disenfranchised communities, and is marked by negative outcomes for communities of color. The current reality has resulted in distrust from impacted communities. To address inequities and improve outcomes, the current behavioral health crisis system must be redesigned and trust reestablished through an authentic community engagement and buy-in process. To date, authentic community engagement has not been a consistently established process in behavioral health crisis response systems. However, there are adjacent areas which do have an established history of authentic community engagement and buy-in that can be considered for application to this system. There is a significant opportunity for philanthropic organizations to contribute to these efforts in ways that federal, state, and local governments cannot. This brief discusses the current behavioral health crisis landscape and offers opportunities for philanthropic organizations to consider related to effective and authentic community engagement and buy-in.

I. Introduction

In 2020, the COVID-19 pandemic, coupled with increasing awareness of structural racial inequity in the United States ignited by the killing of George Floyd at the hands of law enforcement, has exposed deep-seated inequities in behavioral health care systems. Currently, behavioral health crisis systems often produce avoidable adverse outcomes for racially marginalized, historically disenfranchised (LGBTQ2S+[1] and disabled), rural, and under-resourced communities. These negative outcomes are often a consequence of utilizing law enforcement as the default response to behavioral health crises, especially in regions that lack an appropriate crisis system. This results in an overreliance on hospital emergency rooms and jails, rather than the appropriate community health-based response. In fact, jails and prisons have become the largest de facto behavioral health treatment providers in the United States.[2] In 2018, people with mental illness accounted for 25 percent of all fatalities at the hands of police, with many of those deaths occurring during a response to a mental health emergency.[3] In order to address inequities and improve outcomes in the existing behavioral health response system overall, the behavioral health crisis system must be redesigned — an undertaking which will require both the full participation of crisis services recipients and a fundamental shift in how stakeholders and communities are defined and engaged.

To anchor a reimagining of behavioral health crisis systems, this brief proposes three key principles, each explored further below:

- To create trustworthy and effective solutions, it is both urgent and necessary to redesign behavioral health crisis systems in strong collaboration with impacted communities, the health care system, housing, social services, and law enforcement systems.
- An active, sustained commitment to authentic community engagement and buy-in is an essential component of all successful redesign efforts.
- The current state of the system presents a unique opportunity for philanthropy to advance behavioral health equity through strategic investments, especially in strategies that federal, state and local governments are often unable to fund.

Currently, there are no prominent documented efforts to establish this process related to behavioral health crisis response. However, there are adjacent areas with a greater history of authentic community engagement and buy-in that may lend themselves for consideration for application, and some of those efforts are discussed below.

Developing a Common Language

Developing a common language sets the stage to build context, operationalize terminology, and level the "knowledge playing field" so there is a shared understanding as system redesign occurs. The United Nations Office for the Coordination of Humanitarian Affairs defines community engagement as "a two-way dialogue between crisis-affected communities, and humanitarian organizations."[4] This definition emphasizes that effective community engagement enables people to meet their needs by building on innate community assets, such as knowledge, culture, and resiliency. For the purposes of this brief, "community" refers to individuals and their families who are underserved or not served well by current behavioral health crisis systems, including people with lived experience (PWLE), their families, and residents of impacted areas. Although "community" members are often stakeholders as well — those who are interested in or affected by a process, intervention, or initiative — for clarity in the context of this brief we limit the term stakeholders to those within organizational and power structures such as law enforcement, call centers, emergency medical services (EMS) providers, mobile crisis team providers, and faith-based leaders. Thus, community engagement would refer to the sharing of power and

decision-making between the two stakeholder groups — communities and organizational and power structures. Shared decision-making, which is critical to achieving successful community engagement, occurs when the system's agents and the intended recipients of crisis services co-create solutions with equal power and influence.[5]

Shared decision-making also entails developing an understanding of each stakeholder's unique needs and characteristics while centering the preferences and solutions raised by communities most affected. Alongside community engagement, buy-in is an important component of maximizing the impact of an intervention. Buy-in is the commitment of a community, individual, or organization to support and take part in an intervention.[6] Buy-in is more than acceptance of a shared vision and plan; it is a willingness and ability to act, compromise, and dedicate resources to achieve a common goal. Authentic community engagement goes a step further to ensure ongoing meaningful collaboration between community and providers, beyond the initial buy-in phase, so that redesign efforts are successful and continuously assessed by those who utilize those services.

Identifying the Right Participants

It is imperative to recognize which stakeholders respect the community, care about the issue, and are actively working to change behavioral health care systems. Each of these stakeholders is essential to every part of the crisis response process, from the initial needs assessment to the ongoing evaluation. Stakeholders should also be involved in the communications process, as they know their preferences for receiving information and understand how to convey the information equitably with their communities.

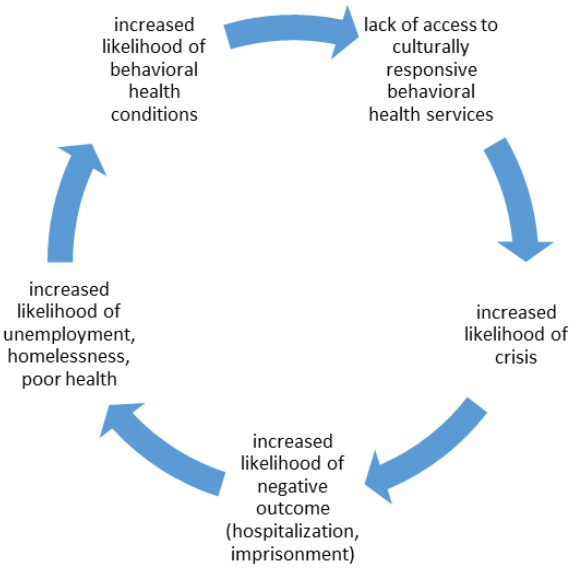
Community includes not only leaders, but also individuals and families whose voices are often not considered and who are directly impacted by the issue at hand. A growing body of evidence shows that people actively involved in their health and health care have better outcomes, reducing costs in the long term.[7] This evidence supports the need for increased involvement of people with lived experience and their families in the development of an effective crisis response system. This is particularly important given that for decades, people with mental illnesses were deemed incapable of constructive participation in decisions regarding their needs. The inclusion of stakeholder voice in every aspect of redesigning crisis response will positively improve that system process. Stakeholders know their needs best and should have access to a platform to communicate those needs. As we consider reimagining the crisis response system, it is essential to consider stakeholder and community feedback to center the conversation on the identified needs and desires of those who are directly receiving crisis services, which are often reinforcing broader inequities.

II. Opportunities for Change

Effective Practices within the Crisis Continuum and Knowledge Gaps

Sequential Intercept Modeling (SIM) is a useful tool to illustrate how people with behavioral health crisis needs meet and flow through the criminal justice system due to a lack of crisis services. As a conceptual model, SIM can inform community-based responses to shift from ineffective and costly criminal justice interventions to more effective and humane behavioral health and human services interventions. Rebecca Boss, a Senior Consultant with the Technical Assistance Collaborative (TAC), developed the Community Intervention Opportunity Cycle, which illustrates the compounding impacts due to lack of access to culturally responsive behavioral health crisis services. This model, illustrated below, emphasizes community engagement and buy-in with people with lived experience (PWLE) and their families as essential components in disrupting the sequelae of inadequate access to culturally responsive behavioral health services.

