REALTIME FILE

NDRN-Alternative Emergency Response to Mental Health Crisis
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>> Ian: All right, all right, I think we will go ahead and get started. Good afternoon or good morning to some of you. My name is Ian and I'm the senior -- I'm a senior disability advocacy specialist for the National Disability Rights Network. It is my pleasure to be kind of hosting, seems like a strong word, but be at least facilitating this workshop on advocating for new emergency response crisis and we have myself, we have Phil, Hector, Cherene, and we are talking about this issue as it has become one of the news items that we have seen a lot as people who experience disability and their interactions with the police. It doesn't turn out so well and that is happening more and more, so more and more jurisdictions are trying different methods to respond to certain community crisis.

Where here to talk about that and we have -- we'll have presentations and then your questions at the end. At the bottom of your bar, you have the chat box that you can open up and then there's the closed captioning option and later, you can also ask a question via voice, and you can do that by raising your hand in the reactions pod at the end of the bottom bar, and we'll know who would like to enter or ask a question in that way.

Right now, I'm going to turn this over -- oh, OK. It's not reactions, it is in the participant link, thank you for that. Let me start with my colleague and friend Phil who will give you some guidelines that we have been working on at NDRN that is help shaping our thinking around alternative responses to community crisis. So, with that, Phil, I will turn it over to you, friend.

>> Philip: Thank you very much, Ian. Thank you very much for joining us. I want to spent a minute talking about NDRN's work in this area of supporting efforts to develop new emergency responses to community crisis, and some of the principles that we have identified and these are in our conversations with PAIMI Council Members around the country and people who are affected by police interactions, particularly people with disabilities, as well as NDRN's overall principles emphasizing personal autonomy and decision making. This is just kind of guidelines when you try to think about what should happen, what you don't want to happen responding to nonviolent situations in the community. We believe all interactions with people in crisis should be nonviolent and noncoercive, so any emergency should be on a voluntary basis. People should not be forced into situations that they don't want and that means the outcomes of community crisis intervention should not include incarceration or involuntary commitment to a mental health or other locked facility that has been an issue that has coming up in areas where there are co-responder models that is where police and mental health professionals responsible to energy and frequently that results in an involuntary commitment and that is something that our speakers may address.

It is important to remember that people in crisis who are seeking emergency assistance are not people necessarily with a mental illness or the person with a diagnosis, the personal crisis does not necessarily require mental health interventions, we're talking about emergency situations where is people need help, it does not mean they are looking to see a psychiatrist or they need to go to jail. It means they need help. Something that has come up is the role of peer support and advocacy, which we believe that should be central to any community-based, non-police emergency response program. It should be a peer-support component built into that and finally, affected communities need to be involved in the development and implementation of the

emergency response programs.

That goes to all levels, not only to emergency response program itself, but also in making sure there are services in the community. There is no point for an emergency response system if there is no place to bring people, so emphasize those points and I will stop there and turn it over to our speakers.

>> Cherene: Thank you so much, Phil. I appreciate it.

>> Philip: Welcome, Cherene is associated with the disability rights North Carolina, but also her own background in this area, which she will go into. Thank you so much for joining us Cherene.

>> Cherene: Thank you, Philip. I appreciate it. My name is Cherene. I am a psychiatric survivor. I came into mental health services at a fairly young age around 12 or 13, so if I do the math, I have been personally involved in mental health for about 33 years or so. I also work in the mental health system for 27 years nationally and internationally and to give you a little bit of context, I live in Charlotte. I'm the C.E.O. of an organization called Promise Resource Network and I'm the project Director of peer voice North Carolina. To give you a little bit about each, promise resource network is completely directed and staffed by survivors of a variety of different lived experiences and we have around 50 employees now and we operate 16 different programs, 16 different peer initiatives from diversion on the jail side to reentry on the jail and prison side, we do a lot around employment, supports around housing and homeownership. Our aims are flee-fold. One is to accelerate those who have been impacted. Our second aim, we do a lot of work around the peer support, our second aim is to shape system change to be trauma informed, facilitate while healing and recovery, so we do a lot around practice change, around technical assistance training and consulting work. Our third aim is social justice, so we look at policy-related issues, legislative changes, things that really do impact those of us with psychiatric substance use, former incarceration, experience of homelessness that are on the policy side. We impact that type of reform.

