“…That's the fear of every parent that has to call the police…”:

Preliminary Qualitative Findings of the Community Engagement Committee of Jackson County

A Working Group of the Crisis Response Network

July 29, 2022

Table of Contents

***Summary*..... 1**
***Top Level Findings*..... 5**
***Hypothesis #1: Involuntary Commitment*..... 12**
***Hypothesis 2: Housing*..... 18**
***Hypothesis 3: Values*..... 26**
***Hypothesis 4: Biases and Discrimination*..... 41**
***Hypothesis #5: Law Enforcement*..... 48**
***Methodology*..... 60**
***Works Cited*..... 64**
***Appendix A: Codebook*..... 65**
***Appendix B: Coding Visualizations*..... 74**
***Appendix C: Listening Session Prompts*..... 77**

Summary

The Community Engagement Committee (CEC) is at the heart of the transformation of the current Behavioral Health system.

The purpose of the CEC is to gather input from those who use the crisis systems (aka "the community") and provide that feedback to the Crisis Response Network (CRN) Planning Committee to be used in the design of the system that provides services to those in mental health or substance-use crises. The CEC also offers feedback on any large proposals within the CRN, providing a mechanism to include community voices in system design and policy decisions.

In the wake of high-profile tragic incidents in which individuals who were experiencing mental or behavioral health crisis died during interactions with law enforcement officers, many people and even federal guidance has called for the creation of non-police crisis response services. These services would include someone to call, someone to show up, and somewhere to go. Such services, often modeled on the CAHOOTS program in Eugene and Springfield, Oregon, are launching around the country, and residents of Jackson County have understandably called for the creation of such services locally. Doing so is not a simple task, however, and must be carried out thoughtfully, based on input from community members, and designed in a robust and sustainable manner. Jackson County faces many somewhat unique challenges, including the need to serve residents in highly rural communities and to respond to the needs of a large population of unhoused and other vulnerable populations.

Terms and phrases like "crisis stabilization center," "behavioral health," and "mobile response," can seem strange or confusing at first. A few of the terms that are used throughout this report include:

Behavioral Health: a general term used to refer to both mental health and substance use (SAMHSA-HRSA Center for Integrated Health Solutions, 2015).

Crisis: any situation in which a person's behavior puts them at risk of hurting themselves or others and / or prevents them from being able to care for themselves or function effectively in the community (NAMI, 2018).

Crisis Stabilization Center: somewhere to go during a crisis. A Crisis Stabilization Center provides short-term observation and crisis stabilization services and referrals in a welcoming, non-hospital environment, and is one of three core components of effective crisis services (SAMHSA, 2020)

Mobile Crisis Response: a team of people available to reach any person in the service area in a timely manner. Sometimes also referred to as "crisis mobile team response" or similar, mobile crisis response is one of three core components of effective crisis services; mobile crisis response is the "someone to show up" portion of services (SAMHSA, 2020).

988: sometimes referred to as a regional crisis call center, 988 is the phone number to call or text when someone is experiencing a behavioral health crisis. Trained operators in the local region will provide support remotely, and connect people to the most appropriate resources available, such as mobile crisis response where possible. 988 is one of three core components of effective crisis services (SAMHSA, 2020).

In January 2022, the CEC held a series of three Listening Sessions online, inviting people to contribute their past "lived experiences" and ideas for future systems. Over 40 individuals attended those events, participating in small breakout groups led by trained facilitators who asked questions of the groups like, "Tell us how you want this system to work and what you

need from crisis services. What do you need from a crisis response system?" and "If you were to envision new crisis response services, do you have any thoughts of what principles and values you would like to see incorporated?" With permission from participants, those discussions were recorded and transcribed. Participants in these sessions included individuals with lived experience of crisis, parents or caregivers of individuals who have lived thought crises, and people who work in adjacent systems such as schools, libraries, and social services.

Alongside that series of Listening Sessions, CEC member Tracy Owen, a NAMI trained peer to peer teacher, has conducted one on one interviews to collect stories and testimony from individuals about their past experiences of crisis or crisis services in Jackson County.

Together, those interviews and the transcripts from listening sessions make up our current qualitative data regarding the needs and experiences of individuals in Jackson County. The following document represents several months of collective effort to systematically review and digest those stories and perspectives and formulate them as lessons to learn and recommendations for the design of new or expanded crisis response systems in Jackson County.

Finally, it is worth keeping in mind that all of the members of the CEC come to this work with their own experiences of crisis. Most members have either lived through mental or behavioral crisis themselves, or have been a caretaker for a family member living through crisis, or both. This means that the CEC are themselves community members working to center the experiences of community members in the design of crisis services. It also means that hearing the experiences that people share with the CEC can, at times, be triggering or re-traumatizing, and that at other times hearing those experiences can be cathartic or healing. In reflecting on these experiences thus far, CEC members identified two quotations from the interviews which resonated with their experiences seeking help in existing systems:

"…Individuals suffering from the mildest forms of mental illness may receive treatment while those with more intractable illnesses are left to fend for themselves. It is shameful."

"…He does not do drugs. He will drink. Because the dichotomy between where he would [have] thought he would be at this age and where he is now is very hard for him to handle…"

CEC members highlighted these quotations, although they do not appear in our analysis below, because they speak to some of the common experiences of frustration that people that provided testimony share, and also to the difficulties that people who live through crisis may have in reconciling their idea of themselves to the realities that they may find themselves in. These are understandable, rational, and deeply human experiences which speak to the aspirations that people have to live full and dignified lives. It is important that anyone seeking to support those in crisis understand that these experiences illustrate more than frustration. They speak to the feelings of isolation, humiliation, and anguish that our neighbors, our friends, our family, and we ourselves, are living through.

The CEC recognizes that for many people who work in crisis services or behavioral health, the critiques of existing systems contained in this report may be difficult to hear, even if the terms and recommendations are familiar. For those readers outside of these systems, particularly those readers who do not have lived experience of crisis, some of the content may be shocking or upsetting. We appreciate the time that each reader invests in reckoning with the experiences recorded here.

The CEC intends to continue to collect testimony from individuals with lived experience of crisis, and will periodically update this report accordingly. At the same time, we recognize that the serious work of designing and implementing expanded crisis services, such as a mobile

crisis response team, must begin immediately, so that one day soon we will have a system that has built in safeguards to make sure that no one falls through the cracks.

Top Level Findings

Based on an inductive analysis of what we heard from community members, the qualitative analysis working group of the CEC developed a series of hypotheses and design recommendations relevant to crisis response systems in Jackson County. Those ideas and recommendations are listed briefly here, followed by detailed analysis. The evidence supporting that analysis is in the pages below.

Hypothesis 1: Families and caregivers are sometimes stymied by a lack of options when a person in crisis does not meet criteria for involuntary commitment.

Design recommendations:

a. Involving family members and other informal caretakers can be an integral element of successful care when a person is in crisis. This is especially the case when an individual is oppositional to treatment. Family members and caretakers deserve appreciation and respect for the significant benefits that they provide. Therefore, consideration and supports for family members, and as much transparency in communication and information sharing as legally permissible is of vital importance.
b. Sending someone to check on the welfare or wellbeing of a person who may be in crisis serves an important function. At present, such "welfare checks" are conducted by law enforcement, but law enforcement officers are unlikely to be well equipped to this task. To be effective and to build community trust, welfare checks should involve clear,

compassionate, communication, and should include an analysis of the individual's overall situation, beyond basic assessment of suicidality and capacity to care for self. Therefore, welfare checks should be conducted by non-police mobile crisis responders.

c. Gaining the trust and informed consent of individuals in crisis may be extremely challenging at times, particularly if the individual has had past negative experiences attempting to navigate the system, is a "complex" case, or is oppositional. Implementing a "no wrong door" approach across crisis services, to ensure that no one is turned away without help or otherwise left to navigate the system alone while in crisis, is a core component of building trust and consent. "No wrong door" is achieved through a system change which involves both cross provider collaboration and frontline dedication to ensuring that everyone who seeks services is connected with appropriate care, and will often involve coordination via a crisis stabilization center.

Hypothesis 2: Having a safe place to reside, such as stable housing, is intimately connected with behavioral health and wellbeing:

- when people do not have a safe place to reside, they often experience both crisis,
- those who experience crisis often find themselves without a safe place to reside,
- those who deal with these overlapping struggles are disproportionately likely to also struggle with substance use disorders,
- and those attempting to recover from crisis struggle with finding safe and stable places to live.

Design recommendations:

a. The harms and negative outcomes associated with not having a safe and stable place to live are reinforced by policies which criminalize homelessness and which make it more difficult to access housing or to recover from crisis, increasing the demands on acute care. When possible, and in keeping with state and federal guidance, crisis services should reduce or mitigate these harms by actively removing barriers to physical safety, stable housing, and dignified care.

b. Service providers should take the housing needs of individuals who are in crisis into consideration as part of any assessment. Because housing is often complex and dependent on community or familial connections, such assessments should go beyond a determination of whether the individual can access shelter, and be geared toward connecting the individual and, where acceptable, family members of the individual, with housing resources and supports. This may also include creating supports for families that provide housing to those in crisis, and offer trainings for families to address housing needs for loved ones when parents are gone.

c. Unhoused individuals are at high risk for a variety of mental and behavioral health crises, and find it very difficult to navigate systems which are intended to help them secure shelter and stable housing, as well as the systems which are intended to help them access care. Crisis services could be a crucial in helping navigate those systems and removing barriers. To achieve this, a “no wrong door” approach to housing and emergency shelter should be implemented across crisis services, just as there will be a “no wrong door” approach to accessing care.

Hypothesis 3: Interviewees shared the values that they would like enacted through crisis services, as well as their ideas for how those values might be operationalized in that system. The values described are parallel to those described in current best practices for behavioral health, such as concepts described under the framework of trauma informed care.

Design recommendations:

a. Incorporate all six guiding principles of Trauma-Informed Care at all levels of organizations involved in crisis services: safety, trustworthiness & transparency, peer support, collaboration, empowerment, and humility & responsiveness.
b. Many of the guiding principles of Trauma-Informed Care can be fortified by listening to community members and incorporating their feedback into the practices and communication strategies of service providers. The Community Engagement Committee recognizes our role in this work, and are especially committed to ensuring that perspectives of historically marginalized communities are integrated into the planning of crisis services and the continuous improvement of such services.
c. Making people feel welcome, included, and that they belong is a central value of crisis services which is crucial to the task of providing dignified care based on informed consent to those in crisis. Crisis services can be welcoming in the way that they communicate with individuals and communities, and through the presence of individuals in the system with lived experiences of crisis, such as peer support specialists.

Hypothesis 4: People who have lived through crises have experienced barriers to care based on whether they have money, whether they have insurance, whether they have stable housing, or

whether they have presented with the same symptoms previously, etc. These barriers run the gamut from implicit biases or microaggressions to discriminatory behaviors.

Design recommendations:

a. Staff and clinicians play a key role in eliminating discrimination in crisis services. In particular, biases regarding low socio-economic status, homelessness, and disability have been mentioned in testimony we collected. Crisis services has a responsibility to examine and eliminate such biases internally and develop strategies to help people who have been harmed by these biases to be met with equity, dignity, and respect. Progress on this goal should be specific, actionable, and measurable.
b. For a "no wrong door" ethos to be meaningfully incorporated into crisis services, all members of our communities need to know and trust that if they seek help, they will not be turned away due to lack of insurance or ability to pay for services. Unlike many aspects of our healthcare system, crisis services are designed to be free of charge. Providers should work to communicate to the public in general and to high-risk populations in particular that crisis services are free.
c. Individuals with mental or behavioral health challenges have experienced barriers to receiving care, including being told that they do not meet criteria for care or that they are not eligible due to co-morbidities or a dual-diagnosis. A key example of this is when someone self-medicates with substances to deal with crisis, and is therefore disqualified from accessing needed services. Crisis service providers should take every step possible to ensure that health status or substance use history does not function as a barrier or bias for those seeking services.