Figure 1: Community Intervention Opportunity Cycle



Rebecca Boss, 2021: Technical Assistance Collaborative

In efforts to improve access to culturally responsive behavioral health services, the U.S. Substance Abuse and Mental Health Services Administration's (SAMHSA) National Best Practices identify three core components (crisis call centers, mobile crisis teams, and crisis receiving centers) to ensure access to behavioral health crisis care anytime, anywhere. This care should be accessible to anyone, regardless of race, ethnicity, or location. However, as noted above, disparities in access and service delivery caused by racism, insufficient services in rural areas, culturally insensitive practices, and funding barriers have resulted in an inequitable system; adoption of SAMHSA's three core components will not in itself create a more equitable system.[8] [9] An equitable system is one

in which every individual has the same opportunity to be healthy, successful, and have their needs met. National, state, and local momentum currently exists to reimagine crisis services due to the impending deadline for 988 implementation, American Rescue Plan Act investments in mobile crisis services, and other enhanced federal funding for crisis response. However, planning efforts are uneven across the country, and some key stakeholders are unaware of, or otherwise not engaged in, these efforts.[10] Without authentic community engagement and buy-in, a unique opportunity to transform crisis response will render the same patchwork of services rather than a comprehensive and transformed system. At the same time, these federal efforts, as well as multiple forums focused on transformed crisis response, provide opportunities for authentic community engagement that can disrupt the cycle presented in the diagram and reduce inequities that are embedded in our traditional responses. The next sections highlight examples and research on community engagement strategies that can lead to accomplishment of this goal, through providing a framework for true community engagement.

Community Spotlights

Community Spotlight: Texas

The Meadows Mental Health Policy Institute has worked alongside communities throughout Texas, including Dallas, Bexar, Travis, Abilene, Galveston, and El Paso counties, to transform their responses to mental health emergencies. The programmatic approach has been through the development of multi-disciplinary response teams (MDRTs)[11], and planning, implementing, and evaluating the success of this approach has depended on the engagement of a broad range of stakeholders. These stakeholders have historically been traditional parties such as law enforcement, mental health providers, local philanthropic organizations, health systems, and housing agencies, with an increasing reliance on the perspectives and views of persons with lived experience and their families. Techniques for gathering information include individual interviews, focus groups with multiple parties, analysis of archival materials, and quantitative analysis relying on statewide and local data bases. Findings and recommendations are vetted by stakeholders for accuracy and "fit" with the community. This approach, combining local expertise with the Institute's expertise, engages stakeholders deeply in the role of key informants and consultants.

This work demonstrates attempts at authentic community engagement; however, the methods employed reflects more of a consultation approach through the use of interviews, focus groups, and quantitative data to surface findings and recommendations. System agents, excluding PWLE, translated the findings and recommendations into policy, programmatic, and systemic interventions. Authentic community engagement and buy-in would include collaboration with shared decision making throughout the entire process, thereby reducing the possibility of misinterpretations, and strengthening implementation and continuous quality improvement.

Community Spotlight: Washington, D.C.

The need for the Washington D.C. Department of Behavioral Health's (DBH) Homeless Outreach Program (HOP) was identified through community engagement and reinforced by intentional input from key stakeholders. Though some stakeholders changed during the process, the core group consisted of DBH, homeless services providers, law enforcement, individuals who were experiencing homelessness and who had acute behavioral health conditions, advocacy groups, and community members. Monthly cross-sectional meetings with law enforcement, fire and emergency services, community members, and individuals with lived expertise were held to allow for input into the formation, strategy, and ongoing evaluation of the program. HOP employed peer support staff, a psychiatrist, social workers, and behavioral health specialists who worked with providers and law

enforcement "homeless liaisons" in order to target individuals and connect them to intensive wraparound supports and behavioral health services. HOP provided comprehensive outreach and crisis response to individuals experiencing homelessness throughout the District and ensured short-term case management support until a person could be strongly connected to ongoing behavioral health providers.

Twice over the course of eight years, the program merged with existing programs to support sustainability, and in the course of these adaptations the purview and scope of services shifted. The monthly meetings and ongoing evaluation became more sporadic as the program shifted, and turnover in essential staffing led to low attendance at these meetings. In 2019, HOP was absorbed into the Community Response Team. Key stakeholders were engaged during the initial stages by top government officials (Executive Director, Mayor, Chief of Police etc.) and several stakeholders (law enforcement, Public Safety Answering Points, peer support staff) were engaged but the ongoing community engagement moved to a less formal process consisting of staff member outreach and community meetings for consultation. These shifts made the interventions less effective as PWLE and communities most impacted became less involved in the strategy, design, and evaluation of services; this result highlights the need to ensure sustainable engagement with PWLE to maintain the efficacy of interventions.

Community Spotlight: Ohio Community Collective Impact Model for Change

Through grant funding under the federal 21st Century CURES Act, the Ohio Department of Mental Health and Addiction Services (OhioMHAS) awarded funding to two cohorts of Ohio communities to participate in the Community Collective Impact Model for Change (CCIM4C) initiative, a two-year program to reduce opioid-related deaths and increase access to treatment in the state of Ohio. During the initiative, 18 communities across the state utilized a data-driven, strategic planning process with a focus on community trauma, using the Tool for Health and Resilience in Vulnerable Environments (THRIVE) and the Adverse Community Experiences and Resilience (ACE/R) framework, and an emphasis on working collectively across the continuum of care, using a collective impact model, to address the opioid crisis and social determinants of health in their local communities. Eleven communities were involved in the first cohort (2017-2019) and seven communities are currently involved in the second cohort (2019-2021).

The initiative had two overall goals:

- Reduction in opioid use disorder (OUD) deaths as a result of increased collaboration between prevention, treatment, and recovery supports
- Increased access to OUD treatment, including medications for opioid use disorder (MOUD)

To achieve these goals, each community designated a backbone organization (e.g. county behavioral health authority or community-based coalition) that identified the scope of the problem and available interventions already in place in the area, brought together a wide range of stakeholders in multiple sectors, and developed a strategic plan across the continuum of care to mount a more comprehensive response. These local teams are supported by an overarching leadership team. In addition to a strategic plan across the continuum of care, the teams are tasked with developing a strategic plan that goes beyond the typical responses to the opioid crisis, addressing the complex social problems that fuel this public health emergency, such as childhood trauma, poverty, unstable housing, economic opportunity, and social isolation.

A key driver of the CCIM4C Initiative was that each community created a local ecosystem that reflected the community context. These local ecosystems ensured that participating communities were able engage a wide range of organizations to move forward on the opioid epidemic with a common agenda.

For future improvements, it is important to note that CCIM4C lacked engagement with PWLE and their families. The majority of respondents evaluating the Model's effectiveness were project directors (54%), member partners (15%), coordinators (8%), executive directors (8%), evaluators (5%), and other (10%). Most respondents (88%) were female and a large majority of respondents (95%) reported their race as white.[12] Although communities participating in the CCIM4C model made progress in creating a common agenda and working across the continuum of care to address the opioid crisis, the primary actors included local government, behavioral health providers, and other system agents. Including PWLE and beneficiaries of services would strengthen the model's efficacy and impact.

III. Principles, Barriers, and Models

This section highlights principles, barriers, and models for authentic community engagement and buy-in. As mentioned earlier, the upcoming implementation of 988 presents a significant opportunity to reimagine a more humanizing and effective crisis response system co-designed by impacted communities. For 988 to be successful and to assure integration with 911, it will require broad buy-in and support and high levels of trust with historically disenfranchised communities and both traditional and non-traditional stakeholders. To do this, behavioral health, health, law enforcement, and other partners must include individuals and communities who will be the beneficiaries of crisis services in every step of the crisis response process, including preliminary conversations, decision-making, implementation, and evaluation.

