

2021-22 COMMUNITY ENGAGEMENT REPORT

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THE MAIN MESSAGE FROM COMMUNITY MEMBERS

The current behavioral health crisis response system is unpredictable. Sometimes the response has been timely and helpful, but not always. This inconsistency is a major problem, as people don't know whether help will show up soon, who will show up, what will happen when they arrive, and whether the situation will be safe for everyone.

“THANK YOU FOR HOLDING THIS SPACE; VOICES ARE BEING HEARD SO TRUE CHANGE CAN HAPPEN.”

Trust in the current system has been damaged by too many experiences with crisis response situations that resulted in greater distress or trauma – sometimes involving police, but not always. Communities are understandably skeptical.

People want to be treated with compassion and respect by everyone involved during a behavioral health crisis. All call center staff, community responders, and other professionals need to be well trained, culturally competent, and representative of the community they serve, including peers when possible. It is important to understand that a behavioral health crisis episode is an incredibly upsetting moment when people are at their most vulnerable. It is also often just one moment in the longer-term situation with which people need help, so coordination with other community services during and after an episode of distress is essential.

Before promoting the expanded and integrated crisis response system, the response must be consistently helpful and safe. That is the only way to earn trust. You only get one chance to make a first impression. Once the system is predictable and dependable, then there are many ways to raise awareness broadly. Public education about how the services work will also be critical to building trust. Even though people may be cautious until they see proof that it works, people are hopeful and excited about the promise of an integrated crisis system that is safe, helpful and responsive to the needs of all community members.

THE GREATER BALTIMORE REGIONAL INTEGRATED CRISIS SYSTEM (GBRICS)

The Greater Baltimore Regional Integrated Crisis System (GBRICS) Partnership is a public-private partnership that invests \$45 million over five years in behavioral health infrastructure and services in Baltimore City and Baltimore, Carroll, and Howard Counties. The overall goal is to reduce unnecessary Emergency Department (ED) use and police interaction for people in need of immediate access to behavioral health care. The GBRICS Partnership was developed by a broad coalition of 17 hospitals, four Local Behavioral Health Authorities, and many behavioral health experts and community leaders across the four local jurisdictions.

By building upon the strengths of the current behavioral health system, the GBRICS Partnership intends to achieve its goal by implementing the following components for the region:

- 1. Comprehensive Call Center:** Create a regional, integrated call center accessed by 988 that is supported with infrastructure for real-time bed and appointment capacity and referrals tracking, coordinated dispatching of mobile crisis response plus dashboard reporting.
- 2. Mobile Response Teams (MRT) Services:** Expand capacity and set regional standards following national best practices.
- 3. Open Access Services:** Support behavioral health providers to offer same day walk-in/virtual services for people in immediate need of behavioral health care.
- 4. Community Engagement & Outreach:** Support culture change to increase awareness and use of the 988 as an alternative to calling 911 or using the ED.

As the Regional Administrative Manager for the GBRICS Partnership, Behavioral Health System Baltimore (BHSB) will issue competitive procurements and provide funding to community-based and other organizations to provide these services. Funding opportunities and contracts will be designed to meet community needs and achieve the goals of reducing unnecessary ED use and police interaction for people in need of immediate access to behavioral health care. The project will run from 2021 to 2025 and will include ongoing evaluation of progress in meeting its goals. For more information, please visit

www.bhsbaltimore/learn/gbrics-partnership.

This report summarizes input shared by community members and often includes recommendations for how to structure the services that will be funded and implemented by the GBRICS Partnership. These services, listed above, are referenced as 'Partnership-funded services' throughout the report and are specifically identified when appropriate.

THANK YOU

This effort would not have been possible without the tremendous support of our partners, including our fellow Local Behavioral Health Authorities, hospital partners, and current behavioral health crisis response providers. We especially want to highlight and thank our committed community engagement partners who helped sponsor events over the last year:

Baltimore City Community College; Black Mental Health Alliance; City of Refuge; Faith Presbyterian Church; Greater Baybrook Alliance; Healing Youth Alliance; Heart Smiles; Historic East Baltimore Community Action Coalition; HOPE Wellness and Recovery Center; Howard County Autism Society; Humanim; Immigration Outreach Service Center; Johns Hopkins Medicine; Maryland Coalition of Families; National Alliance on Mental Illness (NAMI) Metro Baltimore; No Boundaries Coalition; On Our Own of Maryland; Pathfinders for Autism; People on the Go; Sisters Together and Reaching (STAR); United Way of Central Maryland; and the University of Maryland Baltimore.

PURPOSE AND DESIGN OF THE GBRICS COMMUNITY ENGAGEMENT ACTIVITIES

The GBRICS Partnership committed early on to meaningful community engagement to help inform system change and established a Community Engagement Committee (CEC) and Local Community Engagement (CE) Subcommittee in each of the four local jurisdictions to help facilitate these efforts. The CEC and Local CE Subcommittees discussed what strategies to pursue and identified community roundtables and an online survey as two effective ways to engage with communities. The purpose of these activities was to connect with community members to listen to their views, hear descriptions of their experiences, and consider their ideas regarding behavioral health crisis response services.

The CEC and Local CE Subcommittees conducted 27 roundtables from July 2021 to March 2022. Most were held by video conference with the exceptions of those held at the On Our Own Wellness and Recovery Centers, Humanim, No Boundaries Coalition and the Greater Bay Brook Alliance in collaboration with City of Refuge. Roundtable participants received a brief description of the transformed crisis response system as envisioned by the GBRICS Partnership followed by a discussion centered around participant views about the type of response they believe would be most helpful when someone is in urgent distress due to mental health or substance use. A second point of discussion was if they would call a crisis hotline to get help for themselves or someone else, and why they would or would not do so. These questions formed the basis for the online survey as well. See **Attachment A** for a list of the survey questions.

WHO PARTICIPATED IN THE ROUNDTABLES AND THE SURVEY

ROUNDTABLES

The Community Engagement Committee organized the roundtables to ensure a diverse mix of community participants. Some of the roundtables were geographically focused while others were organized around specific groups such as youth or immigrants. See **Attachment B** for a list of the roundtables, dates, locations and/or sponsoring organizations.

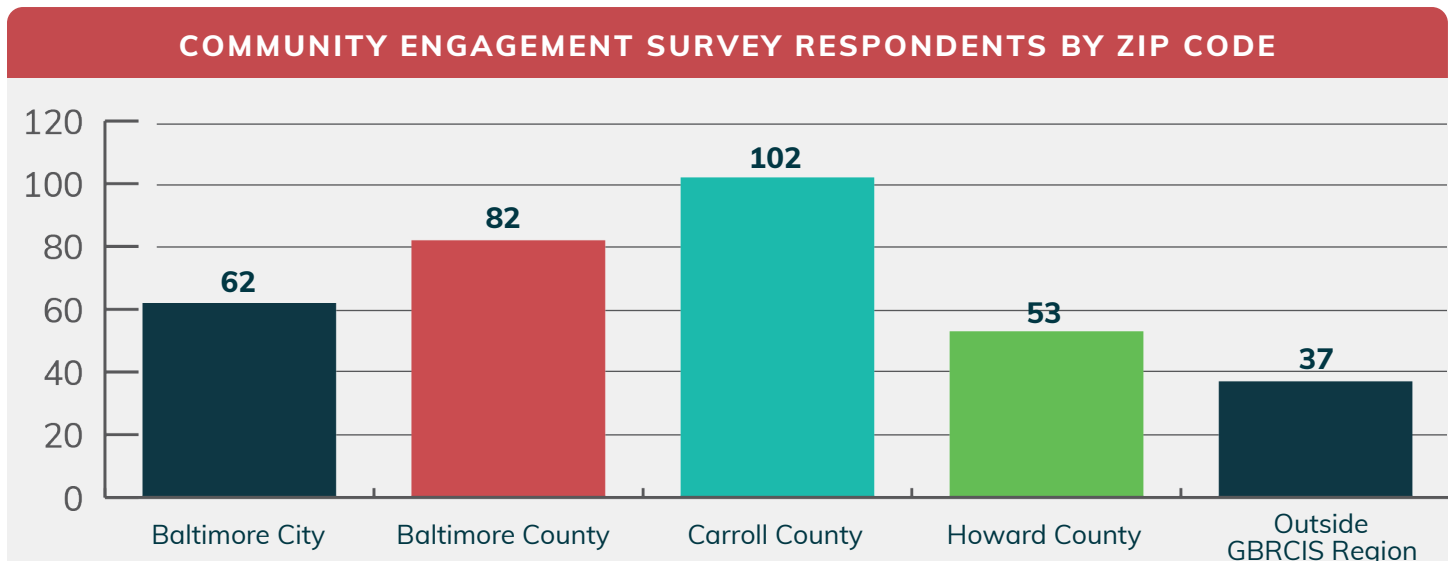
In total, more than 325 community residents participated in the Roundtables from across the Greater Baltimore region. The roundtables were also diverse in terms of member characteristics, including participants of different racial ethnic groups, recent immigrants, Spanish speakers, people with lived experience with behavioral health challenges, family members, people with disabilities, faith leaders, LGBTQ communities, peer advocates including peer recovery specialists, behavioral health providers, law enforcement, and other first responders.

