Health Equity Considerations for a Crisis System

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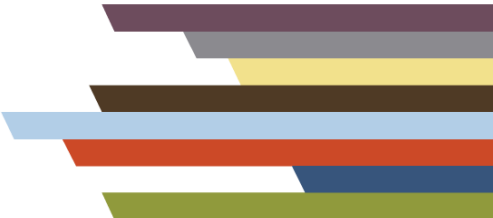

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Introduction

In the U.S., national discourse on the development of an improved crisis response system has been growing, but not enough attention has been placed on the importance of creating an equitable system. The *Roadmap to the Ideal Crisis System*[1] highlights a few strategies; however, there is a general lack of understanding about how to move the system towards equity. The challenge of building an equitable crisis system is that localized systems across the country are trying to build a crisis system that is effective and economically sustainable. The fundamental problem is that without a large system to model, smaller-scale crisis systems are riddled with inequity and significant effort is required to integrate equitable practices into the existing systemic frameworks. Education, criminal justice, and social welfare are all systems that people are pushing to be more equitable. Our challenge today is to **start** with equity as we seek to design the ideal crisis system.

Providing a step-by-step guide on ensuring diversity, equity, inclusion, and accessibility is not feasible because crisis response systems vary greatly by county, region, and state. However, we must acknowledge that eliminating behavioral health disparities and moving toward equity in a crisis response system is not a check-the-box endeavor. Implementing a standard set of recommendations is not enough to eliminate health disparities. Designing, implementing, and managing a crisis response system is arguably the toughest work in behavioral health.

Excerpts on equity from Roadmap to the Ideal Crisis System

> *Diversity within the community and the presence of racism, micro-aggressions and differential treatment of communities' members based upon race, language, housing status, prior contact with law enforcement and other differences may trigger biased assumptions by responders. The structure and set-up of crisis services can help diminish the impact of bias on those in crisis (p. 131).*

> *Team diversity: The team should reflect the ethnic, cultural, and linguistic composition of the community served and have access to translators for any anticipated need, including American Sign Language (ASL) (p. 125).*

> *Appreciate diversity (p. 132).*

Peer Support & Trauma-Informed Care

It is important to acknowledge the *Roadmap* includes essential elements, such as peer support and trauma-informed care. Multi-disciplinary teams should include peer support providers and peer support should be an integrated part of the crisis services continuum. Peers offer an excellent

[1] Roadmap to the Ideal Crisis System - National Council for Mental Wellbeing (thenationalcouncil.org)

opportunity to ground crisis work with lived experience and present a potential strategy to enhance diversity, equity, and inclusion efforts. However, only including peers is not enough. In addition to having the organization prepared to employ and support peer workers, there needs to be consideration for employing peers from various races/ethnicities and backgrounds. This requires continuous work to ensure recruitment and hiring practices are inclusive and equitable.

Trauma-informed care was another component discussed in the *Roadmap* and has become somewhat of a standard recommendation in behavioral health. According to Sweeney et al., "Trauma-informed practices understand that the fundamental operating principles of coercion and control in mental health services can lead to (re)traumatization and vicarious trauma. Deliberate steps are taken to eliminate and/or mitigate potential sources of coercion and force, and accompanying triggers."[2] What is not often discussed or recognized is the importance of addressing implicit bias to effectively implement trauma-informed practices. For example, some may automatically think when they hear a Black man talk about experiencing police brutality that he must not have *complied* with the officer's request or he must have done something that warranted the brutality. This is a salient point for those crisis response systems that work closely with law enforcement. An equitable, trauma-informed crisis response system must be prepared to identify traumatic triggers and must rely on established evidence-based practices when providing care to individuals who may have had traumatic experiences with law enforcement and other service systems.

While peer support and trauma-informed care are important strategies to address diversity, equity, and inclusion and eliminate behavioral health disparities, crisis response systems that do not adopt a health equity lens will continue to victimize and traumatize marginalized groups of people and perpetuate existing health disparities.

Health Equity Lens

A health equity lens can be defined as "strategically, intentionally, and holistically examining the impact of an issue, policy, or proposed solution on underserved and historically marginalized communities and population subgroups, with the goal of leveraging research findings to inform policy."[3] Within the context of a crisis system, policy refers to the decisions made that guide both the funding and structure of the response system. The health equity lens challenges us to intentionally think critically about the crisis response system. This lens is a series of questions to consider during the design and implementation of the crisis response system:

Who is positively impacted by the crisis response system?

Who is negatively impacted by the crisis response system?

Are certain groups not accessing the crisis response system?

Who is facing barriers to receiving services from the crisis response system?

Are people being traumatized/retraumatized by the services within the crisis response system?

Is our crisis response staff reflective of our community?

What is the public perception of the crisis response system?

Is the crisis response consistent across race/ethnicity/gender?