Seven Core Principles for Community Engagement

In 2009, a group of practitioners and scholars in the fields of public engagement, conflict resolution, and collaboration developed a set of seven useful principles, which they suggested could be applied to a range of projects.[13] For the purposes of this brief, the principles have been adapted for relevancy to behavioral health crisis community engagement efforts. In the Kettering Foundation's annual newsletter, David Mathews explored the task of obtaining a better understanding of the decision-making process: how resources are recognized and committed, how actions are organized, and how a community learns from its efforts.[14]

1. ***Preparation***. Through adequate and inclusive planning, ensure that the crisis system design, organization, and convening of the process fulfills a clearly defined purpose and the needs of the people served.
2. ***Inclusion and demographic diversity across all processes in crisis system design***. Equitably incorporate diverse populations, voices of people with lived experience, ideas, and information to lay the groundwork for quality and equitable outcomes and democratic legitimacy.[15]
3. ***Collaboration and shared purpose.*** Support and encourage participants, government and community institutions, and other stakeholders identified by the communities served to work together to advance system transformation, implementation, and sustainability.
4. ***Openness and learning.*** Help all involved listen to each other, explore new ideas unrestrained by predetermined outcomes, learn and apply information in ways that generate new options, and rigorously evaluate community engagement activities throughout the entire process for effectiveness.
5. ***Transparency and trust.*** Be clear and open about the process, and provide a public record of the organizers, sponsors, outcomes, and range of views and ideas expressed. In most cases, this will require intensive work to repair trust in the crisis system and those who have perpetuated the system.
6. ***Impact and action.*** Ensure each participatory effort has real potential to make a difference, and that participants are aware of that potential.
7. ***Sustained engagement and participatory culture.*** Systems implementing or redesigning crisis response systems should promote a culture of participation within programs and institutions that support ongoing community engagement of all communities served. A special focus should be placed to reach under-resourced communities, rural, and historically disenfranchised populations.

Appendix A illustrates a more detailed application of these principles to behavioral health crisis community engagement efforts, including relevant community examples.

Barriers to Community Engagement within the Crisis Continuum

There are many barriers to the implementation, scalability, and sustainability of effective crisis intervention practices. Trust, or its absence, however, is a cornerstone. Without sustained, intentional efforts to develop trust and create strong relationships throughout the engagement process, the impact of community engagement will be diluted. A growing challenge in community engagement and buy-in is the widely documented waning of trust in institutions, government, and behavioral health care and crisis response systems.[16] Institutional mistrust poses serious challenges to those seeking to engage communities in effective dialogue, decision-making, and participation processes related to health care and crisis response systems, and exacerbates preexisting barriers such as the following:

- **Insufficient funding.** Competition for resources, real or perceived, exists when some stakeholders' gain is seen as others' loss. This situation can lead to territorialism, duplication of services, inefficient use of resources, diffuse accountability, and fragmented funding. A competitive environment can also foster passive-aggressive collaboration between groups that fear losing resources. Funding and its allocation present a primary challenge to more widespread adoption of crisis services. Despite significant investments in crisis services, there is continued concern related to financing a comprehensive system of care.[17] [18] Funding is needed for strong community partnerships to assist with diversion from less appropriate settings, increase awareness of crisis services, and establish linkages to community services.[19]
- **Bias and unresolved conflict.** Perceptions of biases in people or organizations leading the process or in the information provided can undermine collaboration and implementation. The crisis system is ripe with unresolved conflict as individuals have endured a system that did not meet their needs, and often, caused detrimental harm. There are current tensions around the role of law enforcement within behavioral health response; however, many communities without effective response services continue to rely on law enforcement as primary responders to behavioral health crises. This further exacerbates tensions between the community, law enforcement, and trust in behavioral health systems. Unresolved prior conflicts can further fuel bias due to legacy considerations, such as past involvement with the behavioral health system that did not meet people's needs, or stakeholder tension from prior negative interactions.
- **Polarization**. Political polarization of health care, particularly behavioral health and crisis response systems, and the reliance on preconceived notions guiding processes, creates tension between individuals and can impede cross-system collaboration.
- **Hyper-professionalization and elitism.** While there is significant focus on ensuring individuals with lived experience are involved in the crisis workforce, the distance between professionals and the recipients of services has increased as governance of systems and processes, activities, and service delivery has become increasingly specialized, complex, and detached from its implementation in communities. The barrier is magnified by the tendency among funders, providers, regulators, and others with technical or clinical expertise to assume that they understand the problem and solutions better than individual communities.
- **Time constraints.** To fully support buy-in, communities must commit to the process, which can take time. Without the support of leaders to allow for this time and facilitate buy-in, changes will not happen. There are continuous changes within the crisis system; ARPA enhancements to mobile crisis go into effect April 2022 and the deadline for 988 is July 2022.[20] [21] The rapid pace and drive to stand up a crisis system prior to these deadlines can directly conflict with the ability of localities to participate in authentic community engagement.
- **Poor coordination.** While 988 planning has set the stage for cross-sector collaboration with planning workgroups, unclear or inconsistent communications between stakeholders, especially between systems of care, providers, interest groups, and the communities most affected, hinders effective collaboration and sustainable change.
- **Lack of leadership.** The scaling of innovations is often undermined by the low priority accorded to mental health by policymakers, the challenge of changing poorly organized services (e.g., over-

centralized care), and poor management or leadership of systems.[22] While there is currently significant national momentum to prioritize crisis services, to create effective crisis systems, there needs to be leadership that understands the nuances of community needs and the tensions that may create barriers to effective systems.

- **Incongruent values.** Providers, funders, governmental organizations, people with lived experience (PWLE), historically disenfranchised people, and rural communities all view issues through the lens of their experiences and values, which often affects both their perception of the problem and their opinions on potential innovations. In crisis response, tension exists in primary focus of response being rooted in public safety versus public health which creates incongruent values and these differences in values manifest in different approaches to shifting the paradigm.
- **Diffuse accountability.** Crisis response has long been a scattered array of services rather than a coordinated system with various entities serving as primary responders. These poorly defined responsibilities and authority across the systems can, at times, cause stakeholder blaming and retraumatization. The reasons that such barriers exist, and the responsibility for creating solutions, are often neither well understood nor agreed upon.
- **Lack of recognition**. Individuals respond well to recognition and are often driven to contribute by acknowledgment that their expertise is valuable and legitimate. Often, the strengths and assets of PWLE, historically marginalized, and rural communities are overlooked or not appropriately recognized, which can create distrust and negatively affects system implementation and sustainability.

Popular Models to Support Community Engagement and Buy-in

The Collective Impact Model

Many states and localities, including Denver, North Carolina, and Ohio, have utilized the Collective Impact model to address public health issues, such as the opioid crisis. [23] This model recognizes the complex nature of issues and creates a structured form of collaboration in which a network of key stakeholders works to advance equity through learning, aligning, and integrating actions to create system-level change. It involves identifying a common agenda, creating shared measurements, mutually reinforcing activities, and engaging in continuous communication. The model also requires a backbone support agency with unique and dedicated staff to support the process.[24]

- **Strengths:** Implementation teams report success in bringing together executive-level leaders across the community to develop a shared consciousness, improve cross-system coordination, and align funding.
- **Weaknesses:** The model does not adequately address equity, nor does it prioritize engaging people most affected by the issue. This results in strategies uninformed by essential community knowledge of root causes, and solutions that do not meet the needs of the most impacted communities. Additionally, the model is not as effective in rural areas due to contextual distance.[25]

The Active Community Engagement Continuum

The Active Community Engagement (ACE) continuum allows for analyzing community engagement and the role it plays in lasting behavior change.[26] It provides a framework to empower communities through three phases of community engagement: consultative, cooperative, and collaborative. Five characteristics are used to empower communities through those phases: pre-program assessment; access to information; inclusion of communities in decision-making; developing capacity to advocate to institutions; and governing structures and accountability of government to the public.[27]

- **Strengths:** The model offers a spectrum of approaches that provide an accessible and concise roadmap to measure the success of community engagement efforts. It is particularly useful in establishing

benchmarks and milestones of success upon launch of a community planning initiative, and it is applicable to both simple and complex efforts.
- **Weaknesses**: There is limited research on the model's effectiveness in systems redesign and in the development and adoption of innovations by diverse stakeholders. The model does not provide examples of communities involved in the evaluation and continuous quality improvement processes.

Human-Centered Design

Human-Centered Design (HCD) has become popular in the health and human services sector due to its efficacy and accessibility. HCD prioritizes empathy to deeply understand the needs and behaviors of beneficiaries. This framework involves fast-paced data collection through interviews, journey mapping, and observations that are synthesized to design prototypes that are tested and scaled.