Hypothesis 5: People we spoke with feel that non-police mobile crisis response would enable greater trust from community members and be helpful in de-escalating crisis situations. This perspective was broadly shared by those who have had both positive and negative past experiences with law enforcement in moments of crisis.

Design recommendations:

a. Mobile crisis response teams can be highly effective at building trust with individuals in crisis and de-escalating tense situations without the involvement of police. In designing the policies and procedures which stipulate how mobile crisis response teams will work with law enforcement, and under what circumstances, the community mental health provider should ensure that law enforcement officers are involved only when absolutely necessary, such as when an individual is an immediate danger to themselves or others. Therefore, the community mental health provider should develop these policies and agreements in consultation with community members with lived experience of crisis.
b. When individuals in crisis are subjected to citations, physical coercion, arrest, or incarceration, it makes things worse for them. This undermines public trust and may lead to lasting harms, including traumatization of the individual and family members as well as increased barriers to recovery such as loss of all personal belongings, personal documents, vitally important prescription medications, and psycho-social supports. Crisis service providers should design mobile crisis response policies and procedures so as to avoid these sorts of outcomes whenever possible given state and federal laws and the safety of all concerned.

c. Individuals in crisis and their families and caregivers need to know that if they call for help that it will not put them at risk for physical violence. Mobile crisis response can be a solution to that need. To do this effectively, mobile crisis must work in close collaboration with law enforcement agencies, and must be designed to have the scale and capacity to respond to the large percentage of calls for service which do not require a police response.

In addition to these recommendations, the CEC received testimony from many participants which reinforced steps which are already in the works, such as the intent to set up a crisis stabilization center, the creation of non-police mobile crisis response, the involvement of more peers and peer support specialists in crisis care, and the expansion of community education focused on de-stigmatization. Finally, testimony also acknowledged the importance of identifying adequate and sustainable funding sources for the services recommended.

Hypothesis #1: Involuntary Commitment

Hypothesis #1: Families and caregivers are sometimes stymied by a lack of options when a person in crisis does not meet criteria for involuntary commitment.

(relevant codes: Doesn't fit criteria, Help rejecting, Caregiver and family related concerns, Family as caregivers, Family members and welfare checks, Involuntary hospitalization, inclusive of all sub-codes)

SUMMARY

In the 23 pages of quotations from the listening sessions on lack of options for a person's loved one when they don't meet criteria for involuntary commitment, there were five broad categories:

a. system critique,
b. police critique,
c. recommendations,
d. stigma, and
e. positive comments.

There were 13 comments on system critique, eight on law enforcement, 16 recommendations, four comments on stigma and three positive comments. Some of the quotes presented multiple categories within a single statement.

a. The system critique comments included discussion about the lack of the continuation of care, especially with "complex cases." Participants referring to "complex cases" seemed to mean that the person in crisis is averse to treatment. Participants described their experience that under existing systems such aversion to treatment often means that law enforcement officers

become involved, either as first responders or as part of an involuntary psychiatric evaluation.

"And they said that's about all we can do right now. He's not willing so what can we do? And I realized that's a problem…If you follow these [rules], we can help you, but if we don't follow them…"

"I would love to envision for crisis services is a no wrong door approach… the last thing you want to be told is I'm sorry that is not something we can help you with."

"My son has schizophrenia. He is currently in Oregon State Hospital guilty [and] accepting sanity because he committed a crime and the system failed every step of the way… If we take him to the hospital, they're just going to let him go…He had some very violent texts and emails…so then the police come [and] they talk to him [but] oh, there is food in his cupboards… we can't take him to the hospital because he is able to take care of himself…"

b. In the cases where this is not the situation, but it is still a complex case, one person tried to commit suicide by overdose and only was institutionalized after this incident not before the incident when they were the most susceptible. In another case, the person also had mild dementia and was suicidal. Other participants described their experiences of welfare checks performed by police, which ranged from being ineffectively brief or cursory to being downright harmful or traumatic when police escalated to violence.

Critiques of the role of law enforcement ranged from descriptions of inappropriate or unwarranted violence by law enforcement, to lack of inadequate training of police officers, to officers displaying a lack of compassion. All eight comments on law enforcement stated that police should not be involved at all with a mental health crisis except when absolutely

necessary. Even then, participants felt that police should appear alongside a mobile crisis unit of trained mental health professionals. One participant noted that in her experience police officers are just as frustrated with this situation as family members are, feeling that they lack the resources and knowledge to deal effectively with mental or behavioral health crises.

"We've had two interactions with the police that have been very negative…. I kept getting advised by his [ill loved one] therapist to call the police if he does that [becomes violent/hits] to make an impression on him that's not okay… I did it and regretted it ever since… it could have been far worse, but it was traumatic for him. Not helpful. Gave him a very deep-seated fear of the police. They guy [police officer] was not trained…and he really just was intimidating."

"And I've had a couple of opportunities with JCMH to talk to law enforcement just about my experience as a family member…that when officers would share something, they would say oftentimes family don't know what to do. And they feel desperate, unconnected and that law enforcement doesn't always know exactly the resources to share with the family either."

c. Among the comments related to involuntary commitment and a lack of options were some specific and concrete recommendations. There were 16 plus recommendations among all of the categories. These recommendations ranged from more humane treatment of those with mental illness, to more training, to implementing a mobile crisis team, to creating a functional stabilization unit, to variable ways of getting information dispersed (verbal, written etc.), to taking care of the caregiver especially when the loved one is oppositional to treatment, to taking more time when doing a welfare check and making sure to ask certain questions during the welfare check (not just the basic three always asked), to court commitment follow up after the six months termination.

"Our experience is our son will follow the rules for six months, as soon as his court commitment is over, he will no longer take medications…go to meetings, he fires his case manager."

"One thing that came to mind was the APD office… I've gone there in support of my son as his guardian. And so we've been able to leave there with more detailed information, but their process is at least in our experience 100% verbal. So when you leave there, you don't leave with pieces of paper that tell you what you talked about that day, what the next steps are, there isn't anything to refer to later."

"… when a family member is in crisis, then the family really needs to be involved…it's not like the needs of the consumer are the only needs because the whole family needs some kind of help getting through crises in those situations…"

d. Stigma was mentioned in four comments. Most of the comments discussed social stigmas against people living with mental illness in general. There was one comment about inhumane treatment of clients in a psychiatric ward setting.

There were three positive comments. One of them was from someone who didn't consider their situation to be serious but would call JCMH about relationship issues and trouble sleeping because of panic attacks. This person said the people on JCMH crisis line were very good listeners:

"I'm alone so I don't have a real support system [in Ashland] …so my fall back in an emotional crisis was to call county mental health…. They're very good listeners. And they've always been pretty helpful. [However], I hesitate to call because I feel that I don't have the kind of crisis that

they consider a crisis…I'm not suicidal and I'm not in physical danger… where my needs would be is relationship issues… or something comes up from the unconscious at night."

Another participant offered praise for the CAHOOTS model and would like to see something akin to it in Jackson county. The third said that JCMH was good at handling their family in a crisis but did not go into specifics:

"I really like the CAHOOTS model. I agree with person #2… people coming to the home and kind of having that respect for everyone…I also had a son who had lived experience of forced hospitalization in Eugene, wasn't involved with CAHOOTS and really felt some trauma around it…"

"In the planning of the CAHOOTS model, treatment places and sanctuary for those vulnerable people who save serious MI issues must be taken into account. Individuals suffering from the mildest forms of MI may receive treatment while those with more intractable illnesses are left to fend for themselves. It is shameful."

Design Recommendations:

a. Involving family members and other informal caretakers can be an integral element of successful care when a person is in crisis. This is especially the case when an individual is oppositional to treatment. Family members and caretakers deserve appreciation and respect for the significant benefits that they provide. Therefore, consideration and supports for family members, and as much transparency in communication and information sharing as legally permissible is of vital importance.

b. Sending someone to check on the welfare or wellbeing of a person who may be in crisis serves an important function. At present, such "welfare checks" are conducted by law enforcement, but law enforcement officers are unlikely to be well equipped to this task. To be effective and to build community trust, welfare checks should involve clear, compassionate, communication, and should include an analysis of the individual's overall situation, beyond basic assessment of suicidality and capacity to care for self. Therefore, welfare checks should be conducted by non-police mobile crisis responders.

c. Gaining the trust and informed consent of individuals in crisis may be extremely challenging at times, particularly if the individual has had past negative experiences attempting to navigate the system, is a "complex" case, or is oppositional. Implementing a "no wrong door" approach across crisis services, to ensure that no one is turned away without help or otherwise left to navigate the system alone while in crisis, is a core component of building trust and consent. "No wrong door" is achieved through a system change which involves both cross provider collaboration and frontline dedication to ensuring that everyone who seeks services is connected with appropriate care, and will often involve coordination via a crisis stabilization center.

Hypothesis 2: Housing

Hypothesis #2: Having a safe place to reside, such as stable housing, is intimately connected with mental health and wellbeing:

- when people do not have a safe place to reside, they often experience crisis,
- those who experience crisis often find themselves without a safe place to reside,
- and those attempting to recover from crisis struggle with finding safe and stable places to live.

(Relevant codes: Housing and where to live, inclusive of all sub-codes)

Among the many comments received related to housing and homelessness, a large number support the hypothesis that having a safe place to live is intimately connected to mental health, and no comments received contradict that idea. While much of the discussion of housing is outside the narrow scope of questions concerning the design of crisis services in Jackson County, it has been included in this report because participants consistently articulated perceptions about the connections between crisis and housing status, indicating the need for crisis service designs to be informed by the realities and stresses that the community faces concerning housing and homelessness. The comments on these themes can be divided into 5 relevant themes or categories:

a. Impacts of mistakes in assessment or treatment
b. Capacity or availability of housing
c. The role of law enforcement officers
d. Loss of housing due to disabilities or mental health
e. Models that can work

1) In describing the impacts of mistakes in assessment or treatment of an individual who is experiencing crisis, participants were cognizant that such mistakes might happen to anyone. Mistakes made by providers do not just impact clients without housing, of course. But those without secure or permanent housing may find it especially difficult to advocate for themselves or see such mistakes addressed, and a seemingly minor mistake may result in worsening conditions for an unhoused individual:

> *"The person at [Service Provider O] said that mom needed to hit 'rock bottom' and told me not to help my mom. My mom was 75, with moderate dementia at the time this was said. This was very upsetting, considering my mom's continuing state of cognitive decline and age… The only other places left were the shelter or the street with mom's car… All the people who conducted the welfare checks said mom was fine when mom was NOT and in fact turned out to be actively suicidal… Mom went to the pharmacy and somehow got a 90 day prescription of medications... [she] took every pill she had... Mom died by the next day."*

2) Many of the participants who contributed their experiences described issues with the capacity of housing and housing with treatment supports. There is simply not enough affordable housing for people with behavioral health challenges: general housing, specialized housing, supportive housing, age-appropriate housing, or treatment beds. Two participants endorsed the idea of a "no wrong door" approach to accessing housing and emergency shelter. Comments from family members or caretakers of individuals who have experienced crisis also indicate the difficulty of maintaining safe and stable housing in informal, family settings.

"I know so many people who have children who are mentally ill and they don't know what to do or how to help them. They have nowhere to live and they're on the street. It's a huge crisis. No one place is not going to be able to serve all of Jackson County. I think there needs to be 10 places. I think that there needs to be so many more… In England, they have the NHS, and that's where you go. You talk to one agency, one organization, and they're going to point you in the right direction. And here, where do you go? What do you do? How do you get your son or daughter into a house that is good for them? Everybody seems to be competing for government funds. And we're all stuck in the middle. So I think there needs to be many more houses, and it needs to be available by going to one agency."

"I'm a parent of two adult sons, who have difficulty in living situations outside of our home or actually, even inside our home. The reason my loved one is not homeless right now is because he lives with me. The critical need—housing–being provided by the family is an important aspect of avoiding crises. When a family member is in crisis, then the family really needs to be involved. It's not a one-time need. And it's not like the needs of the consumer are the only needs because the whole family needs help getting through crises."

