NAMI Ask the Expert: Help, Not Handcuffs Part 2
Legislation and Community Models
Thursday, March 25, 2021, 4:00 - 5:30pm EST

Featuring Panelists:

- **Angela Kimball**, National Director, Advocacy & Public Policy, NAMI
- **Hannah Wesolowski**, Directory, Field Advocacy, NAMI
- **Ebony Morgan**, CAHOOTS Program Coordinator, White Bird Clinic

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Dan Gillison, Chief Executive Officer, NAMI (00:00:00):

Thank you Teri, and good afternoon and good midday to all of you all. We're very excited to have you with us, and NAMI is very excited to host this series. On behalf of our board and our board president Shirley Holloway, NAMI staff and NAMI national state organizations and affiliates, we welcome you to this session on today. We're very excited to have you with us. To get us started, I'd like to introduce you to our chief medical officer, Dr. Ken Duckworth, Ken.

Ken Duckworth, Chief Medical Officer, NAMI (00:00:35):

Good afternoon everyone, and thank you for joining. As you know this is part two in a four part series, looking at creative alternatives to help people get help, not handcuffs. Today we're extremely fortunate to have the leadership of NAMI's policy and advocacy arm, the national office, and also a special guest from CAHOOTS, which has the all time greatest acronym I've ever seen. Crisis assistant helping out on the streets. What could be a better definition of creative alternatives? Our speakers are Angela Kimball. Angela's our national director of advocacy and public policy, and is a major force for good and unifying the voice of multiple mental health organizations to get results.

Hannah Wesolowski is our director of field advocacy and Hannah connects to the state and local affiliates to conduct an orchestra of field advocacy. And Ebony Morgan is a registered nurse and the director of the CAHOOTS program at the white bird clinic. Ebony is driven by a passion for addressing the effects of socioeconomic inequalities and structural racism on public health and safety. She's going to be teaching us about what many consider the national model on a creative mobile approach to people in mental health crisis. I want to thank you all. I'll turn up again at the end for Q&A. Dr. Brister has told you how to submit questions and I'll be doing my best to sort them and to get a good conversation going among our experts. Thank you all.

Angela Kimball (00:02:36):

Thank you for your introduction Ken. I'm Angela, and in the second webinar in our Help, not Handcuffs series, we'll provide an overview of the crisis response system NAMI would like to see across the country and share with you what's happening at the federal and state level to make this happen. I want to begin by sharing some reminders of trauma and tragedy of inadequate crisis care. People with mental illness end up on our streets, in our jails, in emergency departments, every single day, and between 2015 and 2021 in four fatal shootings by police were of people with mental illness. Of those, one and three were people of color. Over two million times, every single year, people with serious mental illness are booked into our nation's jails. And finally, the rates that people are dying by suicide or overdose are simply unacceptable. Our people deserve help, not handcuffs.

Angela Kimball

Fortunately, there's a real opportunity to change the paradigm for crisis response, and it starts with 988. What is 988? Our slides are a little, just fine. I'm going to stop there. So what is 988? 988 is a three digit crisis line number for people in a mental health, substance abuse or suicidal crisis. It's going live across the country by July of 2022. And as you'll see from this timeline, 988 was recommended a couple of years ago and formally established last year by the Federal Communications Commission or FCC. Then 988 was ingrained in law through the National Suicide Hotline Designation Act that was signed into law last October. 988 is a number for our crisis line network, it forms the foundation for re-imagined crisis systems that can provide a mental health response to mental health crises.

Before we talked about the full 988 crisis system, I'll share a little about the national suicide prevention lifeline and the role it will play in 988. The lifeline is funded by SAMHSA, the federal Substance Abuse and Mental Health Services Administration. It offers free confidential support, 24/7 through a network of 170 low prices call centers all across the country. And when you call the 10 digit lifeline number, if you press one, you routed to the national veteran's crisis line. If you press two, you're routed to a Spanish call center network, and all other calls get routed by the lifeline to their local crisis center. If that local crisis call centers unable to answer in time, the call is rerouted to the lifelines national backup network. With 988, the same system will be used to route and respond to calls.

The difference is that many more people may be making calls and we expect the network of call centers to expand to handle not just more volume, but a wide range of mental health, substance abuse and suicidal crises. I just spoke about the national lifeline manager role. And now I want to talk about the role of call centers at the local level and the rest of the 988 crisis response system. We're really talking about three core components or pillars. Call center hubs, mobile crisis teams and crisis stabilization programs. State, or local 988 call centers should have well trained staff and be available through phone and text and chat. They should serve as hubs that have strong connections with other emergency systems and with local mental health and substance use provider networks

They should be able to dispatch mobile crisis teams and ensure connections to other services, including crisis stabilization and really robust call centers like the Georgia crisis and access line have more capabilities. Like master's level clinicians who are able to do mental health and substance use assessments. They have the ability to schedule urgent outpatient appointments while people are on the phone and they have electronic bed inventories, so they can tell where there's open crisis and detox beds. I know some of you are probably thinking, I want to know more, well sign up for our next webinar in this series, because we're going to have the George's crisis line folks on to share more.

I want to say that if Georgians have this, why shouldn't you? And that's frankly, why we're doing these webinars, to showcase what's possible, so you can fight for the system you deserve, not what you're necessarily getting. The next part of the system, is mobile crisis teams. Mobile crisis teams are often staffed by a mix of clinicians and other mental health staff, including peers, mobile crisis teams, as the name implies, travel to where people are at. They help assess and stabilize, deescalate the situation and may help a person into a higher level of care or other services and supports. Mobile crisis teams are an essential pillar of the system, because people who are experiencing severe symptoms of mental illness or substance use disorders often need an in-person response.

There are many different models from mobile crisis teams, co-responder models for example, include both mental health staff and law enforcement officers. And in a little bit, you'll get inspired hearing from Ebony, who will talk about the CAHOOTS model, which is a mental health only mobile crisis team. The third pillar of our system is crisis stabilization. Crisis stabilization can refer to multiple options and increasingly common option is a crisis stabilization unit that's in the living room like setting and provides observation and stabilization help for under 24 hours. But for many people there'll be need for it or other options like short term crisis facility, crisis residential care, inpatient hospitalization, or other intensive services.

And really strong crisis stabilization programs have peer supports, they have detox facilities. They help people get the right follow up care and they accept all police referrals with zero rejections and some have dedicated areas for first responders to drop off an individual and turn around within five or 10 minutes. Again, we'll show you what this can look like in one of our upcoming Help, not Handcuffs webinars. And now I want to share how this might look in a real life situation. I'll share a version of this. When my son experienced a psychotic episode few years ago, a friend was able to call a dedicated behavioral health crisis line for me, but with 988, it would be much easier to remember and dial.

My son was delusional and threatening at times, so this was not a situation that could be resolved over the phone. In my case, the crisis line dispatched mobile crisis team that included CIT trained police officers, but they took a back seat to the behavioral health clinicians. The lead clinician established a rapport with my son and after spending time with me and with him putting together all the pieces, going through the house, she said, I'm hearing Alex that you haven't slept for days and things are getting intense. I'll bet, you'd really to get a good night's sleep. Do I have that right? And he said, yeah, my head hurts and I just want to sleep, but I can't. She said, the doctor at the hospital will definitely be able to help you get to sleep and help your head stop hurting. Does that sound okay to you? Are you willing to go with me?

Remarkably he said, yeah, I'll go. I want my head to stop hurting. Now, the next step in this journey was a crisis stabilization unit, which after 23 hours moved him into a psychiatric inpatient unit because he was still delusional and paranoid. While I can't say the hospitalization and the rest of the journey went well, the crisis response piece did, and this is what we want across the country, because under different circumstances, my son or anyone we know with serious mental illness could easily have ended up in jail or worse shot and killed because of their behaviors.