- **Strengths:** HCD is a highly creative and agile approach to problem-solving that results in new solutions that are client-centered. The original model did not utilize an equity lens, but in practice, many in-field adaptations have incorporated equity considerations.
- **Weaknesses**: HCD relies heavily on the commitment of those facilitating the process to engage people with lived experiences and historically disenfranchised communities as equal partners in the co-creation process. The model is effective when PWLE are included in conversations about their needs, experiences, and behaviors as well as in conversations about designing and implementing innovative solutions. The degree to which PWLE are involved in this process rests solely on the individual facilitators.

These models have features that facilitate community engagement and buy-in; however, none of the models offer a comprehensive framework grounded in the seven core principles described previously, nor do they necessarily address common barriers to community engagement and buy-in. Therefore, we propose an innovative framework in the next section that leverages the strengths of the aforementioned models while overcoming common barriers.

Develop a Comprehensive Community Engagement and Buy-in Framework for Behavioral Health Crisis Innovations

As outlined previously, there is a need for a comprehensive and transdisciplinary approach to community engagement and buy-in that addresses critical elements of systems redesign while centering the experiences of PWLE and their families. Current community engagement and buy-in approaches for PWLE and under-resourced communities are inadequate. When considering community engagement, the dominant strategies include community meetings, focus groups, surveys, and tokenizing representation on planning committees. Typically, government actors extract information by these methods and then take that information to more traditional stakeholders to develop programming. Even collaboration with cross-systems stakeholders can be fraught with tension and territorialism. Some communities utilize social innovation and other creative problem-solving processes, such as Human-Centered Design, to address behavioral health crisis inequities. However, these programs are often utilized in a way that does not engage communities, share decision-making power with PWLE, recognize the disparate racial impact of current responses, or address the complexity of behavioral health systems. A truly comprehensive framework should integrate the best features of the following models, frameworks, and models:

1. **Collective Impact Model**: This model creates space for diverse stakeholders to collaborate in a structured way through a common agenda, shared measurements, mutually reinforcing activities,

continuous communication, and backbone support. This framework also facilitates the successful scaling of the most effective components of a program.

2. **Team Science**: This framework is an evidence-based approach that augments community engagement and buy-in and the translation of effective measures into policy and practice by focusing on institutional infrastructure, team-building, interpersonal dynamics, trust, shared vision, and rewards. This model also facilitates multiple stakeholder groups to work together towards the identification and implementation of complex interventions.
3. **Community-Centered Integrative Practice**: This approach focuses on culturally responsive ways of approaching, engaging, and empowering diverse communities and stakeholders while respecting their identities, positions, indigenous wisdom, values, and histories.
4. **Equity-Centered Community Design**: This community engagement and buy-in process utilizes design thinking, equity, and humility-building while integrating history and healing practices and addressing power dynamics to develop effective solutions with both impacted communities and traditional stakeholders.
5. **Innovation Dynamics**: This is a framework to consider complex social problems and identify the social norms that reinforce those problems. Innovation Dynamics utilizes six lenses — actors, history, limits, future, configuration, and parthood — to surface stakeholder motivations and behaviors and strengthen buy-in.
6. **Transdisciplinary Science**: Complex interventions require work across many disciplines and sectors, and need community knowledge to unearth innovative and viable solutions. An integrated, transdisciplinary, and relational approach addresses historical shortcomings in a way unlike the fragmented approaches that are overly clinical, discipline-specific, and ignore community knowledge and other cultural assets.
7. **Continuous Quality Improvement Framework**: This framework fosters curiosity and rapid iteration to "fail fast to succeed sooner." This data-driven, iterative approach encourages stakeholders to look for ways to improve interventions through a culture of continuous refinement and adaptation. Improvement cycles occur more often than traditional evaluation approaches and thereby accelerate the process of achieving better outcomes.

To fully develop a framework based on these elements, additional resources are needed, especially to make it accessible and useful to non-professionals. A training curriculum, facilitator guide, coaching materials, branding, and marketing would be needed for ease of learning and dissemination.

Federal, State, and Local Government Roles: Supporting Community-Based Crisis System Collaborations and Integrated Crisis Systems

Federal, state, and local governments must play a role in fostering and advancing community crisis system collaborations, but many such efforts reflect the strengths and weaknesses of the models discussed above. The idea of a reimagined approach to community engagement and buy-in rests on the notion that crisis system and services design, implementation, oversight, and improvements must be centered in advocacy, voice, leadership, and the needs articulated by service users and policy and practice drivers. The absence of adequate federal or state guidance can lead to a gap between local, community-centered planning and successful implementation. Arizona provides a good example of state guidance. Arizona's' contracts with health plans contain the following requirement, "… work in partnership with Contractors [indicating other health plans] in its service area to meet, agree upon, and reduce to writing, a memorandum of understanding detailing and/or joint collaborative protocols with the following: [list of state agencies, justice partners, and tribal entities]… each collaborative protocol, at a minimum, shall include… mechanisms for resolving problems…" This is forcing the health plans to work with others across a system. Of note, in other sections of the contract, health plans are required to engage and utilize PWLE and their families in the leadership and operations of the health plan.

Government often establishes an intent for inclusion of PWLE choice of by creating requirements for some level of participation. SAMHSA established a requirement for the Mental Health Block Grant to create a state mental health planning council that includes PWLE and their families. HRSA requires that the boards of Federally Qualified Health Centers have 51-percent representation of patients served by the health center. These health center patient board members must, as a group, represent the individuals who are served by the health center in terms of demographic factors, such as race, ethnicity, and gender. However, these examples, and even the contractual requirements highlighted in Arizona, risk a tokenizing approach unless carefully evaluated and monitored for effectiveness.

See Appendix B for a detailed overview of how federal, state, and local governments have negatively and positively influenced the development of community crisis collaborations. The overview includes current barriers, current initiatives, and examples of efforts to support community collaborations, as well as opportunities for federal, state, and local government to offer effective support.

IV. Opportunities for Philanthropy

Advancing Equity-Based Decision-Making to Guide Strategic Investments

Currently, both private and governmental efforts have resulted in limited authentic community engagement. Philanthropic investments can play a critical role in fully engaging communities and stakeholders, including people with lived experience (PWLE), in the design, implementation, and evaluation of a reimagined crisis response system.

The COVID-19 pandemic and the latest manifestations of the movement for racial justice serve as a reminder that racism is a key driver of inequity in the United States, as racially marginalized communities continue to be disproportionately impacted by the pandemic. Racism also drives behavioral health inequities resulting in:

- Lack of access to culturally relevant care
- Poorer quality of care
- Misdiagnosis (both under- and over-diagnosing)
- Criminalization of behavioral health and substance use disorders
- Higher economic burden to impacted families and the system

There is much more emphasis today on employing the voices of PWLE in formal governmental processes. However, the evolution of behavioral health systems has not eliminated and in some cases has exacerbated disparate racial impact. Studies point to the continuous over-diagnosis of schizophrenia and under-diagnosis of mood disorders in the Black community.[28] Additionally, there is an overrepresentation of white clinicians serving an increasingly racially diverse patient population, further exacerbating implicit bias and inequities in the design, development, implementation, and evaluation of services.[29] As noted above, overreliance on jail and hospital emergency departments as default responses to mental health emergencies exacerbates the longstanding issue of overrepresentation of Black and Latinx groups in the criminal justice system; while arrests and jail populations have declined during COVID[30], racial disparities within the overall reduction in arrests were significant.[31]

To advance effective community engagement and behavioral health equity in this rapidly changing environment, philanthropic investments should be guided by these values[32]:

- Invest in focused strategies that address barriers identified by racially marginalized and underserved communities and amplify solutions co-designed by those communities.
- Invest in strategies that shift from a victim or needs analysis in an attempt to "fix" disenfranchised communities to a systems change approach that recognizes the role of systems in perpetuating inequities.
- Invest in strategies that seek to heal the long history of behavioral health inequity and in approaches that shift resources and power back to people and communities of color while utilizing cultural assets, community knowledge, and resiliency that are often underfunded and devalued.

