Cuyahoga County Crisis Response Services Needs Assessment

Final Report

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Executive Summary

The Alcohol Drug Addiction and Mental Health Services Board of Cuyahoga County (ADAMHSBCC) contracted with The Begun Center for Violence Prevention Research and Education at Case Western Reserve University (Begun Center) to conduct between January and July 2018 a comprehensive community needs assessment of Cuyahoga County's crisis response system. The crisis response system is a complex and tiered one comprised of crisis response services that support individuals in crisis (hereafter "clients") whose safety and health are threatened by behavioral health challenges, including mental illness, developmental disabilities, substance use, and/or overwhelming stressors. The objective of this assessment was to include a broad range of participants to reliably surface the major underlying themes characterizing the responsiveness of the system in meeting clients' and their families' needs. The goal of this effort was to present these themes in ways that could be useful in assessing the effectiveness of the current system and later informing planning efforts for improvement. Given the nature of a needs assessment, this resulting report touches on the service strengths and crisis resolution achievements of the current system— but focuses primarily on gaps in existing services and impediments to cross-agency collaboration as voiced by many of those whom use, design, fund, manage and implement the many intertwined services of this vital community health and safety net.

The data gathered during the course of this assessment illustrate many of the crisis response services'—and consequently the overall crisis response system's—strengths and weaknesses, as well as provide service improvement ideas for future consideration. The assessment team collected data from three purposively sampled groups comprised of (a) crisis response service agency staff, (b) individuals with mental health diagnoses, and (c) family members of clients with mental health diagnoses. Qualitative data were collected from 486 participants in 49 focus groups/interviews. Quantitative and qualitative data also were acquired from 115 respondents to an online survey completed by crisis response service agency staff. These participants and respondents in combination are referred to as "contributors" below.

Findings show the primary responders to a mental health crisis are FrontLine Service's Mobile Crisis Team (MCT), police, sheriff and other security personnel (hereafter "law enforcement"), and emergency medical services (EMS). Several behavioral health providers and schools utilize their own crisis response services prior to contacting the MCT or law enforcement. Findings also highlight that in most instances crisis response is not a one-step process; it often involves a tiered response with a complex array of pathways to services. The accessibility of given pathways during a crisis is influenced by numerous factors such as the time of day, whether or not the client is insured, and whether or not the client has been using alcohol and/or non-prescribed drugs, etc. Although in some cases a client's caregiver may directly contact law enforcement, the MCT or the client's behavioral health provider, this is likely not the final step in the crisis response. For example, on the one hand, although a client's caregiver may call the MCT, the MCT may indicate that law enforcement needs to be contacted to transport the client for inpatient hospitalization or admission to a crisis stabilization unit. On the other hand, if MCT is contacted during regular business hours

and the client is linked with a behavioral health provider, the MCT may instruct the client's caregiver to first contact their provider for assistance. In other scenarios some behavioral health providers may have their own crisis response protocol, but if they are not able to de-escalate the client, the provider may then contact law enforcement and/or the MCT for assistance. However, in most instances if the client requires treatment via an emergency room (ER), inpatient hospitalization or crisis stabilization unit, law enforcement usually are responsible for client transport, unless a family member or behavioral health provider deems they can safely transport the client. In potentially more complicated types of scenarios, if the client is a child then a parent or legal guardian likely will be the first person contacted to provide consent for the child to enter one or more pathways of service.

Eleven major themes emerged from the data collected:
1. **Strengths in Crisis Response Services**—Strengths include the wide array of behavioral health services in the county and the system's ability to address some of the mental health issues faced by uninsured and homeless clients, in particular. Other strengths include FrontLine Service's 24-Hour Crisis Hotline and the County's growing cadre of Crisis Intervention Trained (CIT) law enforcement officers.
2. **Protocols for Crisis Response**—Among both service providers and clients there is a general lack of understanding of the crisis response system's procedures and protocols.
3. **Assessing Behavioral Health Needs of Clients**—Delays, service duplication and absence of services negatively impact completion of behavioral health assessments to determine client status and admission criteria during a crisis.
4. **Crisis Resolution**—Crisis episode resolution is hampered by a) delays in crisis response, b) the quality of response provided, and c) the absence of available treatment options.
5. **Crisis Intervention Training**—CIT law enforcement officers and the ongoing efforts to train more officers how to appropriately intervene in a client's mental health crisis are both key system improvements.
6. **High-risk/Chronic Utilizers**—For high-risk/high utilizer clients, the system often works as a temporary fix due to insufficient continuity of care.
7. **Challenging Populations**—Violent clients, elderly clients, clients who engage in substance abuse, as well as transitional youth are particularly challenging for the current system. If not linked properly with services to receive consistent mental health treatment, these clients can quickly become high-risk/chronic users of the system.
8. **Nexus Between Crisis Intervention and Continuum of Care**—There are gaps in establishing and maintaining continuity of care when transitioning clients from a crisis episode, but it is vital to strengthen the system particularly for those who are high-risk/chronic utilizers.
9. **Adult vs. Child Crisis Response Units**--There was no consensus for either a separate or unified child/adult response system; however, training for crisis workers must be specialized because the protocols, resources and interventions associated with children vs. adults are vastly different.
10. **Language and Cultural Barriers to Crisis Response**—Crisis resolution is hampered by a shortage of language translators, as well as a dearth of translators trained in mental health terminology. First responders can benefit from greater knowledge that mental illness carries varying degrees of

stigma within families, neighborhoods and other social groupings, as well cross-culturally, and for this and other complex cultural reasons some clients may decline services. Additionally, first responders also can benefit from greater awareness that their own stereotypes associated with client ethnicity, socio-economic standing, and crisis locale may affect the ways in which they approach and/or work to resolve a crisis.

11. **Resources and Capacity**— Consistent themes were the need for increased resources and greater efficiencies governing how resources are deployed (i.e. greater support for FrontLine's Mobile Crisis Team, more psychiatric units and crisis stabilization beds, adequate stabilization admissions for eligible clients, adequate stabilization services for ineligible clients, greater continuity of care, and an expansion of the Provider Emergency Support Program (PESP)).

The community stakeholders who contributed to this needs assessment also articulated additional topics for future consideration in improving the crisis response system.

- A better advertised crisis response system;
- Uniformity of behavioral health assessments across the county;
- An integrated data system tracking clients' system usage and responder data;
- Cross-system coordination among criminal/juvenile court and crisis service providers; and,
- Expansion of the Crisis Intervention Trained (CIT) officer education to non-law enforcement crisis responders, as well as the addition of an abbreviated introductory course.

In sum, Cuyahoga County crisis response system's greatest strengths lie in its large and growing number of behavioral health service providers, an established 24-hour crisis hotline, an increasing cohort of CIT law enforcement officers, and a nascent PESP program for high-risk/chronic utilizers. Awareness of this complicated response system could be further increased by refining, streamlining and widely communicating crisis response procedures and protocols to first responders, service agencies, clients and their families, and the general public. Additionally, adopting a uniform behavioral health assessment for use countywide likely would reduce delays for clients seeking mental health services during a crisis. Finally, additional stabilization services for those clients ineligible for inpatient care not only would augment the effectiveness of the system, but also would decrease the number of clients from already challenging populations transitioning into high-risk/chronic utilizers of the system. Many contributors advocated for 24-hour crisis intervention units that could provide comprehensive triage, assessment and services for clients.

Introduction and Background

In January 2018, the Alcohol Drug Addiction and Mental Health Services Board of Cuyahoga County (ADAMHSBCC) contracted with The Begun Center for Violence Prevention Research and Education (Begun Center) at Case Western Reserve University to conduct a comprehensive community needs assessment of Cuyahoga County's crisis response system. This system is a complex and tiered one comprised of crisis response services that support clients whose safety and health are threatened by behavioral health challenges, including mental illness, developmental disabilities, substance use, and/or overwhelming stressors.

The objective of this assessment was to include a broad enough range of participants to reliably surface the major underlying themes characterizing the responsiveness of the system in meeting the needs of clients and their families. The goal of this effort was to present these themes in ways that would be useful in assessing the effectiveness of the current system and later informing planning efforts for improvement. Given the nature of a needs assessment, this resulting report touches on the service strengths and crisis resolution achievements of the current system—but focuses primarily on gaps in existing services and impediments to cross-agency collaboration as voiced by many of those whom use, design, fund, manage and implement the many intertwined services of this vital community health and safety net.

Methodology

Assessment Setting, Rationale and Research Ethics Approval

Between February and July 2018, the assessment team collected data for this comprehensive community needs assessment from three purposively sampled groups comprised of (a) crisis response service agency staff, (b) individuals with mental health diagnoses, and (c) family members of clients with mental health diagnoses. Qualitative data were collected via 48 focus groups of two or more persons and one individual interview, and both qualitative and quantitative data were gathered via an online survey. The rationale for this assessment stems from its role in providing the ADAMHSBCC with stakeholder articulated themes that could be used for assessing the current system's effectiveness and informing planning efforts for future improvement. The assessment team designed open-ended focus group/individual interview questions and an online survey to elicit from participants information on their perspectives of crisis response services' established protocols and practices, as well as their actual experiences interacting with the crisis response system. This research was approved by Case Western Reserve University's Social/Behavioral Science Institutional Review Board.

Participants

Participant eligibility criteria were being 18 years of age or older and having knowledge of and/or experience interacting with Cuyahoga County's crisis response system. Participants were recruited and interviewed between January and July 2018. Potential participants were identified originally by the ADAMHSBCC, and then the assessment team sought to recruit them via email and telephone. Through snowball sampling, participant recruitment expanded to include additional crisis service agencies on the knowledgeable recommendation of participants who had already completed a focus group/interview. The participant pool also was enlarged through subsequent recommendations by the ADAMHSBCC. A list of the agencies represented by the focus group and interview participants is included in Appendix B. The number of focus groups increased due to the assessment team's desire to increase the volume of community stakeholders and improve the quality of feedback. The assessment team discussed the data with one another throughout the duration of collection, developed working hypotheses to interpret what was reported, and revised and evaluated iteratively the topics, questions, themes, and responses.[1] The vast majority of focus groups were conducted at agency sites, although several were conducted via conference call to accommodate participants' needs. The single interview also was conducted over the phone.

A total of 486 focus group/interview participants and 115 survey respondents took part in the assessment. Because neither the focus group/interview participants nor those who took the online survey were identified by name, some overlap is possible between focus group/interview participants and survey respondents. While a handful of participants were previously known to assessment team members due to team members' historical agency-based employment or roles on other Begun Center research projects, most participants were unknown to team members. None of the potential participants declined to be interviewed or withdrew participation post-consent. Recruitment continued until team members felt sampling data saturation was achieved in July 2018. The assessment team members were either experienced researchers or research administrators, and all were employed by Case Western Reserve University.

Following verbal informed consent, one or more assessment team members conducted the focus groups/interview. The focus groups/interview lasted from 20 to 75 minutes, 47 focus groups were audio-recorded and transcribed, and the assessment team took detailed notes during the focus group and interview that were not audio-recorded.

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[1] Hammersley, M., & Atkinson, P. (1993). *Ethnography: Principals in practice* (2nd ed.). New York, NY: Routledge.

Analyses

Analyses of the focus group/interview and online survey data was conducted in the following ways:

Focus Groups/Interviews

The focus groups/interview provided an opportunity to explore "rich points" or descriptions of protocols, experiences, perceptions, and opinions of crisis response services that were offered in knowledgeable or experienced participants' own words and were outside the assessment team's knowledge or experience.[2] The qualitative focus group/interview data—in the form of audio recordings and the assessment team's notes taken during the focus group--were entered into a Microsoft Word™ file. This resulting focus group text was analyzed using systematic text condensation developed by Malterud, based on Giorgi's phenomenological analysis.[3] The focus group/interview responses were analyzed through the following structured STC process. Two assessment team members gained a general impression of the data by reading the responses and highlighting preliminary themes. The documents were then reread by the same team members with the goal of identifying specific units of meaning relating to the core themes of this assessment. The contents of these meaning units were condensed and sorted by the same team members to more accurately cover distinct topics. The two team members, respectively, removed from the broader context of the focus group/interview discussions consistent statements about participants' experiences, perceptions and opinions of the crisis response system. These meaning units were then removed by the two team members who did the text analysis and arranged into 11 major themes. All four assessment team members discussed the major theme findings. Some of the raw data underlying the analysis are presented through direct quotes of the focus groups and interview participants. The focus group questions are listed in Appendix C.

Prior to the start of each focus group, participants were asked to record (a) their job title, (b) how many times in 2017 they had been involved with or made a referral for crisis services in Cuyahoga County, and (c) how many years they had been involved with or made referrals to Cuyahoga County's crisis response system. The focus group participant information questionnaire is included in Appendix D.

Of the 486 focus group/interview participants, 85 were clients. The remaining 401 participants were service providers who listed 117 job titles, which were collapsed into 12 categories (see Table I).

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[2] Agar, M. (1980). *The Professional Stranger*. New York, NY: Academic Press.

[3] Malterud, K. (2012). Systematic text consolidation: A strategy for qualitative analysis. Scandinavian Journal of Public Health, 40, 795–805. Giorgi, A. (1985). Sketch of a Psychological Phenomenological Method. Phenomenology and psychological research: essays. Pp 8-22. Pittsburgh, PA: Duquesne University Press.