We're grateful that momentum is building everywhere, rapidly for a mental health response to mental health crisis. But it will take advocacy and funding at both the federal and state level to realize this vision. NAMI and our allies have been working with Congress to help states with funding streams that can help them plan and build crisis services. Last December, the fiscal year, 2021 budget at the federal level, included a 5% set aside in the community mental health services block grant for this fiscal year, dedicated to crisis services. It also included the emergency funding for SAMHSA that can be used for crisis services and a $5 million increase to the lifeline. In this month, American Rescue Plan at key provision with the aptly named CAHOOTS Act provision, this lets states tap into an increased federal medical assistance percentage or FMAP rate of 85 percentage points for Medicaid programs that want to incorporate mobile crisis states.

This creates a huge financial incentive for States to adopt mobile crisis. That provision also included $15 million in grants for states to plan to implement or expand mobile crisis teams. These were important wins and provide opportunities for states, but they're not enough. Significant and stable federal state and local funds are need to expand the capacity of the lifeline network to serve the increased demand and scope of services, to implement and expand mobile crisis teams, including specialized teams for children, and to develop crisis stabilization programs that truly serve the needs of people with severe mental health substance use and co-occurring disorders.

What's next at the federal level? Well, right now SAMHSA's working on a required reports to Congress on estimates of costs for implementing a 988 crisis response system and that's due April 17th. This report will help fuel future ask for state and federal funding. In the meantime, NAMI and our partners are beginning work to expand federal funding from the lifeline for mobile crisis teams and for crisis stabilization in the fiscal year, 2022 federal budget. And with that, I'll turn it over to Hannah to share what's happening at the state and local level. It's a lot, Hannah.

Hannah Wesolowski (00:14:22):

Thanks Angela. The thermal action Angela discussed has created an opportunity for states to transform crisis response, mandating that this three digit number 988, be available for a broader scope that includes mental health crises. And then it'd be available by July, 2022. Congress is providing growing resources to help states drive more robust crisis care, which Angela just went through, like mobile crisis teams. But congressional action alone is not enough. States are going to have to act to make sure the comprehensive crisis services are available when someone dials 988. Frankly, whether states act or not 988 is going live by July, 2022. The question really is, what is going to be available on the other end of the phone when someone dials 988? Are they going to be able to get the help that they need?

So far there have been 17 States that have introduced legislation related to implementation of 988. Frankly, no two bills look alike and that's because each state currently has very different models and systems in place for crisis care. Late last year, early this year, the national association of state mental health program directors created model legislation, which was influenced with feedback from NAMI and other mental health organizations to really act as a roadmap for states on what to consider and address and legislation. It includes a few things. First it specifies requirements for 988 hotline centers and crisis response services, including statewide mobile crisis teams and crisis stabilization programs.

It also enacts user fees, which are a monthly surcharge on all foam bills to ensure 988 has a sustainable funding mechanism. And along with that, it creates a trust fund to collect and protect that 908 revenue and prevent those funds for being used for non 988 system related use. It's common that when revenue comes in, it's diverted elsewhere and it's really a mechanism to protect those funds. It also designates a state oversight body to oversee 988 implementation and ensure that all state entities are cooperating to fully implement a crisis response system. In some cases it's even indicating who should be involved in that oversight body, like peers and family members. Finally it ensures interoperability between 988 and other state emergency systems like 911, so that these systems can communicate with each other in a crisis when it's needed.

I mentioned user fees, and I want to talk about that a little bit more. Unfortunately we all know that there's always too little funding for mental health services and supports. The federal legislation that was passed last year, specifically allows states to impose a user fee. Again, that's a monthly surcharge on all phone lines, and it is clear that these fees can be used to route calls made to 988. So route them to that national network and those call centers, but it can also be used for quote, personnel and the provision of acute mental health crisis outreach and stabilization services. Basically Congress opened the door that these funds, if states impose them, can be used to fund not just the operations related to the 988 number, like a call center, but then they can also be used for services needed on the other end of the phone, like a mobile crisis team or crisis stabilization.

And that's really important. It gives states an opportunity to introduce a new funding stream, to support better crisis care. And frankly, that's a really rare opportunity. It's the first truly new funding stream for mental health since the affordable care act passed 11 years ago in 2010. These are really minimal. They range from eight or 10 cents a month to a dollar per month in one state. If you look at your phone bill right now, if you pulled it out, you'll already see a fee for 911 on most phone lines. These fees range so much because it's really dependent on what services states are requiring be available in their legislation and what services the state already has in place and how it funds them.

The important thing about this is that the revenue for these fees is really steady and consistent, and that's different than a state budget allotment. State budgets are approved every single year or every other year and they're always under threat, especially during downturns in the economy, which is often when crisis services are needed even more. In reality, it's probably going to take federal funding, state general funds, services that can be built in Medicaid and private insurance and these user fees together to make a robust crisis care system possible. We really need all of these things to put the services that have too long been underfunded into place.

Hannah Wesolowski

I won't spend too much time going through the details of all of these pieces of legislation, although I'm happy to talk to anyone on the side. But this is really to give you a flavor of the legislation that's out there and how it differs. I will note that in the last week, Utah and Virginia's bills have been signed into law. Both of these have either eliminated or no user fee, but they have companion bills that fund more robust crisis services in their state. Washington state's bill is one that's moving through the legislature with great bi-partisan support and it has a graduated fee structure. So that fee increases over time and it requires comprehensive crisis services.

California and Colorado both allow a state agency to regularly assess what annual fees are needed to fund the estimated costs for services up to a capped amount. Those fees couldn't be endless, there's a cap level of how much they could be. We think that that mechanism to regularly review the fee amount like in California in Colorado is helpful, because at the end of the day, we really don't know what the demand is going to be for 988. We know we have the existing calls to the national suicide prevention, lifeline and mental health related calls to 911 that will now be read it to 988, but there will also be people who are frankly, afraid to call 911 for fear of a law enforcement response. And as 988 becomes more known to the public, there will also be people who just didn't know where to turn for help, that'll be calling that 988 number.

It's hard to estimate right now what the cost of a 988 system will be, because it's going to depend on what demand looks like. It's really critical that we have the ability to readjust to meet that demand and actually help people on the other end of the phone. Everyone has a role to play in 988. First, get engaged in your state's planning discussions. Almost everyone is a stakeholder, from peers and family members, to teachers and mental health providers to law enforcement officers. Every single one of those individuals has important perspective to add to the conversation. Most states currently have a planning committee for 908 implementation. There may be an opportunity to join that conversation and influence what's being built or being re-imagined in your state right now.

Aside from that, your local community also has an important role to play here, because local communities play a major part of implementing a crisis response model. If you look at most CIT programs or co responder models, they're often initiated at the local level. And whether your community has an existing system or is building a brand new one, just make sure that what they're doing is tying into your state's larger 988 network as that effort moves along as well. I also encourage you to connect with your state legislators and tell them why a crisis response system is needed and how it would impact you or your community. If there's legislation that's introduced, follow it to see if there are opportunities to testify and share your experience and perspective.

Personal stories matter and telling them that a mental health crisis deserves a mental health response is important for them to hear. I strongly encourage you to recruit others to share their experience with policy makers as well. Finally, as you're doing today, learn about the models that are out there. You can't build what you can't envision. Every state or community is at a different point in their crisis care that they have available. You may only have a law enforcement response right now, and maybe looking to implement a crisis intervention team, or you may have a great CIT program already in your community and are now looking to implement a co-responder model.