The Weissberg Foundation, a small family foundation based in Arlington Virginia, provides an excellent example of the aforementioned strategies in practice. Trustee Nina Weissberg was inspired after participating in a six-month learning series organized by Washington Regional Association of Grantmakers titled "Putting Racism on the Table."

This resulted in the Weissberg Foundation engaging in the following programmatic activities to ensure more racially equitable grantmaking[33]:

- **"Reparative" grantmaking**: Prioritizing funding people of color-led organizations, which have been and continue to be egregiously underfunded by philanthropy, that are explicitly striving to advance racial equity through advocacy, organizing, civic engagement and/or other power-building strategies.
- **"Partly-participatory" grantmaking**: Sharing grantmaking decision-making power by engaging community reviewers throughout our proposal review process, including co-creation of our application assessment rubric; compensating them fairly; and building a pipeline to their board.
- **Going beyond the "no" with declined grant applicants**: Inviting 2-way feedback conversations with declined grant applicants and providing acknowledgment grants to those that get to a certain stage in the grant review process to signal appreciation for their efforts.
- **Tending to the ABCs**: Going beyond funding by ramping up our strategies around Amplification, Building capacity and Collaboration in ways that help grantee partners meet their larger vision for racial equity.

It is recommended that philanthropic organizations develop an equity-based decision-making framework designed to guide strategic investments to support behavioral health crisis innovations that advance behavioral health equity. The purpose of such a framework is to ensure that philanthropic investments catalyze behavioral health innovations, system processes, and policies that proactively eliminate racial, LGBTQ2S+, disability, and rural inequities while maximizing benefit and minimizing harm to affected communities. A noteworthy example developed by the National Innovation Service for Equitable COVID-19 Homelessness Response illustrates the utility of an equity-based decision making framework.

Community Spotlights of Effective Community Engagement and Buy-in Strategies within Adjacent Systems

Community Spotlight: King County Regional Homelessness Authority (Seattle, WA)

King County and the City of Seattle declared homelessness a state of emergency in 2015. January 2017, the nationally mandated one-night count of people who are homeless found 11,643 people experiencing homelessness. County and city governments, providers, United Way of King County, and local philanthropy worked hard to improve system capacity amidst a growing housing affordability crisis. However, system efforts were consistently undermined due to diffuse authority, separate funding and contracting processes, and funder autonomy slowing down programmatic changes to meet rapidly changing community needs resulting in increasing numbers of unsheltered residents. Reports and collaborative efforts such as One Table and the Regional Affordable Housing Task Force pointed to the fractured nature of homeless services and the need for unification efforts.

In 2018, the City of Seattle and King County collaborated with National Innovation Services (NIS) to launch a community engagement and buy-in process to design a stronger regional response to the homelessness system. PWLE and communities most impacted by homelessness were seen as important stakeholders throughout the planning, research, design, governance, and implementation process. The goal of the design process was to produce a holistic and integrated system versus applying a band-aid approach to structural failures. NIS's mission was to help the community develop a homelessness system that was inoculated against inequity.

The NIS led community-engagement and redesign process led to an Inter Local agreement in December 2019 approved by the King County Council, Regional Policy committee, and Seattle City Council in the creation of a

new King County Regional Homelessness Authority (KCRHA) to oversee a coordinated and unified response to homelessness. This formal agreement marked an unprecedented collaboration between Seattle, King County, King County's cities, people with lived experience of homelessness, and philanthropy and business to improve coordination of services, funding, and governance in addressing the crisis of homelessness.

KCRHA's theory of change has been grounded in the belief that "if we create a homeless crisis response system that centers customer voice, then we will be able to focus on meeting needs and eliminating inequities, in order to end homelessness for all." KCRHA utilized an equity-based decision-making framework to ensure that the homeless service system's processes and policies are designed to proactively eliminate racial inequities and advance equity. This decision-making structure was mandated by the Inter Local Agreement and Charter whom PWLE played a major role in drafting. KCRHA's guiding principles reinforce accountability across all of its activities, decision-making processes, governance, and strategic planning to its customers. The KCRHA launched in early 2021. The CEO hired to run KCRHA, Marc Dones, is a person with lived experience. Staff of the authority reflects communities overrepresented in the homelessness system with many having lived experience of homelessness.

KCRHA demonstrated its commitment to elevating the voices of those with lived experience of homelessness by joining with several philanthropies in funding the Lived Experience Coalition (LEC). The LEC was founded completely by people who have experienced homelessness with the stated mission "of working beyond oppressive structures by unifying our voices, speaking truth to power, and working together to dismantle multisystem barriers impacting people who are experiencing homelessness and involvement in the criminal justice system, face unmet behavioral health needs, and/or fleeing violence or emotional /psychological victimization. The LEC has over 250 members who are actively engaged in advocating for systems change through the following key activities:

- Working with system stakeholders to end homelessness
- Advocating for equitable and people-centered system change
- Building community to support unsheltered neighbors
- Providing leadership development and employment training for people with lived expertise.

Support provided by KCRHA and philanthropy allowed the LEC to provide members with $30/hour stipends to remove barriers to engagement, leadership development and coaching, and staff support for members serving on various committees and workgroups. Philanthropy, government, providers, and the business community have partnered with the LEC in their efforts to develop innovative, equitable, and win-win solutions that work.

Philanthropy played a major role in supporting the LEC's advocacy efforts for systems change and is an excellent example of how philanthropy can lead with values that shift resources and power back to people and communities of color by recognizing their cultural assets, community knowledge, and resiliency that are often underfunded and devalued. In fact, the LEC played a major role in assisting philanthropy in designing the King County Partners Group known as We Are In. Philanthropic organizations partnered with PWLE, civic leaders, housing and advocacy groups, business, providers, and faith-based communities to coordinate and align non-governmental efforts through an intermediary body that works closely with the KCRHA to address ongoing and emergent needs in regional homelessness. The We Are In board consists of 50% of PWLE with the remaining seats filled by philanthropy, business, and civic leaders.

This community's engagement and buy-in strategies not only embodied the Seven Core Principles of community engagement but also embodied an approach that utilized the best features of Collective Impact, Equity-Centered Community Design, and Transdisciplinary Science while being responsive to and honoring the identities, positions, indigenous wisdom, values, and histories of all stakeholders, especially those most impacted by homelessness.

Community Spotlight: Project Peace (Tacoma, WA)

The practice of authentic community engagement and buy-in can help drive racial equity and systemic change efforts while healing historical mistrust between stakeholders if done correctly. It is essential that community engagement directly inform strategic planning and policymaking efforts. One example where deep community engagement and buy-in strategies have been effectively utilized to inform institutional and structural changes is in the City of Tacoma.

In 2015, Project PEACE (Partnering for Equity and Community Engagement) arose from a group of African American faith-based leaders who feared that racial unrest could happen in Tacoma due to increasing tension between law enforcement and racially marginalized communities. The mission of Project PEACE was to do the difficult work of healing and building trust between marginalized communities and law enforcement. The project aims included:

- Acknowledge the historical harm between racially marginalized communities and law enforcement.
- Cultivate a deeper understanding of those harms and begin the healing process through intergroup dialogue between communities most affected and law enforcement.
- Transform community safety by making concrete changes in collaboration with communities most affected and law enforcement.

In order to accomplish the aforementioned aims, a Project PEACE Executive Committee (PPEC) was formed. PPEC included historically disenfranchised community members, law enforcement, grassroots leaders, city officials, and youth and young adults. PPEC oversees Project PEACE to assure relationships between law enforcement and communities of color are built and improved, information relevant to Project PEACE actions are shared with the larger community, and opportunities are created for law enforcement and communities to engage in healing, dialogues, and shared learning opportunities.