"[Provider C] has some supportive housing. And they were willing to let my son come in, but because of the shortage of rentals here, I was afraid to let him do that. Because if it failed, I couldn't get him back into his apartment. There is no guarantee I could find another place if it didn't work out because there's a huge waiting list. And there are only so many people allowed in there. So it isn't working."

"I would love to envision crisis services as a No Wrong Door approach where the answer is never, 'We just can't help you with that.'... The last thing you want to be told is, 'I'm sorry, that's not something we can help you with.' That would look, for me, like a resource hub."

3) In describing experiences related to housing or homelessness and mental health, participants frequently also brought up the role of law enforcement. Participants who were currently or previously unhoused relayed the ways that law enforcement responses to mental or behavioral health crisis resulted in further trauma or additional difficulty in recovering and finding safe and secure housing in the future. Similarly, participants who are housed described experiences in which involvement of law enforcement put their housing status, and thus their mental health, at greater risk.

"I was homeless because of this and was arrested multiple times for yelling on the street. Psychotic episodes is what I call them. Every time I was arrested in Medford and taken to jail--even after explaining to each police officer that I was having psychotic episodes and had a mental health disorder. I was taunted by the police multiple times and it made it difficult to stop screaming at the world."

"My son was psychotic and there were no treatment places available. I tried having him stay with me. He frightened my neighbors (not to mention myself) and jeopardized my housing. He had to leave my home. Police in several local towns did nothing except move him along. He finally received a felony charge and was placed in Jackson County Jail for 6-1/2 months in solitary confinement… No mental health services were arranged for him… The 6-1/2 months of solitary confinement greatly damaged my son a and it may have irreparably damaged our relationship as well."

"I have seen my loved ones who have had interactions with the criminal justice system because of something that fundamentally is not a crime. Mental illness or substance abuse is the big one. Go to jail, get a record. Even to have more than a decade clean and sober, they still cannot get housing in the Rogue Valley. I feel like all that could have been prevented if treatment was just available in the first place. That should be the first line response. We don't have places for people to go that are free, but also easily accessible. We're defaulting to putting people in jail, which has more harmful impacts down the line."

d) Participants with lived experience of mental illness or other forms of disability described having lost their housing due to discrimination focused on disabilities or social stigma around mental illness. From the perspective of some interviewees, those experiences of discrimination extend to rules which require removal from supportive or subsidized housing once some degree of recovery from the illness has been achieved.

"He usually was thrown out of his housing for behavior, even though it was housing for mentally ill. When he quit his meds, they put him out of foster care. When in his own apartment, it was his behavior or not following the rules... He would go outside and scream a lot. It was his fault, but no one could reach him."

"It's real easy to get kicked out of housing. Then you don't get your section 8 and it's back to, 'Where do I live?' ... You could prevent a lot of crises if you have someplace to live."

"Just when housing is finally stabilized through supportive housing, and that person starts to feel safe, is able to sleep well and engage in treatment and starts to get better, that's the ticket for getting removed from supportive housing, and having that whole process unravel again. And I've seen that not just with my own family, but with others that we know who felt like they won the

lottery ticket to get in. Just to then start feeling better, and then to be scrambling to try to find something stable right after that."

"I've tried to find help, but I felt that there were some barriers to it…So I ended up going without because it wasn't accessible. I also am a disabled person. Before September 2019, I was on again-off again homeless for over a decade. And because of my disability issues, a lot of services are simply not things that I even bothered trying. I'm chemically sensitive among other things, which means that I can't really access spaces where a lot of industrial cleaners, perfumes, and colognes are used. Many scented personal products are used… I would like to see something more accessible and available to all kinds of people."

e) Finally, participants also described their understanding of some programs or models which they believe have been helpful and effective. The programs described varied and are not being named so as to protect the confidentiality of participants, but some commonalities emerge. Among these are principles of "housing first" (i.e., low barrier shelters and supportive housing facilities) and a commitment to inclusivity and a welcoming environment. Participants also discussed the benefits provided by peer respite centers, both in terms of reducing the need for emergency services and in terms of allowing consumers to return to their normal housing situation after a period of healing and recovery.

"I'm reminded of [Supportive Housing Provider C] model where people can be together and not always rely on an official counselor. That model offers social life. People share their situation… I volunteered [at a temporary Christmastime emergency shelter in Jackson County]. I saw people that I knew from the street. It was so different than always being on the street and being handed a package meal because they could sit down and talk to each other and sleep and not

sleep and food came in from the community. It was a very loose, informal kind of help. Your dogs could be there and your kids could be there. If there were more things like that available, that would be wonderful."

"Oftentimes when someone has a mental illness, they can feel separated from people in general. And so just those informal social connections are lacking. It reminds me of the [supportive housing provider D] model that's in Jackson County. They just hold a space for people in recovery to come together, to make friends, to talk with people who get it, who can understand some of the experiences that they're going through."

"...It's a peer respite where women could go... Sometimes someone else could reach out to her son when it's hard at home, and everyone could have a break, and it wouldn't require all the trauma that comes from hospitalization."

Design recommendations:

a. The harms and negative outcomes associated with not having a safe and stable place to live are reinforced by policies which criminalize homelessness and which make it more difficult to access housing or to recover from crisis, increasing the demands on acute care. When possible, and in keeping with state and federal guidance, crisis services should reduce or mitigate these harms by actively removing barriers to physical safety, stable housing, and dignified care.

b. Service providers should take the housing needs of individuals who are in crisis into consideration as part of any assessment. Because housing is often complex and dependent on community or familial connections, such assessments should go beyond a

determination of whether the individual can access shelter, and be geared toward connecting the individual and, where acceptable, family members of the individual, with housing resources and supports. This may also include creating supports for families that provide housing to those in crisis, and offer trainings for families to address housing needs for loved ones when parents are gone.

c. Unhoused individuals are at high risk for a variety of mental and behavioral health crises, and find it very difficult to navigate systems which are intended to help them secure shelter and stable housing, as well as the systems which are intended to help them access care. Crisis services could be a crucial in helping navigate those systems and removing barriers. To achieve this, a “no wrong door” approach to housing and emergency shelter should be implemented across crisis services, just as there will be a “no wrong door” approach to accessing care.

Hypothesis 3: Values

Hypothesis #3: Interviewees shared the values that they would like enacted through crisis services, as well as their ideas for how those values might be operationalized in that system. The values described are parallel to those described in current best practices for behavioral health, such as concepts described under the framework of trauma informed care.

(relevant codes: values, inclusive of all sub-codes; communication skills; peer-support staff; safe place; crisis system collaboration; and community education.)

Individuals who shared their experiences of crisis with us often described the values which are important to them and which they believe must be integrated into crisis services at every level of organizations. Using an open and axial method for analysis of what participants shared, the analysis working group identified 12 subcodes which all fall under the area of "Values." Those subcodes are:

1. Accessibility for Non-Traditional Uses
2. Accountability
3. Connection
4. Continuous Quality Improvements
5. Humanity
6. Humility
7. Non-profit
8. Privacy and Confidentiality
9. Strengths-based
10. Trauma-informed
11. Trustworthiness

12. Welcoming

Additionally, some comments related to values were grouped under other codes and subcodes, such as "communication skills," "peer-support staff," "safe place," "crisis system collaboration," and "community education." Some comments relating to specific populations of interest, such as communities of color, LGBTQ+ communities, and lower income or socio-economic status communities, are also relevant to the values which participants stated as being important.

In thinking through the meaning of comments and discussions across these different areas of values, it has been our observation that most or all of the values described by participants bear a close relationship to guiding principles of Trauma Informed Care. Indeed, some participants mentioned trauma informed care explicitly, whereas many others described values, attitudes, and practices which fall under the "Guiding Principles of TIC," set forth by the Center for Disease Control and the Substance Abuse and Mental Health Services Administration's National Center for Trauma-Informed Care (learn more at https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/). Those six principles are safety, trustworthiness & transparency, peer support, collaboration, empowerment, and humility & responsiveness.

Below, we have summarized how the values which participants described as important to crisis services fit with these six principles, and have provided key quotations from interviews which illustrate how participants see that these values should and could be operationalized in crisis services. At the end of this section is a brief list of recommendations about how these values can be integrated into the creation and expansion of crisis services in the Rogue Valley.

1) **Safety:**

In the context of services for mental and behavioral health, safety can be thought of as meaing that "throughout the organization, patients and staff feel physically and psychologically safe" (Trauma-Informed Care Implementation Resource Center, 2018). These sorts of concerns about safety were mentioned by participants very frequently, and included concern for the safety not only of individuals who are living through crisis, but also the safety of staff members or healthcare providers, family members, and other people close to the situation. Often when questions of safety arose, participants were particularly focused on the potential physical risks that people in crisis encounter when interacting with law enforcement officers. Because Hypothesis 5 is focused exclusively on the role of law enforcement, discussion focused on how to improve safety by limiting engagement with law enforcement is primarily located in that section. By contrast, the comments presented here reflect the importance that a sense of physical and psychological safety plays in mitigating the experience of crisis, as well as the aspirations that participants voiced for what a safe and effective form of crisis response might look like and feel like.

"… a safe little space to talk about whatever and let's get you on to some medications. And this is this is what the medications do. Let me just in a calm, casual environment, explain it to you. Are you hungry? Do you need anything to drink?... But I think I think safe spaces is the first step for any of us that have these crises."

"Because you still need some aspect of security. When things are out of hand. It just needs to be handled in a way that's humane."

"But the idea of a physical place I thought it should be have a homey environment with like couches and plants and something like that feels more like home and serve the people coffee and tea and get them relaxed, before they start in or even have a sandwich or something to if they're hungry, because I know a lot. I know times when I've gone to counseling and I didn't have enough to me and it you don't. You don't get a benefit from it when you're hungry. So I think serving food and tea and having it homey and telling them it's confidential and they don't have to fill out a lot of paper work or a lot of forums or a lot of dealing with the system so that they feel that their privacy is being honored and they're not being put into something that they feel trapped."

"Oh, what would have really helped is if all of a sudden I had this picture of a very safe cozy like little bedroom and someone was in there going, you know what? Everything is good. You're all right. This is a safe little space to talk about whatever and let's get you on to some medications. And this is this is what the medications do. Let me adjust in a calm, casual environment, explain it to you. Are you hungry? Do you need anything to drink? Are you good?... The worst thing possible was for me to go into crazy chaotic ER with bloody people, and then have a police officer standing over me not introducing himself and then having to go pee with the door open. I mean, in so many ways I just was in just the worst possible place worse than even just being at home. So, I envisioned, gosh, wouldn't it be great to mobile unit, maybe a nice little cozy van, bring the person in there. Calm down, give him some water to drink and chill him out and chilling about we'd get him into a calm space. And then, you know, you take the next steps from there."

2) **Trustworthiness & transparency:**

The principle of trustworthiness and transparency can be understood in terms of service provider behaviors which are predictable, dependable, and in the best interest of the individual in crisis, as well as a commitment to communicating the rationale for decisions and determinations to everyone involved. The Trauma Informed Care Implementation Resource Center defines this principle as “decisions are made with transparency, and with the goal of building and maintaining trust” (Trauma-Informed Care Implementation Resource Center, 2018). Testimony from participants which was related to trustworthiness and transparency overlaps substantially with other themes, such as safety and collaboration. For example, some participants make a link between the value of trustworthiness and a commitment to practices of de-escalation, a concept which came up frequently in testimony:

“please, no police, please send someone with experience with mental health. Who can come and help me deescalate the situation because for one thing, and also somebody who has some distance, I'm too emotionally involved to deescalate anything.”

“I've had good experience with police, too, that did deescalate. And they handled it well. It's just but it's, uh, you'd never know what you're going to get when you cause the problem. Well, if you get the one who knows what they're doing or not?”

In other comments from participants, the idea of transparency came up in terms of wanting to ensure that the motives of providers, and in particular, whether payment of some form might be required to access care:

"Because I know like, my experiences in hospitals personally and like, and if I was in crisis, and someone wanted to talk to me about insurance, my all of my like, 'oh, they actually do care,' would be out the window, like, 'oh, they just want my money. They just want to get paid.' …. So, I think just being really careful about how that's approached, and making it clear that like, 'I am here because I care, and I support you and I'm not here, because I need all your insurance information so that I get paid'."