Ultimately, it's our hope, as I hope you've heard today, that we can all work toward limiting law enforcement involvement in helping people in a crisis. This isn't going to happen overnight. It's actually going to take years to fully implement a system we want to see, but every step along this continuum is an important one. Today you're going to get to hear about one model, the CAHOOTS program, that has been a leader in mobile crisis teams. Before we leave, I just want to share Angela's information and my information, you can reach out anytime with questions that you have. You can also learn more about NAMI's work at nami.org/advocacy. Now I'm pleased to introduce Ebony Morgan, program coordinator for the CAHOOTS program to tell us more about their model, Ebony.

Ebony Morgan (00:23:40):

Hi. I work with CAHOOTS, I am the Program coordinator. CAHOOTS stands for Crisis Assistance Helping Out On The Streets. In Eugene in Springfield, Oregon, which are neighboring cities, when someone calls nine one, one or the non-emergency police number for help with a non-violent and non-criminal situation, CAHOOTS can get dispatched instead of police. This is especially true if the call has a mental health or a substance use component. Eugene has had this alternative to a police response in place since 1989. So over 30 years at this point. We're part of the public safety response system in our area, providing a unique alternative to police in times of crisis.

We operate in unarmed pairs with an EMT and a crisis worker, and we respond to calls all over the city in our van offering crisis intervention, support and resources to the community members that need it, whether they call for themselves or someone calls on their behalf. For people unfamiliar with our program, it can be really tricky to describe how exactly we operate and what exactly it is that we do. The best ways that I've found to explain it are by providing some examples. We consistently start our shift, making sure that our van, which is a large cargo size van, that we have it set up to be able to transport, is stocked with basic needs and supplies, medical equipment, and other gear in general, that might be useful to the clients we encounter or ourselves.

Our van is outfitted to transport clients as well as hold our equipment. Once we're ready to start the shift and we know we have everything that we need, we use the police radios that we carry to alert dispatch that we're ready to take calls. Once they know we're ready, they're going to give us the location of our first call. We'll drive from our office over to that address. They'll give us the details of what we're going to as much as they can, but it's usually very little, which is better because we show up without an expectation. We can go in open-minded and ready to be helpful in whatever way is most effective. Once we get there, we'll tell them that we've arrived through the radio and enter the scene.

And from there, a call can look a lot of different ways, depending on the nature of what it is that we're approaching. Let's say in this first example, maybe this call was a concerned passer-by, who wants someone to check on somebody who they know sleeps outside in their area. They see them every morning and they usually get up and move by 8:00 AM, but they haven't moved yet, and it's noon. Let's say we check on them. We approach that person. And we say, hey, someone noticed that you hadn't gotten up and moving today and they were just wanting to make sure you were okay. They tell us they haven't moved because they hurt their foot the night before, they accidentally cut it on something, and they don't want to go anywhere to see a doctor, but they would like someone to look at it.

They just really have bad experiences at the hospital and they're just not in the mood to do that. And maybe they're really anxious about what a foot injury means when they're unhoused and they need to be able to move around. We conveniently have a medically trained team member who can do a medical assessment and provide basic medical care. Perhaps on this call, it's as simple as cleaning and wrapping a small wound on an otherwise healthy human and an effort to prevent an infection. Our crisis counselor, while they take care of that wound, can keep that person occupied and provide counseling for what we call situational anxiety. Once done, the shift partner who was doing the wound care can educate the client on the signs that you should watch for, if something started to appear infected or causing a further problem that would warrant seeking further medical treatment, which we can help you connect with in the future.

We build that rapport. We help them understand what it is they should watch for and try to prevent any further complications. And now the client gets to feel some relief and can move on and get back to business as usual. Once we finished with that client, we're going to go back to our van. We're going to sanitize our gear. We're going to hop back in and let dispatch know that we're done with that call. If appropriate, sometimes we'll let them know that if sometimes we're sent, if a business is like, I don't want this person sitting here, but I also, I'm not trying to get them arrested, I just need them to do something different.

Ebony Morgan

We'll let them know, hey, we're done, we're clear, they decided to move along, this is handled. We'll let them know they don't need to follow up in any way and let them know we're clear for our next call.

Let's say while we were on that call, because this happens, we heard that officers were being requested by a concerned family member for a client that we have a lot of experience with, but the family members don't know that we're an option. We can offer to go because we know that we have rapport with that person. We often handle those interactions with that person on our own. If dispatch agrees that it's appropriate for us to handle it, we will drive over to that location. Say we get there and that person is feeling suicidal. And their suicidal ideation is more severe than our ability to provide on the spot counseling can resolve. One of the options that we have, is to transport the client to our local hospital that has a specific psychiatric component to its emergency room, where they're prepared for a mental health crisis.

We can inform the client of that if they don't already know, and the client can choose to come with us to the hospital of their own accord. We can't force you to, and if we can't be certain that you're going to be safe by yourself, then we really try to get you to be willing to come with us, because it's a lot more comfortable to come with us of your own choice and just ride in the back of our van than to be handcuffed and put in a police vehicle and taken there against your will. And so we try really hard to let people voluntarily choose to engage in support. We would tell dispatch that we are transporting our client to the hospital, and then we will call the hospital and let them know that we're on the way, similar to the heads up that they received from medics when they're doing an ambulance transport, because paramedics will alert the hospital on the way.

So when we get there, we'd hand off the client to the hospital staff and give report to the nurse and the social worker, we'd advocate for the client and maybe share what we hope the hospital can do for them. And then we'll be onto the next, just like before. There's a lot of different ways that mobile crisis intervention can look.

Teri Brister (00:30:42):

Ebony. This is Terry. I apologize. We're trying to catch your slides up with you. We wanted to make sure we were in the right place.

Ebony Morgan (00:30:51):

I got it. We're right where we should be.

Teri Brister (00:30:52):

Terrific. Thank you.

Ebony Morgan (00:30:54):

Thank you. We are, as the CAHOOTS program and doing mobile crisis intervention, we're sometimes referred to as behavioral health first responders. In principle, what that means is that we meet you where you are to provide you support. This can look like crisis counseling, suicide prevention, mediation. Sometimes we'll go out, especially over the last year or so, when everybody's been stuck inside, people are struggling to share space that much and get along and it's normal. That's normal. What we get to do is come in, and we have two people. We can separate you. We can hear you both out. We can bring you back together and try to figure out what the common goals are. What are we stuck on? What can we do about it to make the rest of the day go better before it just continues to escalate into something that is now more concerning?

Ebony Morgan

We can provide grief counseling. One of the things that the police department has shared with us as a responsibility is death notifications. Because while we're there, we can also help you connect with the supports around you that you know exist, but might forget about in the moment. We can help you try to plan some next steps. We can do welfare checks when people are concerned about others, talk to you about substance abuse, provide non-emergency medical care and take you to necessary services. The tool we use most to do all of this, is our training. In addition to our training, we carry our med bag, which is good for basic medical interventions and wound care. We have other medical equipment in case we're the first on a scene that requires life-saving interventions, in which case we'd use our radios to request paramedics.

We also have Narcan in case we're the first on the scene to an opiate overdose, because sometimes people do call us instead of other services because they trust us. So we got to be ready for whatever we're going to walk up to. One of our greatest tools and the most discussed, is de-escalation, which is defined as a reduction of the intensity of a conflict or potentially violent situation. In doing that, scene safety is always our number one priority, which is how we have never had a serious injury or death of a team member or client as the result of an interaction. On CAHOOTS, we combine EMTs and crisis workers, because we recognize that medical and mental health are equally important components of overall health.