TABLE I. Contributors' Job Titles

Job Title	#
Director or CEO of Agency/Organization	13
Chief Clinical Officer/Clinical Director/Medical Director	13
Program Administrator/Supervisor	110
Director of Student/Pupil Services	6
School Counselor/Social Worker	12
Counselor/Therapist/Crisis Worker	105
Parole/Probation/Court Administrators & Personnel	29
Crisis/Education Coordinator/Information Specialists	27
Department of Child and Family Services/Adult Protection Services	15
Law Enforcement	45
Advocate	7
Miscellaneous	12
Missing*	7
Total	401

*Seven staff members participated in client groups and provided no information regarding their job title or involvement with referrals to the crisis response system.

Of those reporting the number of times they had been involved with or referred to the county's crisis response system (n=393), 36% recorded >10 times, 38% recorded 1-10 times, and 26% had not been directly involved. Of those reporting the number of years they had been involved (n=366), 35% had more than 10 years of experience, 15% had 6-10 years, 32% had 1-5 years and 18% had less than a year (Median=5.5 years). It is important to note that of the 45 law enforcement participants, 31 (69%) were confirmed to be CIT trained or in the process of being CIT trained.

Online Survey

The assessment team created online surveys in coordination with the ADAMHSBCC. One survey was sent out by the ADAMHSBCC to civil and criminal court professionals, law enforcement officers, behavioral health providers, county governmental agency representatives, and mental health advocates.

The quantitative data collected via this online survey was collected via Qualtrics™, downloaded into Excel™, and then converted to SPSS™. All analyses were conducted using IBM SPSS version 24. The online survey also included five open-ended questions. The qualitative data acquired therein was analyzed in the same way as the focus group/interview qualitative data described above in *Focus Groups/Interviews*. The online survey questions for agency staff and advocates are included in Appendix E.

Initially 232 surveys were sent via email to key personnel within the various agencies. The accompanying email message included a request for these recipients to forward the email to other staff to complete; therefore, the actual number of surveys distributed is unknown. It is not possible to calculate a response rate without knowing the number of surveys distributed. Approximately 205 surveys were received. Of the 205, 90 were found largely incomplete, leaving a total of 115 completed surveys.

Although a separate online survey also was developed and distributed to 15 mental health clients and their family members, no responses to this survey have been received to date. The online survey questions clients and their family members is included in Appendix F.

The majority of the survey respondents worked for either a behavioral health provider (34%, n=39) or law enforcement (36%, n=41) (see Table II).

TABLE II. Agencies and Organizations Represented in Online Survey

Agencies/Organizations	#	%
Law Enforcement	41	36
Behavioral Health Provider	39	34
Other	9	8
School/District	7	6
Cuyahoga County Court of Common Pleas	5	4
Hospital/Medical Center	5	4
Client/Client Advocacy Group	3	3
ADAMHSBCC	1	1
Jail/Correction Facility	1	1
County Agency/Dept.	1	1
Adult/Child Care Facility	1	1
Self Employed	1	1
Unknown/Missing	1	1
Total	115	100%

The majority of the respondents have been with their agency for many years, 44% more than 10 years (n=50), 17% 6 to 10 years (n=20), 24% 3 to 5 years (n=27), and 13% were 2 years or less (n=15). Data was missing for two of the respondents and one indicated he was not working (2%, n=3).

Respondents were asked to indicate how many times within the last two years they have responded to or been involved with crisis support. Of those reporting the number of times they have been involved with or referred to the county's Crisis service system (n=115), 48% were involved more than 10 times (n=55), 11% recorded 6-10 times (n=13), 15% recorded 3-5 times (n=17), 13%

recorded 1-2 times (n=15), and the remaining 12% indicated that had not been involved at all with crisis services within the last two years (n=15).
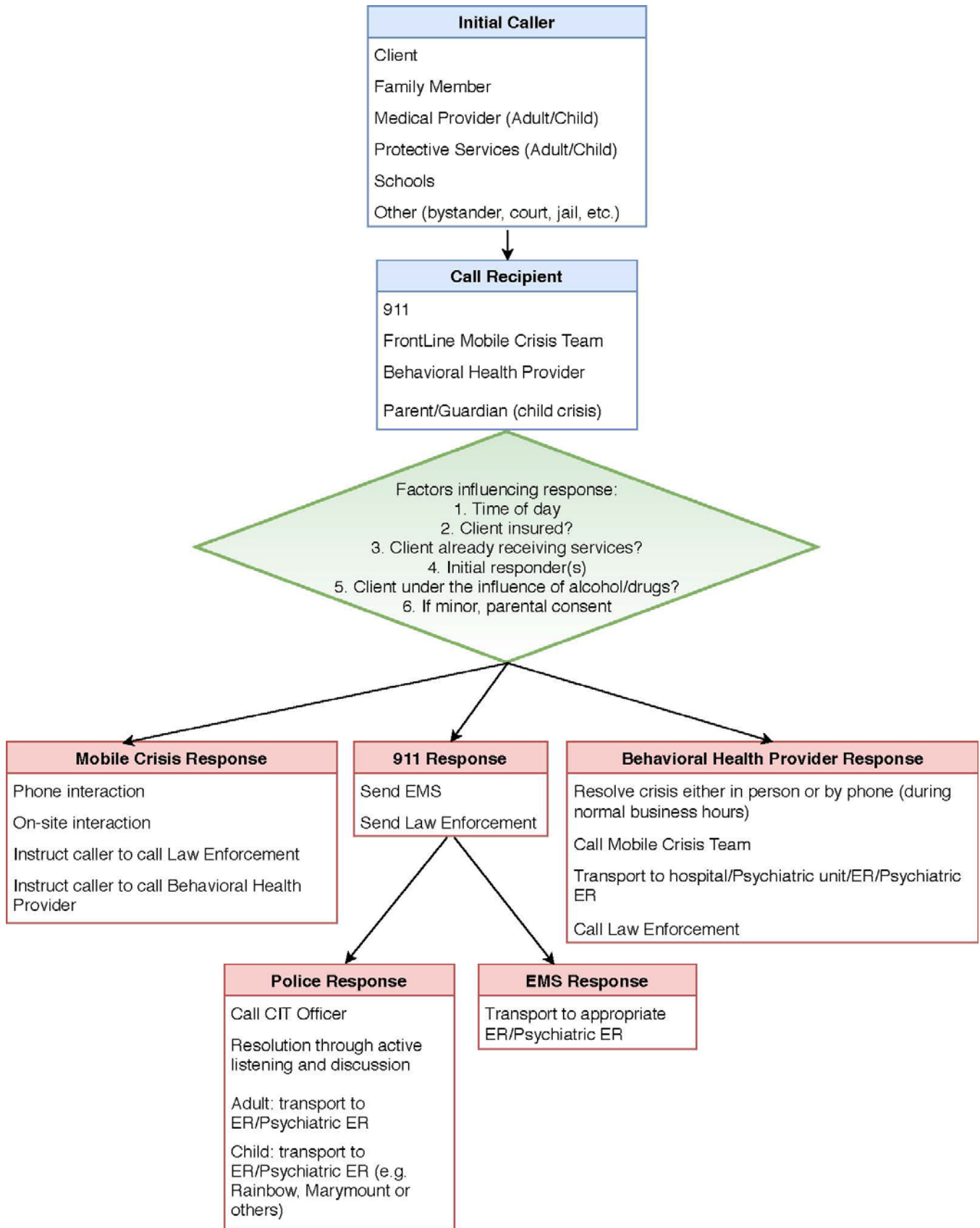
Findings

Introduction

To understand Cuyahoga County's crisis response system, it is important to map out the different pathways utilized by clients or their caregivers/representatives/others to resolve a crisis. The pathways described herein are based on data obtained from the focus groups/interview, even though there may be other avenues for responding to a client in crisis.

Primary responders identified by focus group participants were FrontLine Service's Mobile Crisis Team (MCT), law enforcement, and emergency medical services (EMS). Some participants also referenced dialing 911 and relying on the dispatcher to route the caller to the appropriate responder. Several behavioral health providers indicated that they have their own crisis response services that would be utilized before contacting MCT or law enforcement. Schools also are known to have their own crisis response services that may include contacting a family member, MCT or law enforcement if transportation is needed.

In most instances, crisis response is not a one-step process; it often involves a tiered response involving a potentially complex array of pathways to services. The accessibility of given pathways is influenced by various factors such as time of day, whether a client is insured, whether the client has been using alcohol and/or non-prescribed drugs, etc. Although in some cases a client's caregiver may contact law enforcement, MCT or their behavioral health provider directly, often this is not the final step of the crisis response. On the one hand, although a client's caregiver may call the MCT, the MCT may indicate that law enforcement needs to be contacted to transport the client for inpatient hospitalization or admission to a crisis stabilization unit. On the other hand, if MCT is contacted during regular business hours and this client is linked with a behavioral health provider, the MCT may instruct the client's caregiver to first contact their provider for assistance. In other scenarios, some behavioral health providers may have their own crisis response protocol, but if they are not able to de-escalate the client, the provider may then contact law enforcement and/or the MCT for assistance. However, in most instances, if the person requires treatment via an emergency room (ER), inpatient hospitalization or crisis stabilization unit, law enforcement are usually the party responsible for the transport, unless a family member or behavior health provider deems they can safely transport the client. In potentially more complicated types of scenarios, if the client in crisis is a child, then a parent or legal guardian will likely be the first person contacted to provide consent for the child to enter one or more pathways of service (See Figure 1).

Figure 1. Pathways for Crisis Response

Initial Caller
- Client
- Family Member
- Medical Provider (Adult/Child)
- Protective Services (Adult/Child)
- Schools
- Other (bystander, court, jail, etc.)

Call Recipient
- 911
- FrontLine Mobile Crisis Team
- Behavioral Health Provider
- Parent/Guardian (child crisis)

Factors influencing response:
1. Time of day
2. Client insured?
3. Client already receiving services?
4. Initial responder(s)
5. Client under the influence of alcohol/drugs?
6. If minor, parental consent

Mobile Crisis Response
- Phone interaction
- On-site interaction
- Instruct caller to call Law Enforcement
- Instruct caller to call Behavioral Health Provider

911 Response
- Send EMS
- Send Law Enforcement

Behavioral Health Provider Response
- Resolve crisis either in person or by phone (during normal business hours)
- Call Mobile Crisis Team
- Transport to hospital/Psychiatric unit/ER/Psychiatric ER
- Call Law Enforcement

Police Response
- Call CIT Officer
- Resolution through active listening and discussion
- Adult: transport to ER/Psychiatric ER
- Child: transport to ER/Psychiatric ER (e.g. Rainbow, Marymount or others)

EMS Response
- Transport to appropriate ER/Psychiatric ER

Major Themes

The primary objective of this assessment was to include a broad enough range of focus group participants and online survey respondents to reliably surface the major underlying themes characterizing the responsiveness of the crisis response system in meeting the needs of clients and their families. Below are 11 major themes that emerged from the qualitative data collected during the course of the focus groups/interview and online survey (the quantitative data gathered via the survey is presented in the following section). The assessment team's discussion of each theme is often supported by direct quotes of focus group/interview participants and survey respondents (hereafter referred to collectively as "contributors.") Quotes were selected on the basis that they best illustrated one or more key points within each theme. While many positive features of Cuyahoga County's crisis response services were identified during this needs assessment, contributors typically highlighted impediments, barriers and opportunities for improvement in the focus groups and survey.

Theme 1: Strengths in Crisis Response Services

Overall the contributors were appreciative of the crisis support services available within Cuyahoga County. One strength regularly recognized by contributors was the system's array of available mental health services, and the county's ability to address some of the mental health issues faced by uninsured and/or homeless clients, in particular. Contributors emphasized that collaboration is key when addressing a crisis and often does occur effectively among first responders and behavioral health providers.

"When the system is forced to work together, it can be successful."[4]

Another strength regularly mentioned was the telephone availability of FrontLine's Mobile Crisis Team (MCT) members.

"I called mobile crisis for a manic episode where I couldn't sleep and I was really on edge and I was extremely impulsive and I needed to come down—and they were really good at talking me down."[5]

"It's accessible to anywhere in the county. They always have staff to be able to respond 24 hours a day."[6]

Follow-up provided by MCT members to ensure that a client, formerly in crisis, had been linked with services was another commonly cited strength. MCT members appear to be persistent in their follow-up to ensure cases are appropriately assigned and needed referrals are made.

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[4] Focus group PESP meeting hosted by the ADAMHSBCC
[5] Focus group Life Exchange Center
[6] St. Vincent Charity Medical Center, Psychiatric Emergency Department

"I made a joint call with a clinician to MCT to monitor a safety situation for overnight for a client who was dually disordered and very intoxicated. He had been missing for a number of hours. MCT followed up and made calls and outreach overnight. They checked in with us the next morning. That 24-hour, overnight monitoring, while we were busy getting them into see a treatment provider, was very helpful."[7]

"They've [MCT] been following through. They called back to check on, to see if you have followed through with the services or the recommendations that they made."[8]

Additionally, the response of a CIT law enforcement officer often was noted as a system strength, particularly in the City of Cleveland where CIT training has been most concentrated.

EMS crews also were widely praised for their ability to assist a client and transport him or her safely to a hospital ER. EMS support, in turn, regularly helps to prevent these individuals from initially ending up in jail.

The PESP (Provider Emergency Support Program) group also was mentioned as a strength because of its ability to address problems with individuals who frequent the county's hospital ERs when experiencing mental health crises. Additional strengths recognized by contributors included the well-trained staff at the behavioral health agencies within the county and the development of specialty courts within the Cuyahoga County and Cleveland Municipal court systems.

Theme 2: Protocols for Crisis Response

Contributors made evident the many available pathways to resolving a mental health crisis that exist in the county. Law enforcement and MCT were most commonly cited as the agencies first contacted, however, EMS also was mentioned as an initial contact. Some individuals, family members, and peer support service agencies stated they may go directly to the ER if they can safely transport a client, rather than initiate a crisis response by phone. Schools and behavioral health agencies have developed their own internal crisis response protocols, and will contact MCT and/or law enforcement only if they are unable to resolve the crisis themselves. Some contributors were familiar with the successes of the co-responder unit operating in the City of Cleveland's 2nd District where a CIT police officer and mental health worker co-respond to clients.