WHO PARTICIPATED IN THE ROUNDTABLES AND THE SURVEY

SURVEY

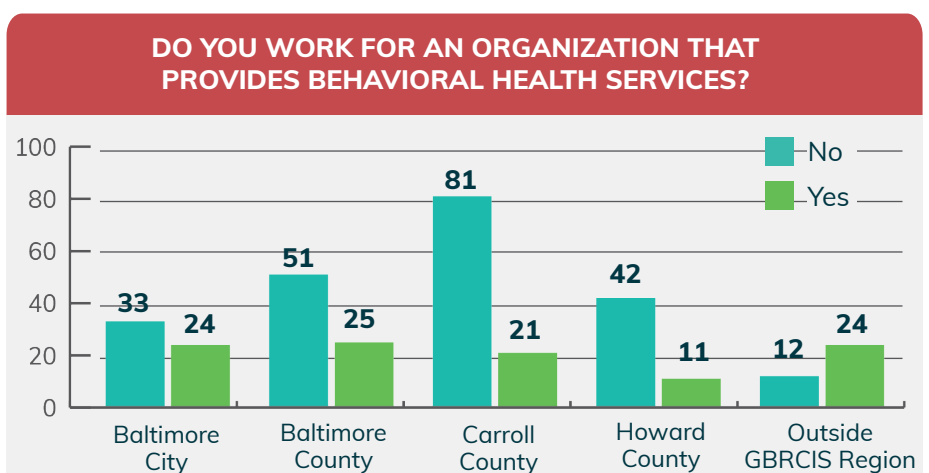
The community engagement survey development, promotion, and analysis were conducted in an informal, but inclusive manner, as opposed to the rigorous qualitative and quantitative methods that are common to market research and academic studies. The survey was fielded online in both English and Spanish using SurveyMonkey. CEC and Local CE Subcommittee members were encouraged to distribute the survey via websites, list serves and email, in addition to a printed palm card distributed at in-person meetings and events. The survey was promoted in at least one community newspaper. The survey, email text and palm card were also available in Spanish.

Between November 1, 2021 and February 21, 2022, 258 people filled out the survey: 250 in English and eight in Spanish. The chart below is a rough indication of the geographic distribution of the survey respondents, based on the zip code information they provided. NOTE: that some zip codes are in multiple counties, making county of residence not exact.



A large majority (80%) of survey respondents noted that they or a loved one have personal experience with mental health or substance use challenges. Regarding the degree to which survey comments came from people with inside knowledge of how the behavioral health system works and/or a vested interest in the current system, two thirds (66%) of respondents said that they do not work for an organization that provides behavioral health services. For respondents from Baltimore City, that number is more evenly divided. About two thirds of people from outside the region who filled out the survey work for a behavioral health organization.

NOTE: zip code data leads to duplicate counts for zip codes that are in more than one local jurisdiction.



THEMES FROM COMMUNITY ENGAGEMENT ACTIVITIES

In both the roundtable discussions and survey responses, participants described their experiences with behavioral health crisis and their attitudes towards the behavioral health system. Many participants had direct experience which may have involved calling a crisis helpline or 911, interacting with a Mobile Response Team (MRT) and/or law enforcement, and managing the aftermath of the crisis episode. The discussions touched on a wide variety of topics, but some clear themes did emerge.

In the descriptions of themes below, the breadth and diversity of comments have been simplified to make the information manageable. This section is organized around 12 themes that covers much of what was discussed. The comments included in quotations are direct quotes of community members at roundtables or from survey responses. The other information is derived from notes that summarized the discussions.

The hope is that this report reflects the perspectives shared through this process and the gratitude the BHSB has for the generous community expertise shared with us. Many thanks to the more than 500 residents of the Greater Baltimore region who participated in this process.

THEME #1: EARN THE TRUST OF COMMUNITIES AND OVERCOME SKEPTICISM

“WE HAVE BEEN GIVEN A LOT OF FALSE HOPE IN BALTIMORE”

The most foundational takeaway is that many people in this region do not trust that they will receive the help they need – and be safe – if they call for help during a behavioral health crisis. This is often a direct

result of their past experiences while they or a loved one was in behavioral health crisis. Many people shared experiences that were traumatic or deeply troubling, and it will be difficult to earn their trust.

Many participants also shared positive experiences and a sense of hope that the crisis response system can be strengthened to better serve people in crisis and their loved ones. Indeed, many expressed appreciation and strong support for the idea of listening to the community to learn how best to expand and integrate the system. The GBRICS Partnership has the opportunity to earn the community’s trust if the transformed crisis response system truly meets their needs.

“UNTIL I SEE THE SYSTEM DOING A WHOLE REBRANDING, I WANT NOTHING TO DO WITH IT. IT IS LIKE MOVING PEOPLE TO NEW SEATS; YET YOU ARE OPERATING WITH THE SAME MENTALITY”

EXPERIENCES SEEKING HELP DURING A BEHAVIORAL HEALTH CRISIS

Negative Experiences

Many people shared difficult and painful experiences. Participants reported feeling disrespected by crisis staff or police, or that staff were condescending or dismissive of their situation. This is alarming considering the vulnerability of those in suicidal or behavioral health crisis. Others shared experiences where seeking help made things worse.

“Because I had thoughts of harming myself with no plan [I called the crisis line]. They told me that a crisis team was coming with a social worker and the police showed up treating me like a criminal.
I will never again call a crisis line.”

“I have seen both sides, I have seen it go well and I have seen it go horribly wrong. What happens if you get that person with the nonchalant, I don’t care attitude?”

Stories of negative experiences shared by people from historically underserved groups were common, including people of color, immigrants, and people with physical and intellectual disabilities. For example, parents of neurodivergent or developmentally disabled children conveyed numerous troubling experiences, including weeks-long hospital boarding, insensitive treatment by staff and police, and refusals to help parents despite frequent aggression and violence by their children. Transgender individuals also voiced hesitation to engage with the crisis response system due to previous humiliations, incarceration, and uncertainty of how staff would honor their gender-identity.

These experiences fed into a general sense of skepticism and mistrust. It is understandable, as Baltimore region residents have experienced years of broken promises and stubbornly persistent problems of poverty, violence, and inequity. Some participants expressed a feeling that the proposed changes within the transformed crisis response system would end up being more of the same. Overcoming this skepticism will be critical to the success of this initiative.

Positive Experiences

While participants described many difficult experiences, many people trust the system, have had good experiences, and are hopeful for improvement. Some participants felt that seeking help through the crisis response system saved their lives or the lives of their loved ones. Others appreciated the professionalism and caring of staff. Still others appreciated the anonymity of helplines, or simply having an alternative to calling 911.

