**10.16.19 Notes on Crisis Services Subcommittee: MH Working Group**

The members of our subcommittee represent law enforcement, people with lived experience, and the provider community. Coming from these three very different communities we all were in immediate agreement that the crisis system in Maine today is not meeting the needs of the community. There are many concerns and issues that we all see on a regular basis.

First and foremost, there is not a guide to crisis resources in communities across the state. Where are the CSUs located and can someone just go there? Can police bring someone there? How do you get mobile crisis to come to your home? These are the questions that many consumers and law enforcement have all the time.

A second major point is that crisis is a level of care and not just a coordination of services. Crisis hotlines are defined as “a direct service delivered via telephone that provides a person who is experiencing distress with immediate support and/or facilitated referrals. This service provides a person with a confidential venue to seek immediate support with the goal of decreasing hopelessness; promotes problem-solving and coping skills; and identifies persons who are in need of facilitated referrals to medical, healthcare, and/or community support services” (SAMHSA, 2012).

Yet it seems that crisis hotlines are not providing a “direct service” many times. The caller is primarily assessed as to whether they are going to harm themselves or someone else (are you suicidal or homicidal?). If your crisis falls short of that, you are referred to call a list of providers to try to get an appointment. If it seems you are still in need of crisis support, they often simply tell you to go to the ED or meet the mobile crisis unit at the ED.

When the prior administration put crisis services out to RFP – the RFP was not built with any provider or consumer input and lacked an understanding of the clinical and community realities of delivering crisis services. It was not outcomes focused nor understanding of the diverse geographic disparities across our largely rural state. After the new contracts began, the system was shifted to a FFS system in April of 2018 that pays for services provided after the fact, but does not maintain the infrastructure to be prepared to respond as needed in a crisis. Much akin to only paying a fire station after it puts out a fire, but then not maintaining the staff and infrastructure so that it is ready for the next one.

**Recommendations from our discussion:**

1. A review of the system is warranted – not just the call and response statistics but the actual crisis interface service. We need to seek feedback from those with lived experience and law enforcement as to what is happening at the community level across the state.
2. Information about the current system needs to be collected and disseminated. (How many CSUs are there and where? How to activate a mobile unit? Who is the local crisis services provider?)
3. Suggestions to explore:
   1. How do we add more peer support into the system? Can there be warm handoffs from the crisis call to peer supports?
   2. How can we enhance the crisis response service itself?
      1. Can crisis response do more therapeutic intervention in the moment as well as refer?
      2. Can we rely on telemed services to do a warm handoff to a therapist for immediate follow up?
   3. Can we think up ways to get information into the hands of the law enforcement that may show up at a crisis call such as medical alert wrist bracelets people could choose to wear with information such as “who to call in a crisis” or “how to help me feel safe”?
   4. Should there be a separate system for youth and adults in crisis?