Finally, some participants spoke to how they envision values of trustworthiness playing out on a practical level, and how these might be enacted and communicated through community collaborations and through careful design of facilities:

"… It could be more a friendship visit… an educated person to visit with clients for an hour every week just to be a friend and see so they can trust them more… (at present) the trust is missing between the client and the service."

"If we get a crisis stabilization center I'd like to see it be as comfortable and welcoming as possible. Soothing colors, not sterile. Plants in the room. Have it feel like home. I think peers on staff 24/7 so the client has someone to speak to. The client should be the most important consideration, not insurance. It should be healing-centric and able to connect to whatever services the person needs after they stabilize at the center. They shouldn't have to track down

where they can go next. They should be able to receive medication at the center, so they don't have to deal with the long waits to get in to see a psychiatrist."

3) **Peer support:**

When participants mentioned "peer support" in testimony they were referring to several different concepts as well as existing services or peer support organizations such as NAMI, but often the idea was accompanied by a sense of the ethos or cultural values associated with the concept. Trauma Informed Care Implementation Resource Center defines peer support as "individuals with shared experiences are integrated into the organization and viewed as integral to service delivery," (Trauma-Informed Care Implementation Resource Center, 2018). In the context of crisis services, that would presumably mean that individuals with past lived experiences of crisis, such as living with serious mental illness, substance use disorders, homelessness, or other forms of crisis, are part of client-facing crisis response teams as well as being promoted into managerial and leadership positions. In addition to describing their aspirations for how peer support specialists might be integrated into crisis response services, participants relayed their experiences having received informal, but invaluable, peer support from members of the community. Participants expressed support for the value of peer support in the following ways:

"If you're really this caring person that really wants to help them. I'll tell you why it feels really good to be talking to you. I mean, It feels really cool. When somebody is like, like, when I was homeless, a couple people took, like, talk to me. And you know, they sat down with me and stuff. And it wasn't nobody from an organization... It was like just people, you know, I mean, and, like,

you know, I've done it. I'm thinking right now how to help a couple people that are homeless. And I'm like, Yeah, I mean, I'm envisioning what we can change."

"And then the other the only other thing that comes to mind immediately, is just the use of peers in this whole bigger picture, you know, having folks who have gone through these experiences, folks with lived experience, being able to work side by side with folks who are in crisis… And I've had the pleasure of working with a couple of peer groups in the Rogue Valley, including Jackson County, and I am just, I am blown away at what they can achieve that takes providers sometimes a really long time to get done."

"Some churches have what's known as a Stephens ministry. And it's for that purpose, not just the mentally ill, but for people, you know, who are struggling, I have seen quite a few other churches around here have that. And there are also some other organizations along the lines of NAMI that can help."

"And I was just wanting like anybody to just come talk to me and take me under their wing…And I was more stable because I had like people around me, because I would usually just trip out because I was by myself."

"Oftentimes, when someone has a mental illness, they, they can feel like separated from people in general."

4) **Collaboration:**

The value of collaboration was voiced throughout participant interviews, as were concerns about the negative outcomes that participants have witnessed due to a lack of collaboration or coordination. The Trauma Informed Care Implementation Resource Center defines this principle in terms of how "power differences — between staff and clients and among organizational staff — are leveled to support shared decision-making," (Trauma-Informed Care Implementation Resource Center, 2018). Participants described the importance of collaboration between different providers or agencies within the system, stating that:

"... there needs (to be) new development of collaborative understanding between all the pieces of the system that says we're going to do this in different way"

"There's just the need for more coordination between service providers, it seems that unless the psychiatrist and the therapist and other support people are in the same organization, there is a real lack of communication and a lack of like team structure that really supports that person's care and their needs. So, I would love to see kind of a more intentional collaboration between entities to ensure that it's not the person that may be in crisis is trying to rally their team together."

Additionally, participants discussed possibilities of collaborations between crisis services and volunteers or service organizations, envisioning the capacity that the community has to act as mentors and peer support specialists:

"But if you don't have this kind of coordinated knowledge base to be able to say and identify, Okay, this individual, I can see what they really need right now, is it you know, they're a 20-year old, and they needed an example of someone who has gone through this, they're now 30. And,

they have a job, they're stabilized and someone to kind of walk walk along with them… Oh, and let's get one of those volunteers, one of those great volunteers and maybe among those volunteers, there might be someone who's, who's male, 30 years old, you know, had these specific issues and has the kind of personality that you know, might match with"

"I would want, you know, this to be open to everybody… to a completely non-denominational or non-religious organization, you know, and say, 'hey, look, you know, I'm just, you know, what I do is this, I'm a contractor,' and maybe somebody out there is wanting to learn how to build houses, and I can just kind of talk to him and go for walks with him and tell him what my life is like and support that, you know, just looking, just opening that up and somehow getting out to the public that, you know, that this, that this mental health organization is looking for volunteer mentors?"

Finally, participants also voiced support for collaboration with the community at large, so that providers of crisis services have opportunities to hear from individuals with lived experience about the difficulties that they face, including in attempting to access care through those service providers:

"I think would be really great is to have more of these more sessions like this regularly in the community, to really get from, for people with lived experience to really gauge is a system getting better, what's getting better? Is it not getting better, what pieces of it are not getting better, and really keeping those voices, current and kind of in real time as a good feedback loop to the system that's trying to improve itself, right? Because the system doesn't know the end users

perspective, unless it really, really, asks for that voice. And so many service providers are busy trying to get the job done, but they aren't necessarily always able to really do a good check in with the folks they're serving. So, this could be that voice that would be super helpful. And I know I would, I would love to hear more voices."

5) **Empowerment:**

Empowerment in the context of mental or behavioral health services relates to an organization in which "patient and staff strengths are recognized, built on, and validated — this includes a belief in resilience and the ability to heal from trauma," (Trauma-Informed Care Implementation Resource Center, 2018). Comments from participants which relate to empowerment were often coded under related themes, such as "strengths-based" and "accessibility for non-traditional users," as well as under the code for "trauma-informed" itself. In discussing values and practices related to empowerment, participants focused equally on the importance of developing forms of care which put an emphasis on the strengths and resilience of the person in crisis, as well as developing systems which do a better job of ensuring that individuals are empowered to seek care in general:

"It is good to give people some tools that they could use on their own and there could be a follow up afterwards, if the people are open to it to like, check in with them, or they could check in with you or you could check in with them. And see how they're doing and how they're progressing and maybe give them some referrals to if they wanted ongoing help."

"What I would love to envision for crisis services is sort of a No Wrong Door approach. And then in a situation where the answer is never 'we just can't help you with that'."

"Sure, I think, you know, assessing, assessing situation, seeing sort of what level of crisis we're at, trying to remind folks of the strengths that they have, and the tools that they have to help mitigate the crisis in the situation."

"…Trying to remind folks of their, of the strengths that they have, and the the tools that they have to help mitigate the crisis."

"And they need obviously need to be trauma-informed, strength-based, person-centered, you know, trained and all of that I think will be really important as well. Also somebody dedicated to provide a facilitate kind of warm handoffs in, and who's very knowledgeable about the system."

6) **Humility & Responsiveness:**

Humility and responsiveness is the principle within the trauma-informed framework which is focused on the importance of confronting and transforming biases and systemic discrimination. Some versions of the six principles instead refer to this concept as "cultural, historical, and gender issues." The Trauma Informed Care Implementation Resource Center defines this principle in terms of how "biases and stereotypes (e.g., based on race, ethnicity, sexual orientation, age, geography) and historical trauma are recognized and addressed," (Trauma-Informed Care Implementation Resource Center, 2018). In the context of crisis services in Jackson County, a thorough engagement with this principle of trauma-informed care necessarily entails an examination of what communities are most likely to be impacted by those sorts of biases and historical traumas. The Community Engagement Committee has identified several

specific populations of interest as likely being impacted by these factors, and also likely to provide unique or specific insights regarding the design of crisis services. Those communities include: Hispanic or Latino/a/x communities, LGBTQ+ communities, unhoused communities, and youth or young people, each of which the CEC is currently working to solicit input from for inclusion in future drafts of this report. Additionally, it is important to recognize that the twin legacies of race-slavery and colonization place particular burdens of historical trauma on Black and Native American communities. Because these populations make up approximately 1% and 1.7% of the county population respectively, the CEC has not, as of yet, determined effective means of soliciting input from these groups (U.S. Census Bureau, 2021).

While efforts to solicit perspectives from the populations and communities listed above have thus far been hampered by the COVID-19 pandemic and other factors, some participants in the listening sessions and individual interviews which have been conducted identify as members of those communities listed. Additionally, a sizable portion of participants to date described barriers to accessing care which arise due to bias or stigma against them due to socio-economic class, insurance status, or educational attainment, each of which tend to overlap with other experiences of bias and discrimination among historically marginalized communities. The following excerpts are reflective of testimony provided to the CEC concerning biases and historical trauma:

"I think the people who are going to be responding to these crises need to, you know, have a have a warm and welcoming demeanor, and not be intimidating and help the help that people feel like it's okay."

"I was impressed by the compassion shown by the CAHOOTS staff when they came to present a couple years back. They really understand what a person is experiencing: if a homeless person is

hungry because he has bad teeth and can't chew the granola bars that the shelter is handing out, CAHOOTS notices and gets the person some soup. Observant. Practical. Compassionate."

"Because I know like, if my experiences in hospitals personally and like, and if I was in crisis, and someone wanted to talk to me about insurance, my all of my like, oh, they actually do care would be out the window, like, oh, they just want my money. They just want to get paid."

"So a lot of kiddos who just came to the country are living with aunts, and uncles, and things like that, or, you know, just people who, you know, their parents trust for them to stay with. And sometimes that's kind of an issue, because, you know, these kiddos are all alone, and don't always have the support that they need. You know, based off, like, you know, some of them, you know, have to pay some amount of money to stay, or they kind of help with the bills and things like that. And, you know, so a lot of them are trying to find jobs, but that's kind of difficult, when they can't really get jobs, because, you know, they're in school. And they can't find any jobs after school, because, you know, they need documentation and things like that."

Design recommendations:

a. Incorporate all six guiding principles of Trauma-Informed Care at all levels of organizations involved in crisis services: safety, trustworthiness & transparency, peer support, collaboration, empowerment, and humility & responsiveness.
b. Many of the guiding principles of Trauma-Informed Care can be fortified by listening to community members and incorporating their feedback into the practices and communication strategies of service providers. The Community Engagement Committee

recognizes our role in this work, and are especially committed to ensuring that perspectives of historically marginalized communities are integrated into the planning of crisis services and the continuous improvement of such services.

c. Making people feel welcome, included, and that they belong is a central value of crisis services which is crucial to the task of providing dignified care based on informed consent to those in crisis. Crisis services can be welcoming in the way that they communicate with individuals and communities, and through the presence of individuals in the system with lived experiences of crisis, such as peer support specialists.

Hypothesis 4: Biases and Discrimination

Hypothesis #4: People who have lived through crisis have experienced that decisions about whether people can access care are determined by whether they have money, whether they have insurance, whether they have stable housing, or whether they have presented with the same symptoms previously, etc. These experiences run a gamut from implicit biases or microaggressions to discriminatory behaviors.

(relevant codes: Navigating Crisis System, No Wrong Door, Stigma, Difficulty identifying provider, Psychiatric diagnoses, Doesn't fit criteria, Socio-economic status, Accessibility for non-traditional users, Connection, Humanity, Non-profit, Trauma-informed)

Summary:

Despite a willingness to access care, the issue of where to start or who to call when in crisis is a notable concern for those we spoke with. When a person in crisis does call, they have experienced that the person on the other line may be unfamiliar with the services available from other providers and therefore points the caller in the wrong direction or doesn't have anything helpful for them at all.

"The last thing you want to hear when you are in crisis is 'I'm sorry, that's not something I can help you with'."

"I don't want to have to call 20 different services or take days and weeks to get help when I'm in a crisis."

"[The person in crisis] shouldn't have to be the one to call around to different places hoping that whoever's on the other end of the phone happens to know the right answer."