Most participants also stated that they would call a crisis helpline if they needed help.

From the survey:

74% said they would call a helpline

24% said they might call a helpline

5% said they would not call a helpline

Most roundtable participants also said they would use the helpline.

There was excitement for the reforms and expansions planned through the GBRICS Partnership. One participant said that having 988 as an alternative to 911 and law enforcement intervention “does something for my spirit.” Another said communities are “hungry for something that works.” This goodwill can be built upon to earn trust and overcome initial skepticism. It was also clear, however, that goodwill and trust will evaporate quickly if services are not effective and dependable.

“We need this beautiful care.
When in crisis, you need to know that
someone who cares is coming to help.”

“[Calling the crisis helpline] has helped me refocus and avoid harming myself. It feels nice to have someone to hear you and provide un-biased observations and recommendations.”

“People in West Baltimore want better just like they do, we want healthiness just like they do, we want vitality just like they do.”

THEME #2. PROVIDE DEPENDABLE, TIMELY, SAFE, AND HELPFUL SERVICES

The crisis response system was described by participants as unpredictable. If you call a crisis helpline or 911, it's hard to know for sure what will happen to the person in distress. As such, the system must improve this inconsistency for the transformed crisis system to succeed.

As people described their experiences and aspirations, a continuing theme was the need for the crisis response to be predictably timely, safe, and helpful. Without that, if people decide to reach out for help, many will continue to go to a hospital emergency department or call 911 because the response is immediate and somewhat predictable. Partnership-funded crisis services are competing with 911 and emergency departments and need to provide the same level of dependability.

**“WE WILL USE THE
HOTLINE IF IT WORKS”**

“When in distress, it is super easy to become overwhelmed and give up. Wait times might cause someone to hang up. I think that even a quick answer of a real person saying, you are in the line, just please hold can make a difference.”

Timely, Available Services

**“I WAS TOLD THAT A CRISIS TEAM
WOULD TAKE HOURS TO RESPOND TO
OUR REQUEST FOR HELP. A LOT CAN
HAPPEN IN THAT AMOUNT OF TIME.”**

“Just hearing the words “press 1” triggers all the infuriating experiences I’ve had calling every government office, doctor’s office, etc. where it’s designed to serve their interests and not mine. This is the last thing I would resort to if I were in a crisis or if I were helping someone else in crisis unless I knew a live person would be picking up the line and I had interacted with them or at least their coworkers before.”

When in crisis, people want help right away and at any time. Many participants shared how dispiriting it would be to get put on hold or reach a voicemail when calling a helpline and underscored the need for 24/7 call center service every day of the year. A more frequent reported problem was unreliable MRT response times. People shared their experiences of waiting hours for a MRT to arrive, sometimes all day after a call was made. Others felt certain neighborhoods or suburbs were less likely to get an MRT dispatch. Partnership-funded services must provide timely and consistent interventions to earn trust.

Eliminate Barriers to Accessing Services

Numerous comments focused on the importance of making services accessible. Many people suggested that supportive counseling should be easily accessible via the hotline, including text, chat and app messaging without strings attached. They mentioned that sometimes people just need to talk and don’t want to engage in any new services or interventions. This perspective was common across groups but was particularly highlighted during the youth-led community conversations with other youth.

This sentiment was similar for MRTs. People thought it was important to ensure autonomy and allow individuals to direct who intervenes and what programs to be transported to if needed. Participants also thought MRTs should be dispatched when a caller needs them without significant barriers. Jurisdictional boundaries should not play a role as they often have for residents in the past. MRTs should also be able to work with individuals under the influence of drugs or alcohol without automatically dispatching law enforcement. Detox and residential programs should not be the only non-law enforcement options.

Some people criticized policies that don’t allow family members to call for a loved one in crisis. Several people described the problem of the hotline operator requiring the individual in crisis to speak with them and consent to a MRT dispatch. One family member asked, **“how can a person undergoing auditory and visual hallucinations call the hotline?”** Family and loved ones want to help but cannot until this barrier is addressed.

Eliminate Barriers to Accessing Services (cont.)

Many participants also highlighted the need for distinct, low-barrier services for children and youth. One parent stated, **“if [your child is] in a crisis, you are past a phone call.”** This view that crises involving children needed at least a response by an MRT if not higher levels of care was common. Residents also thought children and youth needed to be treated more patiently and compassionately by MRTs and law enforcement.

Ensure Effective Services through Transparency and Accountability

The need to monitor service outcomes underlies many of the recommendations shared during CE activities. Participants frequently cited a lack of accountability as a key contributor to current system inconsistencies. Comments included frequent quality reviews, developing ratings, and sharing this information with the public. Some also suggested a ‘soft launch’ where the GBRICS Partnership could use outcome data to phase in services as they meet certain benchmarks.

“... the Crisis Team refused to assist when my husband had stopped taking his psychiatric medications and was being aggressive toward me. He finally did come to the phone and told the Crisis operator that he was fine. Crisis intervention teams must be willing to make decisions on a case-by-case situation and realize that when someone with a mental illness says they are OK or refuses to come to the phone because they believe they are OK and family states differently, there must be a way to get the needed assistance without having to make multiple calls and then live with the outcome.”

THEME #3. REQUIRE HIGH-QUALITY TRAINING ACROSS THE SYSTEM

“There is a lot of stigma regarding mental illness and SUD and it’s easy for someone who’s not trained or have personal experience to stigmatize and make assumptions about those they are trying to help which can mistakenly cause panic in all involved.”

When asked about the type of response or support that would be most helpful, more than half of the people who filled out the survey made some type of reference to a well-trained team designed to handle behavioral health crisis situations. Participants repeatedly voiced that proper training is essential for everyone who has a role in the crisis response system, including call center

staff, MRT members, police officers, EMTs, hospital staff and other key partners. Training must address a breadth of staff competencies with increased and routine scrutiny of the system to ensure that everyone involved is properly trained.

Participants frequently mentioned training to ensure understanding of key clinical skills such as de-escalation, motivational interviewing, and trauma-informed care. They also highlighted training on responding to aggressive children or youth, avoiding triggers, and being knowledgeable of the symptoms of common diagnoses. Many other comments focused on the personal tone and approach needed to intervene in a crisis, describing the ideal crisis response teams using words such as compassion, respect, empathy, sensitivity, kindness, calm, helpful, and caring.

Many recommended training to understand the unique needs of specific communities, such as the Black community, youth, those with intellectual or developmental disabilities, those with experience in the foster care system, and the transgender community. Training on how to engage with neurodivergent children and youth was highlighted as a particularly acute need.

Baltimore City residents gave emphasis to trainings that ensure cultural competence. One respondent shared that depending on how an MRT shows up and conducts themselves, they could be seen as law enforcement themselves. Another highlighted the prevalence of systemic racism and serious trauma, life-long and multi-generational. She stated that crisis staff need to approach people from Baltimore less clinically. Staff should ask, **“what has happened to you rather than what is wrong with you. Make it less medicalized. People’s behavior is often an understandable response to serious stress.”**

Participants also emphasized that people from the communities to be served should provide cultural competence training. Peers and persons with lived experience have essential knowledge and must be relied on for high-quality training of this sort.

THEME #4. COORDINATE ACCESS TO OTHER NEEDED SERVICES, INCLUDING FOLLOW-UP AFTER CRISIS

Crisis response is just one point in the continuum of care for someone facing mental health or substance use challenges. Many community members called out the need for behavioral health services both before and after a crisis occurs. This is more than a general desire for better access, but a reflection of what is needed to help a person stabilize after a behavioral health crisis.

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“[WE NEED] MORE IMMEDIATE SUPPORT FOR SERVICES. EVERYTHING HAS SUCH EXTENSIVE WAIT LISTS AND PEOPLE IN DISTRESS CAN’T ALWAYS AFFORD TO CONTINUE TO WAIT FOR HELP.”