Do all areas of the community have equitable access to a crisis response?

Are translation services available for non-English speakers or those with limited English proficiency?

The first step to addressing disparities within the crisis response system is to identify them. Identifying the issues and creating solutions with those affected is critical to promoting equity. It's also important to note this is not an exhaustive list of questions that can be used to create a health equity framework.

[2] A paradigm shift: relationships in trauma-informed mental health services | BJPsych Advances | Cambridge Core
[3] Applying a Health Equity Lens to Evaluate and Inform Policy - PMC (nih.gov)

Rather, these questions encourage critical examination of the crisis response system and prompt intentional consideration of groups who may feel ostracized by the system, may feel the system is inaccessible to them, or who may have had negative experiences within the system. They provide opportunities to begin identifying issues, noticing gaps in services and data, and then start laying the groundwork for implementing strategies to address disparities.

What if you do not know the answer to these questions?

It is critical to acknowledge that a health equity lens may cause you to ask questions that you do not know the answer to. Or worse, you may ask a question and assume the answer. The point of the lens is for us to think critically and ask ourselves tough questions about the crisis response system. If you "think" or "assume" all groups have equal access to the system, go ask those marginalized groups. Not sure what the community's perception is on your crisis response system? Go ask community members from diverse backgrounds. Listen to what people are telling you and use that information to inform your crisis response system.

Culturally and Linguistically Appropriate Services (CLAS) Standards

The U.S. Department of Health and Human Services has developed the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. When applied to the crisis response system, these standards offer a way to improve the quality of services for all people and reduce behavioral health disparities. The principal standard is to "provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs."[4] The other 14 CLAS standards are classified under the themes of governance; leadership and workforce; communication and language assistance; and engagement, continuous improvement, and accountability.

"The provision of health services that are respectful of and responsive to the health beliefs, practices, and needs of diverse patients can help close the gap in

Cultural Competency

Cultural competence is defined by the American Psychological Association as the "ability to understand, appreciate, and interact with people from cultures or belief systems different from one's own.[5] While there is much discourse about cultural competence vs. cultural humility vs. cultural proficiency—the more critical discussion is how we effectively work with individuals from cultures other than our own within a crisis response system. As previously discussed, implicit bias can be a barrier to providing trauma-informed response care, and it can also be a barrier to cultural competence.

Learning about yourself and other cultures, interacting with diverse groups, and getting formal training on diversity-related issues in clinical practice are all ways to develop cultural competence[6]. Addressing implicit bias is critical to moving beyond one's own cultural superiority to see the strengths and values in another's culture.

Linguistic Competency

A noted challenge for crisis response systems is implementing and sustaining linguistically appropriate services. While it would be ideal to always have multi-lingual staff members available to provide care in languages other than English, a much more realistic expectation is to have immediate

[4] What is CLAS? - Think Cultural Health (hhs.gov)
[5] In search of cultural competence (apa.org)
[6] How do I become culturally competent? (apa.org)

access to interpretation and translation services. Crisis staff should be trained to effectively use these different technologies and services with clients,in addition to having training on working with an interpreter. These services should also be offered when the crisis response is mobile (either through the phone or video using a tablet). Linguistic competency is a challenge, but intentionally addressing this vital need can help to promote an equitable crisis system.

Social Determinants of Health

The Social Determinants of Health (SDOH) are "non-medical factors that influence health outcomes."[7] They are the conditions in which people are born, grow, work, live, age, and worship, combined with the overlapping social structures, political systems, development agendas, policies, and economic systems that overall affect a person's quality of life outcomes. Disparities across these areas can also be a major cause of health inequities, particularly when populations do not have equal access to imperative resources. These circumstances (i.e., social determinants) are believed to drive many deep-rooted world health inequalities, such as lower life expectancy, higher rates of child mortality, and greater burden of disease among disadvantaged populations. Other examples of SDOH include but are not limited to racism, sexism, homophobia, ableism, xenophobia/nationalism, education disparities, income inequality, housing insecurity, transportation access, health systems and services access, social isolation, food insecurity, unemployment, and public safety concerns."[8] Within this definition, it is important to recognize the Social Determinants of Mental Health which are "the more nuanced factors that influence an individual's emotional and psychiatric well-being." Insufficient food, inadequate housing, lower socioeconomic or social status, lower educational levels, trauma, and challenging environmental conditions are among the factors associated with worse individual and community health and well-being."[9]

While it is easy to cognitively understand the importance of the multitude of factors that contribute to one's health and wellness, it is more challenging to take these into consideration during a crisis response. A framework that many behavioral health professionals are familiar with and can start to help a crisis response system address the SDOH is Maslow's hierarchy of needs. Often visualized as a triangle, the hierarchy of needs begins with a base of physiological needs, followed by safety, love and belonging, self-esteem, and at the top is the need for self-actualization. According to Maslow's theory of human motivation, which this hierarchy is based on, when a need is substantially met, an individual will move on to the next need. While a crisis response system cannot address any of these needs fully, the hierarchy provides a way to begin to address them within a crisis response.