The National Institute of Mental Health reports that mental illness, especially depression increases the risk for many types of physical health problems, including stroke and type 2 diabetes and heart disease. Similarly, the presence of chronic conditions can increase the risk for mental illness. When CAHOOTS arrives on scene, we bring both the medical and crisis intervention perspectives, which allows us to have a more holistic approach to each call. We prioritize a client centered approach in which we encourage people to identify their own needs and help people figure out how to best meet their needs once we've established them. We provide trauma informed care, which means we treat the whole person, and in doing that, we consider past trauma and the resulting coping mechanisms, when we're attempting to understand behaviors and treat the patient, there's no judgment involved in that.

We practice regularly harm reduction, which looks like supporting policies and providing interventions that are designed to lessen the negative impacts either social or physical consequences associated with human behaviors and decisions. The unarmed de-escalation is really the root of how we arrive and what makes us our own entity in combination with our mental health training or an unarmed and consent dependent response. Consent dependent means that the clients have a choice, whether or not they engage with our services, and we cannot force anyone to do anything. Given that, it's crucial that we be extremely skilled in de-escalation and carry rapport and trust in our community. When people see us, they need to believe that we are there to purely be helpful. Our new staff undergo more than 500 hours each of field training, and more than 30 classroom hours before they're considered trained.

In our work, we also strongly believe in the responsibility that we have to advocate for the community. To quote the American Public Health Association, "In order to assure that everyone has the opportunity to attain their highest level of health. We must address the social determinants of health and equity." This is a really big ask, because it involves a lot of systems working together to build bridges and support those and develop those bridges between those who have more than enough and those who do not have enough. We have to work together as a community to show all of the members of our community that we are in this to support them.

Who shows up in our work, is one of my favorite things to talk about because I think it's a really, really neat approach. We have an EMT on our staff and this is the medically trained half of our two person response team. We have varying degrees of licensure involved, but they operate within the scope of an EMT. We have EMTs that range in level from basic to advanced, and we have nurses on our team as well, that fill this role. Due to the nature of our work, our medics are also trained in crisis intervention and how to be a crisis responder. In order to support the work of our crisis workers, there's a lot of teamwork and partnership that goes into showing up.

Ebony Morgan

With having a medical component as part of our service, one of the things that we're able to do is emergency room diversion.

We are able to divert a significant number of medical calls for service from the ambulance and the paramedics and or from the emergency room and connect people with the appropriate resource for whatever they're experiencing. We can assess basic medical concerns. We can provide wound care and talk about substance use and the impact that's having on health. We can ensure that people are thriving. If we notice that someone is failing to thrive, which means in general, that their health is just not intact, they're not quite able to succeed. Why? What resources can we connect you to that are preventing you from getting to that place? This is absolutely a crisis, and that is a crisis intervention. If there's people who frequent certain systems, they can call us and we can help connect them with what is going to get them the best outcome for what it is that they're going through.

Along with our medical component, we have our crisis workers and we don't require a certain level of licensure for our crisis workers, but they must be eligible for QME certification or Qualified Mental Health Associate certification. We have QMHPs on our staff that provides supervision to our QMHAS, and some of our team members in our crisis worker roles are licensed as social workers or LCSWs. We combine these two practices extremely intentionally. As an example, anxiety can present in a lot of ways that resemble a heart issue. I can briefly tell you about a call I had, where we were called for a human that was experiencing anxiety. My own experience has shown that sometimes you can't quite name it, but someone just doesn't look quite right and you pay attention to that.

One of the first things I noticed was that this client was very pale and appeared very anxious, the rapid pace of his breathing didn't seem nervous. It really seemed like he couldn't catch his breath. We talked and checked his vital signs, and out of caution, we asked if he was experiencing any chest pain, and he said, yes, but I thought that anxiety made me feel that way, because it does. This is where having both perspectives is so important. Certain conditions can mimic each other in ways that make it really difficult to rule out which is happening without having testing available. That's what we shared. We said, it seems appropriate to call an ambulance, to get you to the hospital. We requested the ambulance through our police radio that we carry and the client was reluctant to that idea.

One of my personal favorite things to do is educate the client and help them make an informed decision for themselves. You're a person, we respect your right to make choices. Let me help you understand the full scope of this choice. Once we had outlined why we were concerned, he agreed that it seemed wise to go get checked out. The paramedics came also agreed, and they took him to the hospital that was most equipped for cardiac events. We do work in partnership with the other services in our area to make sure that people get connected to what they need. Primarily our closest relationship is with our local police departments. We were not designed to replace any part of the current system. We're an addition to the current structure of public safety. We fill the gaps that police were not designed to handle, like mental health concerns or homelessness.

We are not trained in law enforcement and do not have the same authority as police. We built this relationship many, many years ago, over 30 years ago. It was originally law enforcement working with self-described hippies. And the name CAHOOTS came out of this idea that we were now in CAHOOTS with the police. It was an interesting choice to make. But what had been noticed is that the service that White Bird, which is CAHOOTS larger parent agency, the service that White Bird was providing benefited everyone. It benefited the community members that were able to walk in with a mental health crisis. It benefited the police when they were able to drop someone off that did not need to be in jail, but did need some support.

Over time this partnership grew into what it is now. And what it looks like now, is that I attend monthly meetings with the Eugene police department, and in those, we problem solve, we work together to figure out the best possible resources and how to provide them to the community together. What else we could advocate for? We put our heads together on what else will help our community members.

Ebony Morgan

We give each other feedback and we try really to show up for the community and connect the need with the resource. Why send the people that are not quite prepared to deal with this sort of thing when you could send somebody who gets it? Certain situations are not necessarily appropriate for us. Since we're unarmed, we don't have lights and sirens, and if you don't consent to engage with us, then we don't get to make you.

If it's a violent scene and weapons are involved, if it's a criminal situation, you're looking for some criminal reaction. That's not us. If you're requesting law enforcement duties or it's a really serious emergency medical situation, we might be able to participate and help with some of the other pieces, we can usually find a way to be useful, but it's probably not our show. But there's often an overlap and we will respond alongside police and or paramedics. This is different from what's typically referred to as a co-response, because we're arriving separately. We're bringing each of our own strategies and protocols to a call and we're working together to achieve the best possible outcome, which for us is often jail diversion.

Instead of having to go to jail for public intoxication, maybe we can take you to the sobering center. Maybe we can help you come out with a better plan than what's going forth right now. If someone is exhibiting any signs of a cardiac issue and we're on scene, we're going to ask for the paramedics to respond, to do an EKG and check the heart rhythm and make sure that either we're okay to transport or that they need to. Because we can't provide medical interventions in the back of our van during transport, some things aren't appropriate for us. And so what we do is work with these partners to figure out in what way we can best meet the situations needs.

Part of our working so closely with the police departments is that we are dispatched by the same dispatchers. This is a really crucial piece of how we operate and how we stay safe, how this work gets done. CAHOOTS calls come into Eugene's 911 system or the police non-emergency number. The call takers and dispatchers are trained to recognize non-violent situations with a behavioral health component and route those calls to CAHOOTS. If the person is requesting police, but the situation is appropriate for CAHOOTS, the call taker can offer the CAHOOTS response. This is how some people learn about our service and get familiar with what we do. The call taker takes the details like where it is, what's the name, who are we looking for and what's being requested.

And then the calls are ranked by priority and dispatch will contact us via our police radio and provide us the details. We also use our radios to communicate back to dispatch if we need any backup police or paramedics, or if we're transporting somebody and other updates as necessary. One of the things we're asked a lot is why not a co-response, or why is this better than a co-response? I can't say that exactly, right? But what I can tell you, is why we aren't one and why we don't need to be one. How do we do this in a way that is different? This slide outlines that there were more than 20,000 calls that we were associated with in some way. It doesn't mean we responded to every single one of these calls, but when the call came in, maybe they asked for us, maybe we responded.