Adding to concerns about who to call were concerns about accessing help due to lack of money, too much money (i.e., being poor but just over the threshold for receiving insurance and/or subsidies) or due to fear of losing resources like one's job or one's housing.

"Until recently, Medicaid didn't even cover my psychiatrist and even though I know it couldn't hurt to go, I couldn't afford it."

"For us, transportation to services and money are a barrier. We could never get financial assistance because we make just over the monetary boundary for Medicaid and none of the places we called would talk to us without money in hand."

"But I never, ever wanted to get the police involved. I didn't want my loved one to get into trouble, to go to jail and potentially lose their job, health care, and potentially housing."
"Colombia care has some supportive housing, and they were willing to admit my son, but I was afraid to do that. If it failed, I was afraid I couldn't get him back into his apartment because of the shortage of rentals around here."

Beyond issues of resources or knowing who to call, many people bemoaned the lack of *availability* or *timely access to* help.

"I feel hopeless when thinking about being in a crisis and having to wait months to see a therapist because I'd probably be dead."

"Forced onto a six-month waiting list for a psychiatrist through the CCO, my suicidal sibling presented to the hospital three times in a month but they kept letting her go without admitting to the BHU. When she finally did attempt suicide, she was admitted."

"There is very limited access to crisis care and even therapy for people with emergent issues within the city of Ashland - it's very difficult getting regular appointments."

The issue most salient from among the transcript, interview, and story excerpts pulled for this hypothesis seemed to have two nuances – both of which appear related to the word "discriminatory" in our hypothesis. Discriminatory behaviors and barriers were experienced on a variety of levels: interpersonal, such as when an individual person engages in bullying or hate speech, cultural, such as stigmas or implicit biases against individuals or populations, and systemic, such as when a individuals or groups are structurally marginalized based on their race, class, gender, health status, or other aspects of their social identity. Participants particularly mentioned a sense that having a dual-diagnosis of mental illness as well as substance use disorders, subjected people to discrimination and marginalization.

People felt responders and providers were making decisions about what a person in crisis did or did not need based on some reason known only to the decision maker and which did not consider the "voice and choice" of the person in crisis or their loved ones. Strong feelings of frustration and fear were expressed.

"I don't call for help because I was arrested many times because of how I act when I'm ill and even though I learned how to tell the police when they showed up that I'm schizophrenic, and I'm having a bad time, they would just ignore me and treat me like I was being violent even when I wasn't even being violent."

"Police determined my son needed to go to jail and not the hospital because they did not understand he had a mental illness episode and can't control his behavior and the things he's saying."

"Individuals suffering the mildest forms of mental illness may receive treatment, while those with more intractable illnesses like my son are left to fend for themselves, it's shameful."

"My son was in crisis in 2019 and went to three Asante hospitals seeking help only to be minimally treated or not at all. In his mental state of agitation and anxiety he was loud. The signs in these hospitals say anyone who is loud or aggressive will be denied service. How is someone with paranoia or anxiety supposed to get treated when they are agitated?"

"Even though I am an assessor, and my spouse is a nurse and a judge agreed with us that my son needed to be in a hospital and not a jail, the 3rd party doing the assessment determined he didn't 'meet criteria,'."

"A lot of families I work with don't reach out because of cultural beliefs and stigma associated with mental illness and/or they see it as being 'weak,'."

"Mental illness has a big stigma around it in this community so it's hard for our family to reach out because we will be labeled and put down by the community and the system."

"A family member was found guilty of a crime and the lawyer wanted him to plead guilty except for being insane but he didn't want to admit to being mentally ill."

"I've tried getting help in a crisis but there are too many barriers to it because they wanted more information than I was comfortable sharing. I am disabled and 'on again, off again' homeless, so a lot of services aren't even accessible."

"Being a legal guardian and having Information about history, past hospitalizations, etc., isn't respected here during a crisis."

> *"There's a lot of fear surrounding asking for help and like wanting crisis support. I think that's a big thing. People are scared, they're just gonna end up in the hospital and then be turned away and nothing is going to be done."*

<u>Design recommendations</u>:

a. Staff and clinicians play a key role in eliminating discrimination in crisis services. In particular, biases regarding low socio-economic status, homelessness, and disability have been mentioned in testimony we collected. Crisis services has a responsibility to examine and eliminate such biases internally and develop strategies to help people who have been harmed by these biases to be met with equity, dignity, and respect. Progress on this goal should be specific, actionable, and measurable.

b. For a "no wrong door" ethos to be meaningfully incorporated into crisis services, all members of our communities need to know and trust that if they seek help, they will not be turned away due to lack of insurance or ability to pay for services. Unlike many aspects of our healthcare system, crisis services are designed to be free of charge. Providers should work to communicate to the public in general and to high-risk populations in particular that crisis services are free.

c. Individuals with mental or behavioral health challenges have experienced barriers to receiving care, including being told that they do not meet criteria for care or that they are not eligible due to co-morbidities or a dual-diagnosis. A key example of this is when someone self-medicates with substances to deal with crisis, and is therefore disqualified from accessing needed services. Crisis service providers should take every step possible

to ensure that health status or substance use history does not function as a barrier or bias for those seeking services.

Hypothesis #5: Law Enforcement

Hypothesis #5: People we spoke with feel that non-police mobile crisis response would enable greater trust from community members and be helpful in de-escalating crisis situations. This perspective was broadly shared by those who have had both positive and negative past experiences with law enforcement in moments of crisis.

(relevant codes: law enforcement, mobile crisis response, de-escalation, incarceration, lasting impacts of justice involvement)

Summary:

Portions of the testimony or focus group discussion which support our hypothesis that a non-police response would facilitate greater trust can be broadly grouped into the following categories:

a. description of past negative experiences with officers,
b. description of negative impacts of individuals living with mental illness being incarcerated or otherwise justice-involved,
c. a sense that police officers are ill-equipped to connect individuals in crisis with needed resources or that no such resources exist, or description of past attempts to access medical or psychological care which resulted in unwanted or unwarranted interactions with law enforcement.
d. anxiety or fear concerning the prospect of seeking help via 911, police welfare checks, or similar existing mechanisms,

e. relatively good or benign interactions with police which led the participant to believe that a non-police crisis response option would be wise or beneficial.

In describing past negative experiences with law enforcement officers, participants relayed their firsthand experiences as either an individual who was in crisis due to a mental health condition, or as a family member or caretaker of such an individual. Some of those stories include incidents in which police were physically violent toward the person in crisis, while in others the negative experience described by the participant was the result of implicit or explicit threats of violence toward the person in crisis or other loved ones. In either case, a common theme was a sense that the presence of law enforcement officers further escalated an already volatile situation, and sometimes led to additional psychological harms or traumas, even in those incidents in which no physical violence occurred. The following direct quotations provide a sense of what some people have experienced:

"The doctor's office called in a welfare check all the while I was on the phone pacing and crying. The police in force showed up at the rural home with their guns leveled at the house. My sister tried to approach them and explain what happened but the police yelled at my sister and put her in the back of the patrol car. The police would not leave and as they were yelling at the me, I got physically sick to my stomach because of all the stress. I was afraid a bullet was going to rip into me."

"I called 911 and stated my son needed hospitalization for a mental health episode. When the police arrived, they instead chased [my son] through the house and were tasing him in the living

room with [my] daughter present. Then the police chased [our]son through the neighborhood and when they finally caught him they took him to jail instead of to the hospital."

"JCC called for a welfare check. Six to eight different police officers showed up at the scene in a firing squad type of way."

"Every time in Medford Oregon I was arrested and taken to jail even after explaining to each police officer that I was having psychotic episodes and had a mental health disorder. I was taunted by the police multiple times and it made it difficult to stop screaming at the world. Correctional officers also disrespected me every time they checked on me and would hear me screaming they would just mock me… It took days to get to medication or to get to a counselor and I spent days in jail which was unfair I believe because all I did was yell…I… did not harm anybody. I don't think anybody should go to jail for that."

"You don't know what to do, so you dial 911 to request help. Little did I know what I was unleashing on my son by requesting assistance. A swat attired armed police team arrived on my street… The trees across the street had an armed swat policeman behind each one. Three armed police officers went up the front porch and knocked on the door. When my distraught, unarmed nude son, trying to struggle into a pair of jeans, opened the door, the police shot him with a taser. Then, because the police had totally escalated the situation, they handcuffed my son, put him in a police car and took him away… This is what mental health care in the Rogue Valley looked like in 2011 and it has continued to devolve."

"I called 911 thinking I was getting an ambulance [for my daughter]. Instead, I got the police, the Ashland police… And I came out and four big policemen were pushing her against the dumpster. Meanwhile, she's telling them, you know, she's being hurt. She wants me to rescue her. The police are telling me to leave her alone. They handcuffed her throw her in the police car. I said you can't take her to jail. You have to take her to the hospital. I keep calling and say take her to the hospital. Finally, in the morning, I get a call from the hospital that say they say we have your daughter. I say Thank God. They said 'do you know she has bruises all over her body?' I said 'no.' So my daughter is unconscious in the ICU for having a mental health crisis…"

"…And I kept getting advised by his therapist to call the police if he if he does that. And I resisted that for a long time. And then I did it and have regretted it ever since. You know, it could have been far worse, but it was traumatic for him. Not helpful. It gave him a very deep seated fear of police."

Accounts presented to the CEC concerning negative impacts of individuals living with mental illness being incarcerated or otherwise justice-involved included specific harms which came about while in jail or prison. There were also ~~as well as~~ broader and more pervasive concerns that when individuals who are dealing with mental or behavioral health crises are entered into the criminal justice system they end up facing a variety of future life challenges. Those challenges include difficulty securing safe and stable housing, difficulty securing stable and meaningful employment, and difficulty rebuilding trust with family members, caregivers, or other

community members, not to mention having to carry the feelings of personal shame and failure that come with being unnecessarily adjudicated a criminal The following direct quotations provide a sense of what some people have experienced:

"In 2015, my son was manic and was picked up by the police… He was arrested and in jail was severely beaten and tortured. Judge dismissed charges and he spent time in hospital. He got an added diagnosis of PTSD and has struggled ever since."

"Every time in Medford Oregon I was arrested and taken to jail even after explaining to each police officer that I was having psychotic episodes and had a mental health disorder. I was taunted by the police multiple times and it made it difficult to stop screaming at the world. Correctional officers also disrespected me every time they checked on me and would hear me screaming they would just mock me… It took days to get to medication or to get to a counselor and I spent days in jail which was unfair I believe because all I did was yell…I… did not harm anybody. I don't think anybody should go to jail for that."

"I learned to tell the police every time they showed up, you know, I was like, I'd be like, 'I am schizophrenic, 5150, I'm tripping you know,' I mean, and, and they would just ignore that and treat me like, you know, like if I was being violent and stuff, but I wasn't even being violent."

"But I never, ever wanted to get the police involved. Because I didn't want my loved ones to get into trouble, to go to jail to lose their job to lose, you know, you lose your job, you lose your health care, potentially you lose your housing."

"My son was psychotic and there was no treatment place(s) available. I tried having him stay with me and he frightened my neighbors (not to mention myself) and jeopardized my housing. He had to leave my home and over a short period of time, after police in several local towns did nothing except move him along, he finally received a felony charge and was placed in Jackson County Jail for 6-1/2 months in solitary confinement before… The 6-1/2 months of solitary confinement greatly damaged my son a great deal and it may have irreparably damaged our relationship as well."

"I have seen my loved ones who have had interactions with the criminal justice system because of something that fundamentally is not a crime, you know, mental illness or substance abuse is the big one, go to jail, and then you know, get a record. And because of that, these crimes are now preventing my family members even who have more than a decade clean and sober, they still cannot get housing in the Rogue Valley… And so you know, these, like property crimes, drug related crimes, which sometimes escalate to things that are a little bit more serious… I feel like all that could have been prevented if treatment was just available in the first place."