“Call center staff need to understand the crisis may be due to things outside of a person’s control. For example, the individual may be living without heat, experiencing food insecurity. What care is offered or provided in this situation? The teams should consider partnering with other organizations to provide services as you support the individual in distress.”

Coordinated Access to Other Services

Community members emphasized the importance of expanding access to care outside of the crisis. This includes avoiding waitlists and same day appointments to behavioral health services like psychiatry, intakes, and therapy. Residents suggested giving access to other social services like housing, nutrition assistance, and job training as well. Several participants emphasized the need for support in getting the appointment made beyond just giving people a list of resources. Some community members also highlighted the importance of connecting to specialty care when appropriate such as psychiatric rehabilitation, assertive community treatment, and behavioral analyst support for those with intellectual or developmental disabilities. Many suggested using the call center to connect people to resources of all types which they might need – **“as an access point, even if they are not in crisis.”**

Follow-Up After a Crisis

The need for access to more services across the behavioral health continuum extends well beyond crisis response, with many people noting the critical importance of follow-up after a crisis event. Many people wrote that care continue to be needed after the crisis is over **“like follow-up care after surgery.”** Recommended follow-up services included peer respite programs, in-home support, and routine check-ins by phone, text and in-person. These services were viewed as essential to preventing future crises and avoiding a cycle of repeated crises, disruptive interventions, and higher levels of care.

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“Where the system has failed for me is that after the mental health team comes in to deescalate a situation, there is nothing after. You hear, “all is well now” because the initial mental health breakdown is over. But, then you get home before any real help is given and the cycle repeats itself. I would like to see that after the team comes to help, that there is real follow up help at hospitals, etc. to continue the work that is just started.”

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THEME #5. ENSURE INCLUSIVE SERVICES AND CULTURAL REPRESENTATION

Beyond the general need to provide culturally competent services, community members voiced the importance of ensuring the crisis response system is meaningfully inclusive and reflects specific communities. People offered many examples, including but not limited to communities of color, specific ethnic groups, immigrants, people who speak languages other than English, the LGBTQ community, youth, and individuals who have disabilities.

“IT IS FRONT DOOR THINGS LIKE THIS THAT SEND A MESSAGE OF WHETHER OR NOT WE ARE WELCOME.”

“The biggest concern I have right now is that we have a population that a lot of people are not paying particular interest in... I know a lot of people who are visually impaired and totally blind who are actively addicted, but afraid to ask for help because they think people do not understand because they are blind or visually impaired.”

Inclusive and Culturally Sensitive Services

Participants routinely voiced the importance of culturally sensitive and inclusive services for all types of groups. Even small details in how crisis response services are designed will convey cultural responsiveness. Some specific considerations and recommendations included:

- 1. Prompt and accurate interpretation and translation.** Participants reported that the delay in translating written materials felt disrespectful of those who speak other languages. They also cautioned to get high-quality translation and interpretation services since a translated phrase may mean something entirely different in another culture. Participants suggested carrying cards with illustrations to communicate with people who may be Hard of Hearing or who have limited English skills. Others highlighted having text, chat, and sign language interpreters for those who are Deaf or Hard of Hearing.
- 2. Cultural sensitivity for immigrant and refugee experiences.** Participants encouraged crisis providers to consider the specific challenges that come with being an immigrant, such as the stress from moving across the border, being undocumented, and children potentially being bullied for being an immigrant. Refugees have also experienced trauma in their lives and in the process to get to the United States.
- 3. Cultural sensitivity and inclusive language for transgender individuals.** Transgender participants reported significant trauma accessing services and interacting with police. Partnership-funded services must be welcoming and affirming. They should recognize a variety of gender identities on forms and incorporate this throughout their services.
- 4. Inclusive services for individuals with disabilities.** The experiences and needs of individuals living with different disabilities frequently came up during CE activities. Some mentioned working with national advocacy groups for the blind to design materials and interventions. The needs of neurodivergent children must also be considered, with staff who can provide sensory stimulation and other basic interventions to support these individuals.

“We called the crisis response team for a transgender woman who was still transitioning. She had a skirt on that she only wore at our center. About six cops circled around her outside and made fun of her. **It was traumatic to everyone there especially her.**”

Importance of cultural representation

Community members emphasized the importance of cultural representation within the system and having staff who look like the communities they serve. This was true across the board but was especially highlighted during the youth-led discussions. Youth were unsure how comfortable they would be in discussing behavioral health concerns with adults. They noted it was important to have people to with whom they could relate. For example, an LGBTQ youth might not feel comfortable speaking to a straight woman about their sexuality.

THEME #6. REDUCE SYSTEM RELIANCE ON POLICE FOR BEHAVIORAL HEALTH CRISIS RESPONSE

Many participants felt law enforcement should play little or no role in responding to behavioral health crises. These individuals frequently cited inappropriate use of force, including lethal force, by police as their biggest concern. Black residents of Greater Baltimore during the Black Mental Health Alliance Roundtables and other discussions were particularly opposed to law enforcement's current role in crisis response. Strong feelings opposing law enforcement's involvement in behavioral health crisis response were also expressed by several transgender participants.

“[SEND] ANYONE OTHER THAN THE POLICE!”

“Responding to a mental health crisis with police, who have arrest powers and the ability to apply lethal force but are not trained mental health providers is not something I would recommend.”

“Do not call law enforcement if there is no crime.”

Appreciation for Law Enforcement

“I previously worked with Balt Co Crisis response as well as a mobile crisis team in Louisiana. I found that the presence of officers with the Baltimore County team afforded us more opportunity to intervene (as we could hear/see 911 calls come out and intercept them as appropriate) as well as giving the opportunity for a different engagement technique if the person with mental illness was reluctant to speak to clinician. Most understood the presence of officer was for clinician safety.”

Many participants also shared positive experiences with law enforcement during a behavioral health crisis response. Some stories highlighted the professionalism and helpfulness of police, although this was less common than more problematic examples. Participants pointed out the importance of training. Some specific examples included the effectiveness of Howard County Crisis Intervention Team (CIT) training and training to education law enforcement on working with neurodivergent residents. Some residents also stated that police were needed to ensure the safety of other crisis response personnel.

Working Together with Law Enforcement

While there were strong feelings about this issue, most participants recognized that law enforcement needs to play some role, but that the partnership could be improved. Participants highlighted the importance of law enforcement staying in the background and letting mental health professionals take the lead. It was also recommended that police wear plain clothes, refrain from using sirens and lights, and speak calmly to be more effective during a behavioral health crisis.

“Behavioral health providers cannot replace law enforcement. **They need to work together.**”

“[We need] compassionate police officer and clinician collaboration.”

Tendency to Escalate, Including Use of Force

When expressing concern about law enforcement involvement in behavioral health crisis response, many comments focused on the tendency of police to escalate the crisis. Law enforcement intervention was often described as aggressive. The demeanor of police who are trained to detain and apprehend criminals could cause people to become more agitated. Giving orders in an authoritative way could cause anxiety and could lead to unhelpful behavior by the person in crisis. This could then lead to arrest and use of force. One young person described being thrown against a wall and being treated “like an animal.” The vignette on the following page provides a vivid example of how law enforcement intervention can escalate an already agitated and distraught person in crisis.

“Having a police officer respond, without being accompanied by a mental health professional, risks escalating a situation. Officers are trained to use their guns, so there is a greater risk of the person in crisis becoming injured or killed. Also, people may react differently to an authority figure with a uniform and gun versus a mental health professional who understands the behaviors they are seeing and may better be conveying caring and collaboration to help the person.”

“Used to work as social worker in community behavioral health- 9 out of 10 times police (which always arrive to 911 calls even if not requested) escalate situation, dismissive to person in crisis, dismissive to staff or someone else trying to help person in crisis; people get more upset when police are called. A middle ground is needed - something can be a crisis but not where police are involved.”