But out of these 20,000 calls, we asked for police backup after arriving 311 times, which is not a whole lot. This is for a lot of various reasons. One is that the dispatchers do a really phenomenal job of making sure that we're responding to things that are appropriate for us. Others are that de-escalation is a lot easier when you're non-threatening. This is what I might look when I'm on shift, I don't wear makeup. I'm going to be casual. I'm going to have my hoodie on that says CAHOOTS. That's what I have. Everything about my body language, everything I say, I'm very mindful that we appear non-threatening and we appear just as helpful as our intention is to be.

The other piece is that a mental health crisis is not inherently dangerous. It doesn't mean that we are at risk just because someone's having a mental health crisis, feeling suicidal and homicidal are not the same thing. We maintain a lot of scene awareness. We communicate clearly with our partners. We have our radios just in case we do need some further support.

Ebony Morgan

We really trust our intuition and really, really, really consistently prioritize constant de-escalation and just keeping scenes calm and controlled to the best of our ability. The tools we have are very, very valuable. The things that we prioritize in news, but we don't pretend that they're appropriate for every single situation.

Our funding, in Eugene we're funded through the city, and that is via a contract that we have with the Eugene police department. Our agreements of service are negotiated between myself and the White Bird agency and the Eugene police department in that city. Some of the funding comes from the police department and some of it just goes through the police department to come to us. In Springfield, the neighboring city, it's a combination of funding from the county and from the Springfield police department, also through the city. In addition to that, we have a little bit of wrap around funding from a local Medicaid provider for the healthcare system diversions we do, because they recognized that the ability to divert people from the emergency room saves a lot of money on other end. It is not a primary source of funding, but it's a neat addition.

When you take a hard look at the function of public safety, as we know it, it's really apparent that our system is designed on many levels to be reactive instead of proactive. And this is also true for our healthcare systems. Recent changes have pushed some preventative medical care to be more accessible to those with health insurance, but we have a long way to go towards true accessibility. As a nurse who's passionate about public health, I often dream about what it would take to create an ideal situation. What does it look when we have needs met? There are a lot of things I think, but what if, for starters, we met the needs of our community members proactively, and people simply didn't find themselves in a crisis over basic needs.

Within CAHOOTS, something we often say, is that we are only truly as strong as our community resources. If you're having a crisis that requires a resource to resolve, we are not magically able to be that resource. We can help connect you, but if it doesn't exist, we're limited in what we can offer. If you're having a housing crisis and we don't have shelter options for you, we can help your state outside, be slightly warmer, or maybe a little more dry, but we can't resolve the true crisis. We can reduce the harm, but we can't solve it by ourselves. If you're too intoxicated to be safe in public, we can transport you to a sobering center. But if we don't have one, our options are extremely limited. We're torn between helping you make it on the street, despite being unable to fend for yourself and transporting you to the emergency room, even though you don't need life-saving treatment. And neither of those things is particularly appropriate.

So with that gap in a resource, you've got to just make the best choice with what you have, which we're very good at, but it's better when those needs can be met. We're extremely grateful for the network of community supports that exist in our area. We're also acutely aware that it's not quite enough. CAHOOTS is a really inspiring model to me and I really enjoy talking about it. It doesn't pretend to be perfect. We don't pretend to answer all of the questions out there about what does it mean to show up for the community in a better way, but we are something different. If there's anything about this model that jumps out at you or speaks to you or would make sense in your area, hold onto it and advocate for it. I really appreciate your time today.

Ken Duckworth (00:50:15):

Thank you to each of our speakers. That was a superb summary of 988, and one brilliant community response. Let's take some questions. The first question is for the NAMI leadership, let's do a little more detail on the funding of 988. Is that fee per phone, per user? Is it ongoing? Is anybody resisting it? That sort of thing. It's about the stability of 988, and the funding that would attend to it.

Hannah Wesolowski (00:50:51):

That's a great question, Ken, and I'll take that. Angela feel free to jump in. It would not be per call, it would be for everyone within a state. If our user fee got implemented, it would appear on all phone bills. A mobile phone bill or a landline phone bill, and it would be something that would be long term. It wouldn't just be for a year, it would be long term. Like I mentioned, if you looked at your phone bill right now, you already pay a small fee every month for 911 services. It's likely higher than what you will see for 988. But this is a way to get these programs started and provide those stable resources to make them available.

There is some resistance because it is an additional fee on residents. But by doing it this way, it's a very small amount spread across the entire population. No one knows when they're going to be in a mental health crisis. No one knows when they're going to need a service like this. It's something that makes it available for the public good for everyone to benefit from. Angela, I don't know if there's anything you'd add there.

Angela Kimball (00:51:54):

No, I think you captured it perfectly.

Ken Duckworth (00:51:59):

Second question for the NAMI team. What happens if you dial 988, and you don't live in Eugene, Oregon, or another remarkable place, what is the expectation for your outcome?

Angela Kimball (00:52:16):

That's a great question. This is both the promise and the reality of 988. Depending on where you live you may experience a different set of services when you call that number. What we're hoping, is that across the country, as people become aware of what is possible, they'll advocate and make sure that their policy makers start funding the kind of services that we're talking about everywhere. But the reality is, if you live in a place where there are no mobile crisis teams, there won't be one to dispatch to you if you call 988. That's why everybody's advocacy is so important, because while we have great services in a lot of places around the country, we also have so many places where these kinds of services that you've heard about today, simply aren't available.

Ken Duckworth (00:53:16):

Thank you. Some questions for Ebony and CAHOOTS. Many questions for this remarkable program. Let's talk a little bit about the kind of deescalation training people get. Is there a certification in that? How do you know that I have this epaulette or skillset?

Ebony Morgan (00:53:45):

There is a little bit of an it factor component. And the people-

Ken Duckworth (00:53:50):

What did you say? I'm sorry there's a little bit of...

Ebony Morgan (00:53:53):

There's a little bit of a component that we can't quite put a finger on, right? The ability to respond to something and remain calm, control your own emotional response in regards to someone else's. If you have that we can teach you from there. If you can stay calm in a crisis, we can support that, within the hours and hours of training that we provide the hundreds of hours.

Ebony Morgan

Most of it, aside from the classroom chunk, where we break down the specifics, outline the expectations, we'll give you some of the tools for de-escalation that we know, and that we have. It's field training. You ride along with a fully trained pair and watch those skills, observe those skills, and then practice those skills with the people next to you that can make sure that it's being implemented safely and going well.

We prioritize letting people practice because we believe it's the best way to really hone that to, in order to control your own nervous system response, to really be able to stay grounded in those high stakes situations, you just have to practice it. It's safest to do that with people around you that are skilled in it and can support you in that. We provide mostly on the job training and we don't have a certificate out of our training that we provide for folks, it's just our job.

Ken Duckworth (00:55:08):

It's just part of the culture and supervision.

Ebony Morgan (00:55:12):

Precisely.

Ken Duckworth (00:55:12):

Do you then meet and process how that call or visit went after each one? What is your self learning component to this, Ebony?

Ebony Morgan (00:55:24):

Yeah, we have a debrief process. And often after, especially during the training process, after each call, we get back in the van and that's our zone, between calls, where we get to sit in there, get to the next one and talk about it. That's where we can provide feedback or make positive observations and say, this is what went really well. This is what might work better. For me, one of the first things I learned, is that, I'm sitting in on a screen right now, but I'm six feet tall and I have a very serious face sometimes. And so if I stand in front of you and just kind of uncomfortable and I'm just here like this, trying to listen to you, it might be really intimidating to you. And I don't feel that way. I'm just nervous. I don't know what's going on, but it looks intimidating and I can't deescalate you if you're scared of me.