Nonetheless, it became apparent during the assessment process that there is a wide lack of awareness and understanding of Cuyahoga County's crisis response system.

"I didn't even know the mobile crisis team existed and I have had mental health issues for over 10 years."[9]

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[7] Focus group ADAMHSBCC Suicide Prevention regularly scheduled meeting
[8] Focus group Women's Recovery Center
[9] Focus group ADAMHSBCC Lunch and Learn gathering

"We don't know. Is it really known to all the providers what's out there, what's available? Like could we use it, like if we did have a crisis, could we call mobile crisis to come here at nine o'clock at night or are we using the police?"[10]

Depending on whom is initiating the call for service, any lack of system understanding could affect how the call is routed. Some contributors were unclear regarding the procedure for seeking assistance in or responding to a crisis. While there may be a general understanding within the community regarding which agencies and organizations provide crisis response services, knowledge of the process for responding to a crisis, which agency should be contacted in what order and under what circumstances is unclear.

"There's no good community roadmap for crisis"[11]

"[T]here's lots of misconceptions of how all these crisis support systems work."[12]

Responding to a crisis usually involves several steps. It is a tiered response often influenced by several factors, most notably (a) the time of day when the initial call is made, (b) whether the client has insurance, and (c) whether the individual is already receiving mental health services from a behavioral health provider. These factors influence what pathway is best for resolving a crisis. However, there is a lack of understanding among service providers and clients as to which pathway to follow in any given crisis.

"There are so many doors . . . . [P]eople in the middle of a crisis . . . are not familiar with the system. It's hard for them. I don't think the community does a great job of saying, 'Here's one central [plan]. Here's who you call in a crisis.'"[13]

"So one of the big things is lack of knowledge and understanding of what's out there available that you could possibly utilize."[14]

"We called FrontLine then they said they could not be involved because this student is involved with this other agency, and so there's this not knowing who to turn to or what is needed to take the next steps."[15]

"I've always been told not to use them [MCT] during office hours. It's our problem during the day, it's their problem at night. So I don't know if we play so well together."[16]

For example, if a family member is calling on behalf of a client and the call is placed during the day (between 9:00 am and 5:00 pm), the family member may contact 911 who in turn directs the call

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[10] Focus group New Directions/Crossroads
[11] Focus group Bellefaire Jewish Children's Bureau
[12] Focus group Connections: Health•Wellness•Advocacy
[13] Focus group Bellefaire Jewish Children's Bureau
[14] Focus group Law Enforcement training for Crisis Intervention Trained (CIT) Officers
[15] Focus group Educational Service Center of Northeast Ohio Pupil Service Directors Meeting
[16] Focus group Jewish Family Services

to MCT. If the client is connected with a behavioral health provider, MCT may instruct the caller to first contact the individual's case manager for assistance, although this often was described as problematical if the case worker is not available. If, however, the call is made during the evening (after 5:00 pm) or on the weekends, MCT may work directly with the individual and if the MCT crisis worker is unable to assist the individual in resolving the crisis over the phone, the MCT crisis worker may then contact law enforcement to transport the individual to the nearest ER or psychiatric ER. While in some instances, the MCT member may respond to the client on-site, a clear majority of contributors with experience interacting with MCT indicated that this was rare and explained that MCT members usually address crises over the phone.[17] If 911 directs the call to law enforcement, a CIT officer will respond, if available, and if necessary transport the client to the nearest ER or psychiatric ER.

Contributors regularly reinforced that the most difficult time for addressing a crisis is between 5:01 pm and 8:59 am. Many behavioral health agencies are not available to provide support or services after business hours, so law enforcement and MCT are usually the first responders. Contributors noted the lack of options available in the system to respond to a crisis after business hours.

"Confusing, overlapping service providers. System is hard to navigate.
Most 24-hour services are police and phone lines." [18]

Theme 3: Assessing Behavioral Health Needs of Clients

A behavioral health assessment for a client must be completed to determine his or her status (e.g. actively psychotic or under the influence of drugs and/or alcohol) and admission criteria (i.e. required level of care and facility eligibility). Contributors raised numerous barriers to assessment completion.

Time delays in clients receiving treatment were commonly viewed as one primary challenge. If a school counselor cannot gain parental/guardian consent to complete an assessment of a child, for example, this can delay crisis resolution. In another example, in seeking an adult client admission to Northcoast Behavioral Health, the MCT is responsible for assessment completion. If a MCT member is not readily available to conduct the assessment—which according to contributors often is the case—crisis resolution is delayed.

"Sometimes [clients] get more irritated because we're making them talk
to somebody else on the phone [to complete an assessment], when they're wanting to go to the
hospital. Most of our people want to go to the emergency room."[19]

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[17] In 2017 MCT responded to 16,064 calls to its Adult and Child crisis programs. A total of 2,960 in person crisis assessments were attempted and of those 2,270 were completed by MCT. Additional analyses of MCT data was outside the scope of this project.
[18] Online survey response
[19] Focus group Hitchcock Center for Women

In some instances MCT completes a screening over the phone to determine what the client needs and if MCT determines the client is in crisis, MCT will complete a behavioral health assessment in person.

> *"It becomes a weakness if they're screening over the phone instead of coming out."[20]*

Delays also may occur due to the variety of assessments a client may be asked to complete.

> *"We've found that if Mobile Crisis is called for another opinion,*
> *even though we've had an ER opinion, we've had my intake staff do an assessment,*
> *we've had a psychiatrist on the floor do one, and Mobile Crisis comes out and does another—so*
> *the patient is very aggravated now—and now if Mobile Crisis doesn't think the patient needs to go*
> *to Northcoast, they're sent to St. Vincent's for yet another second opinion." [21]*

Additionally, in cases such as this one, contributors argued that if staff at the final facility at which the client was taken rely solely on the information obtained during their own assessment, they may miss a need for intervention, as the client's assessed status may be different than that captured by other earlier assessments.

> *"The [school] crisis team does their assessment and that conclusion is that*
> *the student probably needs to be hospitalized, then they go to the hospital,*
> *the hospital does their own assessment, now the kid is tired of telling the story and*
> *may not even be in crisis anymore because it has been many hours."[22]*

Some contributors also were uncertain as to whom is responsible for completing a behavioral health assessment for admission to a psychiatric inpatient unit or crisis stabilization bed. There are diverse gatekeepers, such as MCT, who must perform the assessment for the client to be admitted.

Contributors also voiced unease about some clients moving through the system without being assessed at all because responders believed the client's crisis stemmed from psychosocial rather than psychiatric causes. Many contributors believed that first responders, including law enforcement and MCT, were more likely to attribute an individual's behavior to psychosocial causes rather than psychiatric ones if the individual had an active criminal or juvenile case. These clients are referred to their probation officer or case worker for assistance instead of being assessed for treatment of a mental health crisis. For instance, a contributor described a call to law enforcement related to domestic violence where a child was the one committing the violence, and the response was to treat the case as a criminal one. The child was taken to the detention center, but then detention center staff soon called MCT for assistance because the child was hallucinating.[23]

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[20] Focus group Cleveland Municipal Court Probation Department
[21] Focus group Behavioral Health Units at Cleveland Clinic, Lutheran and MaryMount Hospitals
[22] Focus group Educational Service Center of Northeast Ohio meeting of school counselors
[23] Focus group Cuyahoga County Family and Children First Council meeting

Theme 4: Crisis Resolution

Many contributors targeted crisis resolution, specifically, for discussion and focused heavily on impediments to meeting clients' needs. Numerous contributors did not believe the current system sufficiently met the needs of clients because of (a) delays in crisis response, (b) the quality of response provided, and (c) the lack of available treatment options.

1. <u>Delays in Crisis Response</u>
Some contributors argued that mental health crises often involved slow responses by law enforcement and MCT.

> *"Sometimes for mental health . . . because it's not a medical emergency, I have seen where it's a lower priority . . . . If the person is having a mental health emergency and they're violent, then they tend to respond of course more quickly. But if you're just going through a normal episode without violence, sometimes it can take a little bit longer."[24]*

If first responders are unable to stabilize the situation, the next step usually involves removing the client from the scene. Delays often result during the determination of whom will transport the client, especially if the client is a child. For example, a case worker recalled working with a child having an emotional breakdown. The case worker indicated neither she nor a county worker could put hands on the child so she contacted law enforcement. Law enforcement arrived and said they also could not touch the child, so they called EMS. In the end, the only way EMS was able to load the child under his or her own will was to put on the ambulance lights.[25]

Client transport also may be delayed if a client is too violent or poses too much of a danger to themselves or others for family members or friends to do so. Law enforcement is often tasked with transport—but may hesitate if the client's symptoms are not readily apparent. In one situation, a behavioral health provider recognized that an adult client required transport to Lutheran Hospital. Law enforcement was called and eventually dropped-off the client, even though they had expressed their reluctance to do so because they felt they were not the appropriate transporter. Subsequently, the hospital felt that the client did not meet criteria for admission, but the behavioral health provider knew this was incorrect because the client had threatened to shoot pharmacy staff. Subsequently a supervisor called a manager at Lutheran's Psychiatric Unit and in the end the client was admitted.[26]

Additionally, some behavioral health providers believe unnecessary delays are caused by law enforcement officers' lack of understanding of their role in transporting some clients, and this misunderstanding is further compounded by additional misunderstandings surrounding the issuance and enforcement of "pink slips" (or Applications for Emergency Admission).

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[24] Focus group Life Exchange Center
[25] Focus group Beech Brook
[26] Focus group Connections: Health•Wellness•Advocacy

"I had an experience with a police officer and I handed him a pink slip. He had no idea why I was giving him this piece of paper, so I'm like trying to explain to him. Literally he—about two hours later—brought it back to me, because they didn't know what it was."[27]

"Cleveland police department shows up to a very high-risk individual who spent over a year at Northcoast for a very severe assault. His family was frantic in calling the police to get him to the hospital. The police show up and say there is nothing they can do, 'He needs to be pink slipped and that's on the doctor.' And so the family is calling a doctor who hasn't seen the patient in over a year to do a pink slip. Last I checked the Ohio law is that a mall cop can do a pink slip. There's a lot of misunderstanding."[28]

Moreover, if the client must be probated and a judge is required to issue the pink slip, delays in crisis resolution are common, especially if the crisis occurs in the evening or on a weekend.

Family members also cited instances in which MCT and/or law enforcement refused to transport a violent client despite the knowledgeable recommendations of a family member. For example, if the client presents as non-threatening, law enforcement may be prevented by protocol from further action because the client is not actively committing any crime. A daughter described contacting MCT on behalf of her father. He had been attacking her grandmother with a kitchen knife. In the end, MCT would not sign-off for the client to be transported to a mental health facility due to the father's account of what happened—not the daughter's.[29]

Although one of the strengths of the crisis response system often recognized by contributors is the availability of the MCT by phone, delays in crisis resolution regularly result when a behavioral health assessment is needed to determine whether admission to an inpatient psychiatric unit or crisis stabilization bed is necessary. If admission is sought to Northcoast Behavioral Health or FrontLine's crisis stabilization unit, MCT must complete the assessment. Some public hospitals will forgo seeking admission to Northcoast Behavioral Health and admit the client to their own their inpatient unit if the wait time for MCT to perform the assessment is too long.[30] If admission is sought to a private hospital, the hospital usually has its own assessment process.

"There's just a lot of people that fall through the cracks that need hospitalization, whom we can't link with hospitals. We just can't. She's [referring to a client] definitely paranoid and delusional, but not enough to get her anywhere . . . because unless you're wielding your machete at the moment, you're not getting in the hospital, and if you are, you're not going to be there very long and we don't have alternatives."[31]

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[27] Focus group Far West Center
[28] Focus group Southwest General Hospital Behavioral Health Services
[29] Focus group Life Exchange Center
[30] Focus group Southwest General Hospital Behavioral Health Services and Behavioral Health Units at the Cleveland Clinic, Lutheran and Marymount Hospitals
[31] Focus group Cuyahoga County Public Defender's Officer

Delays in the county's ERs also extend crisis resolution. Given the extended wait times in the ERs, many clients and their family members may leave rather than wait for assessment completion and determination of whether or not the client can be admitted to a hospital or crisis unit. This occurs with both adults and children. While it may appear that the crisis has resolved itself, the underlying cause of the crisis has likely gone unresolved, and there may be a recurrence in the future.

"I know there's no place to put them and parents are leaving the ER's and going, after 24, 36 hours, 'Forget this, I'm just going home with my problem.' So we just wear them down until it's not a crisis anymore and that's our treatment and I hate to say that out loud, but that's what happens. We literally wear them down until people are like, 'Okay, forget it, I feel better.'"[32]

If a client requires medical clearance, this often extends the wait times even more. A contributor recalled a client who was very violent and started decompensating in the community. To get him into Northcoast, he had to be medically cleared by the hospital. There were difficulties with the law enforcement in getting him to the hospital. The client agreed to go to MetroHealth Medical Center ER and he sat in the ER for 36 hours, but they were not able to get him into a bed at Metro. There was also no bed available at Northcoast.[33]

Delays also can directly affect law enforcement services elsewhere. If law enforcement transports a client to the ER, often they must wait until assessment completion before leaving to focus on other law enforcement matters.