On the peer-voice piece of it that is our statewide effort and we operate through coalitions, specific coalitions. A few of them are named there. We do a lot of work to bring peer support into the justice system around diversion and all of the intercepts and we do world around enforced treatment, so that gives a little bit of what we do. We do operate a 24-hour a day, seven-day a week peer-run line. And we are starting a peer run respite here within the next month, so we're pretty busy at our organization. OK, next slide.

So, to just give you a little bit of context, I live in Charlotte, North Carolina. There are a couple of things to know about Charlotte. We are a southern city. We are a city of 2.1 million people. We are about 550 square miles of a city, so we are geographically spread out and we are very diverse in a variety of different ways as a city. In addition to our city, we have six towns in our community, which are mini cities so that gives you a little bit of the layout. Being in a southern city I can tell you my experience from moving from Chicago and New York and working all over the country and internationally, definitely the culture of being in a southern city takes on a different realm when we're talking about human rights and disability rights, so introducing

alternatives to police interventions can seem pretty radical in a southern city, but we are seeing these emerge in North Carolina. We have designed the community response team. We have a variety of mobile crisis teams in Charlotte, so we do have co-responder model with police and clinicians. We do have CIT and do trainings for our officers. You can call and request a CIT officer and we do have a mobile crisis team, so these things already exist here in the city of Charlotte.

I will tell you we have looked at involuntary hospitalizations as one example in our city. Since we started introducing co-responder models, our involuntary rate has increased 135% over the last 10 years as a state, so the trend is absolutely upward around a different variation of confinement. While we have done a better job of reducing for jail diversion and reducing incarceration, we have not done that great of a job of other versions of confinement and one of the things we share to people, to the person who is persons emotional distress, whether it is confinement in a jail or confinement in a hospital, it is still confinement. Being in a hospital is much more restrictive than it is being in jail, in prison, so we want to do hospital diversion and we want to do diversion from IDC. Can we go back to the previous slide, Phil? That's OK. No worries.

We have an absolute need for hospital diversion. We have a need to reduce commitment as the positively last resort around emotional distress and we have a significant issue around trauma-informed approaches, understanding culture, understanding the culture of poverty and creating safe spaces and environments where we are showing up connected to our community and supporting wellbeing. Thank you. Now we can go on to the next lied.

So, just a little bit about the team. This team is one that is by community for community. One of the things we have heard loud and clearly and we have said is people with lived experience is we do not want clinicians and white vans coming into our community that won't necessarily be welcomed just like officers in black uniforms are not necessarily welcomed. It requires us to reimagine this idea of community-based organizing and what the composition of a team and quite honestly what their function is. For that reason, we envision a team that is in community, that is supporting sort of the social determinants, supporting upward mobility, supporting people to get out of poverty, doing clothing drives, being there for community barbecues, people that are present in the community is the type of team that we are looking for, not just the team that is called in when there is an emergency or a crisis situation, and so that is a really important factor that you need to know in this.

We are looking at nonviolent, noncriminal calls, so things that are related to mental health, substance abuse, homelessness, welfare checks, basic needs those are the types of calls that we are looking to redirect away from police intervention if at all possible. We do identify it as a mobile team with a variety of different supplies and resources available in the van, available at the disposal of the team, therefore, making it available in the community. Some are medical based, some are contraception based, obviously, PPE, tents and tarps and food and diabetes supplies, hygiene products, things like that are what we are planning to be available in the van with this team.