I learned to soften my shoulders, step back a little bit and make sure I'm on whatever level you're on. If you're sitting down, I sit down. If you're on the ground, I'm going to kneel with you. We're going to figure out how to be non-threatening to you primarily, and that's individual based. And that conversation where I learned about my own body language was in the van, after a call, where we just talk about it and they say part of what might've made them uncomfortable is that, you're up here and they're down here and you've built a power dynamic already.

Ken Duckworth (00:56:33):

Great. One of the questions is about your relationship to the police. The one question is, or the 20,000 calls you get, not now going to the police, so do they love you because you are saving them from many calls? I think a different question is, how does the culture of the police department and the culture of CAHOOTS integrate?

Ebony Morgan (00:57:01):

Perfect.

Ken Duckworth (00:57:02):

So there are two questions. One is, the numbers of calls and are you taking a workload off of them so they can do their thing? And then how do the cultures fit together?

Ebony Morgan (00:57:13):

We absolutely are. It's tricky to quantify full because it is. Because calls come in and we respond and sometimes then we call them. Sometimes they're on calls and they call us, they say, this is not something that we feel we can deal with, this as mental health, and we should get CAHOOTS in here. And so we'll show up then. We do our best to track those, but we do take a significant load of crisis based mental health calls off of our local law enforcement. When we show up on a call that they've asked us for, I always hear, thank you so much, I'm so glad you're here. I don't know what else I would have done. When we call them, because we need them, it might not be particularly often, but when we do need them, we need them, and so we are grateful that they arrive as well.

There's a very mutually supportive dynamic there. We save them some time and some energy and some resources and save people in the community from getting a response that is inappropriate or informed enough to meet those needs. And then we also lean on them as well. There's a mutual respect. And so that ties into what this relationship is like. There's a respect for each of our own pockets. There are many things that they do that we do not do. It's really tricky to quantify in dollars, how much we save them, for example, because a lot of the things they do, aren't just straight hours. They go back and they have to do their research or do their investigations or whatever they're doing. I'm not the expert, but they do a lot of things that we don't have to do. We just show up, meet you where you are, help you in that moment and move on to the next.

It's easy to do a direct comparison, but even though the work we do is different, our common goals are, how do we give the best resource to the community that we can? What is it that we can provide and how do we provide it to the best of our ability? We might have very different ideas about what that looks like and how we're going to achieve it, but we can work together to figure out where each of those things fit. Focusing on those common goals is where we're able to get past some of the political tension, past some of the differences of opinion and get right into, this is our community. We are all involved in this community. So how do we support it to the best of each of our abilities and what can we bring together to support it together?

Ken Duckworth (00:59:24):

A question comes up about the community. How many of the people that you interact with, do you already have relationships with? That is to say, how many of them are brand new and how many of them are, well, Mr. Smith, we saw you a couple months back, we took you to A or B, we're checking in again? Could you define that a little bit?

Ebony Morgan (00:59:48):

Absolutely. I'm not going to pretend to have the numbers on that in front of me.

Ken Duckworth (00:59:52):

No, we're good. We're good. Ballpark.

Ebony Morgan (00:59:55):

But I can say, I think that we do ultimately through the nature of mental health, see people repeatedly, whether that is, we've met you a year ago and now it's a different team, different situation, or we see you lots of days. That's all right too. Just because you're in a crisis now does not mean you will not be in a crisis tomorrow. There's no cap on that. But we do, I think they're equally important pillars of our work, of meeting new people where they're at and continuing to provide crisis intervention for folks that we're very familiar with. The familiarity can play to our advantage or disadvantage depending on the situation, so neither of those is better.

Ken Duckworth (01:00:37):

Can you develop the advantage and disadvantage idea of being connected to the people you're serving?

Ebony Morgan (01:00:44):

Of course, but we can't give people what they want all the time. We are not miracle workers, we're just humans. We're humans that care about the other humans in our area and have a certain skill set that we can apply to help you have a better day. But sometimes that doesn't mean that we can meet the need that you're asking for. And sometimes the way that I do crisis intervention, isn't going to be your favorite. You might not like me. You might call for CAHOOTS and you might get me. That's how that'll be. If you are meeting us for the first time, you don't know what to expect, we have the world is our oyster, we can figure out what to do if we're meeting you for the 20th time, and you already know that we can't do X, Y, and Z, which is what you really want. You might not be thrilled to see us.

Ken Duckworth (01:01:29):

Right. You can't give them an apartment.

Ebony Morgan (01:01:30):

Right. Yes. We notice the need for housing resources, always willing to do that. No, I can't house people. I don't have access to that. So that's just definitely-

Ken Duckworth (01:01:42):

Of course. Do you work with families? Is another question. How do you think about the family engagement in this process?

Ebony Morgan (01:01:53):

We certainly do. Family networks are so strongly connected that there's bound to be some miscommunications in there or some barriers in there, with one another, and we can show up to try to support that. What we always try to do is figure out, to the best of our ability quickly, what is the root here and how can we make some space, get to it, bring it back together? Sometimes that looks just informing people of what resources are available. It looks what's really happening here is a fundamental communication breakdown. You're saying this, and you're wanting to hear this, and they're really similar, but they're just not meeting in the middle. We are not ongoing therapists. We are not ongoing providers. We are immediate intervention. So what we can do is bring it down, talk about ideas. Have you considered talking to somebody externally to try to figure out how you can meet in the middle?

Ebony Morgan

A lot of people have a lot of stigma around that, where like, we don't need to go to therapy. We have this under control. Well, yeah, of course you do. But what if we were all a little bit better? What if we all practiced a little bit of skills? It's connecting people with the resources that exist and informing them on what they're really about, so that we can promote that family component. We do engage with a lot of families and I do think, I will say that I think adolescent crisis response is also extremely important and it is its own unique entity to such a degree. Each of those interactions with children is so important, because you're framing how they're going to see the rest of any professional intervention forever, that it does deserve its own response in my opinion. We do the best we can and I think we're decent at it, but it's really very specific, I would also advocate for that.

Ken Duckworth (01:03:35):

A question for all three of you. Funding for this model, Ebony described local, county police. It sounds like there's a lot of threads pulling this together. Let's say I live in a different town in Oregon, let's say Salem. Right? How far is that away Morgan?

Ebony Morgan (01:03:59):

That's going to be about an hour drive.

Ken Duckworth (01:04:01):

Ebony, sorry, an hour drive. So an hour away, Ebony, this program probably does not exist. Right. How would people in Oregon advocate for funding for an analogous program an hour away? You have the resource and Ebony and her team, right there, the how to, but the funding piece, is it going to be localities? Would it be statewide? How might you think about that? Probably this is Angela and Hannah. What's the advocacy for the NAMI community on this piece of funding program akin to Ebony's program?

Hannah Wesolowski (01:04:50):

I think it's a little bit of all of the above. As I mentioned, you have communities where we have CAHOOTS, that have really implemented this robust system, but it's not statewide. Local communities have a lot of power, but local communities are also very limited in the resources they have available. States can allocate resources and mandate that these services be available. We are seeing that in a number of states. Colorado, for example, has statewide mobile crisis teams, but they also need more. Most states that have it probably need more and we're advocating for federal funding, because states are in a really tight budget environment, especially right now in the wake of COVID. And so funding new services is going to be particularly difficult, not impossible, we're urging nominees and our mental health advocates to fight for that.