- ✓ *Can a warm meal and shelter prevent an individual from needing psychiatric admission to a hospital (physiological needs)?*
- ✓ *Can a conversation with a mental health professional help an individual feel safe (safety need)?*
- ✓ *Can a conversation with a peer support worker help someone feel connected and not alone (belonging need)?*

A crisis response system cannot account for all of the SDOH, but it can start to think about addressing these basic human needs as part of the response. Being aware of local resources and developing working partnerships with a variety of providers can strengthen the crisis system to help meet the needs of individuals in crisis.

Stigma

Addressing stigma is another major area that requires consideration to promote diversity, equity, and inclusion within a crisis response system. Stigma can keep people from accessing this critical, life-

[7] Social Determinants of Health at CDC | About | CDC
[8] What is a social determinant of health? Back to basics - PMC (nih.gov)
[9] Social Determinants of Mental Health: Where We Are and Where We Need to Go - PMC (nih.gov)

saving system, and similarly, it also prevents individuals from achieving the most equitable care. The American Psychiatric Association defines different types of stigma as follows:

- ***Public stigma*** *involves the negative or discriminatory attitudes that others have about mental illness.*
- ***Self-stigma*** *refers to the negative attitudes, including internalized shame, that people with mental illness have about their own condition.*
- ***Institutional stigma*** *is more systemic, involving policies of government and private organizations that intentionally or unintentionally limit opportunities for people with mental illness".*

A crisis response system needs to address public stigma by accurately describing the services provided and how people can access appropriate help. A crisis may not always be suicidal ideation with intent. It's important the public is aware that help is available and what services are offered; otherwise they won't know where they can receive services if they or someone they love are in crisis. Without this knowledge, stigma about behavioral health services can be a barrier. For example, does the public think involvement with the crisis system will automatically include involvement by law enforcement? Does the public believe local facilities are unsafe due to misconceptions about mental healthcare? An equity-focused crisis response system can help dispel myths to decrease stigma and increase access.

Institutional stigma needs to be addressed through policy and modeling effective practice. Are there policies and procedures in place that dictate a certain course of treatment without concern for context? Are people treated differently if brought in by law enforcement than if they came in with family? Do individuals who are there involuntarily understand the rights they have? Addressing institutional stigma can help us create a more equitable response system while also promoting trauma-informed care.

Design Thinking

Design thinking is a human-centered approach to design.[10] While this brief is not able to go deep into all the components of design thinking, there are a few key elements that can help design an equitable crisis response system. Empathizing involves placing yourself in the shoes of those receiving services, especially when considering the experiences of those in marginalized communities. From the initial contact through the full response, a crisis system should always be asking: What are the needs of people, and how does the response meet those needs as defined by the individual? It cannot be overstated; we must see the need from the person's perspective to meet that need. The final two steps in the design thinking process involves prototyping and testing solutions. A crisis response system should be willing to learn from their own experiences and the experiences of others. To create equitable solutions, a system embrace must change and be prepared to redirect efforts when and if current methods are not working. Deciding on a solution and then keeping it in place, even if it is not working, is part of what perpetuates inequity.

> ***Design thinking can help us understand the experiences and needs of those groups who experience behavioral health disparities and create solutions to meet their needs.***

[10] What is Design Thinking? | IxDF (interaction-design.org)

Want to learn more about advancing behavioral health equity?

This brief hopes to illuminate some key considerations for advancing health equity within a crisis response system. It is not a full guide on addressing equity, diversity, and inclusion within the system. Designing, implementing, and managing a crisis response system is naturally difficult. However, starting with a focus on equity can help create a system that is responsive to the diverse individuals in our communities. Instead of trying to build a crisis response system and then rework the system to be diverse, equitable, and inclusive, we must be intentional about developing equity as part of the design. If you are not sure where to start, begin by looking at the data available and apply the health equity lens. Meet with groups who may not be accessing the crisis response system or who have had negative experiences to get their perspectives. Whatever your next steps are, make sure you remember that we are all learning how to build and provide a crisis response system that is equitable.

For more information, check out these resources:

- Health Equity, Diversity, and Inclusion Readiness Toolkit: A series of curated resources to educate and guide behavioral health professionals to create equitable systems.
- Health Equity, Diversity, and Inclusion More than a Checklist: Builds on the previously mentioned toolkit that builds a framework for advancing behavioral health equity.
- MHTTC National Coordinating Office's Racial Equity and Cultural Diversity Resource Collection
- Southeast MHTTC: Crisis Care Guide: Mental Health Equity in Underserved Populations

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