We are kind of designing this as an 8-12 month project, but the first handful of months being community involvement and community direction, so it would be leadership from community and one of the areas that the community is deciding upon is where will be the dispatch with a mobile team like this? Is it going to be a 911 dispatch that will require a retraining of 911? Is it going to be 211? Is it going to be an independent line? Is it going to be a combination of both and they will all co-exist and be connected to each other? Those are decision points that still need to be made.

The biggest and what I would say our weakest spot is the division to what? You can't do hospital diversion if there is not an array of trauma based, culturally competent, sensitive, helpful, effective, I would say effective resources to divert people to. To us, sending someone to a crisis stabilization unit that is as locked, that also requires involuntary confinement is another confined space off of the hospital grounds and called hospital diversion. We are looking for real options that attract people that they want to engage in because they find it helpful and healing and safe. This is really the biggest challenge for us is the diversion to what, because we offer an array of peer-run programs. We have options available already to the community. Our warm line gets several hundred calls a week, and we do not use 911 and we do not IVC people. We are zero coercive and zero force, so with our warm line, we don't call 911 and do that type of thing.

We are looking at the data, the funding and the replication. We want to scale this beyond our community and what we are going to do is spend our first several months organizing and planning and designing together and we are going to implement it for six months and gather the data and determine is this neutral, is this effective, or is it harmful? If it is harmful, it goes away. Six months, pilot, done. If it is neutral then we are looking at modifying to make it helpful and if it is effective, we are going to learn from what worked well and build on the effectiveness. OK, last slide.

So just a couple more -- oh, that was the last slide. We are good.

>> Philip: Go ahead.

>> Cherene: Yeah.

>> Ian: Wrap up here?

>> Cherene: Yeah, we are going to do questions and answers at the end. Certainly, share your questions in the chat box and I'm glad to be here and grad it is getting the national attention it deserves, so thank you, Ian and Philip and Hector.

>> Ian: Thank you. Thank you very much. If we could go now to my friend Hector Ramirez and he has some information about programs and ideas and things that they are working on in Los Angeles area. Maybe not just Los Angeles, but in California, urban area, so Hector, it is all yours.

>> Hector: Thank you. Good morning, everybody. Thank you for having me here and having this space. My name is Hector Ramirez. My pronouns are he, them, we. I currently live with my family here in what is Los Angeles, but the great lands of the -- Indians. I'm on the Board of Directors for the disability rights in California for the wonderful state of California. I serve on the Board of Directors for the National Disability Rights Network, which is holding this event and is composed of memberships from all 50 states and U.S. territories. I'm a person with a disability. I'm autistic and I have a psychiatric disability and I'm hard of hearing, as I'm using CART to listen to you. I am more than anything, a disability rights advocate. I have been doing this my whole life and somebody that grew from an institution at the age of 4, came out before the A.D.A. was a thing, so I'm pre-A.D.A. generation and pre-many disability rights that we have, so I follow a long line of disability rights elders, so I follow that path and I'm glad that I was really given the opportunity to speak with you today here about this particular issue.

In addition to serving on those two bodies that I mentioned, I also serve in two different levels. at the state level, I'm on the behavioral task force, which is now tasked with reshaping behavioral services for the whole state of California and I recently got appointed to Los Angeles County reimagine community and I will highlight this community in reference to the work that Cherene and the other advocates throughout the state are doing. In the relation to alternatives to incarceration was voted by the voters on November 3 and it dictated that the annual -- of Los Angeles County, the reality it isn't. It is $25.6 billion this last year and with this measure, it was decided that we were going to create a community commission to address issues like the one that is being presented hereby actually having money directed to this. This came through the conversations during the Civil Rights protests that we had over the summer and not just here in Los Angeles, but across the nation. It was one of the measures that came out of the conversations about defending the police or funding alternatives to provide services in the community.