Image 1: Project PEACE participants. Photo: City of Tacoma Office of Equity and Human Rights

PPEC gathered community input through six community listening sessions in which over 800 people participated, followed by the creation of a report that laid out goals for the future. The listening sessions lasted 3.5 hours and included food and beverage. The majority of the listening sessions were conducted in small dialogue groups, with each group having two trained facilitators and a recorder taking notes. The groups all included law enforcement and community members sitting in a circle. The first portion of the session focused on race and racism so

participants can develop a shared language around structural and institutional racism. This initial segment is followed by a short lesson on the history of racism in the United States (adapted from the larger Undoing Institutional Racism workshop by the People's Institute for Survival and Beyond). Both of these listening session components served to educate and build awareness' about racial equity, priming participants to make connections between individual experiences and structural issues in the remainder of the listening session. Back in small groups, participants then dived into two conversations. First: what did you learn about police growing up, and what has been your experience with Tacoma Police Department? Then: what advice or guidance would you suggest that the police department pay attention to?

Following each event, participants were asked to take an online survey:

- When asked to rate their opinion of Tacoma Police Department before and after the engagement, 34% (statistically significant change) became more positive or hopeful, and 3% (statistically insignificant change) become more negative.
- When asked to rate their understanding of the challenges that exist between the police and residents, 38.6% (statistically significant change) became more positive, and 5.4 (statistically insignificant change) became more negative.
- When asked if they thought Project PEACE community conversations will improve relations between the Tacoma Police and residents, responses were mostly agreed. The majority of the sample identified as people of color. There were no significant differences as a function of race, age, or gender, although the race difference remained for the youngest group.

Following a successful series of Project PEACE conversations, the PPEC in partnership with the Tacoma Police Department expanded the initiative and achieved the following outcomes:

- Established a Citizen Police Advisory Committee and developed a Community Trauma Response Team.
- Launched a community co-designed Undoing Institutional Racism/Implicit Bias/De-escalation Training for law enforcement.
- Launched an annual survey to track and analyze the level of trust that citizens, especially racially marginalized and historically disenfranchised communities, have with the Tacoma Police Department.
- Made significant progress in diversifying the workforce of Tacoma Police Department.
- Increased non-enforcement contacts with community members in neighborhoods, business districts, schools, and community centers.
- Established ongoing Project PEACE gatherings with youth young people in the community.

Project Peace received recognition as a best practice from President Obama's 21st Century Policing Task Force and the National Civic League highlighted Project PEACE as a promising practice. Inspired by Project PEACE, the City of Tacoma has expanded the work of Project PEACE and in October 2020 passed Resolution 40622 – *Heal the Heart of Tacoma*. This initiative is aimed at creating systemic change that strengthens and heals communities, provide the foundation necessary to achieve greater equity in service delivery, and increase trust in local institutions. Heal the Heart is community-led, and invites local organizations to bring their expertise to the table to transform Tacoma into an anti-racist city.

Much can be learned from Project PEACE to ensure 988 is well publicized and well received by supporting the engagement of historically disenfranchised communities, especially, communities of color and rural communities, to inform the implementation of 988 and to foster trust in it as a crisis response that is different than 911. Project PEACE was exceptional in its approach to building trust by weaving Healing-Centered Engagement to create a more humanizing milieu that strengthened stakeholder relations. Project PEACE assumed very stakeholder has

some trauma that they are carrying whether it is PWLE or law enforcement. By creating an intentional space for stakeholders to be vulnerable and human by prioritizing the emotional climate and wellbeing of stakeholders to foster healthy relationships and group dynamics, the City of Tacoma was able to cultivate a safe and supportive environment that led to trust, broad buy-in, and systemic change.

Create a National Community Action Hub

Effective community engagement and buy-in practice is essential to designing behavioral health crisis response systems that work. However, most local governments and communities lack the capacity and skills to facilitate this kind of engagement. Supporting communities in developing, scaling, and sustaining effective solutions while advancing research, knowledge development, policy reform, and implementation is possible. A National Community Action Hub could make this a reality. Given that community engagement varies across the United States and that there is currently no federal guidance on effective practices, investments to create a National Community Action Hub could support both behavioral health crisis services and cross-sector collaboration.

The National Community Action Hub can serve as a home for technical assistance, training, and coaching provided to communities in employing the Comprehensive Community Engagement and Buy-in Framework for Behavioral Health Crisis Innovations outlined above. A National Community Action Hub can also evaluate the efficacy and reach of community-led initiatives, ultimately contributing to the literature on what is most effective in various communities.

History of the National Hub Model

The Action Hub model was developed by Dr. Heather Mosher at the Institute for Community Research (ICR) in 2015 in response to the need for an effective, system-level mechanism for receiving continuous input from young people with the lived experience of homelessness. Additionally, input was needed for the development of youth leadership and youth-adult partnership in policy advocacy and research towards ending youth homelessness in Connecticut. Funded by the Melville Charitable Trust, the initial concept of the Youth Action Hub was developed by ICR in partnership with the Center for Children's Advocacy. During its first year, the Hub conducted a statewide study on young people's access to housing services, and presented these findings and recommendations to policymakers. Hub members were also active partners on committees and task groups, helping translate data and evidence into changes in practice and policy.

The Action Hub Model

The Action Hub model is designed to change unequal power dynamics within decision-making groups working to end disparities. The model intends to create a system where PWLE are equal partners in the design, implementation, and evaluation of services they receive, as well as in the development of comprehensive policy and innovative practices to end racial and social disparities. The model uses supportive employment and participatory action research to grow community leaders who have been disproportionately impacted. Participatory action research embodies equitable participation of community members in all phases of research and uses research collaboratively to enact social transformation. The Hub model provides stable part-time employment and on-the-job training for a diverse group of PWLE.

Action Hub Model Background and Purpose

Within the work to end homelessness in Connecticut, youth who have experienced homelessness and housing instability are leaders, researchers, and policy advocates through the Youth Action Hub of the Institute for

Community Research. Similar efforts are needed to engage adults with lived experience with behavioral health systems to build the political and civic will to advance behavioral health equity. An Action Hub model can be developed with both youth and older adults and can offer meaningful leadership and partnership with people with lived experience in statewide or local efforts to improve behavioral health systems. Creating decision-making processes that include PWLE as equal partners can help ensure that behavioral health systems, policies, and programs are shaped by the most impacted populations and their specific needs.

V. Conclusion

This moment represents a tremendous opportunity for philanthropy to take bold action to influence real, sustainable change in the behavioral health crisis system. This reimagined system must be co-designed with stakeholders and community members to maximize the potential impact of the system, including improved outcomes, reduced disparities and inequities, and greater system efficiency. We outlined two evidence-based strategies, community engagement and buy-in practices, that share decision-making power with people with lived experience and their families. We also provided a framework that can be operationalized for the co-creation/co-design process. This new system will overcome structural and systemic barriers in the existing behavioral health crisis system and move impacted communities towards more equitable outcomes.

Appendix A: Seven Principles and Considerations for Behavioral Health Crisis Response System Transformation

Adapted from the "Core Principles for Public Engagement" outlined in the National Coalition for Dialogue and Deliberation's *Resource Guide on Public Engagement* [PDF].

1: Preparation

Through adequate and inclusive planning, ensure that the crisis system design, organization, and convening of the process serve both a clearly defined purpose and the needs of the people served.

Considerations

- The introduction and national rollout of 988 presents an opportunity to ensure that the correct participants are at the table for each step of the planning process.

Initiatives

- American Rescue Plan Act (ARPA) planning grants to implement Medicaid mobile crisis programs are allotted based on the ability to utilize those funds to conduct a statewide needs assessment, which includes evaluation of equity strategies.
- Intentionally define the strategy, purpose, and include communities in the design of the enhanced mobile crisis program.