But it takes a little bit of all of the above and some of the services are billable to insurance, but certainly not all of them. And we need additional funding from the local state and federal level to work all around that and connect all of those threads, and certainly connecting the partner systems, fills some of those gaps as well. I think for a local community, looking at this, it's talking to your local leaders, but also connecting with statewide organizations and state agencies to see where they are, to provide resources in communities that where it doesn't exist already, is a great place to start.

Ken Duckworth (01:06:20):

Angela, this might be for you. The Biden bill has billions of dollars going into mental health, which as you have taught me is a novel first letter in front of the word illion, right? We used to live with millions when we're lucky. A question that comes up is, is any of that funding likely to be able to create more resources like CAHOOTS?

Angela Kimball (01:06:52):

Absolutely. We think so. Some of these dollars are starting to flow to states from SAMHSA, the Substance Abuse and Mental Health Services Administration. Some of the guidance that they've been giving states, is that, crisis services is an acceptable use of some of these grant funds. This is an opportunity for people who want to reshape crisis systems in their community to talk with their mental health authority in their state about what resources are available and how can they tap into those to actually create what they want to see in their community.

Ken Duckworth (01:07:31):

So this is a big opportunity for advocacy and engagement, it sounds like.

Angela Kimball (01:07:36):

It absolutely is. I will caution though, that the kinds of funds that we have now are significant, but they are one time-ish funds. We got funds at the end of last year and also this month with the American Rescue Plan. Those can be eased over time, the American Rescue Plan dollars, but not forever. You're looking at a relatively short time span to build programs up. That's why working at the federal level to try and get more permanent funding streams. Set aside in the block grant, we want that to become permanent, so that states can count on those dollars every single year to come in and help support. Despite, we were thrilled to see the CAHOOTS provision in the American Rescue Plan for Medicaid funding.

So states choose those individuals who are covered by Medicaid, there could be a Medicaid funding stream to cover those mobile crisis services and at a very high match rate, which basically means that for every dollar a state puts into their Medicaid system, they can get several dollars back from the federal government for that service. Again, it's all about braiding together funding. I think what you've really alluded to here, Ken, is a fact that we don't have a nationwide funding infrastructure for crisis services, for mental health crisis. That is what we're trying to knit together here. The more diversified the funding stream, the more stable it is.

And that's why I talked about the user fees. One nice thing about user fees, is they tend not to fluctuate in the same way that state funds and local funds can. So state budgets go up and down, depending on the economy in the state, user fees tend to be much more consistent-

Ken Duckworth (01:09:44):

Interesting.

Angela Kimball (01:09:47):

... stable piece that can help support the overall funding.

Ken Duckworth (01:09:53):

Thank you, Angela. Ebony, a few more questions for you. Let's talk about culture, diversity language. One specific question about immigrants who need services and may not be citizens yet, people with language problems, challenges, people who aren't familiar with the, disorganized mental health system in quotation marks. From a cultural perspective, how do you think about that and how do you train your team to think about how to respect culture and learn about culture?

Ebony Morgan (01:10:37):

That's something that we are highly prioritizing right now and previously regrettably did not put as much energy into. We were so focused on building a program that would function within the structures that exist, which was tricky. And now we are desperately bringing in trainings and embodying practices that deliberately center accessibility, equity, and how we can make our service accessible to truly everyone. There are components of our community that are really communicating clearly to that being dispatched through our local police departments is a barrier for them, they are unwilling to call in and give the information necessary to get our service. That's just something that we're talking through. We're talking through that with our police partners to say, this is a barrier being expressed to us. Is it possible to have our own dispatchers? Is it possible for us to have another way to do this and still work together?

How do we meet this need and still provide the service the way we provide it? There's a lot of reflection going on for us. Over the last year, there have been a lot of conversations about our different approaches and a lot of dialogue about what makes it right and what makes it wrong. That's why I often say, CAHOOTS does not pretend to be perfect. We're trying. We're trying as hard as we can. It is my priority that we figure out how to be equitably accessible. I'm not going to lie and say that we've already figured it out, but we are trying to model a behavior that demonstrates a desire to embody that principle and make sure that whether or not we speak the language, we have translation available, whether or not we fully understand your culture, we know how to ask.

We know how to engage the varying components of people's backgrounds in the way that we provide care. We are educated and competent in honoring what makes you unique, what makes your family unique, what makes your culture unique, your community and saying, how does that influence what you want to do today? We make room for that, so that you don't feel the need to tell us what that is. We're going to ask you how we can best support you. That is true in the nature of our work, but it does take a certain amount of mindfulness to make sure that people are comfortable and know that you are safe for them to exist in their truest form. That's the only way that you can truly reach people, is to make sure they know that they are safe with you.

Ken Duckworth (01:13:15):

What a beautiful answer, Ebony. That's a beautiful answer. It's also impressive that a fundamentally sound groundbreaking program, 30 years in is still engaging in discussions on how to get better, right? It's not like it's a fixed model with fidelity as I'm hearing it. This is a creative, organic interplay.

Ebony Morgan (01:13:39):

Yes. And a huge component of that is that we are a collective and we are consensus based. I might take the reign say on making things in our program come to real life. I'm the one that negotiates with our partners, talks about our budgets, speaks publicly because I care so much and I like it. But also everybody's opinion carries just as much weight as mine. I don't make independent decisions. Anything we agree to do, the entire team talks about at a meeting that we have once a week and agrees to do together. Anyone's perspective, if somebody says, hey, I want to advocate for this community, because this decision that we're going to make, doesn't seem we're listening or caring about them. Everybody says, what? We forgot that and is mortified.

And it's just like, okay, great. Okay, cool. Let's go back to the beginning and loop that in. And so we don't proceed with things without having all of the brains on our team, participate in that and make sure that from all angles, we're thinking about the impacts that people are going to experience from decisions that we make.

Ken Duckworth (01:14:41):

There's a question about staffing and this is nuance. I'm going to go through a couple of threads.

Ebony Morgan (01:14:48):

Okay.

Ken Duckworth (01:14:49):

What is the vibe on the team, are you searching for people? Do you have a lot of turnover? Do you have people for whom this is a calling? Do people get burned out? How do you nurture their self-care? This is question about the people doing this work, this remarkable work, which is obviously filled with challenges. How you think about staff. Do you have openings that you can't fill? This is classic in community mental health, right? I had a doctor, I couldn't fill for three years on an assertive community treatment team, in an inconvenient city. I tried to cover that part time. It was not great, right? Because I couldn't find anyone to do it. Is that your experience or do you have people lining up and say, I want to be part of the super creative model?

Ebony Morgan (01:15:45):

It depends. Part of our problem is that the work that we do is extremely unique and extremely challenging and we may not have along the way have advocated for the best situation for ourselves as employees. So focused on providing the service to the community that we didn't notice that perhaps the compensation and the benefits of doing this work for the community are not the same as other roles that are fairly parallel and require slightly more advanced, but not inaccessible skill sets. What we've noticed recently, is that we're losing people who want to step up and become nurses, or they want to step up and maybe they're like, I'm going to take all this super good experience and take it into law enforcement. Because we've established and provided all of these skills, but we don't have the same fundamental ability to provide a sustainable work environment where you're going to want to stay and retire.

And so that's something that since I've taken this position about six months ago, have been trying to figure out how to prioritize, because we should be a career operation just as much as anybody else. There's no less need for our service. It's just tricky to advocate for that. It's not impossible. So that's what I'm working on, but truly people want to do this work and the people that begin to do it, want to keep doing it, because there's nothing quite like it, if it is right for you, if it's something that makes sense to you. The people that we have often stay for quite a while, if they either not super long or a very long time, it's what I encounter. And it's because there's just nothing quite like it.