"Four guys on our shift minimum, we can't sit around for an hour because now you're tying a guy up for that much time and you're running on minimal officers to begin with."[34]

2. Quality of Crisis Resolution

In addition to delays in responding to a crisis, the quality of crisis response also can be problematic. Although the MCT is available to respond to a crisis by phone and refer the client for mental health services, many contributors remained dissatisfied. A common remark was MCT was "not mobile."

"'Mobile Crisis' is a misnomer. They don't go out to clients anymore in my experience."[35]

"It is not as much direct hands-on. It's not as mobile as it sounds."[36]

"I wanna see a mobile crisis team come in, but I actually need them to be mobile. I mean just answering the phone and redirecting you to someone and not physically coming out, they are not helpful."[37]

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[32] Focus group PESP meeting hosted by the ADAMHSBCC
[33] Focus group Cuyahoga County Court of Common Pleas—Mental Health and Drug Court Dockets
[34] Focus group Law Enforcement training for Crisis Intervention Trained (CIT) Officers
[35] Online survey response
[36] Focus group Cuyahoga County's Prosecutor's Officer
[37] Focus group Cuyahoga County's Family and Children First Council meeting

"Just reaching out on the phone doesn't always cut it for all our clients . . . . Someone just calls them over the phone, versus that face to face contact with that professional."[38]

Contributors, however, recognized that they were not aware of the volume of crisis response calls MCT receives each year. In 2017 MCT received 16,064 calls to its adult mobile crisis and child response teams.

Law enforcement indicated that they regularly receive requests from the MCT to check on a client and confirm if an MCT member is really needed on-scene.

"Ninety percent of our calls . . . are Adult Mobile Crisis calling us and saying, 'Hey, I have a person on the other line that we're talking to and they're in a crisis situation, we need the police to respond to do a welfare check or to let us know if it's more than just what we're getting.'"[39]

Some clients also may be hesitant to seek crisis response services because they are wary of the first responder. Due to a lack of understanding about whom clients should contact, many will dial 911 and then face one of a variety of responders ranging from law enforcement and EMS to the fire department or MCT. Clients also are particularly wary of law enforcement first responders, especially if they have a prior criminal record or have had negative experience with law enforcement in the past.

"You see police come, you think trouble, 'I'm in trouble.' . . . . They [consumers] think they're going away [to jail]. . . everybody who's bipolar has some kind of background. It happens because you step out of line too much with the illness. But if the police are just calm, if they bring social workers and there's a mediator, that buffer, I think is what people like."[40]

Many clients acknowledged holding CIT officers in higher regard, yet the number of CIT officers is still limited and there is no guarantee one will be available to assist. Clients argue that a non-CIT officer's presence on-scene could potentially escalate rather than resolve the crisis. One client recounted that she contacted the MCT and they came out with a law enforcement officer. The officer took the client to jail and would not listen to the MCT crisis worker.[41]

Others contributors indicated having law enforcement on-scene can be very beneficial during mental health crises, especially when the crisis involves a child. Law enforcement officers help to ensure that scenes are safe, especially for parents, when a child is assaulting them or exhibiting aggression.[42]

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[38] Focus group Adult Protective Services
[39] Focus group Law Enforcement training for Crisis Intervention Trained (CIT) Officers
[40] Focus group The National Alliance on Mental Illness (NAMI) of Greater Cleveland Support Group
[41] Focus group ADAMHSBCC Monthly Lunch and Learn meeting
[42] Focus group Cuyahoga County Department of Children and Family Services

3. Limited Treatment Options

Contributors argued that there is a lack of treatment options for those in crisis. Sometimes a client's condition does not merit inpatient psychiatric hospitalization or admission to a crisis stabilization bed. The question then becomes, What is the next step? Because there are no other viable options, clients are usually sent home from emergency departments and instructed to follow up with their behavioral health provider. Contributors emphasized a need for proper treatment options available at all times for individuals in crisis.

"[A] person [must] get to the proper place to get proper help."[43]

"The crisis shelter is a great resource for people who don't need to be in the hospital or are reluctant to go to the hospital, but need some support. But the crisis shelter has very limited beds . . . . So if you can't go to the crisis shelter, but you don't need the hospital, then you're just sort of out of luck . . . . If the person you're calling for is homeless, they automatically assume that you're just trying to get them a place to sleep for the night and they will not take you." [44]

CIT officers, in particular, also noted a lack of services to support youth in crisis and their families**.**

"We'll call the county, but the county won't come out; we'll call Mobile Crisis and they won't come out. Even if we take them to the hospital, the hospital is like 'We are not going to do anything with them.' So there's helplessness within even the law enforcement system of first responders. There's nobody there who can actually help."

Additionally, even if the client meets criteria for inpatient hospitalization there may not be a facility with a bed other than a jail or if they are admitted to the hospital the client may be discharged prematurely.

"We're having a lot of overflow from clients who are going to hospitals and getting released or not being taken. So we're picking up the slack in the county jail or the city jails, so a lot of our clients are ending up incarcerated for mental illness."[45]

Many contributors indicated that ERs will discharge clients too soon or that they are not properly assessing the client's mental health needs and ensuring continuity of care.

"It's almost like putting a Band-Aid™ on something instead of resolving . . . . It's temporary. It's just covering it up for a few hours until they release them."[46]

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[43] Focus group Cuyahoga County's Family and Children First Council meeting
[44] Focus group Magnolia House
[45] Focus group Recovery Resource
[46] Focus group Cleveland Metropolitan Housing Authority Police Department

Theme 5: Crisis Intervention Training

While contributors were mixed in their views as to whether they perceived interactions with law enforcement as beneficial during mental health crises, many sang the praises of CIT officers. Cuyahoga County's Crisis Intervention Trained program (CIT) offers an intensive, 40-hour course to law enforcement officers to better equip them for recognizing mental illness, engaging and deescalating someone in crisis and, if appropriate, referring someone to treatment rather than arresting him or her.

"If you ask for a CIT officer to come out and assist you, if they're available,
it's a whole different outcome."[47]

"One of the things we've noticed recently when we have to call the police
for substance abuse related crisis, that they've been taking more of
a supportive stance and less of a punitive one."[48]

An experienced CIT officer observed that it is imperative to get a CIT officer around a client ASAP because they have been retrained to "step back and assess" rather than to "step in to alleviate the threat." He explained he likes to think of a crisis situation as very similar to a hostage one wherein "You don't jump in or you will end up with a dead hostage." He also observed that his CIT training taught him to ask a client, "Are you seeing anyone? Are you taking any mediations?" and he has been surprised that clients readily answer these questions. He explained that once he gets the client talking he can assess whether to transport to St. Vincent's ER or get a family member on the phone. "The families are really great," he said, and "often help to end the incident."[49]

Behavioral health providers noted that interactions between their clients and CIT officers are more positive than with non-CIT officers when their clients are experiencing a mental health crisis. Case workers will now request CIT officers specifically when initiating a call for crisis response.

"We'd always request CIT officers. They always came. They were trained. They felt equipped to
handle it."[50]

"One of our clients was there sleeping out in front, obviously not medicated, so she awoke with one
of the security guards there . . . . They had some words, some pushing and shoving.
They called CMHA police, which is right next door, so they came over. They ended up getting in an
altercation, wrestling her to the ground. So I just kind of stood by. They did what they had to do, put
her in the car, talked to her afterwards and explained what happened, so they said they were going
to take her to St. Vincent's rather than jail, so that whole situation kind of worked itself out.
One of them was a CIT trained officer."[51]

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[47] Focus group Beach Brook
[48] Focus group ADAMHSBCC Behavioral Health supervisors' meeting
[49] Interview Cuyahoga County Sheriff's Department officer
[50] Focus group Northcoast Behavioral Health
[51] Focus group Cleveland Municipal Court Probation Department

Although the CIT training is available countywide, the majority of officers trained to date are employed by Cleveland Division of Police (CDP). One contributor expressed concern about the extent to which CIT training is utilized beyond CDP.

*"With the DOJ's Consent Decree, the Cleveland Division of Police
has a very strong incentive to have the training. The suburban jurisdictions
do not have the same kind of training nor do they have the incentive for the training."[52]*

Contributors also noted that the wider community is not evolving to support the CIT officers' new ways of responding.

*"Asking police to do all of this stuff . . . de-escalate, divert from jail, take people,
if it's deemed appropriate to transport to a medical facility, and then those people
are just dumped back on the street . . . . You're asking the police do something and
make a cultural change and the rest of the community isn't making the change . . . .
The only people required to change under the Consent Decree are
Cleveland Police Department and the agencies have not changed at all."[53]*

Theme 6: High-risk/Chronic Utilizers

The county crisis response system is designed to serve the needs of all clients, yet there are some people who account for a majority of the calls received by first responders. These "high-risk/chronic utilizers" repeatedly interact with the system and frequent the county's hospital ERs. Law enforcement contributors often highlighted that these individuals make up the majority of their calls for crisis response services.

"We're dealing with the same people over and over again."[54]

For these high-risk/chronic utilizers the crisis response system works only as a temporary solution, and they cycle frequently back through the system, because adequate long term resolution has not been found.

*"They kind of drift in and out of agencies and our focus and some people
never get to an agency, they use 911 and ER's as their treatment program."[55]*

Some of these individuals are high-risk/chronic utilizers of the system because they repeatedly experience problems with their medications or periodically run out of their medications altogether. While ensuring clients maintain regularly scheduled appointments with a psychiatrist is not a necessary component of crisis response services, if an individual is experiencing problems with

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[52] Interview Cuyahoga County Sheriff's Department officer
[53] Focus group Cuyahoga County Court of Common Pleas—Mental Health and Drug Court Dockets
[54] Focus group Cuyahoga County Metropolitan Housing Authority Police Department
[55] Focus group PESP meeting hosted by the ADAMHSBCC

their medication and cannot get a timely appointment with his or her psychiatrist within a relatively short period of time, he/she often will end up in crisis.

Law enforcement officers indicated that many of the individuals deemed high-risk/chronic utilizers will stop taking their medication due to side effects or if they think the medication is not working. One officer stated that he has taken the same client to the hospital several times due to problems with his medication and has taken steps to personally inform the ER physician that the individual needs a medication re-evaluation; however, this appears not to have been done. The physician instead prescribes the same medication and discharges the individual from the ER.[56]

Some contributors acknowledged the benefit of the Provider Emergency Services Program (PESP) as a means to address these high-risk/chronic utilizers.

> *"I think that's an excellent meeting because it brings people like myself, who are in nonprofit agencies, to the table with these hospitals, with the people who are in the emergency rooms who are dealing with the situations at hand, and it enables us to provide a certain quality of care for that client. I think that it is probably one of the most effective strategies that has come about . . . . We've been able to keep clients out of hospitals and keep them stabilized in the community."[57]*

Theme 7: Challenging Populations

In addition to high-risk/chronic utilizers, there are other clients that the current crisis response system is not equipped to appropriately handle. These "challenging populations" include violent clients, elderly clients, clients who engage in substance abuse, as well as transitional youth.

Providers in hospital psychiatric units are noticing an increase in the number of aggressive and violent individuals admitted.

> *"There is usually at least one patient in our unit at all times that is a significant risk for violence, so it's definitely changed over the years."[58]*

In the past these psychiatric units were not designed to provide security similar to that provided in jails or detention facilities, but now they are forced to either increase security or not admit violent clients.

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[56] Focus group Cleveland Metropolitan Housing Authority Police Department
[57] Focus group Beech Brook
[58] Focus group Southwest General Hospital Behavioral Health Services

"Over the past five to ten years we have seen increased numbers of patients with high levels of sociopathy, [and] questionable levels of ability to control behaviors . . . that in past years would have gone into the state hospital system, which had been better prepared to deal with some of those issues, because it also served a forensic population. With Medicaid expansion, those patients are no longer eligible in Cuyahoga County so they will end up on a general inpatient unit with frail elderly patients and much more gender diversity. The focus of our work on inpatient services at our hospitals increasingly is just managing behavior as opposed to actually working on treatment, and it's been very frustrating. We've actually had to change the structure of our treatment programs to accommodate more aggressive adults, because we have inadequate capacity for them."[59]

The number of older clients suffering from mental illness also has grown in recent years. This population poses special challenges because many of these individuals are not currently connected with services, and those actually connected with Adult Protective Services may have case workers who are not trained mental health workers. Many of these clients also can become violent and aggressive when experiencing a mental health crisis.

Responding to a crisis for a client who also is using non-prescribed drugs and/or alcohol is also quite challenging. Several focus group contributors noted the lack of services available for someone who is under the influence of drugs or alcohol, especially if the individual is not eligible for Medicaid.

"The wait for drug and alcohol detox is anywhere from two weeks to four weeks and then finding the place is extremely difficult. Who has a bed, who'll take insured versus uninsured, co-morbidity with the mental health, a lot of programs don't want to take mental health and chemical dependency because they don't have the prescribers to monitor the psychiatric medications or they will out-and-out tell people you can't be on any meds in this program."[60]

Contributors indicated that if the individual is under the influence of alcohol or drugs, the MCT will not come out to provide an assessment. As one client described it,

"You put in this call, you give a piece of your story, as erratic as you are probably going to give it, and then the very next question, is 'Have you done any drugs today?' Well, see here's the thing, even if I did do drugs that day, there's a reason why. You see what I am saying? So sometimes even merely asking me, 'Did I do that today?' it's already like, 'To hell with your problem.'"[61]

Contributors also emphasized that crisis response services need to be receptive to clients with co-occurring disorders.

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[59] Focus group University Hospitals Cleveland Medical Center, Department of Psychiatry
[60] Focus group FrontLine Service
[61] Focus group Life Exchange Center

"We need crisis services for persons with substance use disorders who may be in treatment but having a violent outburst or behavioral meltdown, or as a result of relapse or intoxication."[62]

"Mobile crisis won't come out if you think they are under the influence."[63]

Contributors also observed first responders occasionally misinterpret a mental health crisis believing the individual is under the influence of drugs and alcohol when in fact the individual is experiencing a mental health episode.