2: Inclusion and Demographic Diversity across System Design

Equitably incorporate diverse populations, voices of people with lived experience (PWLE), ideas, and information to lay the groundwork for high-quality and equitable outcomes and democratic legitimacy.

Considerations

- Many programs already exist that were specifically created with the vision of inclusion and diversity; learn from these community-led and peer-run organizations.

Initiatives

- People USA is a 100% peer run organization providing wraparound crisis services to individuals through a forensic mobile crisis team, crisis stabilization units, and Rose Houses, a voluntary short-term crisis respite that provides a home-like alternative to psychiatric units.
- R.E.A.L. is a peer-run organization formed in order to promote wellness and recovery that achieved a 44% decrease in participants needing to go to the hospital.[34]

Minnesota mobile teams are required to ask about psychiatric advanced directives, and to utilize them when clinically appropriate. These directives allow individuals to legally state their wishes in the event that they are unable to make decisions during a behavioral health crisis.

3: Collaboration and Shared Purpose

Support and encourage participants, government and community institutions, and stakeholders identified by the communities served to work together to advance system transformation, implementation, and sustainability.

Considerations

- Identifying preconceived notations of state and PWLE
- Impact of historical trauma
- Compassion fatigue of workforce

Initiatives

- The Newark Community Street Team utilizes individuals who reside in the neighborhoods, including those who have been incarcerated or previously engaged in drug sales, to provide targeted outreach and mentorship to at-risk youth as a method to prevent crime.[35]
- New York City and Washington DC support city-community partnership to create community-driven interventions to decrease gun violence through the use of violence interrupters. As a result of the intervention in New York, crime dropped and the city invested further in the program to enhance sustainability of the success.[36]

4: Openness and Learning

Help all involved listen to each other, explore new ideas unrestrained by predetermined outcomes, learn and apply information in ways that generate new options, and rigorously evaluate community engagement activities throughout the entire process for effectiveness.

Considerations

- Finding the win-win and developing a shared mission and goals that all stakeholders can agree on.
- Spending time to understand each stakeholder's motivations, fears, and other concerns.
- Stakeholders spending time getting to know each other personally.

Initiatives

- Restorative justice is a technique that focuses on community healing through bringing together those most impacted by a crime with the offender. It is also the name of a conflict resolution and community-building organization for preventing and resolving conflicts from bullying to auto theft to assault.
- Restorative Response Baltimore utilizes a "community conferencing" empowerment-focused model, where a trained facilitator brings both parties together for a structured dialogue that ultimately results in shared conflict resolution, a written agreement, and high compliance with those agreements.

5: Transparency and Trust

Be clear and open about the process, and provide a public record of the organizers, sponsors, outcomes, and range of views and ideas expressed. In most cases, this will require intensive work to repair trust in the crisis system and those who have perpetuated the system.

Considerations

- Historic and current mistreatment had created distrust of the "system" by communities of color and rural communities
- Repairing trust between state/local government, law enforcement, and communities of color will take intentional effort
- Requires acknowledgement of the harm that has historically been done by the government and collaborating with the community to move forward
- Tapping into networks can support community engagement and assist in reestablishing trust

Initiatives

- Partnerships with trusted community leaders, such as faith based organizations, has proven an effective strategy to facilitate these discussions.
- Shift law enforcement focus from community-based strategies, moving to more community designed and led approaches, such as credible messengers.
- Salvation and Social Justice is a faith-rooted organization that works across the faith community to organize individuals impacted by systemic inequities to engage legislators, state representatives, and government agencies in order to be part of the solution moving forward.
- System accountability enhances trust. Approaches such as ABLE (Active Bystander for Law Enforcement) which serves to promote a culture of accountability within law enforcement through the prevention of misconduct and encouragement of colleague intervention to prevent harm.

6: Impact and Action

Ensure participatory efforts have real potential to make a difference, and participants are aware of that potential.

Considerations

- PWLE highlighted feeling part of a broader impact and system-wide changes when they felt their input was utilized by other stakeholders and when they saw tangible action from engagement in work groups and community forums with leadership.[37]

Initiatives

- Many states are currently setting their standards for mobile crisis services under ARPA and have the opportunity to ensure participatory effort shapes both data collection and system creation.

7. Sustained Engagement and Participatory Culture

Systems implementing or redesigning crisis response systems should promote a culture of participation within programs and institutions that supports ongoing community engagement of all communities served. A special focus should be on reaching under-resourced communities and historically marginalized populations.

Considerations

- Historically, the identified best practices for evaluation of crisis programming involve in-system data collection and occasional satisfaction surveys of individuals who utilized services.

- Systems should broaden the scope of ongoing evaluation and participation of historically marginalized populations.
- Metrics should focus on evaluating change in impact of those underserved due to health disparities, remote access issues, and inadequate cultural response.

Initiatives

- The inclusion of PWLE on advisory committees to guide practice and support with ongoing evaluation of crisis systems (call centers, mobile crisis and crisis stabilization units).
- Texas created the Behavioral Health Advisory Committee, which includes multiple stakeholders with lived expertise, family members, faith-based organizations, and state representatives, to guide their behavioral health strategy.
- Georgia and Arizona have "Autism advisory committees" to evaluate services, including crisis services, to individuals living with autism to enhance effective interventions.

Appendix B: Federal, State, and Local Government Roles in Supporting Community-Based Crisis System Collaborations and Integrated Crisis Systems

Federal Government

Current Barriers

Collaboration across health and human services, and collaboration with people receiving those services, have been virtually nonexistent at the federal level, with the limited exception of cross-system collaboration efforts deep within a single federal agency. In these cases, plans are developed often with minimal financial support to achieve the goals (e.g., National Strategy for Suicide Prevention[38]). While some federal agencies have used funding strategies to incentivize cross-system collaborations (see below), there is not a consistent mechanism which supports ongoing coordination.

Positive Examples

A noteworthy example of federal investments shaping state and local system collaboration is the Justice and Mental Health Collaboration Program, which supports individuals involved in behavioral health and justice systems. While it is difficult to point to an example of federal interagency collaboration with crisis systems, there are examples of the federal government fostering collaboration addressing other broader needs. The U.S. Department of Health and Human Services (HHS) Administration for Children and Families (ACF) and Substance Abuse Mental Health Services Administration (SAMHSA) have fostered the development of the Systems of Care (SOC) approach, which, at its core, is designed to involve children, youth, and families in child welfare such that they are at the center of advocacy and the decision-making process related to policy development and implementation. HHS and SAMHSA support organizations that exemplify this concept, including the Federation of Families, an organization developed and led by families and youth to serve as the nation's choice for families of children who experience emotional, behavioral, mental health, and/or substance use challenges. Additionally, SAMHSA recently awarded funding to support the first National Family Support Technical Assistance Center. While these examples are not crisis-related, they highlight federal initiatives that promote the power and importance of having people with lived experiences at the center of the decision-making process as well as cross-agency collaboration. Components that are essential for a reimagined crisis system based upon authentic community engagement and buy-in.

Current Initiatives

The federal government recently implemented infrastructure to address the coordination of behavioral health and crisis services. HHS Secretary Xavier Becerra has been vocal about addressing the needs of individuals and families with behavioral health challenges. On May 18, 2021, the Secretary announced the creation of the Behavioral Health Coordinating Council, which is tasked with coordinating all federal government resources to address inequities and gaps within the mental health and substance use disorder system. Additionally, with the anticipated launch of the national 988 crisis line in July 2022, SAMHSA has added personnel to enhance its crisis systems and services expertise and developed coordination across federal agencies to support funding, leadership, and policy direction.[39] SAMHSA has conveyed its intention to work with other state agencies, such as

emergency services (e.g., 911), and to develop policy directions and learning collaboratives for states and local governments. It is unknown if these policy directions and learning collaboratives will ensure that those with lived experience are part of these efforts.