Here in Los Angeles County, we have 10 million people and it is a large number of residents and the reason why I throw out that number because Los Angeles County has the largest number of people with disabilities in the country, but also people with psychiatric disabilities or mental health conditions, depending on what people want to call them and they are located in two places, in our downtown jail or homeless in our street. I know not just from a statistical number, but having lived it and having had family members who have gone through the jail system, because somebody made the mistake of calling 911 asking for help and instead of getting the necessary cultural services, they ended up entangled in the police and the jail system and subsequently go into this horrible turmoil of ending up in the streets.

Another thing about Los Angeles to note is our diversity. Over 40% is LatinX. We have a significantly, if not second largest population of Asian-Pacific individuals that identify from that community. So, as a result of that, many of the individuals oftentimes have interaction with the law enforcement are from those backgrounds because of the number of residents, and interestingly enough, the second largest number of people who interact with law enforcement come from the black community, which is troubling because they don't necessarily represent a significant larger population of residents, but our significantly represented in our justice system.

So, over the summer, as many of you noticed throughout the country there were conversations regarding police interaction with people of color, communities of color, people with disabilities. In Los Angeles County, the majority of people that have been shot by law enforcement have been people of color, particularly LatinX and black and people with psychiatric disabilities being pronounce fully represented in those community, so we as a community march in the streets and some of us get hit or shot by the pellets when we were out there protesting for civil right, we wanted to demand as we had some sort of community action on the racial trends that we also had it around the people with disabilities, particularly people with psychiatric disabilities. That is why our supervisors in our county created this measure, which is not necessarily a defunding measure for police, but a reimagining the county's humongous budget and we look, for example, the programs that Cherene mentioned, community intervention, crisis training, and we have been working on those for the longest time, but we realize we needed a big component. We were doing piecemeal approach to fixing a very broken system and that is why it took such a transformative and brave, you know, step from our supervisors and counties to vote for this. It was voted very well by our representatives, and it was something that has begun to really transform the discussion. We just started meeting. Our commission just literally formed. This is the first time anything like this has been done in the country, so I think this is looking at some model for other municipalities to hopefully, implement and one of the things I'm really also honored about that is, among the people that were selected, we not only made sure it was women were represented, of course, that is the most marginalized community, people of color, but then people with disabilities.

I, as a person with a disability, I sit on this committee and I take my responsibility seriously and it shows the commitment that disability rights is going to play in the movement, not just for L.A. County, but other states, but the role for other states and at least my advocacy in California will play in this and the role that other states can play in similar efforts throughout the country, because we realize that the work that needs to be done is significant and so, it should be funded significantly, and it should be led significantly by members of the community.

Our commission is made up of one-third county officials, one-third board of supervisors appointees and one-third of community members, so we have a variety of stakeholder views at the table and our group initially, right now, we kind of decided that we are going to be focusing on six kind of different areas. The first being, of course, development in education, because we need to educate our community early on about disability rights and the need to right for helpful, culturally appropriate services rather than moving from a cookie model, one model fits all approach, but definitely as a way to do earlier intervention in our communities, by having a real honest conversation about disabilities and mental health needs for people of color, we know our mental health needs are significantly intertwined with racism, particularly the racism that we face, the minute we step out the door.

There is a reason why many of us are depressed or paranoid and that is because of the way we are treated, because of the color of our skin and our gender, women know this far more better than anybody else, the disparities that sits outside. That is one of the things we will be focusing first and second there is a workforce development project, and this is to help develop community agencies. I was interested in the community crisis response model that Cherene

was mentioning we don't have that here. A way to strengthen small businesses in the communities that we live, L.A. County being such a big county, your health outcomes and your justice outcomes literally depend on your zip code and that should not be the case.

The other item that our task force is going to be working is a rental assistance and housing supportive services. We were already dealing in L.A. County with many pandemics, one related to the fires and the climate impact, but also homelessness is a significant one. You can't have mental health if you are on the streets. it does very little, while it is helpful to get therapy when you are homeless, but it doesn't necessarily have the best outcomes, so we have been working at the county and the state level to ramp up our housing initiatives and I tell you just like they can write us a prescription for medication, I wish someone could write us a prescription for housing. I think if they write us that prescription, many of us would take that right away, because housing is such a fundamental need, especially with this COVID pandemic where we know that being in a house has a significant contributing element, not only to worse outcomes with COVID, but also environment and interaction with law enforcement even to this day.