Law Enforcement Contributing to Stigma and Embarrassment

“IF YOU ARE HAVING A HEART ATTACK, THE POLICE DON’T SHOW UP, THE PARAMEDICS DO.”

“I have witnessed police escorting clients in handcuffs and this feels very inhumane and not necessary. Especially when I am fully aware that the client is not a violent risk. I feel they still do not have enough adequate training to manage the mental health population.”

Many participants said that law enforcement interventions make them feel embarrassed. Community members stated that felt like they were in trouble or had been arrested. These individuals expressed that our system should not treat behavioral health emergencies like crimes. Getting handcuffed was often highlighted as traumatizing. Law enforcement response can also trigger past traumatic experiences, especially for communities with a poor relationship with police.

Inconsistent Training and Behavior

Some troubling experiences with law enforcement demonstrated inconsistent training. One African American mother reported that police were nonchalant and accusatory towards her while her child was acting erratic. During another incident, a police officer told a parent that they were, “not going to babysit,” and then preceded to tackle and handcuff a child in crisis. More consistent training is needed to avoid situations such as these, but training alone is not the answer. One parent reported an alarming story involving a police officer who was embedded as part of an MRT. The officer struck a 12-year-old girl who refused to follow their orders and dragged her out of the house by force. The parent speculated this was out of frustration as the child was not a threat. This was especially troubling since they were a formally trained part of the MRT.

“It is most important to keep untrained police officers out of the equation. I know Baltimore City is trying to get trained police officers and a social worker/mental health worker to be outreach teams. It is a great idea. To have the resource of a fully trained mental health team as proposed is a new paradigm whose time has come.”

VIGNETTE OF LAW ENFORCEMENT CRISIS RESPONSE AND ESCALATION

“I am African American, 40 years of age, and for most of my life I’ve struggled with severe mental health challenges. A traumatic event occurred on October 11th, 2021, involving the police, which led to a recent hospitalization. Attending a faith-based twelve step recovery meeting, I went into a state of distress and eventual unresponsiveness. I became suicidal and knowing the police were coming I planned to take my life via police shooting. When the police came and simply touched me (as I don’t respond well to police in situations of mental health), I became explosive but refrained from hurting anyone, as I have never hurt anyone before, nor was I my intent to do so. Backing up significantly, I shouted “shoot me,” “you’re going to shoot me”, and “kill me now”. I fled and hid in a corner outside.

Five police officers and two squad cars surrounded me at a distance, and I became extremely nervous and mentally agitated. I proceeded to impulsively execute my plan of having them shoot me by pretending to have a weapon behind my back. However, after a 40-minute standoff I was ambivalent and relented. Eventually, I revealed that I had no weapon, stripped down to my boxers and socks. At their request, I sat on the ground, and became stable after 20 minutes. After I was calm, they told me they would have to put me in hand cuffs – apparently, this is protocol. I felt demoralized and deceived; they had already agreed to put me in the ambulance to feel safe. I told them I wasn’t willing because of the racial implications, effects on self-respect, and being restrained in such a degrading way.

After more than 25 minutes of petitioning I became unstable again; they all approached me to restrain me. On the ground, they punched me in the face, dragged me, and put me in a squad car (I was resistant but not violent). Unstable again, I began banging my head on the squad car glass; they moved me to the ambulance. Before that an officer screamed at me violently. When moved to the safety of the ambulance I came to my right mind and felt secure away from the officers. This situation in Baltimore County was prolonged because of minimal training (which they admitted to). It led to me being bloody, bruised, and traumatized.

With this in mind, I would have benefited from a 988 line. I would have also benefited from a trained and trusted Crisis Response to avoid all that happened. Many people with mental health issues share the same experiences. Restraints, physicality, and demoralization by minimally trained authorities is unhelpful to the needs of those within the mental health community. I now own responsibility for my actions; however, I still do believe in a better and less traumatic scenario. The truth still stands that I could have lost my life because of my mental health/actions and also due to the fact that the police had access to deadly force.”

THEME #7. COMBAT PERVASIVE STIGMA AROUND BEHAVIORAL HEALTH

Mental health and substance use stigma is pervasive and was pointed out by many community members. Suicide, schizoaffective disorders, and substance use disorders were called out as especially stigmatized. Stigma also extends to the act of seeking help, and participants pointed out how the fear of being judged for seeking help is a critical way that stigma manifests itself.

“We see but do not see people, we ask, but do not hear their problems or see things. **We need to take time to observe and interact with others.**”

Residents thought that addressing this stigma will be important and should be part of the goal of the transformed crisis response system. Working in schools to educate students about behavioral health was one suggestion. Highlighting and expanding the National Alliance on Mental Illness ‘In Our Own Voice’ program that helps community members relate to living with a mental illness was another suggestion.

Participants highlighted that, in some cultures, there is deeper stigma associated with seeking help for mental health or substance use. Community members identified communities of color – in particular the Latino community and Asian communities – as being generally resistant to seeking mental health support. Some faith communities also see seeking mental health support in a stigmatized way. One participant said that there are **“lots of issues with people in the community not believing in taking meds because they just need to pray harder.”**

“I believe there is a lot of stigma around calling these numbers though. Many think of them as a ‘talk me off the cliff’ resource, rather than something that can begin the healing process.”

THEME #8. EDUCATE THE PUBLIC ON WHAT TO EXPECT

“COULD I END BEING LOCKED UP IF I SAY THE WRONG THING?”

At the most basic level, communities need to know the behavioral health crisis response system is available and to understand how it works. Community members felt most people lack this understanding. Many are unclear about when to call a crisis hotline, what services are provided, and what the process is likely to be. Some commented that they did not know what was considered a crisis or an emergency and that lack of clarity could discourage people from access crisis services.

Participants expressed concern about not knowing what might happen when they contact a crisis call center. Persons with lived experience voiced particular concern that their care and the sorts of responses and interventions provided could end up being out of their control. Clear and accurate communication that alleviates such concerns, to the degree possible, is warranted.

The language that is used is also vitally important. Many noted that the terminology used to describe the crisis system was not simple enough. One participant stated, “no one knows what behavioral health is”, and others pointed out that the term “crisis” is unclear. Public education will need to use plain language to successfully connect with priority communities.

“The community frequently are unaware of resources available to them. They feel it is not severe enough to warrant the emergency room and primary care doctors are unsure of where to start other than call therapists and see if you can get an appointment.”

THEME #9. INTEGRATE COMMUNITY PARTNERS INTO THE CRISIS SYSTEM

Crisis services are just one part of a broad continuum of services that support community health and wellness. Community members want to see better connections across and among community partners of all types to not only provide coordinated services but to also improve understanding of community needs and values.

.....
“COMMUNITIES KNOW
WHAT THEY NEED BETTER
THAN OUTSIDERS.”

Partner with Peers Throughout the System

Community members emphasized the importance of peers during many engagement activities. Peers were seen as critical partners in the delivery of services and as thought partners who can help to design Partnership-funded services. They were seen as especially important in lending their credibility to these new services as people with lived experience. Youth peers and the National Alliance on Mental Illness peer-to-peer program were specifically highlighted.

Partnerships to Build Trust and Raise Awareness

Allies who can vouch for the GBRICS Partnership and get the word out were another broad type of partnership suggested by community members. Trusted community leaders were highlighted as particularly important. These leaders could have a formal role like a pastor or school board member, but they could also be informal figures who are well known in their community. Participants recommended that the GBRICS Partnership work to build relationships with these leaders and demonstrate its commitment to authentically serve and engage with the community in question. The Partnership must all work to build rapport with the community at large and help raise its visibility as a viable resource. Community institutions like schools, libraries, soup kitchens, churches, and recreation centers were all suggested partners that can assist in promoting the transformed crisis response system. Youth leaders also thought marketing targeted specifically for youth was needed and suggested partnering with youth-led organizations to achieve this.