Some participants described their sense that law enforcement officers lacked the skills or resources to connect people in crisis with help or treatment. Such descriptions frequently overlap with incidents in which the person in crisis sought medical or psychological care through an ambulance or emergency room, but were confronted with unwanted or unwarranted law enforcement presence, which was sometimes experienced as a barrier to care. A number of participants expressed a sense that police were the only resource available to respond to calls for

help, but they lacked appropriate training to de-escalate the situation or be otherwise helpful. As a result, they may have acted as a barrier to seeking meaningful care. In one strikingly tragic incident, police conducted a series of welfare checks in which they determined that an elderly woman suffering from dementia was "fine," only for her to die by suicide within the week. In describing these past experiences, some participants also relayed their hopes or aspirations for what a non-police mobile crisis response service could or should include. The following direct quotations provide a sense of what some people have experienced:

"My mom went back to the hotel. From there things got considerably worse. Three welfare checks to the hotel and a couple of hospitalizations later over the course of less than a week. All the people who conducted the welfare checks said mom was fine when mom was NOT and in fact turned out to be actively suicidal."

"We have tried to call 911. And then the cops respond… And so most of the times, (my son) can kind of pull himself together to show he isn't a danger to self or others, which is the police standard. And, you know, for the two or three or five minutes when they're here, they said, 'well, nothing we need to do, he's okay.' So they wander off again. And as soon as they're gone, we're back to crisis."

"I was told (by the crisis hotline) to call the police. I don't want to be told to call the police, I want to be able to talk directly to someone who might understand a way to deescalate the situation I find myself in. And I think that mobile crisis team that would be available quickly,

would be more likely to do that, then sending out local police who have very little training in in how to, to de-escalate situations."

"..our experience has been that our son ended up in jail because the police did not understand that he had an episode and that he cannot control that, what he's saying or doing at that point, if there would have been somebody who knew how to talk to him, I think we could have been accomplishing much more."

"And having a visit with mental health instead of police, I also feel like would have been much more calm, and not so scary for the mentally ill person."

"I've actually had fewer violent kind of experience with the police in Medford, but what I've had more often is dismissal. If we take him to the hospital, they're just gonna let him go… And I kept calling the representative at Jackson County Mental Health. So then the police come, they talk to him, he's calmed by that, and oh, they say 'there's food in his cupboards, we can't take him to the hospital because he's able to take care of himself.' But he needs help."

"All I needed was some medication. And instead, I'm in that situation where I'm in the ER, and I've got a police officer looking out for me, and I couldn't go to the bathroom without the door being ajar. You know, it just, it was traumatic."

A frequent theme in participant experiences has been a sense of anxiety or fear concerning the prospect of seeking help via 911, police welfare checks, or similar existing mechanisms.

Participants described past experiences of negative encounters with law enforcement, as well as knowledge of disproportionately high incidence rates of individuals living with mental illness being killed by police. This knowledge and concern about the possible dangers has led many of the people who spoke with us to conclude that they can never use services such as 911. The following direct quotations provide a sense of what some people have experienced:

"I've seen too many examples of mentally ill being killed by police. Our son already has a violent record so I don't think law enforcement would pause. So I can't call 911."

"But I never, ever wanted to get the police involved. Because I didn't want my loved ones to get into trouble, to go to jail to lose their job to lose, you know, you lose your job, you lose your health care, potentially you lose your housing."

"And if we, you know, called for the police to help [I believe] that he would do death by cop. And so death by cop has become kind of a kind of a constant thing theme in our lives…. Yeah… having zero options, really nobody to help in a crisis situation because we don't have a mobile crisis unit of trained people who could help in those situations."

"…and that's the fear of every parent that has to call the police. You know, is this going to be adverse? Are they going, you know, are they going to get killed? Are they going to be dragged away to jail? Are they going to listen to me?"

There were also participants who described relatively good or benign interactions with law enforcement officers. Within these descriptions, a few patterns emerge, such as families who have developed personal relationships with officers in order to ensure the safety of loved ones, and

"And so, um, our last experience with the Ashland Police Department turned out to be pretty good, they were helpful. They were understanding, but they were all people who were familiar with our son in his problems."

"I've had good experience with police, too, that did deescalate. And they handled it well. It's just but it's, uh, you'd never know what you're going to get… Well, if you get the one who knows what they're doing or not?"

"I would definitely not want any police men in uniform. I, I heard what [Participant_C] said about, you know, that could be useful in terms of creating a safe space kind of boundary to keep other people away, perhaps. But no uniforms, or identification as police."

Finally, there was one participant who stated she believes that police have an important role in crisis response. In imagining a likely scenario in which her loved one might need to access crisis services, she suggested that police could or should be present in order to create a boundary or barrier, so that curious on-lookers or pedestrians would not become involved, and to protect the safety of everyone involved. She explained her vision for such as system in the following manner:

"…if I had a dream, a dream mobile crisis, my son has drunk too much he's on meds, he's absolutely out of it somewhere on the property of SOU, which is where he would in the past, just kind of collapse. I would want people to show up. I would want, I would want one policeman there. But I want I would, I would want him to be under the authority of a mental health professional. Or even two mental health professionals. I think that policeman might be necessary to even keep people away, you know, and do things that might be necessary with onlookers, or with other people who want to get involved. And then the almost creating a safe space, okay. So that the mental health people can go in there and talk to [my son]"

Considering the testimony which we have heard and read, and what we as members of the CEC understand about the capacity of crisis response services, we have come up with the following set of design recommendations for crisis services in Jackson County.

Design recommendations:

a. Mobile crisis response teams can be highly effective at building trust with individuals in crisis and de-escalating tense situations without the involvement of police. In designing the policies and procedures which stipulate how mobile crisis response teams will work with law enforcement, and under what circumstances, the community mental health provider should ensure that law enforcement officers are involved only when absolutely necessary, such as when an individual is an immediate danger to themselves or others. Therefore, the community mental health provider should develop these policies and agreements in consultation with community members with lived experience of crisis.

b. When individuals in crisis are subjected to citations, physical coercion, arrest, or incarceration, it makes things worse for them. This undermines public trust and may lead to lasting harms, including traumatization of the individual and family members as well as increased barriers to recovery such as loss of all personal belongings, personal documents, vitally important prescription medications, and psycho-social supports. Crisis service providers should design mobile crisis response policies and procedures so as to avoid these sorts of outcomes whenever possible given state and federal laws and the safety of all concerned.

c. Individuals in crisis and their families and caregivers need to know that if they call for help that it will not put them at risk for physical violence. Mobile crisis response can be a solution to that need. To do this effectively, mobile crisis must work in close collaboration with law enforcement agencies, and must be designed to have the scale and capacity to respond to the large percentage of calls for service which do not require a police response.

Methodology

Planning: The CEC began planning a series of listening sessions in November 2021. The stated purpose of these events was to solicit perspectives regarding the proposed expansion of local crisis services from people in Jackson County with lived experience of mental or behavioral health crisis.

In order to preserve a safe, intimate, and conversational tone at the event, each listening session was broken into several breakout rooms, consisting of a trained facilitator, a notetaker, and between three and eight ~~3 and 8~~ participants. Notetakers and facilitators received training through a series of workshops in early January 2022, led by CEC members Kyle Lane-McKinley and Meesha Blair.

Recruitment: CEC members designed and distributed flyers in both English and Spanish, which were distributed at local grocery stores, public events, health clinics, and other settings. Additional outreach on social media, radio, email blasts, and local events calendars was facilitated by working with partner organizations. All outreach materials placed an emphasis on the need for individuals with lived experiences of crisis to share their perspectives, using a strengths-based model which acknowledges the wisdom and resilience that people who have lived through challenging events can share. Interested individuals were directed to a registration link so that organizers could have some sense of how many people might attend each session. Any participant who requested it was granted a $20 stipend in recognition of their time, which was paid out in the form of a pre-paid Visa card. Seventy-five individuals registered for January 2022 Listening Sessions events, and 47 actually attended.

Setting: Due to the ongoing dangers of the COVID-19 pandemic, these events took place online, over Zoom, in January of 2022. Three Listening Sessions were planned, one of which was to be conducted in Spanish. Unfortunately, none of the participants who registered for the Spanish Language session actually attended. The other two events were well attended. Following a general introduction to the format and the topics at hand, facilitators obtained oral consent to participate and be recorded, and then led small groups in open-ended, semi-structured discussions for approximately 90 minutes.

During each event, one additional CEC member was on hand for technical support, and two members with appropriate training were on hand to offer social and emotional support should any participant need someone to speak with one-on-one. No one made use of this service, but several participants expressed appreciation that it was available.

Prompts: In November 2021 CEC members developed a series of prompts which were used to guide conversation during the listening session. For example, one prompt read: "Is there anything which you would like to see from the mobile crisis in the future? If so, what? What should support from a mobile crisis unit look like?" All prompts are provided in their entirety in Appendix C of this document.

Transcription: following the Listening Sessions, recordings of each breakout room were collected and submitted to an online, automated transcription software tool (called "Otter.ai") which was determined to be secure for health-related information. Kyle Lane-McKinley used

these automated transcripts plus notes from notetakers as the textual basis for analysis. All personally identifiable information (names, street names, employer names, etc.) was stripped out of these transcripts or otherwise anonymized prior to analysis.

Codebook Generation: a group of five members of the CEC volunteered to work together on the qualitative analysis. Work began via an inductive analytic method in which several transcripts were assigned to each volunteer. The volunteers each read the transcripts carefully and made notes on themes or "codes" which arose. Then, working collaboratively, members reduced a compiled list of codes by eliminating redundancies and honing definitions. The full codebook, with accompanying definitions, can be read in Appendix A. Codes are organized into "top level" codes as well as subcodes which fall within broader categories.

Coding software: using qualitative analysis software NVivo, Kyle Lane-McKinley annotated or "coded" each transcript using the codebook which had been created by the working group. This process makes it possible to pull up all information related to a specific code or theme.

Hypothesis Generation: concurrent with the coding process, the qualitative analysis working group identified a series of "hypotheses" or concepts, listed in the "Top Level Findings" above and explored in detail in individual sections. The group developed a series of nearly 30 such concepts, of which five were selected for initial prioritization. Those hypotheses reflect themes which came up repeatedly in participant testimony, and appeared particularly relevant to the task of designing an expansion of crisis services.

Identifying recommendations: after the top five hypotheses had been identified, the working group used NVivo software to pull out all testimony relevant to each hypothesis by determining which codes are relevant to a given hypothesis. By reading through all relevant testimony, working group members were able to summarize all testimony relevant to that hypothesis, and issue a series of brief design recommendations, accompanied by supporting direct quotations from the transcripts (which were edited for brevity and clarity).