This is another way we are reimagining and addressing our disability needs and the other one was capital funding. We need to find infrastructure for housing, not just for rental assistance, but actual housing and the last one is a real significant one and it is providing alternatives to incarceration. In Los Angeles County and like some other states, we have court diversion programs and mental health courts, because nobody should go to jail because being in mental health distress and not for having a disability.

This morning, I wanted to come in, there was a story in NPR that is entitled, I tried everything, pandemic, mental crisis and it was a very well example of what happens with our community when a loved one or family member calls for help and law enforcement is involved. This particular story highlighted a story about a mother who is a nurse and has a young daughter who has autism and she was having difficulty like many of us are having because of COVID and the daughter hit the mother in front of the police officer. The police officer, because of her duties felt it necessary not only to arrest the child but send her to jail when the mother was explaining this is my daughter. She has autism this is one of the things she struggles with and ultimately, the child had to be incarcerated, you know, for having a disability. So, we recognize the system is faulted in many ways and I really appreciate our law enforcement. I really, really do. I think we have to recognize the fact, two things, right now because of so many things that have happened, our law enforcement are human and have a lot of significant mental health stress and trauma from what has been happening, so perhaps they may not be the right response when people are having significant needs that need to be addressed.

Just like we don't send the police officers to put out a fire, we send the fire department to put out a fire. We need to create appropriate systems of response to support our community in times of crisis and in need, rather than making things perhaps worse than they already are. This is something that some of the measures that we in California have been doing and I have been doing as an advocate through my protections and advocacy, I am very glad to have this opportunity to speak with all of you and hopefully provide some information about some of what you are able to do even with your localities, City Councils or Governor and there are

alternatives that we can look at. There is a model that they can look at to model or perhaps build upon. Look at California. While we might be a big county, we can provide a significant amount of, you know, examples of how other states can do something similar and hopefully, look at what Cherene has mentioned and definitely going to bring it back, because I think it takes a collaborative approach from all of us throughout the country to come up with solutions. It is harder to do things by ourselves, but if we do it together collectively and perhaps we can come up with an abundant of ideas and abundancy of solutions. Thank you.

>> Ian: Thank you, Hector. I think that is some great information from you, both about just the different models and, also where we need to work on some of these things, and so I think that -- I think we are at a point where if you would like to ask a question of either Phil or Hector or Cherene, and we'll -- you can ask me a question, too, of course [chuckling] and then we'll get a discussion going on. I know I haven't been able to keep up, but there is a little bit of chat going on that I think Phil, you've been reading some of it. Some of it I can scroll, but are there any questions or mainly comments in the chat, Phil?

>> Philip: People can raise their hand and we can unlock the un-mute you if you want to ask the question directly. I think we have one from Ruth.

>> Ruth: Great. Thank you so much. Really appreciate your focus on this issue and appreciate what the speakers have said up to this point. My name is Ruth. I'm the Director of disability justice program at New York lawyers for the public interest. New York lawyers for the P&A before we centralized and now, we work together with the real P&A and I see Mark here from the disability rights New York.

We've been working, well, we have been working on the bigger-picture issues for 40-plus years, but for the last four years, we have worked solidly on this matter, literally from the second day arrived there when yet another person experiencing a mental health crisis was killed at the hands of police. What we are seeing in New York City is outrageous, it is appalling, it is all of the things that our speakers have talked about fighting against. It is heavily racial of the 16 people killed in the last five years alone, and that doesn't include all of those who are injured, psychologically, physically, just those who are killed, 16 in the last five years, 14 of them black or other people of color. So, we are seeing, I think the same things and maybe more so than others.