Partnerships to Improve Services and Prevent Crises

Community members were also seen as critical partners to help support good mental health and prevent crises from occurring or escalating. Many suggested training faith communities, families, and other community partners to recognize behavioral health challenges and basic methods to intervene. Specific suggestions included Mental Health First Aid training and replicating community health efforts employed in COVID-19 pandemic response. Other suggestions included engaging communities as co-creators in designing services, having partnerships to provide Safe Streets type support for behavioral health, and identifying community members who could serve as ‘anchors’ or ‘buffers’ that would support good mental health and wellness in their communities.

THEME #10. THINK UPSTREAM TO PREVENT CRISES

Many people called out the need to identify ways to prevent the crises before they occur. Participants suggested early intervention with individuals who are struggling as one key approach. Mentorships, community outreach, and peer support were all suggestions. Addressing social determinants of health like housing instability or poor job prospects could also help underlying causes of behavioral health crisis.

“Circulate peer specialists or CIT officers in the community to develop rapport with vulnerable populations **BEFORE a crisis**, especially for people who are unhoused.”

THEME #11. MAKE THE MOST OF TECHNOLOGY

Another theme from the community engagement activities was using technology to improve the quality and convenience of crisis response interventions. One key suggestion was to provide text and chat access to the regional call center. Young people especially might prefer that method of connection. Using telehealth to reach those in crisis and providing tablets to MRTs were suggested to improve access.

The importance of integrating different systems was also highlighted. Improving data-sharing so that individuals do not need to tell their history and circumstances repeatedly was one example. At the same time, some people are concerned about privacy and too much sharing of data. Participants suggested storing completed information release forms and mental health advance directives so they can be easily accessed and used by the crisis system professionals. The system should also be optimized to make appointments directly, have a current resource directory, and information on bed availability and wait lists.

THEME #12. CLARIFY INSURANCE AND PAYMENT ISSUES

If my appendix burst, anyone would see me and take my insurance. **But they will not provide me with mental health services.**”

Several people asked questions about payment and insurance issues. Top of mind for many was the need to ensure that crisis response services and follow-up care are available to everyone, regardless of insurance status or ability to pay. It is important that people know about costs as they learn about the crisis system, otherwise they may not call if they aren't sure what it might cost them. Some people also said that crisis response system staff need to be paid well and that community partners who are part of the crisis response system should be compensated.

INCORPORATION OF COMMUNITY ENGAGEMENT

Time and again, residents implored the GBRICS Partnership to make sure that community ideas and feedback were incorporated into the transformed crisis response system. Community members frequently shared stories of how other organizations or agencies had come to their group in the past to ask for their opinions, then never communicated how that community expertise was used to shape or refine how a program was implemented. The GBRICS Partnership is committed to staying in communication with community members who share their expertise and to showing how their perspectives had a direct impact on the project.

The 12 themes identified in this report have influenced many decisions and will continue to be used as a guide for further actions. Some themes, such as the need to build trust (CE theme #1), are addressed throughout the crisis response system but some other themes are addressed through specific choices or alterations in the approach to implementation. The implementation choices made thus far are described below, with reference to one or more CE themes that they address. A table outlining how each CE theme was incorporated can be viewed in **Attachment C**.

12 THEMES FROM COMMUNITY ENGAGEMENT ACTIVITIES

- | | |
|-------------------|---|
| THEME #1. | EARN THE TRUST OF COMMUNITIES AND OVERCOME SKEPTICISM |
| THEME #2. | PROVIDE DEPENDABLE, TIMELY, SAFE, AND HELPFUL SERVICES |
| THEME #3. | REQUIRE HIGH-QUALITY TRAINING ACROSS THE SYSTEM |
| THEME #4. | COORDINATE ACCESS TO OTHER NEEDED SERVICES, INCLUDING FOLLOW-UP AFTER CRISIS |
| THEME #5. | ENSURE INCLUSIVE SERVICES AND CULTURAL REPRESENTATION |
| THEME #6. | REDUCE SYSTEM RELIANCE ON POLICE FOR BEHAVIORAL HEALTH CRISIS RESPONSE |
| THEME #7. | COMBAT PERVASIVE STIGMA AROUND BEHAVIORAL HEALTH |
| THEME #8. | EDUCATE THE PUBLIC ON WHAT TO EXPECT |
| THEME #9. | INTEGRATE COMMUNITY PARTNERS INTO THE CRISIS SYSTEM |
| THEME #10. | THINK UPSTREAM TO PREVENT CRISES |
| THEME #11. | MAKE THE MOST OF TECHNOLOGY |
| THEME #12. | CLARIFY INSURANCE AND PAYMENT ISSUES |



CRISIS RESPONSE SYSTEM STANDARDS

One of the most significant ways the GBRICS Partnership can influence and reimagine the crisis response system is through its development of new regional Crisis Response System Standards. These standards will set basic expectations for the crisis response system as a whole and for Partnership-funded MRTs. All the CE themes are addressed in some way through these standards, and some components were written or revised in response to CE feedback.

To establish the Standards, the Partnership convened a Mobile Response Team (MRT) Work Group that met over the course of six months in 2021. The Work Group consisted of over 50 individuals representing community members, people with lived experience, representatives from service providers in each of the jurisdictions, and staff representing local jurisdictions including the Local Behavioral Health Authorities. The MRT Work Group routinely revised the Crisis Response System Standards as staff obtained new community input from other community engagement activities.

Each section of the Standards is listed below along with commentary on how CE themes were incorporated. To access the full Crisis Response System Standards to see the complete list of protocols, go to: **GBRICS Partnership – Behavioral Health System Baltimore (bhsbaltimore.org)**

Crisis Care Continuum Description:

- **Services available 24 hours a day, every day of the year:** Services across the transformed crisis system will be made available 24/7 every day of the year, including weekends and holidays. Some jurisdictions currently do not have this level of coverage but expanding availability in this way is one of the goals of the GBRICS Partnership. This should address some of the concerns regarding timeliness and availability of services (CE theme #2).
- **Integrated services available to everyone:** This section goes on to set expectations that the transformed crisis system provide integrated mental health and substance use services, serve all levels of need, and connect with the broader behavioral health system. These expectations are spelled out in more detail later in the Standards and will address many CE themes.

System Accountability: Many of the CE themes were centered on skepticism that providers will consistently follow protocols and adhere to standards set at the system level. Promises have been made before and trust can only be built by delivering on those commitments (CE theme #1). To ensure services meet community expectations, the GBRICS Partnership will establish system and program performance metrics that are measured and reviewed regularly. Crisis services consumers will be engaged in the process to ensure quality, solve problems, and assess customer satisfaction. System administrators will specifically analyze emergency petitions and sentinel events involving law enforcement.

Collaboration: These standards set an expectation that crisis providers have strong relationships with community partners of all types, including community behavioral health providers, street outreach teams, primary care providers, hospitals, schools, 911/EMS, and law enforcement. These expectations will help address themes around access to needed services (CE theme #4) and the need for strong community partnerships (CE theme #9).

Service Competencies:

- **Universal Service Competencies:** Many CE themes centered on the quality and type of services provided through the crisis response system. These Standards establish expectations regarding essential competencies to address these concerns. Crisis providers will need to ensure services are provided in a welcoming, hopeful, safe, trauma-informed, timely, culturally affirming way. There will also be an expectation that providers seek to build trust and minimize the use of restraints.

Service Competencies (cont.):

- **Timeliness Standard:** Partnership-funded MRTs will be expected to respond within one hour 90% of the time, addressing concerns around timeliness of response (CE theme #2).
- **Follow-up Standard:** Follow-up care will be expected to occur within 72 hours of any crisis intervention and will be ongoing until the individual connects with appropriate community resources. Proper follow up is also mentioned later as part of the expected practice standards. These expectations will help address concerns regarding follow up services (CE theme #4).