"[There is an] inability to recognize for years the growing mental health and substance abuse needs of the residents of the county and an insistence on doing more with less. There are any number of continuous improvement efforts that could be made at any level that would make a big impact on the quality of services if only the ADAMHS Board or other constituents made an effort to delve into process improvement."[64]

Providing crisis response services for transitional youth—those between the ages of 16 and 24—can also be challenging. While these individuals do not necessarily require all the child-specific services that would be available to a child and his family, they do require more services than are typically available for an adult.

"You would think that for kids that are in residential, that they'd be teaching those skills. But those are the skills they don't learn, so they come out and they don't actually know how to do Medicaid applications . . . . So you've got a group of people and they're severely mental ill to boot, so I've got a 19-year-old who's been in the system their whole life who doesn't have life skills, has a severe mental illness . . . . They need a little extra support in order to really mange that crisis and be effective in a community setting. They need more triage."[65]

Many of these transitional youth have reached the age of majority but lack the skills and knowledge necessary to navigate their mental health treatment needs, such as applying for and maintaining medical insurance and linking with mental health services. The added responsibilities they must juggle as they age, such as employment, housing and transportation, can create additional stressors. If not linked properly with services and receiving consistent mental health treatment, these transitional youth can quickly become high-risk/chronic users of crisis response services.

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[62] Online survey response
[63] Focus group Women's Recovery Center
[64] Online survey response
[65] Focus group FrontLine Service

Theme 8: Nexus Between Crisis Intervention and Continuum of Care

Contributors discussed the importance of preventing mental health crises and taking the appropriate steps to prevent especially high-risk/chronic utilizers from inadvertently cycling through the crisis response system. Ensuring continuity of care was emphasized repeatedly as a means of improving crisis response services.

"So the way to improve crisis response is to actually do the opposite, improve access to care so you wouldn't need, or you would minimize the need, for crisis response."[66]

"[The system tries] to plug the leak instead of address the problem."[67]

Many contributors argued that continuity of care must be ensured for those individuals discharged from psychiatric inpatient units or crisis stabilization beds. If individuals are not linked with services shortly after discharge, the problems that caused the crisis may simply resurface.

"Do they know the resources? . . . . If all I have is a hammer, everything looks like a nail, so all I know is the hospital and crisis beds, which is great, that's what I am doing, rather than the array of support services that could be available for that youth and family, which may not have anything to do with a hospital or detention home."[68]

Moreover, clients' barriers to accessing continuity of care must be eradicated. Simple things such as transportation to and from medical appointments can be difficult for clients to manage, especially if the client is homeless and/or unemployed. Delays in getting appointments with psychiatrists also can impede continuity of care.

"Take somebody who I know has been chronically homeless, has really disorganized schizophrenia, really doesn't have life skills and is really young. He doesn't have life skills, isn't connected to anybody, really can't handle it for one or more reasons. They're not quite ready because they're not ready to live independently in a group home. Nursing home isn't the right placement. Hospital is not the right placement . . . . Sometimes they go to a homeless shelter and they just cycle, they start cycling."[69]

Contributors cautioned that a quick fix for a mental health crisis should be avoided because the resolution is merely a Band-Aid™, and if the underlying problems are not adequately addressed, the person will continue to cycle through the system. Contributors believe hospitals are too quick to discharge clients and in the absence of additional post-discharge intensive case management services crises will simply reoccur.

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[66] Focus group Southwest General Hospital Behavior Health Services
[67] Ibid.
[68] Focus group Cuyahoga County Family and Children First council meeting
[69] Focus group FrontLine Service

Where we're taking care of our own particular service and then that's all,
the police do the pick up or answer the call and then they drop off to the ER or whatever and then
they're done. The ER does what they do and release and then they're done, and it's got to be a
wraparound to make sure that there are no falls in the cracks,
that people just don't need dropped off, or released from the ER,
at two in the morning with nowhere to go or whatever."[70]

Coordination of mental health services is essential when transitioning someone from inpatient psychiatric hospital or crisis stabilization to the community. Sometimes getting an appointment following discharge with a provider can take months.

"I feel like they make it so you got to go see a doctor to get the meds, and you can fall off your
meds because you got to see the doctor two months later. You can't really get in to see the
doctor."[71]

Some clients, however, will not consistently take their prescribed medications which causes them to become "frequent flyers." They will continue to cycle in and out of the system.[72]

Theme 9: Adult vs. Child Crisis Response Units

Contributors *were* asked their opinion of whether or not crisis response services should be separate for children and adults. Responses varied and there was no clear preference for either a separate or unified system. However almost all contributors acknowledged that training for adult as opposed to child crisis workers must be specialized because the resources and interventions available for each group are vastly different. Usually the services available for children are more extensive and not knowing what is out there impedes workers' abilities to effectively manage the crises.

For those contributors in favor of a separate system, they emphasized the difference in how crisis response services operate for children as opposed to adults and the numerous challenges that may arise when one team is responsible for understanding all of the resources and interventions available for both. They also argued that because available child and adult services and programs are constantly changing, this further impedes a worker's ability to effectively keep up with and navigate a combined system.

"The real skill that's lacking [for a specialist in adult crisis] isn't necessarily
a child/adolescent developmental understanding, it's understanding the system
and the nuances of it."[73]

Some contributors also discussed recent problems with the current unified child/adult response program used by the MCT. High staff turnover and the temporary lack of a staff supervisor were two

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[70] Focus group City of Cleveland Mental Health Response Advisory Committee meeting
[71] Focus group Murtis Taylor
[72] Sheriff's Department Officers with the Cuyahoga County Mental Health Court
[73] Focus group Applewood Center

of the problems identified with the children's unit. Although the MCT had adult workers assist when there was a lack of child workers available, contributors believed that allowing adult crisis workers to respond to a child crisis was ineffective because the workers did not have the knowledge base necessary to adequately resolve the episode.

Contributors in favor of maintaining a unified system similarly acknowledged the importance of specialized training for crisis workers in both adult and child services; however, they emphasized the necessity of integrating services because a crisis often involves more than the client. Understanding the interplay of family dynamics between parents and children is important. Family members also may need assistance with connection to services.

Unified services also were identified as necessary to assist those youth transitioning to adulthood.

> *"It would be better for it to not be so separate, I think unified would be much better, because again you got to keep in mind that everything is in transition, all of a sudden you take a person and you say 'Oh, you're 18, sorry.' They're still not there yet, but you cut them off."*[74]

Theme 10: Language and Cultural Barriers to Crisis Response

Contributors identified a lack of system-wide language translators appropriately trained in mental health terminology as a major barrier to crisis resolution. Language and cultural barriers affect the system's lines of communication and coordination. On short notice, accessing (or not accessing) a translator can cause service delays, interruptions in services, abbreviated services or withdrawal of services. A crisis stabilization unit worker admitted that once they were unable to admit a Spanish-speaking client simply because the unit lacked the means to communicate with them.[75]

> *"[The system] needs to be better prepared to care for clients who are deaf or hard of hearing or speak a language other than English."[76]*

> *"I have experience with one agency that my client wasn't ready to be discharged in my opinion . . . continued incoherence and with serious mental health issues and because they couldn't assess appropriately in HIS language, they let him go. Awful experience."* [77]

Allowing family members or close friends to interpret for a client is not advisable. A case worker for Adult Protective Services indicated that recently a first responder was allowing a family member to interpret for her client who was in crisis. In the end, the worker ended up having her own interpreter assist the client when the situation began to escalate.

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[74] Focus group Beech Brook
[75] Focus group FrontLine Service
[76] Online survey response
[77] Focus group Connections: Health•Wellness•Advocacy

"You're hoping there's a family member there who can translate, but then something might get lost in translation or maybe they're embarrassed because their family is right there, so that's the risk we're dealing with."[78]

While some crisis workers and law enforcement may have ready access to translators via telephone, some contributors felt this was inadequate.

"When it comes to . . . Spanish speaking clients, there may not be a Spanish speaking member on staff. Then they have to rely on phone translations, which again something may be lost in the translation or in conveying the information."[79]

In addition, finding translators who can effectively translate mental health terminologies can add an additional hurdle to effective communication during a crisis.

"So trying to explain to the [translator] what a hallucination or a delusion is and then having them put it in that language, it was almost not worth paying the money to have to go through all that to get them to ask [the client] for a one word 'Yes' or 'No' answer."[80]

Crisis workers and law enforcement also need to be able to distinguish between a person who is agitated and excited versus one who is using hand gestures and/or sign language to communicate. A client recalled an incident in which law enforcement was called to assist at an assault and robbery. Law enforcement misinterpreted the hearing-impaired victim's emphatic sign language as indicating threats of violence. Law enforcement's subsequent aggressive response then triggered a mental health crisis in the victim.[81]

Contributors also underscored that people's backgrounds may impact not only their willingness to seek assistance but how they seek assistance when in crisis. Responders need to develop an awareness and sensitivity that mental illness carries varying degrees of stigma within families, neighborhoods and other social groupings, as well as cross-culturally.

"The cultural barrier is kind of the standard cultural barrier of just how mental health manifests in different cultures and what those behaviors look like."[82]

"A lot of times in the inner city, if a mental health professional is coming out, you know, a lot of people don't wanna even utilize those services because it puts a label on them. So it depends on the neighbors and approach to the family."[83]

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[78] Focus group Cuyahoga County Metropolitan Housing Authority Police Department
[79] Focus group ADAMHSBCC Behavioral Health Supervisors' Meeting
[80] Focus group FrontLine Service
[81] Focus group the ADAMHSBCC Lunch and Learn gathering
[82] Focus group Juvenile Court – Drug Court Docket, Mental Health and Behavioral Health/Juvenile Justice Assessment Teams
[83] Focus group Cuyahoga County Family and Children First Council Meeting

"Someone I know was considering suicide. The fire department and the emergency services were called out, and because she said she was embarrassed, her children were there, and she said, 'No, no thank you.' The fire fighter said . . . 'Then why did you waste our time; we could have been handling a different emergency?'" [84]

"[A client] wasn't supposed to be outside without her head covered . . . and she's asking the police to let her cover herself and . . . they didn't care."[85]

"We also see it with the Muslim population, Arabic, Eastern populations where the traditional western culture of medicine does not fit into their religious beliefs or for example if it's a female who's looking for services, if she's a practicing Muslim, she can't work with a male provider, she can't take certain medications, so just overall lack of culturally sensitive and culturally appropriate services I think for our minority populations is definitely present."[86]

Contributors also mentioned their concerns that first responders may inadvertently stigmatize clients based on their ethnicity, socio-economic standing, and crisis locale, which in turn can affect their response.

"I think given what's going on in our country right now, I think there are some communities that may . . . not even call [for crisis response] because they are afraid what the outcome may be. And given that we did have a situation in our community where . . . a woman did die as a result of a call that she was experiencing a mental health issue. I think it's all depending on your neighborhood, it's all depending on your neighborhood."

"If Tanisha Anderson looked more like you than me, she may still be alive. There's a lot of ignorance, there's structural racism and the allocation of resources."[87]

Theme 11: Resources and Capacity

The need for increased crisis response system resources, more efficient use of resources and capacity improvements also were prevalent themes discussed by contributors. To better illustrate contributors' perspectives, the presentation of these ideas has been divided into subsections.

1. Increased and More Efficient Use of Resources

Contributors argued that the system's structure has numerous weaknesses that could be bolstered by additional well-targeted funding.

"I think the framework is underfunded. I think the bones are there, but there's not enough [resources] to put any meat on it."[88]

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[84] Focus group Life Exchange Center
[85] Focus group Far West Center
[86] Focus group City of Cleveland Mental Health Response Advisory Committee Meeting
[87] Focus group Cuyahoga County Common Pleas Court Corrections Planning Board – Treatment Alternatives for Safe Communities (TASC)
[88] Focus group ADAHMSBCC Suicide Prevention meeting

2. Greater Support of the Mobile Crisis Team

FrontLine Service staff indicated during their focus group that they would prefer to respond more often to crises out in the community, but they do not have the resources to do so. Staff cannot allow callers to the 24-hour crisis hotline to endure long wait times or even have their calls left unanswered.[89]

"[There are] not enough staff for Mobile Crisis. Police do not always respond in a timely manner due to lack of officers on patrol."[90]

Many contributors advocated for more resources for the MCT. The MCT appears overwhelmed with client needs and may not be able to assist them as quickly as they would like to. Mobile crisis is a critical service and many clients call believing they will gain access to immediate services, but due to call volume the hotline often functions more like a warm line.[91]

"Make MCT more mobile."[92]

3. More Psychiatric Inpatient and Crisis Stabilization Beds

Contributors repeatedly mentioned that the existing number of beds restrict client admissions for inpatient treatment.

"It's a long wait when you're making a referral to hospitalize somebody, if you're with the crisis team and you're making a referral, sometimes it takes forever to find the doctor that is going to accept the individual. You could just sit around for hours waiting for the hospital to supply you with that. It's the timeliness of the response, really. That to me is one of the biggest downfalls."[93]

4. Adequate Stabilization Admissions for Eligible Clients

The majority of contributors stressed the importance of the system providing admissions sufficient enough to support adequate stabilization for those eligible for inpatient treatment.

"A person who tries to shoot police officers and has a blood alcohol content of .372 due to being a lifelong alcoholic whose wife has left him and daughter won't talk to him - and he's trying to commit suicide by cop - should not just be released in less than 24 back into the same community because 'he was just drunk.'"[94]

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[89] In 2017 MCT responded to 16,064 calls to its Adult and Child crisis programs, an average of 1,339 calls per month. Additional analyses of MCT data was outside the scope of this project.