But the reason I was so eager to talk today is because I'm concerned, I mean I certainly or I should say we, we work in a huge coalition in New York City with lots of grassroots organizations, peer organizations and so on. I think some of the things that the speakers mentioned that we are 2000% behind is the role of peers. I do ask the question; how do you define peers? We define it as those themselves have mental health experience, lived experience and not family members. I think that is a big debate, but perhaps for another time, but certainly, we support that. We support making sure that you know what the community wants. We have done focus groups. We have done surveys to get to that, so I think that is right. I certainly agree with the diversion from hospitals, from forced treatment, all of that is a piece of what we do.

But, what I'm really concerned about is that the approach that this webinar is taking, if I can say that, and that some of the other groups the speakers are taking is not at the forefront of where the disability rights movement should be at this point. I say that guardedly and hopefully without any kind of offense, but I think I say it because of the experience we have gone through in New York. We were heavy into CIT, which is the gold-standard of crisis intervention training is what it stands for, it is the gold standard of training for police. Nothing against it. It needs to be done, but it can't be front and center, because what is most important is what Hector said about, you don't ask, I think what did he say, you don't ask a cop to put out a fire, you certainly don't ask a cop to come to a mental health crisis.

Our approach is not just minimize the police, but get rid of them entirely. Don't train them as a primary goal, yes as a secondary, because they may come upon someone in the street that can be trained, but don't prioritize that and the other piece I'm really, really concerned about is the co-response team. It is another thing that we initially thought might work. We convinced our elected officials to take that out of their platforms. It's fraught. It has the police still there, so that is the main problem and if you have police and someone who is not police coming together, who is going to go forward and who is going to go back? You're only going to have police response is what our sense is, so I wanted -- oh, I'm sorry, the last point I want to make is a real concern about utilizing the 911 system. I'm glad to hear Cherene say that her group doesn't use 911, but for the same reasons the systems we come up with shouldn't use 911 either because that is utilizing the police. We are looking for a whole, um, again, removal of the police in every which way and every level and putting another member in there. I'm happy to share if I'm technologically gifted enough, I can put our proposal in the chat, or I can send it to Ian and others to get out there. We spent a lot of time to get it and it is modeled on the cahoots model that we haven't spoken out of Oregon, which is recommended, but on top of that or it goes one number better by a heavy, heavy emphasis on peers, peer involvement. Our team would include peers and emergency medical technician, so you have a health care person, but you also have the peer that is trained. I know I have spoken a lot from the heart, because this is literally what I have been working on for four years solidly. I just wanted to make sure those thoughts are out there for people to consider and I'm happy to talk further with others.

>> Cherene: Ruth, may I do a couple of responses to that. Number one, we very much align. We are a nonpolice alternative. We do not want police involvement. We actually don't want 911 involvement. We do believe that a lot of people are going to call 911, so we need a way to reroute those folks, but we also believe that a lot of people are not going to call 911 because of the systemic experience racism, history, everything that we don't need to go through today. We are in alignment.

We looked at cahoots, of course, talked to folks at cahoots. We think one of the weakest link is people with lack of experience. My concern with EMS and wave great EMS person heading up a team in Asheville, North Carolina. I will tell you she is can you from a different cloth. She is really, really interested in noncoercive and non-force approaches that is the exception within EMS, because EMS and those systems are systems and people are traditionally trained. You have to have the right people, whether it is a medic, whether it is a clinician. This is not for

everybody, right? Oftentimes, sometimes certain professions are trained to use a hammer and if all you have is a hammer everything looks like a nail. We are concerned about the overuse or misuse of clinicians, because we will result in confinement. The level of risk assessment is much less -- is more sensitive with folks who are clinically trained if they are not untrained or retrained. I say all of this, Ruth, to say I didn't talk about that aspect of it -- one more thing. Part of this initiative is an analysis of police intervention of the 911 calls of the trending of overuse of force or racism or bias, of police academy and police training. You're right, police are going to be involved one way or another. I agree it should be a secondary, but I also agree we need to reimagine to what that looks like. A couple of responses to your thought.