Staffing: Partnership-funded MRTs will have to meet staffing expectations that will address many of the CE themes. MRTs will have staff needed to provide comprehensive, timely services (CE themes #2/4), staff with expertise or access to the consultation necessary to serve those with disabilities (CE theme #5), and incorporate peers throughout the transformed crisis system (CE theme #9 and others). Every Partnership-funded MRT will include one peer on the team and these teams will help provide a continuum of services with existing MRTs with other staffing models.

Practice Guidelines:

- **Expectations to effectively engage with families and other supports:** Many community members expressed a desire to see crisis providers partner with family when appropriate to provide the best care (CE theme #2/9). Expectations to partner with family will incorporate this feedback. MRT programs are to regard family and other supports as priority customers. They are expected to treat family with respect and rely on them as key sources of information and guidance. Staff will partner with the family to help design treatment approaches and solve problems. Staff will refrain from engaging family if the individual in crisis does not offer consent, but staff will revisit initial denials of consent to emphasize the importance of family and social support.
- **Emergency Petition Standards:** Community members expressed concerns about the emergency petition process where law enforcement would transport someone to a hospital without their consent (CE theme #6). Many felt this process was used too often and was difficult to navigate. The standards attempt to monitor emergency petition use to ensure it is not relied upon too often. They will require MRTs to encourage individuals to engage in treatment voluntarily, attempt to resolve the crisis without an emergency petition, and notify those in crisis of their rights. When emergency petitions are used, they will require supervisory review and tracking.
- **Working with children, youth, and families:** Crises involving children, youth, and families pose unique challenges present in several CE themes such as the importance of training (CE theme #3), providing needed follow-up care (theme #4), and having strong partnerships (CE theme #9). Specific practice guidelines for children, youth, and families were developed to address some of the concerns. The GBRICS Partnership plans to fund MRTs to expand these services to better serve children, youth, and families. Services will incorporate family peer support and youth peers, and will require significant follow up and coordination with schools, child welfare, families, and other key partners.
- **Language Access:** Crisis providers are expected to have some multilingual staff and 24-hour language line access (CE theme #5).
- **Serving Deaf/Hard of Hearing:** Crisis providers are expected to have capacity to serve those who are Deaf/Hard of Hearing through ASL-fluent staff, a Deaf interpreter, and/or captioning services (CE theme #5).

Training Standards: Roundtable participants emphasized the need for consistent and high-quality training for the staff of crisis service providers (CE theme #1/3/5). The standards will require onboarding and annual training. Persons with lived experience will be consulted in developing the required trainings. The required training topics included in the standard are:

- Trauma-informed care, de-escalation strategies, and harm reduction.
- Recognizing medical emergencies (for non-medical staff).
- Self-care.
- Cultural humility and anti-racism.
- Training on the crisis system standards including services for all special populations.



PROGRAM DESIGN

How Partnership-funded services are designed provided another opportunity to incorporate community feedback and address concerns. BHSB has some latitude in how different services are designed and can establish expectations through the grant application process and provider contracting. The design decisions below were made in part to address the feedback received during this phase of the community engagement process.

Services available to all regardless of insurance status: Community members voiced concerns about the ability of individuals to afford services based on their insurance status (CE theme #12). The call centers and MRTs will be required to serve everyone regardless of insurance status.

No hold, voicemail, or long wait times for the regional call center: Communities expressed anxiety about whether the regional call center will be prompt and responsive (CE theme #2). To address this, the goal for the GBRICS-funded regional call center will be to answer 90% of calls made by residents in the region within 30 seconds. The GBRICS Partnership will achieve this goal primarily through adequate staffing, new software and infrastructure supports, and monitoring data from the call center. In terms of voicemail or being put on hold, there will be a prompt when an individual first calls asking if the caller is a veteran or would prefer to speak Spanish, but otherwise callers should not be put on hold or be sent to voicemail.

Text/chat capabilities: Many community engagement participants indicated that the regional call center should be able to receive texts and chats from individuals seeking help (CE theme #2, #4, #11). The GBRICS Partnership is committed to seeking additional funding to be able to provide this access. The regional call center may not have this capability when it first launches but we will work towards having this capability.

Make the most of call center functionalities: Communities suggested the GBRICS Partnership establish other regional call center functionalities such as access to a resource directory, access to past caller history, and the ability to directly make appointments with community providers (CE theme #4, #11). With the new software and infrastructure supports, the call center will be able to make referrals to outpatient appointments and inpatient beds as necessary. The goal is that these appointments will be timely, likely the same day or next day, thanks to the Open Access scheduling process and a real-time bed registry. The GBRICS Partnership will also explore how to save caller information to prevent the need for repeat callers to provide the same demographic and background information on each call, but this may be challenging while maintaining caller confidentiality.

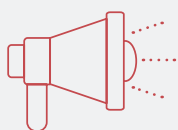
Pilot 2nd/3rd party callers: A key barrier shared by communities members was the inability of current call centers to dispatch MRTs when a loved one or neighbor calls on someone's behalf (CE theme #2). The Partnership is committed to expanding access in this way, but the exact protocols needed to keep everyone safe are complicated. To advance this goal, the Partnership will start by funding a pilot to work out the MRT protocols for responding to some types of 2nd and 3rd party callers without law enforcement escort.

Pilot MRT transport: Communities raised concerns about being transported in police vehicles and being handcuffed (CE theme #6). The GBRICS Partnership wants to address these concerns and will pilot a program to have MRTs transport individuals who need other care and are willing to go voluntarily. When an Emergency Petition is required, the individual will still need to be transported by law enforcement, as required by law.

Accountability and planning through data: The regional call center will use new software and infrastructure that provides much richer data. The system will be able to track how services are provided and how they helped resolve the situation. This real-time data will contribute to better planning and faster problem-solving in the region, which should help many CE themes around dependability, timeliness, and follow-up (CE theme #2, #4, #10, #11).

Consultation with communities to ensure materials are accessible and inclusive: Communities recommended that staff ensure materials to support the transformed crisis system are inclusive (CE theme #5). The GBRICS Partnership is committed to consulting with key communities such as the LGBTQ community and those who are blind regarding our language and materials.

Commitment to never ask about immigration status: Partnership-funded services will never inquire about immigration or share any information they receive regarding immigration status (CE theme #5).



PLANNED OUTREACH AND EDUCATION CAMPAIGN

The GBRICS Partnership is funding a regional outreach and education campaign supported by a market research consultant and the GBRICS Community Engagement Committee. This provides important opportunities to incorporate feedback around building trust, reducing stigma, and educating the community about the transformed crisis response system.

Establish website and other materials to provide education on the process: The GBRICS Partnership plans to create an independent website with educational information about the behavioral health crisis system and how to access services. Printed materials will also be created and distributed in person and digitally (CE theme #8).

Conduct a media campaign to reduce stigma and encourage help seeking: Paid and earned media is another opportunity to raise awareness of crisis services. The GBRICS Partnership plans to invest in such a campaign and will incorporate feedback from community engagement activities. The campaign will include efforts to encourage seeking help during a crisis and addressing stigma related to mental health and substance use, especially in certain racial and ethnic groups (CE theme #7, #8).

Recruit trusted community leaders as partners: Overcoming community skepticism and earning community trust will be one of the more important goals of the Partnership. The GBRICS Partnership plans to build relationships with key formal and informal leaders and recruit them to help support behavioral health outreach and education (CE theme #9).



COMMUNITY FORUM ON LAW ENFORCEMENT INVOLVEMENT IN CRISIS RESPONSE

The GBRICS Partnership is committed to reducing our reliance on law enforcement for behavioral health crisis response. The Partnership appreciates the numerous comments describing how police intervention had escalated previous crisis situations and led to reduced feelings of safety for some community members (CE theme #6). At the same time, law enforcement professionals are critical partners in ensuring public safety and effectively resolving complicated crisis situations. The new regional call center will dispatch MRTs without police escort in many situations but will also need to work closely with law enforcement in responding to others that pose a greater risk to public safety or that involve criminal activity.