[90] Online survey response

[91] Focus group Domestic Violence and Child Advocacy Center

[92] Focus group Cuyahoga County Prosecutor's Office

[93] Focus group Far West Center

[94] Online survey response

5. <u>Adequate Stabilization Services for In-Crisis but Admission Ineligible Clients</u>
There are very few options for clients who do not meet the criteria for inpatient psychiatric hospitalization or a crisis stabilization bed. Contributors recommended the need for additional crisis response services for these clients or in times when these services are unavailable due to lack of bed space. These clients, as well as for those with co-occurring disorders, fall through the cracks. For these clients, an unresolved crisis can further exacerbate their mental health challenges. Central 24-hour crisis assessment hub and intervention centers were mentioned as viable options.

"There is currently no in between." [95]

"We also see a big struggle in the transitions and the program levels of care. So when you're entering into the system in a crisis, you don't always enter into the system at the most appropriate level of care and a lot of that is because of capacity. For example, maybe what you really need is a crisis shelter, but because it is full you end up at the emergency room, which you don't need that level of care, so they're discharging you. So we see a big challenge there in getting folks into the appropriate level of care when they're in crisis, as well as the transition."[96]

These crisis centers would be available to conduct behavioral health assessments, prescribe medication and determine appropriate placement for those in need of more extensive mental health services, but not necessarily at the level of inpatient hospitalization or crisis a stabilization bed.

6. <u>Greater Continuity of Care</u>
Increasing the communication between the MCT, law enforcement, hospitals, and community behavioral health providers also is important to ensure continuity of care. Development of safety plans can help to prevent recurring crises.

*"As a police officer, I feel that when I clear the scene of a person in crisis
I have few options to follow up. I would like to see a resource that will follow up with the person in crisis within 48 hours to attempt to prevent future incidents."[97]*

Multiple systems and players can cause communication to be splintered. A model system would allow for the smooth flow of communication between organizations and systems of care. [98]

7. <u>Expansion of PESP (Provider Emergency Support Program)</u>
PESP meetings occur once a month and are limited to discussing just a few individuals during each meeting. The impact of PESP also is influenced by which agency and hospital providers attend the meetings. Give the large number of high-risk/chronic utilizers noted during the focus groups, it would be beneficial if the program could be expanded to comprise more providers assessing more high-risk/chronic utilizers.

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[95] Focus group Applewood Center
[96] Focus group City of Cleveland Mental Health Response Advisory Committee Meeting
[97] Online survey response
[98] Focus group Domestic Violence and Child Advocacy Center

Online Survey—Measuring Perceptions of the Accessibility and Helpfulness of Crisis Support Services in Cuyahoga County

This needs assessment also employed an online survey focused on the collection of respondents' (n=115) perceptions of the accessibility and helpfulness of crisis support system in Cuyahoga County.

Respondents were asked to indicate whether they felt the response times and accessibility of crisis support services were adequate. Responses were scored on a Likert scale including very adequate, adequate, somewhat adequate and inadequate. A response of "I am unfamiliar with this service" also was included. For reporting purposes, the categories of very adequate and adequate were combined (see Table III).

TABLE III. Responsiveness and Accessibility of Crisis Support Services

Crisis Service	Very Adequate/ Adequate	Somewhat Adequate	Inadequate	Unfamiliar with service	Data Missing
24/7 Crisis Hotlines	59%	13%	8%	19%	1%
Adult Mobile Crisis Teams	41%	16%	16%	26%	1%
Children Response Teams	31%	13%	16%	38%	2%
Adult Crisis Stabilization Units	30%	17%	13%	39%	1%
Children Crisis Stabilization Beds	19%	17%	16%	44%	3%
Psychiatric ED at St. Vincent	56%	20%	9%	13%	2%
Private Hospital/Emergency Room	47%	28%	13%	10%	3%
Law Enforcement	62%	26%	7%	4%	2%
Substance Abuse Crisis Services	28%	19%	21%	30%	2%

Note: Percentage may not total 100% due to rounding

Respondents reported that the most accessible and responsive crisis support services were provided by law enforcement (62%), 24/7 Crisis Hotlines (59%) and the Psychiatric Emergency Department at St. Vincent (56%). Child-related services such as children response teams (31%), adult crisis stabilization units (30%), substance abuse crisis services (28%), and children crisis stabilization beds (19%) were reported by respondents as less responsive and accessible. These survey findings echo those of the focus groups, wherein a lack of crisis stabilization beds and services for those with substance abuse disorders were commonly reported as impediments.

Respondents then were asked if they felt the listed crisis support services were helpful. Responses were scored on a Likert scale including very helpful, helpful, somewhat helpful and not helpful. A response of "I am unfamiliar with this service" also was included. For reporting purposes, the categories of very helpful and helpful were combined. As with services that were accessible and

responsive, crisis support services provided by law enforcement (67%), 24/7 Crisis Hotlines (60%) and the Psychiatric Emergency Department at St. Vincent (54%) also were reported by the respondents as the most helpful. Child related services such as children response teams (36%), children crisis stabilization beds (30%), and substance abuse crisis services (30%) were reported by respondents as less least helpful (see Table IV).

TABLE IV. Helpfulness of Crisis Services

Crisis Service	Very Helpful/ Helpful	Somewhat Helpful	Not Helpful	Unfamiliar with service
24/7 Crisis Hotlines	60%	16%	5%	18%
Adult Mobile Crisis Teams	44%	14%	15%	28%
Children Response Teams	36%	10%	11%	43%
Adult Crisis Stabilization Units	39%	11%	10%	39%
Children Crisis Stabilization Beds	30%	10%	11%	49%
Psychiatric ED at St. Vincent	54%	20%	10%	16%
Private Hospital/Emergency Room	56%	21%	12%	10%
Law Enforcement	67%	25%	4%	4%
Substance Abuse Crisis Services	30%	21%	11%	37%

Note: Percentage may not total 100% due to rounding

The questions about the accessibility/responsiveness and helpfulness of crisis support services were combined to examine whether or not those services reported highest in terms of helpfulness also were accessible. Table V summarizes the results. Law enforcement and 24/7 Crisis Hotlines were reported by respondents as the most helpful, as well as also ranking highest in terms of responsiveness and accessibility. In contrast children crisis stabilization units were identified by respondents as less helpful and also ranked lower in terms of accessibility and responsiveness (see Table V).

TABLE V. Crisis Services Accessibility and Helpfulness Ratings

	% Indicating Crisis Service is Very Helpful/ Helpful	% Indicating Crisis Service is Very Helpful/Helpful who also indicated Response Times/Accessibility of Service is Very Adequate/Adequate
Law Enforcement	66% (n=75)	86.7
24/7 Crisis Hotlines	60% (n=68)	83.8
Private Hospital/Emergency Room	56%(n=63)	74.6
Psychiatric ED at St. Vincent	53% (n=60)	86.7
Adult Mobile Crisis Teams	43% (n=49)	77.6
Adult Crisis Stabilization Units	38% (n=44)	68.2
Children Response Teams	34% (n=39)	71.8
Substance Abuse Crisis Services	29% (n=33)	72.7
Children Crisis Stabilization Beds	29% (n=33)	54.5

Areas of Future Consideration

Contributors to this needs assessment provided valuable insight into the strengths and weaknesses of Cuyahoga County's crisis response services as discussed in the foregoing section. Contributors also raised other system-related topics that lend themselves to future consideration.

Crisis Response Procedures and Protocols

Although contributors were able to identify individual crisis response services available in Cuyahoga County, it was evident across the majority of the focus groups that there exists a wide-ranging lack of clear understanding of the various procedures to employ and/or protocols to follow during crisis response.

"No streamlined process, screening tools or protocol."[99]

"What is the crisis stabilization continuum of care?"[100]

Contributors recommended that a crisis response system protocol be developed and widely communicated to ensure a better understanding of the system, especially by service providers, clients and their family members.

For example, first responders (usually the MCT or law enforcement) are called on to assist a client. While it is unknown how often this occurs, many focus group participants indicated that because the MCT is usually not able to go out into the community that team members will manage the crisis

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[99] Online survey response
[100] Focus group New Directions/Crossroads

over the phone. If the client in crisis is connected with a behavioral health provider, often the MCT will refer the client to this provider for crisis episode resolution. However, the time of day in which such a client experiences a crisis can negatively affect and/or delay crisis resolution. If occurring during regular business hours this procedure may work to quickly and successfully resolve the crisis. If the crisis call occurred during the evening or on weekends, the MCT would need to engage itself and often others more deeply in crisis resolution. Some contributors mentioned that they have or are currently developing their own crisis response services, including services provided after hours and on weekends. It would be useful for the MCT and law enforcement to know which agencies have such services in place.

In another common scenario, if a client's service provider is unavailable another call to MCT often is made. If the crisis is not resolved or de-escalated over the phone to the point where others can safely transport the client, law enforcement usually will transport the client for additional services, usually to the nearest ER. There is one adult psychiatric ER in Cuyahoga County, but whether the client can be taken to it depends on a variety of factors depending on among others client location, medical condition, and discretion of law enforcement.

Once at the ER the decision has to be made regarding whether the client requires inpatient psychiatric hospitalization or placement with a crisis stabilization bed. This determination is usually made after completion of a behavioral health assessment. In many cases contributors expressed a lack of understanding regarding the criteria for either hospital or crisis stabilization bed admission, as well as of exactly which parties are responsible for completing the necessary assessment. If the client is uninsured and admission is sought to Northcoast Behavioral Health or FrontLine's crisis stabilization unit, the MCT is responsible for the assessment. If the MCT is otherwise engaged, assessment delays can and often do occur. For these situations contributors raised procedural and protocol questions, such as, How do we avoid such delays? If admission to other facilities is possible, which facilities are these? What assessments are required? Who is required to complete them?

Additionally, the process to determine whether or not the client qualifies for an inpatient psychiatric unit bed or a crisis stabilization bed also can be lengthy, resulting in the client waiting for hours in the ER. Similarly, given the wait times at many of the county's ERs, clients and their family members may leave before treatment can be arranged and the crisis episode appropriately resolved. If the client is deemed eligible for hospital or crisis bed admission, a bed may not be available and the client will be required to wait even longer for services. Further delays may occur if the client requires a pre-admission medical clearance from an ER physician. Contributors asked, If there are no beds available, if the client is tired of waiting for an assessment to be completed, or if the client is ineligible for inpatient services, what other options are available?

In addition to providing a clearer understanding of crisis response services procedures and protocol, contributors expressed their desire for these to be more widely disseminated.

"There is not enough publicity about these services, except the suicide hotline."[101]

"Make family members themselves more aware of the opportunities and direction to go when they have a family member who needs psychiatric evaluation."[102]

"Somebody came up to me and they're like, 'What's this crisis number and like how do you get a hold of them and how do you sign up and what's it for?' I know I've seen advertisements about suicide hotlines and people think like, 'Oh, it's just if you're suicidal, but not like if there's a psychotic episode' . . . . 'How do I access this?'"[103]

Contributors also raised concern about outdated information.

"Things change so much that by the time it trickles down the line, sometimes the information we have to provide them with is out of date."

Contributors suggested the need for a modern alternative for communicating resource information, such as a mobile phone "app."

"The other thing for kids specifically is, I mean to not have resources mobile on their phone is a bad plan into this day and age . . . What is amazing is on the streets in the community they don't have underwear, but they've got a phone."[104]

Uniformity of Behavioral Health Assessments

Adopting of a uniform behavioral health assessment for crisis episodes was a common recommendation from contributors. Contributors asserted a uniform assessment could be developed that included the majority of the questions that are repeatedly asked across different agencies' assessments. Contributors advocated for greater breadth within one assessment, not more assessments. The assessment could then be updated as the client moves along the pathway toward crisis resolution, which is arguably less time consuming than completing a new assessment each step of the way.

"We need an improved protocol for assessing admission to Northcoast[105]

Currently the MCT is an effective gatekeeper, but if private hospitals had their own assessors this would free up MCT to do more community outreach.
Perhaps social workers in EDs could complete assessments and MCT could review it
for approval, but social workers would remain responsible if an individual did not meet Northcoast's criteria for admission."[106]

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[101] Online survey response
[102] Online survey response
[103] Focus group Jewish Family Association
[104] Focus group Bellefaire Jewish Children's Bureau
[105] Focus group Cuyahoga County Sheriff's Department
[106] Focus group Behavioral Health Units at the Cleveland Clinic, Lutheran and Marymount Hospitals

A uniform assessment also would help to ensure consistent information is obtained from the client and reduce communication barriers between agencies providing treatment. Whether or not a uniform behavioral health assessment is feasible in Cuyahoga County is worth further inquiry.

Crisis Response Integrated Data System

Although outside the scope of this project, complete and up-to-date information about the full extent of the county's crisis response services warrants further exploration. While some data are collected by the MCT and some CIT officers, collaboratively shared information across compatible data platforms appears virtually non-existent. Data from other service providers, such as EMS, EDs and non-CIT law enforcement, are not available to provide real-time or up-to-date information about the full extent of the crisis response system. Information collected could include: (1) the number of crisis service request calls; (2) responding agency/ies; (3) type of response (in-person or by phone); (4) the number of hospital ER visits/admissions for those in mental health crisis, and (5) type of crisis resolution. Among others, these data could support greater evidence-informed, crisis response system policymaking.