Opportunities

The newly formed Behavioral Health Coordinating Council, initiated by HHS, could recommend the following:

- The utilization of federal funding to support state and local communities in creating and advancing crisis system collaboratives that align with the concepts brought forward in this brief regarding a reimagined community crisis collaboration driving policy and practices with individuals and families with lived experience.
- The funding of community technical assistance support to foster reimagined community crisis collaboration that is led and provided by individuals and families with lived experience.

Philanthropy could enable support for the development of a reimagined and collaborative community crisis system through advocacy and messaging to the federal government. When financing of crisis systems and services is explored in several months, the research should consider how federal funding can support the development of a reimagined crisis system.

State Government

Current Barriers

Like the federal government, most state governments have patchwork crisis systems, a situation which does not support systematic community collaboration. With a few exceptions, states have multiple state and local agencies that are involved with crisis services. However, very few prioritize collaboration that will advance crisis systems. For example, some states have a mental health department separate from other entities (e.g., Medicaid), which are in turn separate from agencies that address the needs of other populations (e.g., individuals involved with child welfare or justice systems). The funding of these agencies is fragmented and often has divergent policy direction that does not encourage community collaboration or cross-system partnerships.

Positive Examples

Many states like Arizona set the expectation for coordination between state agencies, justice partners, and tribal entities. States can support standardization of collaboration through the inclusion of that expectation in their provider and MCO contracts. This requires the health plans to work with others across a system. Additionally, Arizona health plans are required to engage and utilize individuals and family members with lived experience in the leadership and operations of the health plan.

Current Initiatives

Several states have enacted legislation pertaining to the implementation of 988, and many bills have introduced topics related to the study or expansion of crisis systems and services overall, beyond 988 itself. Some of this legislation requires the engagement of individuals with lived experience in the evaluation and planning processes.[40] The state of Washington's HB1477 outlines a Crisis Response Improvement Strategy Committee that must include at least four representatives with lived experience.[41]

The State of Colorado has been in the process of creating a Behavioral Health Administration (BHA) to bring together a fragmented system to achieve better outcomes for all Coloradans.[42] The BHA does not place all behavioral health agencies under one umbrella; rather it encourages all Colorado state agencies to collaborate in

the development of shared policies and approaches, including a standardized way to collect and analyze data. Part of the BHA design involves an Advisory Council that includes people representing rural communities, children and youth, criminal justice, local government, Tribal Nations, consumers, families, providers and health care payers, and others. The Advisory Council is intended to provide a space to raise questions and concerns and bring innovative ideas to the broader BHA.

Opportunities

State governments could explore ways to enhance coordination between state agencies that are involved in crisis systems or services, such as through an existing or new cabinet-level position that oversees and integrates behavioral health services across the state, inclusive of crisis services. Further, states could develop practices that encourage the development of sustainable and effective collaboration and place individuals and families with lived experience at the center of the process.

Philanthropy could fund projects that prioritize community collaboration and cross-system partnerships that use community-based data points to measure effectiveness.

Local Government

Current Barriers

Local initiatives are limited without state guidance and funding, as are state initiatives without federal guidance and funding. Missing connections between the three levels of government has resulted in little to no comprehensive, collaborative engagement strategies. This does not mean that there are not "pockets of excellence" within a disjointed system, but it does mean that those efforts are not as efficient as they could be if authentic community engagement and cross-system collaboration were taking place. The Council of State Governments has identified 10 communities of best practice in behavioral health and law enforcement partnerships for crisis response, all at the local level, however there is no consistency in how — or how much —the community is engaged in the process.

Positive Examples

The Tucson, Arizona police department created a Mental Health Support Team (MHST) in January 2014 in response to several high-profile incidents throughout the country, including one in Pima County, where Tucson resides.[43] The MHST serves primarily as a follow-up unit, acting as an entry point into mental health treatment and aiming to prevent incidents through early intervention. The MHST also is the sole clearinghouse for mental health court orders, allowing the police more capacity for other duties. This team, as well as the broader police department, work with mobile crisis teams from the area's local mental health authorities and crisis observation centers to provide officers a quick place to drop off people experiencing a behavioral health crisis rather than taking them to jail.[44] Notably, the MHST is now training other city employees who are likely to encounter people experiencing a mental health crisis, including employees of Parks and Recreation and Sun Tran. This is an example of effective cross-system collaboration at the local level.

Current Initiatives

Despite the fact that Washington, DC operates a 24/7 mobile crisis team throughout the city, there were still numerous calls to 911 for behavioral health related concerns, which resulted in detrimental impacts to individuals and created strain on the law enforcement workforce. An interagency task force collaboration between law

enforcement, public safety, behavioral health, and other city entities identified an unmet need. Through this interactive process, the behavioral health system collaborated with 911 to divert behavioral health calls away from law enforcement onto the existing mobile crisis team. A new pilot program sends unarmed teams of behavioral health experts and peers when feasible to avoid sending armed officers.[45] Notably, the program includes both clinicians and people with lived experience.

The Alaska Native Tribal Health Consortium is a nonprofit Tribal health organization "designed to meet the unique health needs of Alaska Native and American Indian people living in Alaska."[46] The Consortium provides comprehensive medical services, wellness programs, disease research and prevention, as well as rural provider training and other services. Now, the Consortium is training "lay people" — people without specialized training or knowledge — to support health needs, which could be expanded to include behavioral health needs. This program provides a unique opportunity to engage communities in improving their wellbeing.

Opportunities

The Tucson model supports the idea that local law enforcement can collaborate with local behavioral health agencies to reduce the number of people with mental illness who are incarcerated. This model has been scaled in communities across the U.S., and it can have continued success should there be an explicit focus on racial equity and the inclusion of people with lived experience in the design, implementation, and evaluation of the program.

The Bexar County Sheriff's office utilizes a Specialized Multidisciplinary Alternative Response Team (SMART) to respond to calls where a person is in crisis. Members of SMART include a licensed mental health professional, a peer support specialist, a qualified mental health specialist, a specially trained mental health law enforcement officer, and a paramedic. Dispatch plays a vital role in SMART's deployment, and personnel are trained to deploy SMART only to nonviolent mental health calls where their impact can be greatest.

Philanthropy can help support research that will identify core data points that would be indicators of effectiveness in authentic community engagement that can be broadly used for improvement.

Endnotes

[1] Lesbian, gay, bisexual, transgender/transsexual, queer/questioning, two-spirit, and other marginalized sexual/gender identities

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[9] The Front End Project [Fountain House, Haywood Burns Institute, Technical Assistance Collaborative, Center for Court Innovation, Mental Health Strategic Impact Initiative] (2021). *From harm to health: Centering racial equity and lived experience in mental health crisis response*. https://bit.ly/3EDB1er

[10] National Alliance on Mental Illness (2021). *NAMI 988 crisis response research* [PDF]. Paris, France: Ipsos. https://bit.ly/33rjgko

[11] Multi-disciplinary response teams [PDF] consist of a paramedic, a licensed mental health professional, and a law enforcement officer. In Dallas, this program is known as RIGHT Care (the Rapid Integrated Group Healthcare Team). RIGHT Care is an integrated, health-driven approach based on best-practice responses to medical emergencies, and is based on the community paramedicine approach. RIGHT Care relies on multi-disciplinary teams of a paramedic, a licensed master's level mental health professional with at least five years of experience in mental health emergency care, and a tenured law enforcement officer with advanced crisis and mental health peace officer training. The team operates on the principles of community paramedicine: functioning as a single integrated unit, relying on shared knowledge and experience, and responding as a team. Other communities have looked at additional features that may add value. For example, in addition to developing a core three-component team approach like Dallas (paramedic, mental health specialist, police), the Austin 911 system has developed the capacity to use telehealth to augment the paramedic response with a virtual mental health clinician in situations where there is no public safety risk (similar to the CAHOOTS [PDF] model). In Bexar County, a peer support specialist with lived experience has been added to the team. In Abilene, telehealth is used to provide access to a mental health clinician in the 911 dispatch center. These additional components are necessary to meet the specific needs of the communities they serve.

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