Works Cited

NAMI. (2018). *Navigating a Mental Health Crisis: A NAMI Resource Guide for those experiencing a mental health emergency*. https://www.nami.org/Support-Education/Publications-Reports/Guides/Navigating-a-Mental-Health-Crisis/Navigating-A-Mental-Health-Crisis

SAMHSA. (2020). *National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit* (p. 80). SAMHSA, HHS. https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

SAMHSA-HRSA Center for Integrated Health Solutions. (2015). *Glossary*. http://www.integration.samhsa.gov/glossary

Trauma-Informed Care Implementation Resource Center. (2018, August 8). *What is Trauma-Informed Care?* Trauma-Informed Care Implementation Resource Center. https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/

U.S. Census Bureau. (2021, July). *U.S. Census Bureau QuickFacts: Jackson County, Oregon*. https://www.census.gov/quickfacts/jacksoncountyoregon

Appendix A: Codebook

Name	Description
Additional adjacent systems	Any discussion of structures or systems which are closely connected with Crisis Response services but which do not appear under other top level codes.
Ambulance or EMT	Any mention of ambulances or EMTs, including instances in which EMTs act as mobile crisis response or as part of a co-responder model (formal or informal) with law enforcement.
Criminal Legal System	Role of District Attorney, Court, Specialty Courts, Probation, Jail, Juvenile Justice, Community Justice/ probation in behavioral health crisis system or other forms of adjudication; does not include police / law enforcement proper
Education system	Any reference to the role of formal educational institutions (k-12 schools, colleges, etc) as a source of support and / or involvement in crisis response. Includes any reference to concerns about the mental health of students as such.
Informal Solutions	Efforts by the community to solve societal problems on their own, e.g. mutual aid programs, mental health first programs, etc
Transitional housing	Any reference to live-in voluntary care for people living with mental illness or for people transitioning out of homelessness. Includes: Transitional housing / assisted living / peer support respite programs
Additional codes	Any codes which are deemed important to catch but do not fit within other top level codes
Caseload	Number of clients served per crisis response staff person
Community education	Any reference to a need or value of educational programming in broader community, such as programs focused on destigmatization, peer supports, or creation of informal supports through educational initiatives.
COVID-19 impacts	Any mention of challenges or knock-on effects of COVID-19 or pandemic response measures.
Definition of crisis	Any discussion of how crisis is defined by various systems, organizations, or agencies.
Medications	Any mention of psychiatric medications, including rejection / resistance to taking medications
Pockets of excellence	Any discussion of excellence or outstanding results from any or all portions of existing crisis response systems (including law enforcement, county mental health providers, emergency services,

Name	Description
	and existing hotline). Code is suggestive of those qualities or practices which should be nurtured and supported within existing system.
Staff safety	Any reference to the importance that staff members / crisis responders / law enforcement officers have a need to be safe when responding to BH crises.
Barriers to accessing crisis services	Rules, protocols, capacity, funding levels, stigma, lack of insurance, disability access, location, etc that make it difficult or impossible for clients to receive crisis services when needed
Cultural aversion	Any discussion of various forms of care (therapy, medication, medical help) not being a cultural norm or expectation. Includes any mention of norms based on gender identity, such as men not seeking help, or men not being willing to try therapy / psychotherapy.
Cultural competency	Any reference to the importance of crisis responders / other staff maintaining cultural awareness or competency in non-majority cultural values and understandings. Particularly applies to cultural differences associated with racial, ethnic, or nation of origin minorities, but may also apply to sexual & gender minorities (LGBTQ+ communities), youth sub-cultures, etc.
Difficulty identifying provider	Any reference to difficulties in identifying a provider of any sort (therapist, social worker, crisis care, case worker, etc) or in obtaining care from providers.
Doesn’t fit criteria	Any description of being denied care or worry of being denied care because the current symptoms don’t match a narrow definition of “crisis,” or similar, such as meeting criteria for involuntary commitment.
Geographic barriers	Any discussion of difficulties accessing care in situ, such as those in crisis not being able to travel to a clinic or an office
Help rejecting	Any discussion of refusal to seek help or a client's sense that they are not in need of help despite manifest symptoms. Includes any discussion or reference to anosognosia
Hesitant to ask for help	Any discussion of hesitancy to seek help (clinical, crisis services, etc) due to fear of being judged, fear that current symptoms do not constitute crisis, etc.
Navigating Crisis System	Any reference to difficulty in determining how to access care, where to start, who to call for help, etc. Any reference to the need for "one call" or "one stop shop" to find the right service at the right time for each client. Includes the need for educational and wayfinding resources for those who are currently experiencing crisis.
No wrong door	Any reference to the “no wrong door” approach to crisis services, or

Name	Description
	description of experiences of encountering a "wrong door" barrier to care. Includes any reference to challenges of receiving "endless referrals".
Staff capacity	Instances where lack of capacity created a problem or barrier. Suggestions regarding staffing capacity issues
Stigma	Any discussion of the role that stigma plays in determining whether people get help. Includes discussion of how stigma impacts how individuals view themselves, etc.
Traumatization or of client	Experiences of crisis response that traumatize clients and/or alienate clients from seeking services, inc. being advised on crisis call line to call police, police response and involvement in criminal system, etc.
Wait times	Any reference to waiting lists to get access to care, or time between current experience of crisis and an appointment for care.
Challenges or crises experienced by clients	Any discussion or reference to symptoms or diagnosis of mental illness or related challenges which clients seeking crisis response services describe experiencing
Anxiety & Panic	Any stories and/or experiences shared about living with Anxiety & Panic and how it affects ability to live and survive
Comorbid Conditions	Services needed to address combination of mental illness and/or addiction in clients
Depression	Any stories and/or experiences shared about depression
Fear	Any reference to an individual who is experiencing crisis being afraid of law enforcement, crisis responders, EMTs, other providers, or others seeking to provide care.
Psychiatric diagnoses	Any discussion of experiences related to a psychiatric diagnosis (such as schizophrenia or other psychotic disorders). Includes any discussion of how perception of various diagnoses, or stigma regarding diagnoses, may shape the kinds of care or kinds of crisis response encountered.
side effects	any discussion of side effects from psychiatric medications
Substance use	Any discussion of use or abuse of controlled substances in relation to mental health
Suicide	Any discussion of death by suicide, attempted suicide, or suicidal idiation, or concerns that a family member / caretaker has that a person is at risk of suicide.
Components of Crisis Response (via SAMSHA)	Any reference to any of the three core components listed by SAMSHA as key to effective crisis response: someone to call, someone to respond, somewhere to go.

Name	Description
Crisis Call Line (Component)	Crisis hotlines, inc. JCMH Crisis Line, 911, 988 with no barriers to being heard
Crisis Stabilization Center (Component)	Walk-in, drop-off crisis center using “no wrong door” approach to providing crisis services in an calming “safe space” to meet a variety of crisis needs in a local location. Sometimes referred to as a "crisis receiving center" or similar.
Crisis System Collaboration	Seamless coordination between all components of crisis system, inc. record sharing, system information sharing, and “one stop shop” for clients
Mobile Crisis Response (Component)	Trained mobile response team that goes to wherever person in crisis is located and when they need it, e.g. in lieu of police or with police, but without officious uniforms or sirens, prepared to calm and de-escalate crises
family as caregivers	Any discussion related to family or other informal supports for those experiencing crisis
Caregiver and family related concerns	Concerns expressed by caregivers, including family members, which are different from, or contradictory of, the concerns or experiences of clients / patients
Family as caregivers	Any discussion of how friends, family, or chosen family provide mental health supports.
Family members and welfare checks	Any discussion of decision making process which family members / caregivers go through in deciding whether to call for help or seek a welfare / wellness check.
Informal supports	Supports provided by non-clinical spaces, inc. wider community, social connection, family, faith groups, NAMI, etc.
Features of Crisis Response	Any reference to features or aspects of what an effective crisis response system includes / should include.
Client education	Any mention of the importance that educational materials for clients / patients and / or family and caretakers can have.
Communication Skills	Teaching and modeling communications for families of clients, e.g. LEAP, non-violent communication, emotional CPR, respectful, non-judgmental, affirming, reducing stigma, open dialog
Comorbidity with SUD	any discussion of how substance use behaviors among those living with mental illness may present barriers to accessing care or may present additional challenges for crisis response.
Continuous Quality Improvement	Collection of data and client feedback to assess for quality improvement of crisis services
De-escalation	Any reference to the importance of diffusing conflicts or de-

Name	Description
	escalation of interactions between those experiencing crisis and others (whether law enforcement, care providers, family members, or other community members)
Follow Up Care	BH services that follow crisis services with warm hand-offs, referrals, personal appointment-making before leaving crisis center, written follow up instructions like ERs do for medical patients, or navigation services.
New Supports	Any reference to a need for systems which help users / patients to build new or additional supports in their private lives outside of clinical settings. Includes any reference to need for crisis response to link users with additional services (housing, outpatient services, foster care, sexual / reproductive health, food stamps, etc)
Peer Support Staff	Peer Support Staff
Safe place	Any reference to needs for a safe place for people to go to receive crisis services. Includes reference to law enforcement needing a place to take people other than jail or ER.
Staff support	Support for crisis response staff
Staff training	Any issues with mental health staff training, either positive or negative. Any repercussions of said training/lack of training
Supports for caregivers	Support system for caregivers/families of people who experience BH crisis, including family participation in treatment planning and crisis coordination or who should always receive immediate notification of where their loved one is located (such as a jail, hospital, crisis center, etc).
Transportation	Any discussion of the need to supply transportation to those experiencing crisis; includes ground transport.
Welcoming Environment	Providing a non-clinical environment that is homelike and/or includes outdoors. Includes any discussion of what the physical environment of crisis facilities should look or feel like. Includes any discussion of specific amenities desired (showers, free clothes, stuffed animals, educational resources, etc)
Hospitals	Any mention of the role of hospitals or emergency rooms in responding to crises, including hospitalization or attempted hospitalization for mental health conditions.
ER connections to BH system	any reference to hospitals providing patients a link to behavioral health crisis system
Hospital Emergency Room	Any reference to a hospital emergency room
Housing and where to	Any mention of housing, housing insecurity, or homelessness, as

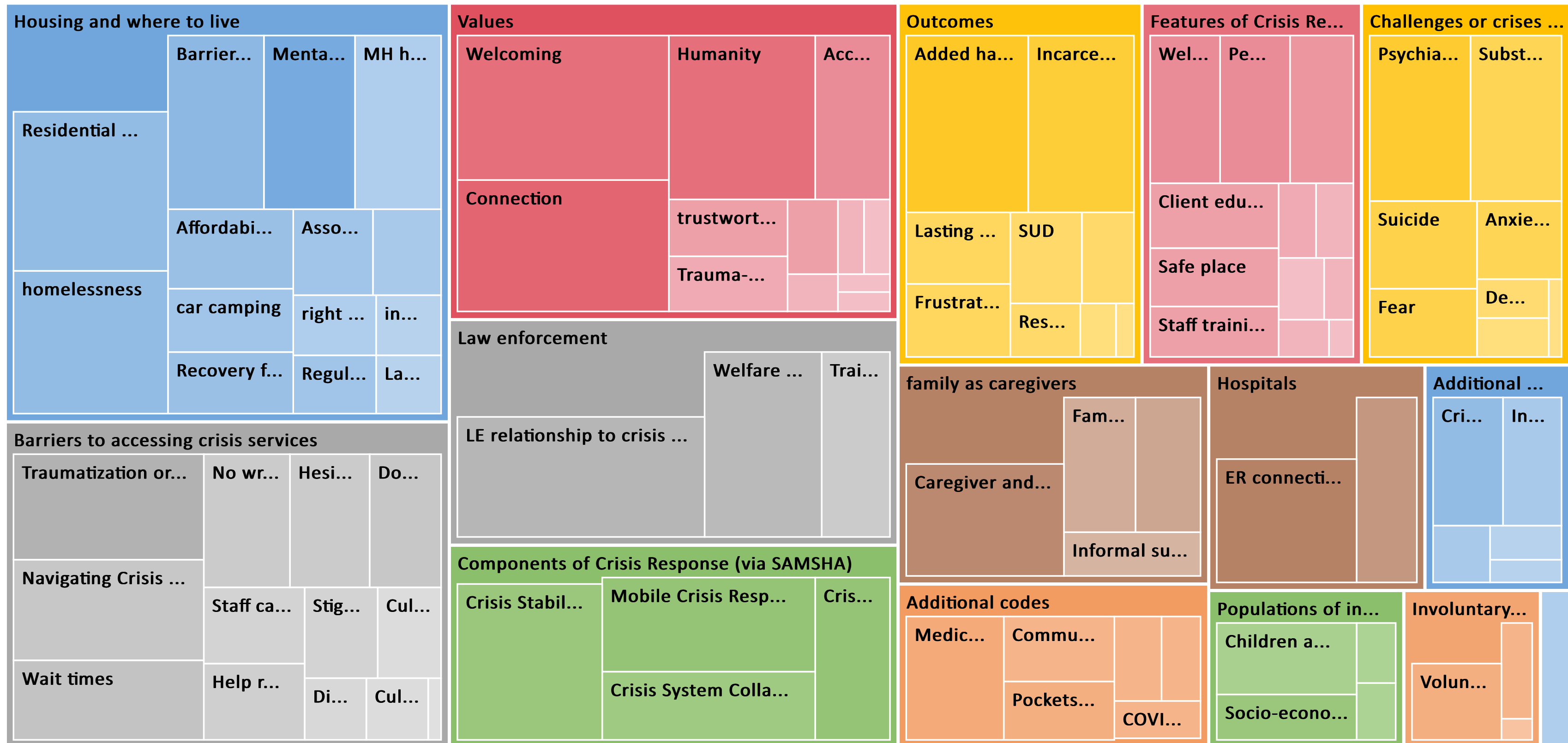
Name	Description
live	well as any discussion of where to live during or after a crisis.
Affordability	Any reference to affordability of housing and / or unaffordability of housing.
Assortment or type	Any discussion of types of housing available or how types of housing may impact mental health and / or recovery.
Barriers to housing	Any reference to barriers to obtaining affordable, safe and secure housing. May include discussion of financial barriers, logistical barriers, racial/equitable barriers, or psycho-social barriers. Also includes any reference to "housing-first" philosophy or similar strategies for removing barriers to housing.
car camping	Any mention of using an automobile or similar vehicle as shelter in place of traditional housing units
homelessness	any mention of people without housing
Housing insecurity	Any mention of experiences of housing insecurity
inventory or lack of inventory	Any mention of housing shortage, or reference to how low inventory of available housing impacts ability to find or maintain housing
Lack of housing as barrier to care	Any reference to homelessness or lack of housing functioning as a barrier to seeking or maintaining mental healthcare.
Mental illness as barrier for housing	Any reference to mental health challenges or similar functioning as a barrier to securing or maintaining housing. Includes any reference to losing housing due to expressing symptoms of mental illness or losing housing due to non-compliance with rules, etc.
MH housing	Any reference to dedicated housing for those experiencing mental illness or crisis
Recovery from homelessness	Any discussion of challenges associated with "coming back" from homelessness. Includes discussion of logistical challenges such as obtaining new identification, record of employment, etc as well as psycho-social challenges such as stigma or internal struggle.
Regulations as barriers	Any reference to regulations on housing acting as a barrier to securing or maintaining housing. May refer to design / permitting regulations or rules about who can access various housing program supports.
Residential Care or Supportive housing	A place to come to for voluntary care and transition to longer term care or other related community based services such as supportive housing.
right to sleep	any mention of a right to sleep, including discussion of individuals who prefer / need ability to camp / remain 'homeless' rather than utilizing shelters or supportive housing options.