"We need to be a village, we need to make sure that we're not just in this bubble." [107]

"From my perspective the biggest problem is the lack of collaboration, the lack of understanding. To use an analogy, we're all in our own little silos, we're not communicating with one another. I think there's a lot of duplicate services that are being provided. People have multiple entries throughout the system and depending on where they're coming into the system, the other parts of that system don't understand or know that, so to your point, people are coming in, but they're just going into a black hole somewhere, I know we have a lot of success stories and that's good, but I think there's just lack of collaboration on just that whole wraparound process." [108]

Data sharing also could augment system efficiency and efficacy. One contributor recalled a case in which a child experienced a crisis during school. Law enforcement was called to the scene and initially wanted to take the child to the detention center, because the child was involved with the juvenile court. The probation officer convinced law enforcement to take the child to an ER, but the ER deemed the child's behavior as psychosocial, not psychiatric, and sent the child home with a safety plan. The child already had a court developed safety plan. What the child required was a behavioral health assessment, but the hospital would not complete one. According to one contributor, there was "an automatic assumption that the child with a juvenile case is acting out behaviorally, not psychiatrically." [109] If data was shared across systems, it could have prevented a duplicate safety plan and the focus could have been more on what behavioral health services the child needed that were not included within the safety plan.

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[107] Focus group Cuyahoga County Metropolitan Housing Authority Police Department
[108] Focus group City of Cleveland Mental Health Response Advisory Committee Meeting
[109] Focus group Juvenile Court – Drug Court Docket, Mental Health and Behavioral Health/Juvenile Justice Assessment Teams

Cross-System Coordination

Contributors were asked whether or not the crisis response system helped to avoid involvement with the criminal or juvenile justice system, and contributors' responses varied.

"If you can get the person at the right time with the right level of service, crisis services absolutely helps keep kids out of DCF, keeps kids out of foster homes and helps keep people out of prison, especially reoffending."[110]

"I feel like once they bring them over to us [psychiatric ER], we can really help and figure out what the psychiatric component and trouble is, so they don't have to take them to jail."[111]

While most contributors recognized the benefit such cross-system collaboration would have, especially if a CIT officer or MCT member was involved, many believed there currently was no impact or difference due to the length of time it took to link a client with mental health services. In some cases, contributors said, it was easier to go the criminal/juvenile justice route despite the negative consequences a criminal record can inflict on a client.

"Often a mom or a dad calls because their child was arrested and they were like, 'We called for help and so we called the police and the police pretty much told us the best thing you can do is arrest and the minute that [car] door closed and they took my kid, I knew I did the wrong thing.' I hear it all the time . . . . And I call and try to help them figure out where their child is and if it's an adult child in jail and try to get the child eligible for the mental health court or whatever . . . . There's not a lot of options to give to them."[112]

"These mental health caseworkers, they're explaining to us, a couple different ones this week, that quit sending them to the hospital, sometimes just arrest them . . . we understand they did something criminal, but at the same time in the field we feel like alright, there's something mental here going on, let's not arrest. And we always were under the interpretation, don't charge them, send them to the hospital because that's what they really need, while the caseworkers are telling us sometimes you've got to charge them, because that gives them a little bit more power over them into maybe forcing their hand into doing what they need."[113]

If the client is violent or aggressive, involvement in the criminal/juvenile justice system may be the only option. Inpatient psychiatric units often do not have adequate resources or staffing to work with these clients.

"The reality is for some of these very violent folks, jail is the only safe place . . . . So ideally those folks would be getting good mental health treatment in a secure jail-like environment. I know people don't want to hear that. They're sick, they belong in a hospital, I get it. But hospitals are not designed for violent people."[114]

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[110] Focus group FrontLine Service
[111] St. Vincent Charity Medical Center, Psychiatric Emergency Department
[112] Focus group Sequential Mapping Initiative Regularly Scheduled Meeting
[113] Focus group Law Enforcement training for Crisis Intervention Trained (CIT) Officers
[114] Focus group Behavioral Health Units at the Cleveland Clinic, Lutheran, and Marymount Hospitals

Staff from the specialty courts, such as mental health courts or drug courts, commented that many times they, not crisis response services, receive referrals for clients in crisis (i.e. first responders often deem the client's behavior psychosocial—not psychotic—due to the client's involvement with the criminal/juvenile system). Specialty court staff believed they were not the appropriate party to respond to the crisis because these clients also suffered from mental illness and crisis workers were better equipped to address these situations. Simply because the client had an active criminal/juvenile court case was not indicative that any behavior at the time of crisis was merely the client acting out. In many cases the underlying cause of the problem was due to a client's mental illness.

Cross-system collaboration among the criminal/juvenile courts and crisis response service providers could help to ensure that clients are referred to the agency better suited to address the crises. Further, if the two systems communicated more efficiently this may reduce or completely eliminate the need for some clients' involvement with the criminal/juvenile system.

Expansion of CIT

In addition to providing more funding for crisis response services, contributors also suggested the need for expansion of existing services or new and innovative ways to respond to crisis. For example, while it was a common theme among the focus group participants to suggest that more law enforcement be trained in CIT, a few others suggested the CIT training be provided to staff at other types of agencies that also provide crisis response services. It also was suggested that all law enforcement receive a very brief introductory CIT course. This could be an overview of crisis intervention, which could include brief testimonials by experienced CIT officers and an abbreviated version of the headset training that simulates what it is like for an actively psychotic client to hear voices. It was argued that this could be done in a couple of hours (while officers wait for availability of the full 40-hour course), and would assist in getting more officers more quickly to step back and ask questions rather than step in and attempt to eliminate a perceived threat which may actually be better understood as part of the client's psychotic behavior.

Conclusion

This needs assessment examined crisis response services within Cuyahoga County. By including the input of a broad range of contributors, major underlying themes emerged characterizing the responsiveness of the entire system in meeting the requirements of clients and their families. Contributors commented on several elements of the crisis response system that are beneficial and effective. These elements include the accessibility of MCT members to respond to crises by phone and the follow-up they provide, de-escalation of client crises by CIT law enforcement, and the collaborative services provided by PESP in addressing and reducing the number of high-risk/chronic utilizers.

While many positive features of Cuyahoga County's crisis response services were identified during this needs assessment, contributors typically highlighted impediments, barriers and opportunities for improvement in the focus groups/interview and survey. Recognized areas of need include among others improving the mobility of the MCT, refining crisis resolution for challenging/high-risk populations, and enhancing the continuity of care for clients when transitioning from a crisis episode.

Contributors also provided insight into ideas to consider in future planning efforts. Throughout this assessment process, contributors described their difficulties in fully understanding how crisis response services operated in the county. The system is large and complicated, and the circumstances of each case influence what pathway is best for resolving a crisis. Widely communicating crisis response procedures and protocols may serve to enhance understanding of this system. Adopting a uniform behavioral health assessment, may also help to reduce delays for clients seeking care during a crisis. Finally, consideration should be given to developing additional stabilization services that could be made available for those clients ineligible for inpatient hospitalization or a crisis stabilization bed. Many contributors advocated for 24-hour crisis intervention units which could provide comprehensive and streamlined crisis triage, assessment, and treatment services, while very likely reducing the number of repeated high-risk/chronic utilizer visits to hospital ERs.

Appendices

A. Acronyms

Acronym/Abbreviation	Definition
ADAMHSBCC	Alcohol, Drug Addiction and Mental Health Services Board of Cuyahoga County
AOT	Assisted Outpatient Treatment
APS	Adult Protective Services
CDJFS	County Department of Job and Family Services
CIT	Crisis Intervention Trained
DCFS	Department of Children and Family Services
DOJ	Department of Justice
ED	Emergency Department
EMS	Emergency Medical Services
ER	Emergency Room
FCFC	Family Children First Council
HIPAA	Health Insurance Portability and Accountability Act
JFS	Job and Family Services
MCT	Mobile Crisis Team
ODJFS	Ohio Department of Job and Family Services
PESP	Provider Emergency Services Program
PRC	Prevention, Retention and Contingency Program
STC	Systematic Text Condensation
TANF	Temporary Assistance for Needy Families
The Begun Center	The Begun Center for Violence Prevention, Research and Education

B. Agencies, Meetings and Support Groups Represented by Focus Group Participants/Interviewee

Cuyahoga County Crisis Response Services Needs Assessment Agencies, Meetings and Support Groups Represented by Focus Group Participants/Interviewee
Regularly scheduled meetings
ADAHMSBCC Behavioral Health Supervisors' Meeting
ADAMHSBCC Lunch and Learn Regularly Scheduled Meeting
Cuyahoga County Educational Service Center (KNA Educational Service Center of Northeast Ohio) Pupil Service Directors Meeting
Cuyahoga County Educational Service Center (KNA Educational Service Center of Northeast Ohio) School Counselors Meeting
ADAMHSBCC Provider Emergency Services Program (PESP) Regularly Scheduled Meeting
Family and Children's First Council Regularly Scheduled Meeting
The National Alliance on Mental Illness (NAMI) of Greater Cleveland Support Group
Sequential Mapping Initiative Regularly Scheduled Meeting
ADAHMSBCC Suicide Prevention Regularly Scheduled Meeting
City of Cleveland Mental Health Response Advisory Committee Meeting
Behavioral Health Agencies/Organizations
Representatives from Behavioral Health Units at the Cleveland Clinic, Lutheran and Marymount Hospitals
Cuyahoga County Common Pleas Court Corrections Planning Board - Treatment Alternative for Safe Communities (TASC)
Cuyahoga County Department of Children and Family Services
Applewood Center
Bellefaire Jewish Children's Bureau
Juvenile Court – Drug Court Docket, Mental Health and Behavioral Health/Juvenile Justice Assessment Teams
Beech Brook – ACT team
Beech Brook – Case Managers
Women's Recovery Center
FrontLine Service – Mobile Crisis Team - two groups
Jewish Family Services
Connections: Health•Wellness•Advocacy - Counselor group
Connections: Health•Wellness•Advocacy - Administrator and Counselor group
Magnolia House
Cuyahoga County Court of Common Pleas – Mental Health and Drug Court Dockets
Life Exchange Center
Southwest General Hospital Behavioral Health Services
New Directions/Crossroads
Recovery Resources
Law Enforcement training for Crisis Intervention Trained (CIT) Officers
Cleveland Metropolitan Housing Authority (CMHA) Police Department
Far West Center
St. Vincent Charity Medical Center, Psychiatric Emergency Department
Sheriff's Department Officers with the Cuyahoga County Mental Health Court
Cuyahoga County Prosecutor's Office
Murtis Taylor – one client group
Murtis Taylor – staff group
Adult Protective Services
Northcoast Behavioral Health
Hitchcock Center for Women
Cleveland Municipal Court Probation Department
Cuyahoga County Public Defender's Office
Cuyahoga County Sheriff's Dept.
Frontline Crisis Stabilization Unit
University Hospitals Cleveland Medical Center, Department of Psychiatry
Interview with CC Sheriff's Department CIT officer
Applewood and Bellefaire Crisis Stabilization Units
Domestic Violence and Child Advocacy Center

**Community Needs Assessment of Cuyahoga County Crisis Services System
Stakeholder Focus Group**

The Begun Center for Violence Prevention Research and Education at Case Western Reserve University is conducting a comprehensive community needs assessment of Cuyahoga County's Crisis Services System. This project is funded by the Alcohol Drug Addiction and Mental Health Services Board of Cuyahoga County (ADAMHSBCC). As part of our needs assessment we are interested in gaining insights from you about the strengths and difficulties of the county's Crisis Services System. In the next series of questions, we will be asking you information on how it operates as well as pointing out any barriers and difficulties you believe impede its ability to meet the needs of persons in crisis. We know that these are broad topics, but we are hoping to learn as much from you as we can. Your insight is extremely important as it will help us provide a more thorough and accurate needs assessment.

We urge each one of you to voice your opinions. There are no right or wrong answers to the questions we pose. The best answer is your honest opinion of how you view the situation. We want to make sure we capture all information discussed during the focus group therefore we will be audio recording it. If you do not wish to be audio-recorded, then you should not participate in the focus group. Your participation is completely voluntary. You can choose to not answer any question or stop answering questions at any time. There is no direct benefit from participating in this focus group and there are no foreseeable risks from participating in the discussion. Your responses will be kept confidential by the researchers, but the researcher cannot guarantee that others in the group will do the same. We are asking participants, however, to treat what is shared in the group as confidential.

The researchers conducting this study are Michelle Riske-Morris and Karen Flynn. If you want to know more about this needs assessment or have questions, please contact Michelle Riske-Morris, by email or phone: (216) 368-4741, michelle.riske-morris@case.edu. If the researchers cannot be reached, or if you would like to talk to someone other than the researcher(s), please contact Case Western Reserve University's Institutional Review Board at (216) 368-4514.

1. The ADAMHS Board has defined crisis as "a situation where an individual's safety and health are threatened by behavioral health challenges, to include mental illness, developmental disabilities, substance use, or overwhelming stressors. A crisis can involve an individual's perception or experience of an event or situation as an intolerable difficulty that exceeds the individual's current resources and coping mechanisms and may include unusual stress in their life that renders them unable to function as they normally would, which may make them a danger to self or others." **Anything you want to add?**

2. How is a crisis responded to in Cuyahoga County? What is, or supposed to be, the crisis service system response process??
    o   Who are these services geared toward?
    o   Who are the key players?

3. Is the current framework for responding to crisis in Cuyahoga County meeting the needs of the clients?
   o Rate on a scale of 1 to 4 with 4 being excellent and 1 being poor?
   o If so, how?
   o If not, what is lacking?