>> Ruth: I want to respond.

>> Ian: We have 15 minutes left.

>> Ruth: Cahoots even though they don't look for peers, 75% of their mental health responders are peers. By no way do I want EMS, which is another group, I want EMT, those with that kind of training and we are probably on a similar page and I will be quiet. you can even mute me.

>> Ian: Thank you very much, Ruth. We have Nancy. I also believe has a question or a comment. Nancy, go ahead. You're still muted. You're still muted. There you are.

>> Nancy: I'm from Kansas. This topic is really important to me, because in Wichita for the past few years which a parent or a family member calls because someone is having a crisis, they say they have a crisis unit. I don't think -- definitely don't have any peers and I'm a peer in it. Anyway, the joke around here is, you know, if you want to die just call a cop. And so I would like any information, Ian has my e-mail address, so I can take it to our PAIMI, which I am a member, our PAIMI people, also our state consumer network who has lots of work in Kansas. So, whatever people can send me, I really appreciate this. This is a topic that is in my heart, because that's where our people go if a cop gets them, they either get locked up in jail until there is a bed at one of the state hospitals.

>> Hector: Nancy, I want to thank you for mentioning our PAIMI councils. I think that is really, sometimes something not a lot of folks know in every state, but every state has a PAIMI council, which is the council for the protections of people with mental disabilities, I believe, that is how I got involved in my state. I think there is a significant way to get involved with the PNI's, but I think one of the things, looking at the cahoots model and the peer conversation, COVID has changed everything. COVID has just thrown a wrench in everything. Here in L.A. County, we really believe in using peers. We just passed peer certification in California, so we will be able to employ our peers and get them involved, so we are at the starting level, and when we look at peer models like the one in Oregon, the cahoots model, we realized event if we have peers responding to emergencies, we don't have the beds or the services. We had a shortage before COVID. Here in L.A. County, our hospitals are at capacity, we don't have that anymore, so that is why we are looking at a real tangible solution, which is housing even if it is temporary housing.

We can't lead people to a cliff offering them help that is not there because of the pandemic, so I think it is important to start using other models that utilize peers, like we here in California have project room home and we are providing hotels that we could provide to the unsheltered or people having emergency crisis and we just expanded it. We tried to build more housing, because our clinicians are in critical shortage right now, so the mobile units right now, I imagine they are stretched thin and most of our hospitals because of the COVID surge, they are at capacity. We have to provide our community other alternatives, you know, but definitely employing our peers in all sorts of the deployment from the planning to deployment to the evaluation.

>> Ian: Thank you for that, Hector. We have Geneva, I believe. You have a question? We still can't see you or hear you. There you are. No, can't hear you yet, but we are almost there. You're still on mute. There try now. Can you un-mute yourself. Try now.

>> Geneva: Hello? I'm sorry. I would need to find out if the PowerPoints will be sent after the meeting. Will the guests send their PowerPoints?

>> Ian: Will we century our PowerPoints? You should have gotten one when you registered, but we will make sure you get one, OK.

>> Geneva: OK, thank you.

>> Ian: They will be on our website, on the NDRN and PAIMI website, OK? And then Edie, you have a question? Did you have a question?

>> Edie: I had a question about family education since those people that are involved with their families, it is often the family that is desperate and scared and don't know what to do, so they call 911. I'm hoping in all of these projects there can be a family education component, maybe working in tandem with NAMI or whatever, because I know there is tension around hospitalization, incarceration -- well, around hospitalization, between those two constituency groups, but we try to educate families. I work in an advocacy agency in Philadelphia and we try to educate families about, you know, the best way to call for help, the best way to deescalate and prevent crisis and also, how traumatizing it can be for people to be involuntary committed and go through the hospital system and making that a last resort. So, I was just curious if family education was any part of your plans.

>> Hector: Yeah -- sorry.