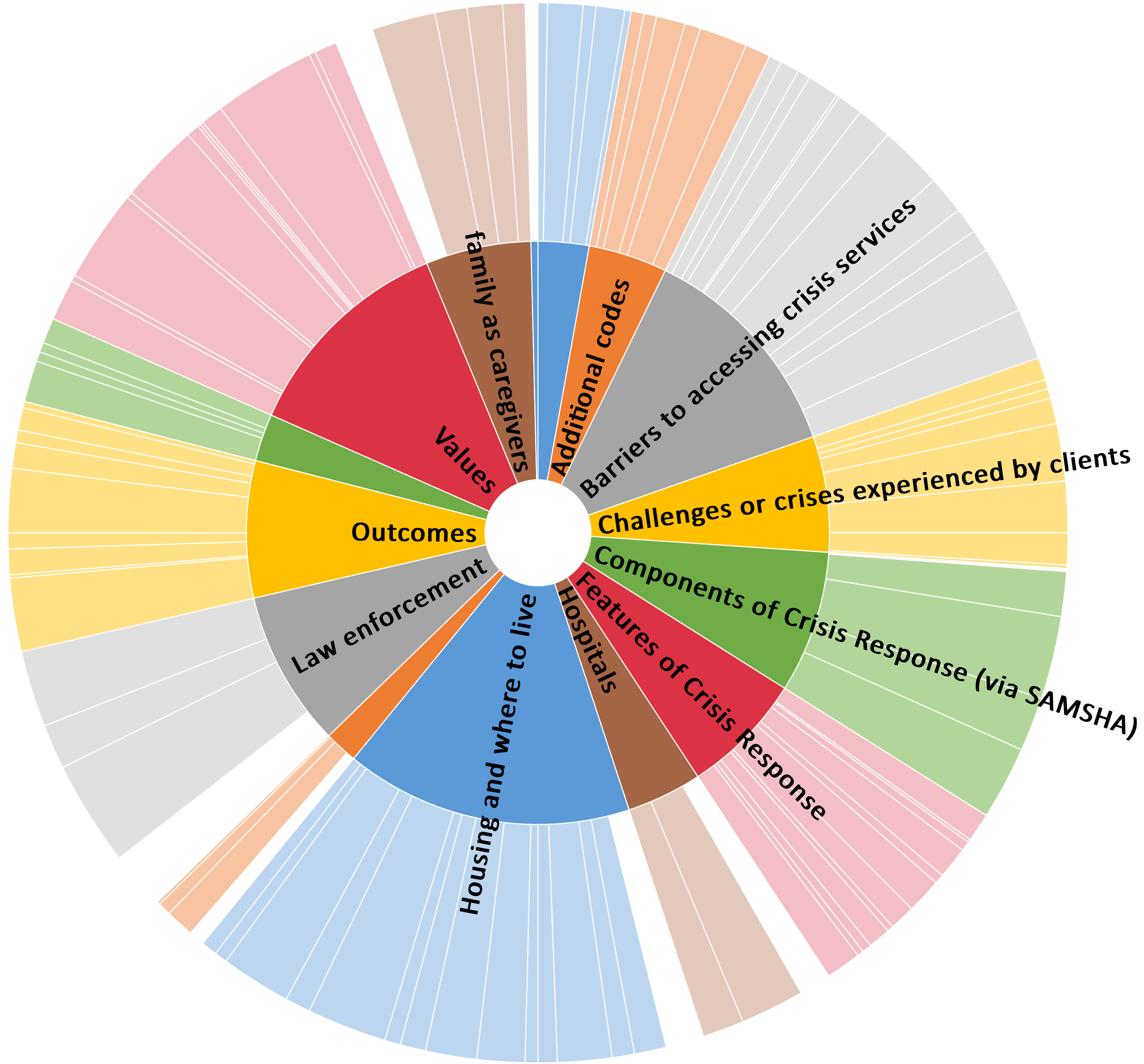
Name	Description
Involuntary hospitalization	any reference to involuntary commitment, involuntary hospitalization, temporary observation periods, or related mental health / psychiatric evaluation
standards for involuntary commitment	any reference to the standards utilized to determine whether someone should be subject to involuntary hospitalization. Includes any discussion of whether standards are appropriate, and whether those standards and legal guidelines are adequately adhered to.
trial visit monitoring	any reference to the practice of trail visit monitoring or related evaluations during or after a period of involuntary hospitalization / civil commitment.
Voluntary vs. involuntary crisis services	any reference to whether crisis services should be based on voluntary / consentual participation. Includes criteria for involuntary care and incentive/coercion-based care – the “can’t be helped” situation and the “no choice” situation
Law enforcement	any reference to law enforcement officers or agencies
LE relationship to crisis response	Any discussion of how law enforcement agencies interface with crisis response services, or how individuals believe that they should interface in an ideal system
Training for law enforcement	Any discussion of the efficacy of existing trainings for law enforcement officers or the need for additional trainings. Includes any discussion of the priority placed on training or best practices by law enforcement agencies.
Welfare Checks	Any discussion of welfare checks (sometimes called "wellness checks" or similar), whether initiated by family / loved ones or by an agency or provider. Includes any and all past stories of welfare checks and suggestions for ideal system.
Outcomes	Any discussion of outcomes for individuals in crisis
Added harm	Encounter with crisis response added to harms experienced by patient / client
Fatal results	Instances of when crisis response, mental health treatment, or SUD treatment was not successful and resulted in death
Frustrations	Any discussion of feelings of frustration with current systems
Harms reduced	Any discussion of individuals experiencing reduced harms or symptoms following encounter with crisis response system.
Incarceration	Any discussion of individuals experiencing crisis being placed in jail or prison
Lasting impacts of justice involvement	Anything related to impacts of conviction or incarceration which extend beyond the formal period of incarceration, such as difficulty

Name	Description
	finding work or housing, etc.
Results of MI	Results of living with mental illness and/or experiencing crisis
SUD	Any discussion of substance use, including substance use disorder or addiction, in response to untreated mental illness or other crises (homelessness, etc)
Warm relations	Any discussion of client / patient encounter with crisis response resulting in the building or maintenance of warm relationships and improved help seeking behavior.
Populations of interest	Any referrence to particular populations of interest or populations which have specific needs. Population may here be defined in terms of social identity (race, gender, class, etc) or any other shared characteristic (geography, etc)
Children and Youth	Any reference to the unique needs of children and youth (includes any reference to Crisis and Transition Services / CATS or transitional aged youth, i.e. young people up to age 24)
LGBTQ+	Any refernce to the unique needs or concerns of individuals / communities who identify as lesbian, gay, bisexual, trans/ non-binary, queer, or related sexual orientation / gender identities.
People of color	Any reference to specific needs or concerns of communities of color (Black, Latinx/ Hispanic, Indigenous, or other non-white racial / ethnic groups).
Rural communities	any reference to specific needs, concerns, or challenges in providing crisis services for rural communities
Socio-economic status	any reference to specific needs or concerns of lower socio-economic status groups or individuals, including how literacy / health literacy / access to education impacts ability to navigate systems.
uncategorized but important	Any items which appear important and relevant but do not fit existing codes
Values	Any reference to values or principles which participants feel should inform or govern the work of crisis response services
Accessibility for non-traditional users	Comments and suggestions around creating better accessibility to mental health treatment for all people, including those not typically thought of as “main stream”
Accountability	Making staff, law enforcement, agencies accountable for behaviors toward clients in crisis, receiving family and client feedback for quality improvement of programs and treatment
Connection	Comments on the need for human connection, affinity, belonging, or other social supports. Suggestions on how to increase it. Results of

Name	Description
	lack of connection.
Continuous Quality Improvements	Any discussion of how the system seeks ongoing input from users and / or community members about quality improvement.
Humanity	Any discussion of the importance of recognizing/ affirming the humanity of each client. Clients are treated as equals and as fully human.
Humility	Assertion that staff and providers should be humble or exhibit humility in working with those in crisis rather than projecting culturally inaccurate assumptions on them.
Non-profit	Assertion that new systems should not be driven by profit motives.
privacy and confidentiality	any discussion of the importance of privacy or confidentiality from providers or components of crisis response system. Includes any mention of hesitancy to share information with providers, or concerns about exposure to stigmatization due to divulging private information or diagnoses.
Strengths-based	Any discussion of the importance of recognizing or affirming the strengths of clients / patients, in contrast to approaches which emphasize the weaknesses or pathologies of clients.
Trauma-informed	Any mention of Trauma-informed care.
trustworthiness	any mention of how trust or lack of trust in existing systems, or trustworthiness / untrustworthiness, impacts experience of patients / clients / caregivers / family members
Welcoming	Any discussion of the importance of being welcoming, culturally appropriate, or inclusive of any and all clients / patients. Also any reference to the need for staff to avoid judgment.

Appendix B: Coding Visualizations





family as caregivers
Additional codes
Barriers to accessing crisis services
Challenges or crises experienced by clients
Components of Crisis Response (via SAMSHA)
Features of Crisis Response
Hospitals
Housing and where to live
Law enforcement
Outcomes
Values

Appendix C: Listening Session Prompts

At Listening Sessions conducted by the CEC in January 2022, the following prompts were used by group facilitators to encourage conversation and ensure relevance:

1. Share your experiences with mental health and substance use related crisis services.

2. Tell us how you want this system to work and what you need from crisis services. What do you need from a crisis response system?

3. We know that struggling with housing can impact mental health, and we know that struggling with mental health can make it harder to obtain or maintain stable housing. Has this ever been true for you? Have you encountered struggles with housing as part of your experiences trying to maintain mental wellbeing?

4. Is there anything which you would like to see from the mobile crisis in the future? If so, what? What should support from a mobile crisis unit look like?

5. What would you like to see from a crisis stabilization center in the future? What should support from a crisis stabilization center look like?

6. If you were to envision new crisis response services, do you have any thoughts of what principles and values you would like to see incorporated?

7. Tell us about the barriers that you face when trying to access care for yourself or someone else.