4. What are the impediments/barriers to accessing or utilizing crisis services?
   o Timeliness
   o Accessibility
   o Communication/Coordination

5. Should there be separate versus unified adult/child crisis services?

6. What are the strengths of Cuyahoga's Crisis Services System?

7. Are services culturally and linguistically appropriate for the individuals served?

8. When police are called out to a crisis, how do think clients and families view the police? Are their interactions perceived as beneficial?

9. Does Cuyahoga's Crisis Services System reduce the need for involvement with criminal and juvenile justice systems?

10. How can we improve the crisis services available in Cuyahoga County?

11. What would an ideal or model Crisis Services System look like?

Community Needs Assessment of Cuyahoga County Crisis Services System
Stakeholder Focus Group

The Begun Center for Violence Prevention Research and Education at Case Western Reserve University is conducting a comprehensive community needs assessment of Cuyahoga County's Crisis Services System. This project is funded by the Alcohol Drug Addiction and Mental Health Services Board of Cuyahoga County (ADAMHSBCC). We want to thank you for your participation in the focus group. While we don't need information on what agency or organization you work for or your name, we would like to capture your role/position with the organization and involvement with Cuyahoga County's Crisis Services System.

Job Title	How many times in 2017 have you been involved with or made a referral for crisis services within Cuyahoga County?	How many years have you been involved with or made referrals to Cuyahoga County's Crisis Services System?

CASE WESTERN RESERVE
U N I V E R S I T Y — EST. 1826

Cuyahoga County Crisis Services
ONLINE SURVEY

The Alcohol Drug Addiction and Mental Health Services Board of Cuyahoga County (ADAMHSBCC) is very interested in learning about how ***crisis services in Cuyahoga County support situations where individuals' safety and health are threatened by behavioral health challenges***, including mental illness, developmental disabilities, substance use, or overwhelming stressors. The Begun Center for Violence Prevention Research and Education at Case Western Reserve University (Begun Center) is conducting a comprehensive community needs assessment of crisis services within Cuyahoga County. We are interested in gaining insight from you about your experiences with Cuyahoga County's crisis services, including information on how they operate, as well as barriers and difficulties you believe impede their ability to meet the needs of persons in crisis.

If you choose not to participate, it will not affect your current or future relations with your agency. If you agree to be a participant, we ask you to complete the following online survey. The survey should take approximately 10 to 15 minutes to complete. **Participation in the survey is voluntary, and no one will hold it against you if you decide not to participate. You may refuse to answer any of the questions, take a break, or stop your participation in this survey at any time.** However, if you decide to stop participating in the study, we encourage you to tell the researchers. There are no known risks, harms or discomforts associated with this study beyond those encountered in normal daily life. Potential benefits to agency staff involved in or impacted by Cuyahoga County's crisis services include improved administration and availability of these services, which will directly benefit clients. There will be no cost to you for study participation and you will not be compensated for your participation in this research study.

The records of this research will be kept confidential. Anytime information is collected, there is a potential risk for loss of confidentiality. Every effort will be made to keep your information confidential; however, this cannot be guaranteed. In any report we might publish, we will not include any information that will make it possible to identify a participant. Research records will be kept in a locked file and access will be limited to the researchers, the University review board responsible for protecting human participants, regulatory agencies, and the ADAMHSBCC. The researchers intend to keep the research data indefinitely, because the data are de-identified.

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Crisis as defined by the ADAMHSBCC for this project is "a situation where an individual's safety and health are threatened by behavioral health challenges, to include mental illness, developmental disabilities, substance

use, or overwhelming stressors. A crisis can involve an individual's perception or experience of an event or situation as an intolerable difficulty that exceeds the individual's current resources and coping mechanisms and may include unusual stress in their life that renders them unable to function as they normally would, which may make them a danger to self or others."

1.   Are you familiar with Cuyahoga County's crisis services?

☐ Extremely familiar   ☐ Somewhat familiar   ☐ A little familiar

☐ Completely unfamiliar

2.   How many times in the last two years have you responded to or been involved with crisis support?

☐ 0 times   ☐ 1-2 times   ☐ 3-5 times

☐ 6-10 times   ☐ more than 10 times   ☐ N/A – I'm not involved with crisis services

3.   In your experience, who are you most likely to reach out to first when faced with a crisis? (Choose only one)

☐ 24/7 crisis hotline   ☐ Mobile Crisis Team   ☐ Law Enforcement

☐ Psychiatric ER   ☐ Private Hospital/ER   ☐ Don't Know

☐ Other (please list)_____

4.   Why are you more likely to reach out first to this service?

_____
_____
_____
_____

Do you feel the *RESPONSE TIMES/ACCESSIBILITY* of the following crisis support services are adequate?	I am unfamiliar with this service	Very Adequate	Adequate	Somewhat Adequate	Inadequate
5. 24/7 crisis hotlines	❑	❑	❑	❑	❑
6. Adult Mobile Crisis Teams (RRT)	❑	❑	❑	❑	❑
7. Children's Response Teams (CRT)	❑	❑	❑	❑	❑
8. Adult Crisis Stabilization Units	❑	❑	❑	❑	❑
9. Children's Crisis Stabilization Beds	❑	❑	❑	❑	❑
10. Psychiatric Emergency Department at St. Vincent's Charity Hospital	❑	❑	❑	❑	❑
11. Private Hospital/Emergency Room	❑	❑	❑	❑	❑
12. Law Enforcement	❑	❑	❑	❑	❑
13. Substance Abuse crisis services	❑	❑	❑	❑	❑
14. Other crisis services, please list	❑	❑	❑	❑	❑
15. For any of the above services, you find somewhat adequate or inadequate, we would appreciate your insight, experiences and/or suggestions.					

How would you describe the HELPFULNESS of the following crisis support services in resolving crises?	I am unfamiliar with this service	Very Helpful	Helpful	Somewhat Helpful	Not Helpful
16. 24/7 crisis hotlines	❑	❑	❑	❑	❑
17. Adult Mobile Crisis Teams (RRT)	❑	❑	❑	❑	❑
18. Children's Response Team (CRT)	❑	❑	❑	❑	❑
19. Adult Crisis Stabilization Units	❑	❑	❑	❑	❑
20. Children's Crisis Stabilization Beds	❑	❑	❑	❑	❑
21. Psychiatric Emergency Department at St. Vincent's Charity Hospital	❑	❑	❑	❑	❑
22. Private Hospital/Emergency Room	❑	❑	❑	❑	❑
23. Law Enforcement	❑	❑	❑	❑	❑
24. Substance Use crisis services	❑	❑	❑	❑	❑
25. Other crisis services, please list	❑	❑	❑	❑	❑
26. For any of the above services, you find somewhat helpful or un helpful, we would appreciate your insight, experiences and/or suggestions.					

27. From your perspective, what are the major strengths of Cuyahoga County's crisis service system?

_____
_____
_____
_____

28. From your perspective, what are the major weaknesses with Cuyahoga County's crisis service system?

_____
_____
_____
_____

29. From your perspective, what changes do you believe would improve Cuyahoga County's crisis service system?

_____
_____
_____
_____

30. In your opinion should crisis services be separate for children and adults? Why or Why not?

_____
_____
_____
_____

RESPONDENT BACKGROUND

31. What is your job title?

☐ Case Manager   ☐ Counselor   ☐ Physician/Doctor ☐ Social Worker

☐ Administrator   ☐ Judge   ☐ Court Staff   ☐ Psychiatrist/Psychologist

☐ Nurse   ☐ Teacher   ☐ Advocate   ☐ Attorney

☐ Client/Client   ☐ Police/Sheriff/Jail ☐ Program Director ☐ Other (please list)_____

32. Who do you work for?

- [ ] ADAMHSBCC
- [ ] Cuyahoga Court of Common Pleas
- [ ] Municipal Court
- [ ] Hospital/Medical Center
- [ ] Behavioral Health Provider
- [ ] County Agency/Dept.
- [ ] School/District
- [ ] Client/Client Advocacy Group
- [ ] Jail/Correction Facility
- [ ] Adult/Child Care Facility
- [ ] Police/Sheriff's Department
- [ ] Other (please list)_____
- [ ] Self-employed
- [ ] Not currently working/unemployed
- [ ] retired

33. How long have you been at your current job with this agency?

- [ ] less than 1 year
- [ ] 1-2 years
- [ ] 3-5 years
- [ ] 6-10 years
- [ ] more than 10 years

Cuyahoga County Crisis Services
ONLINE CLIENT OR FAMILY MEMBER SURVEY

The Alcohol Drug Addiction and Mental Health Services Board of Cuyahoga County (ADAMHSBCC) is very interested in learning about how ***crisis services in Cuyahoga County support situations where individuals' safety and health are threatened by behavioral health challenges***, including mental illness, developmental disabilities, substance use, or overwhelming stressors. The Begun Center for Violence Prevention Research and Education at Case Western Reserve University (Begun Center) is conducting a comprehensive community needs assessment of crisis services within Cuyahoga County. We are interested in gaining insight from you about your experiences with Cuyahoga County's crisis services, including information on how they operate, as well as barriers and difficulties you believe impede their ability to meet the needs of persons in crisis.

If you agree to be a participant, we ask you to complete the following online survey. The survey should take approximately 10 to 15 minutes to complete. **Participation in the survey is voluntary, and no one will hold it against you if you decide not to participate. You may refuse to answer any of the questions, take a break, or stop your participation in this survey at any time.** However, if you decide to stop participating in the study, we encourage you to tell the researchers. There are no known risks, harms or discomforts associated with this study beyond those encountered in normal daily life. Potential benefits to individuals involved in or impacted by Cuyahoga County's crisis services include improved administration and availability of these services, which will directly benefit clients. There will be no cost to you for study participation and you will not be compensated for your participation in this research study.

The records of this research will be kept confidential. Anytime information is collected, there is a potential risk for loss of confidentiality. Every effort will be made to keep your information confidential; however, this cannot be guaranteed. In any report we might publish, we will not include any information that will make it possible to identify a participant. Research records will be kept in a locked file and access will be limited to the researchers, the University review board responsible for protecting human participants, regulatory agencies, and the ADAMHSBCC. The researchers intend to keep the research data indefinitely, because the data are de-identified.

The researchers conducting this study are Michelle Riske-Morris and Karen Flynn. If you want to know more about this needs assessment or have questions, please contact Michelle Riske-Morris by email or phone: (216) 368-4741, michelle.riske-morris@case.edu. If the researchers cannot be reached, or if you would like to talk to someone other than the researcher(s) about; (1) questions, concerns or complaints regarding this study, (2) research participant rights, (3) research-related injuries, or (4) other human subjects' issues, please contact Case Western Reserve University's Institutional Review Board at (216) 368-4514 or write: Case Western Reserve University; Institutional Review Board; 10900 Euclid Ave.; Cleveland, OH 44106-7230. By clicking the "accept" button you are certifying that you are at least 18 years of age; you have read the information provided above; you have received answers to all of your questions and have been told who to call if you have any questions; you have freely decided to participate in this survey; and you understand that you are not giving up any of your legal rights.

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situation as an intolerable difficulty that exceeds the individual's current resources and coping mechanisms and may include unusual stress in their life that renders them unable to function as they normally would, which may make them a danger to self or others."

5. Are you familiar with services available in Cuyahoga County to help a person in crisis?

☐ Extremely familiar ☐ Somewhat familiar ☐ A little familiar

☐ Completely unfamiliar

6. How many times in the last two years have you or a family member responded to or been involved with crisis support?

☐ 0 times ☐ 1-2 times ☐ 3-5 times

☐ 6-10 times ☐ more than 10 times ☐ N/A – I have not been involved with crisis services

7. In your experience, who are you or a family member most likely to reach out to first when faced with a crisis? (Choose only one)

☐ 24/7 crisis hotline ☐ Mobile Crisis Team ☐ Police

☐ Psychiatric Emergency Room ☐ Hospital/Emergency Room ☐ Case Worker

☐ Other (please list) _____

8. Why are you more likely to reach out first to this service?

_____
_____
_____
_____

9. Do you feel the *response times* of crisis services are adequate?

☐ Very Adequate ☐ Adequate ☐ Somewhat Adequate

☐ Inadequate ☐ I am unfamiliar or have not used these services

10. If you felt services were somewhat adequate or inadequate, we would appreciate your insight, experiences or suggestions.

_____
_____
_____
_____

11. How would you describe the *helpfulness* of support services in resolving crises?

☐ Very Helpful   ☐ Helpful   ☐ Somewhat Helpful

☐ Not Helpful   ☐ I am unfamiliar or have not used these services

12.   If you felt services were somewhat helpful or not helpful, we would appreciate your insight, experiences or suggestions.

_____
_____
_____
_____

13.   When involved in a crisis, do you believe the individuals responding to the crisis treated you or your family member with respect?

☐ Very much   ☐ Somewhat   ☐ A little bit

☐ None/Not at all   ☐ I am unfamiliar or have not used these services

14.   When police are called out to a crisis, are their interactions perceived as beneficial?

☐ Very much   ☐ Somewhat   ☐ A little bit

☐ None/Not at all   ☐ I am unfamiliar or have not used these services

15.   If you felt services were somewhat beneficial or not at all, we would appreciate your insight, experiences or suggestions.

_____
_____
_____
_____

12. What are some positive outcomes of crisis services in Cuyahoga County?

_____
_____
_____
_____

13. What are some barriers to crisis services in Cuyahoga County?

_____
_____
_____
_____

14. From your perspective, what changes do you believe would improve crisis services in Cuyahoga County?

_____
_____
_____
_____

15. In your opinion should crisis services be separate for children and adults? Why or Why not?

_____
_____
_____
_____

16. When contacting crisis services, have the services been for you or a family member?

☐ Myself   ☐ A family member   ☐ Both myself and my family

☐ A friend   ☐ I am unfamiliar or have not used these services