>> Cherene: Go ahead.

>> Hector: I volunteer for 20 years and one of the reasons I volunteer because 20 years ago there wasn't that much many more mental health resources to educate our family and they were involved with NAMI and one of the things they learned is the information was not very unified. It fluctuated depending on which affiliate. My family was told if my family wanted to get

me services, they should call 911 and have them take me to jail because I would get medication and that is how I got my nose broke by a sheriff. I was one of the people that survived the experience.

I still volunteer with NAMI, because there are a lot of places that don't have the privilege of having the support that many of us, but I think it is important to have very intersectional mental health education, not just from a medical model, but also from a disability justice approach, and it really needs to be updated significantly, and so we do need to have, you know, health departments and mental health departments take up the responsibility that is theirs to educate the community of mental health conditions, those sort of things. I think that decision or that responsibility, because they may not have a ton of money, it is given to nonprofits to do, so it is really the responsibility of health departments of mental health to have consistent, holistic education, so our family members, caregivers don't accidently hurt people in the process unintentionally, because it happens a lot.

>> Cherene: I want to add to that, to me I would expand beyond family education, because it depends on who is doing the educator. Their paradigm may or may not be compatible with what we are talking about with nonpolice or alternatives, so it determines on who is developing the curricula and what advantage they are teaching from. We have parents who have lost custody of their children, regained custody of their children, have the peer-to-peer support, but we do support around psychiatric advanced directives and supporting people, family members as well to support their loved one to develop on advance instruction in case something like this is needed, so their wishes are known, are honored. Until our state, it is a legal document. There is a lot of nuances to it, but oftentimes, family members are looking far tool, they are looking for an answer, they are looking for resources. They are looking for support. They don't know what else to do and unfortunately, other people could reinforce the message that their loved one is a burden.

I came into mental health systems because of abuse by my family, so there are many, many, many people who have outward manifestation of abuse that looks like mental health, homelessness, substance abuse and incarceration, a lot of times the message is where is the family? In my situation, the last people I will allow you to have you contact is my family and my family will not be involved in try to IVC me again. I want to be sensitive to lots of different types of experiences and dynamics, and make sure that we are not just defaulting to certain messages without really understanding different people's experiences. And then the same thing with peer support. I hear "peer" thrown around a lot. I have worked in traditional clinical systems for years, I have run a peer operation for 16 years and peer became corrupted by behavior health, medical systems, clinical systems that call it peer support. When we say cahoots and no disrespect, because I love cahoots and what they do, but to go back and say 75% of them while are not in a peer role, yes, I have lived experience that is not what we're talking about with shared peer support. It is a paradigm. It is a world view. It is a training. It is a tool. It is a philosophy and a system that is deeply rooted in human rights and Civil Rights. I had lots of conversations with clinician who say, yeah, me too. That is not what we're talking about when we're talking about peer-to-peer relationships. I want to make sure we are not defaulting to things because they have become trendy and we are truly understanding what

these things mean and don't mean and we are using them intentionally to make sure we are supporting people effectively.

>> Ian: I think that is great and I think that is a great place to stop. I really appreciate that, because we especially in this community, we can get into jargon and into themes and we forget what we're talking about and thank you for your comment about families, too. They are not always the ones to go to, unfortunately.

There was a survey link put in your chat box and we would love to -- I think this is just part of a conversation that we'll continue to be having, and so please fill out the survey. We are already out of time; I can't believe it. We the probably talk about this issue it is so important. At least, it is getting more listeners these days and that gives me some hope as well. So, I want to thank Hector, Cherene and I want to thank Phil and I want to thank Marcia for all of their help in putting this together and you guys are great and you have helped to illuminate key issues in this conversation. Don't be surprised if we have a follow-up, so we'll see what you say on your survey. If you want more, tell us that. If there are things we could have done better, tell us that, too. I think we're at the top of the hour. It has been a great, informative hour. Have a good one, everybody. Please stay safe. Goodbye.