But how do we make sure that people that are doing it for a long time are getting adequately cared for so that they [crosstalk 01:17:21], they're not getting tired? So that there's enough of a rotation of human beings, and maybe that looks having similar programs in other areas, you can move around, you can try new things, you can experience different environments. We can all learn from one another. One of the tricky parts about being the CAHOOTS program for so long, is that there was no comparisons to be made.

Ken Duckworth (01:17:39):

Correct.

Ebony Morgan (01:17:40):

We had to figure it out and try to make it the best it could be, existing on a little Island. That's impressive, I'm excited that other people are talking about it, because [crosstalk 01:17:50], wow, that's a good idea over there.

Ken Duckworth (01:17:56):

That's a great idea. That's a better way to do it. Ebony, I hope you continue to take care of other people, but also remember to put the oxygen mask on yourself and your staff. It sounds like you're actively working on that, because of course the brilliance of this model does require some career construct, right? Because you want people who are sophisticated and well trained to stick around. I'm delighted to hear you're working on that. That sounds a little bit community mental health, with its attendant to challenges. We're going to close in a minute. I want to ask each of our panelists, for the people on this call who want a program like CAHOOTS in their locality, or they have something that is CAHOOT-ish but it's not actually as good as this, right?

Any final remarks from each of our three panelists, Ebony, you've been talking a lot. I'll let you go last. You get a little break, relax, take a deep breath. Hannah and Angela, for people on this webinar, they want something like this in their community. They know there's an opportunity, but how might they approach it? Or if you have other final comments, you don't have to answer my question.

Angela Kimball (01:19:27):

Well, it's a great question, Ken. I hope that everybody who's watching today is inspired. Ebony, is a great inspiration to everyone and I would think people would be very eager to have something this in their communities. I would suggest one of the main things that people can do, is get to know their state policymakers and share what they've learned, share that they want to see this in their community. It's just a little reminder that everybody's story is always right. Being able to share if you've had an experience with crisis services and if you can very quickly and concisely convey how great it would be, if there were a response like the CAHOOTS response, that can do wonders in helping educate lawmakers and helping them understand that there's really a lot of public support from moving in this direction.

Ken Duckworth (01:20:27):

Thank you, Angela. Hannah.

Hannah Wesolowski (01:20:30):

I would add, I know that we have a lot of NAMI leaders, and if you're not involved with your NAMI, talk with your NAMI organization, but other organizations that care about this. Other mental health organizations, substance use suicide prevention organizations, also talk to your local law enforcement agency. When we talk to law enforcement, one of the first things that they say is, we are not equipped to respond to these crises. They support having alternative models. And so they can be a great partner and champion who advanced this cause. Also, I'm going to put a plug, go to nami.org/advocacy and sign up at our take action link, and we'll let you know opportunities to advocate for this at the federal level and at the state level too.

But definitely connect with your NAMI organization if you're already not connected and other partners who are like minded to find out what is already happening, and if nothing is happening on this already, then join together to contact those policymakers and tell them that they need to act.

Ken Duckworth (01:21:31):

Ebony, do you have any final comments or remarks for the people attending this webinar conversation?

Ebony Morgan (01:21:38):

Absolutely. I think that Hannah and Angela spoke really gracefully to the steps that you can take and the people you can contact. I encourage noticing that it's all around demonstrated and seem to be beneficial for community members for the current existing systems and for the folks that want to step up and do this work. We work together. We work positively because there is a gap, it's not taking anything from anybody. It's not putting anybody in positions that others aren't already being put in. It's just meeting a need with an appropriate resource, and the chief of police in Eugene and I have conversations all the time about meeting the appropriate need with the appropriate resource. It is not controversial. It is mutually beneficial.

I always remind people of that, because it can be so polarized, but it does not have to be. It's fact, it's reason, it's noticing a need in all of our communities and stepping up to embody it, find the thing. There's so many components of this that matter to each of us individually, whether it's one diagnosis that stands out to you from experience you have, or a trauma that you've experienced in one of these systems, or just something you've learned about, whatever makes you a little fiery, whatever makes you be we need to deal with that. Think about it, read about it and carry that energy forward and make other people think about it and make other people read about it and just advocate.

That's the best thing any of us can do, is just find the thing that lights our soul on fire and say I care about that, and I'm going to try to make a little bit of difference and make somebody think about it. If we all do that a little bit, the people that are making decisions are going to hear it, then they're going to have to do something about it.

Ken Duckworth (01:23:21):

Ebony, we were so delighted and honored that CAHOOTS, the gold standard was going to participate in our conversation, help, not handcuffs, meeting you and listening to you has just warmed my heart about your attitude and humility about trying to work this problem and to make it better. Ebony Morgan, Angela Kimball, Hannah Wesolowski, I want to thank you for this tremendous panel. I want to turn this over to Dan Gillison, our CEO of NAMI.

Dan Gillison (01:23:59):

All right. Well, thank you all very much. Ebony, Angela and Hannah and Ken. Just I really appreciate this overview and what you shared. Ebony, as you said, it's about the mutual benefits. it's almost getting that passionate, excitement of just speaking to people and say, did you know? Did you know there's going to be an alternative to 911? Did you know what that will mean to your community that you live in? Now, with that said, let's look at helping handcuffs, not handcuffs going forward. As we mentioned, this is a series, so we will have an additional community model or models that we will share with you on Thursday, the 22nd of April from four to 5:30 Eastern standard time. And then part four we'll be implementing a new system and that'll be on Thursday, the 20th of May at the same time.

You can register for these sessions at nami.org/asktheexpert. With that said, we really want to close out by saying, the ask the expert is an informational webinar. This is a just a disclaimer in terms of what it is, what it's not and what we hope you can get from it. The bottom line, we can do our work and what we're doing on behalf of communities across the country because of donations. We always like to reference the opportunity to donate to NAMI, and you can do that at nami.org/donate. Now, all of this work that goes into bringing these productions to you is in front of the curtain, but there's a lot of work that goes on behind the curtain. There's a production team that makes this look seamless and just to recognize the team. There's Jordan Miller, she's the lead producer and really constructs this and handles all the technical issues and the overall flow of the webinar.

Dan Gillison

Dr. Teri Brister, does the welcome and stages everything for us in terms of muting, unmuting and how to actually put questions in. Jessica Walthall also assists behind the curtain with collecting the questions. And then Christina Burt also helps with the technical support and making sure that we have backups, so we have that quality assurance. This team, Jordan, Teri, Jessica, and Christina, is extremely important to us, and like all of you all, we're excited to have you with us. In closing, the other thing I wanted to mention is that, the NAMI, our convention, excuse me, will be virtual for the second year. It's going to be on the 27th and the 28th of July. Registration will open on the 5th of April. For students, it's $10 and for NAMI members, it's 15 and for non-members it's $25. We really have some exciting things we're going to be bringing to you.

We had over 300 submissions for topics. We're going to do 60 minute workshops with live Q&A. 30 minute flash workshops, and that's going to be unique. And then a new venue we're bringing, our new platform will be, 10 minute express talks. It's something you've seen in the past in terms of some other labels that you've heard, we're calling them express talks. Going to be very innovative and creative, and that is on the 27th and the 28th of July. Stay tuned, go to nami.org. And again, registration will open on the 5th of April. We wish you all a very good close to your day, a wonderful Friday and a great weekend. And thank you for being with us on today. Ebony, cannot thank you enough for representing your body of work in CAHOOTS. All the best to everyone. Bye now.