To create more transparency around the composition of the teams dispatched during a behavioral health crisis, the GBRICS Partnership will be convening a community forum in 2022 focused on developing guiding principles on how MRTs should be triaged and dispatched in behavioral health crisis response. These forums will include stakeholders representing different perspectives and will aim to build consensus around the appropriate relationship between law enforcement and the behavioral health crisis response system. Such consensus may be difficult to achieve, but the Partnership is committed to developing strategies to keep all members of our communities safe during a crisis.



OUTSIDE THE SCOPE OF THE GBRICS PARTNERSHIP

Many important issues were raised during community engagement activities that are outside of the scope of the project. These concerns included changing policies for accessing residential treatment, emergency room practices, the use of handcuffs, emergency petition requirements, and providing respite to caregivers, among many others. The Partnership hopes that a more efficient and effective crisis response system will reduce negative experiences of all types, but it cannot address all aspects of these issues. Communities are encouraged to engage in advocacy where appropriate and to build other partnerships that can take on these issues.

LOOKING AHEAD

These standards and intentions alone will not address the concerns raised during this phase of community engagement. Achieving these goals will require creative problem-solving and continuous improvement. This may not be achieved all at once, but these efforts should strengthen the behavioral health crisis response system over time. The GBRICS Partnership will routinely assess program operations and regularly seek community input as services are launched.

Thanks again to all who participated in this phase of community engagement. The GBRICS Partnership will develop additional community engagement opportunities over the course of the project and appreciates the tremendous community expertise available throughout the Greater Baltimore region.

ATTACHMENT A: COMMUNITY ENGAGEMENT SURVEY QUESTIONS

1. What is your zip code?
2. Do you work for an organization that provides behavioral health services?
3. Do you or a loved one have personal experience with mental health or substance use challenges? (All responses are anonymous)
4. Sometimes people are in urgent distress due to mental health or substance use issues and need support at home, work, or in the community.
 - a. What type of response or support do you think would be most helpful when someone is in urgent distress due to mental health or substance use?
5. Crisis hotlines provide supportive counseling and other services to people in distress due to mental health or substance use issues, and are an alternative to 911. Would you call a crisis hotline to get help if you or a loved one were in distress due to mental health or substance use? Why or why not?
6. Please tell us about any other experiences, perspectives, or concerns you may have about how to help people who are in distress due to mental health or substance use issues.
7. Tell us more about you (optional): Name, Organization, Email Address, Phone Number

ATTACHMENT B: COMMUNITY ENGAGEMENT ROUNDTABLES

GROUP	DATE
Congressional Depression Awareness Program Roundtable	July 28, 2021
Carroll County Senior Expo	September 15, 2021
Justice and Equity Coalition Meeting	September 15, 2021
Black Mental Health Alliance Clinicians Network Roundtable	September 23, 2021
On Our Own (OOO), Inc. Wellness and Recovery Center Roundtable	September 24, 2021
NAMI Metro Baltimore Roundtable	September 28, 2021
In Our Own Voice Presentation by Carroll County NAMI	September 30, 2021
Black Mental Health Alliance Organizational Members Roundtable	October 7, 2021
Howard County Regional Roundtable	October 21, 2021
OOO HOPE Wellness and Recovery Center Roundtable	October 27, 2021
OOO Carroll County Wellness and Recovery Center Roundtable	October 28, 2021
OOO Howard County Wellness and Recovery Center Roundtable	October 29, 2021
Faith Presbyterian Church Roundtable with Pastor Cat Goodrich	October 31, 2021
East Baltimore County Regional Roundtable	November 3, 2021
Carroll County Regional Roundtable	November 4, 2021
West Baltimore County Regional Roundtable	November 10, 2021
Baltimore City Youth Roundtables (three events)	December 3, 2021
North Baltimore County Regional Roundtable	December 8, 2021
West Baltimore City Regional Roundtable	December 9, 2021
South Baltimore City Regional Roundtable	December 11, 2021
Humanim Howard County Roundtable	December 17, 2021
Intellectual/Developmental Disabilities Roundtable	January 12, 2022
East Baltimore Regional Roundtable with HEBCAC	January 19, 2022
Immigrant Community Roundtable	January 26, 2022
Conversation with Baltimore City Community College	January 27, 2022
East Baltimore City Regional Roundtable w/STAR and clergy	January 27, 2022
Free State Justice LGBTQ Roundtable	March 2, 2022

ATTACHMENT C: INCORPORATION OF COMMUNITY ENGAGEMENT THEMES: AT A GLANCE

THEME #1 EARN THE TRUST OF COMMUNITIES AND OVERCOME SKEPTICISM

Crisis Response System Standards

- Crisis Care Continuum Description
- System Accountability
- Universal Service Competencies
- Training Standards

THEME #2 PROVIDE DEPENDABLE, TIMELY, SAFE, AND HELPFUL SERVICES

Crisis Response System Standards:

- Crisis Care Continuum Description: Services Available 24 hours a day, every day of the year
- Service Competencies: Timeliness Standard
- Staffing

Program Design:

- Call center goal for 90% of calls to be answered within 30 seconds
- Seeking funding to support text/chat capability
- Funding a MRT pilot to respond to more types of callers
- Real-time data used to ensure consistent services

THEME #3 REQUIRE HIGH-QUALITY TRAINING ACROSS THE SYSTEM

Crisis Response System Standards: Training Standards

THEME #4 COORDINATE ACCESS TO OTHER NEEDED SERVICES, INCLUDING FOLLOW-UP AFTER CRISIS

Crisis Response System Standards:

- Collaboration
- Service Competencies: Follow-Up Standard
- Staffing
- Practice Guidelines: Working with Children, Youth, and Families

Program Design:

- Seeking funding to support text/chat follow-up capability
- Direct appointment scheduling through the call center
- Real-time data used to ensure effective follow-up care

THEME #5 ENSURE INCLUSIVE SERVICES AND CULTURAL REPRESENTATION

Crisis Response System Standards:

- Staffing
- Practice Guidelines: Language Access
- Practice Guidelines: Serving Deaf/Hard of Hearing
- Training Standards

Program Design:

- Will consult with communities to ensure materials are inclusive
- Will never ask about immigration status

ATTACHMENT C: INCORPORATION OF COMMUNITY ENGAGEMENT THEMES: AT A GLANCE

THEME #6: Reduce System Reliance on Police for Behavioral Health Crisis Response
<p>Crisis Response System Standards</p> <ul style="list-style-type: none"> • System Accountability • Practice Guidelines: Emergency Petition Standards <p>Program Design:</p> <ul style="list-style-type: none"> • Will pilot a model to have MRTs transport individuals who need higher levels of care • Hosting a forum on who should respond when someone is in distress, including the role of law enforcement and medical personnel
THEME #7: Combat Pervasive Stigma Around Behavioral Health
<ul style="list-style-type: none"> • Outreach and Education Campaign to Reduce Stigma and Encourage Help Seeking
THEME #8: Educate the Public on What to Expect
<ul style="list-style-type: none"> • Outreach and Education Campaign: Establish website and other materials to provide education
THEME #9: Integrate Community Partners into the Crisis System
<p>Crisis Response System Standards:</p> <ul style="list-style-type: none"> • Collaboration • Staffing • Practice Guidelines <p>Outreach and Education Campaign: Recruit Trusted Community Leaders as Partners</p>
THEME #10: THINK UPSTREAM TO PREVENT CRISES
<p>Program Design:</p> <ul style="list-style-type: none"> • Use real-time data for planning and system change
THEME #11: MAKE THE MOST OF TECHNOLOGY
<p>Program Design:</p> <ul style="list-style-type: none"> • Call center functionalities to provide real-time data, bed registry, open access appointment scheduling
THEME #12: CLARIFY INSURANCE AND PAYMENT ISSUES
<p>Program Design:</p> <ul style="list-style-type: none"> • Services will be available to all regardless of insurance status.