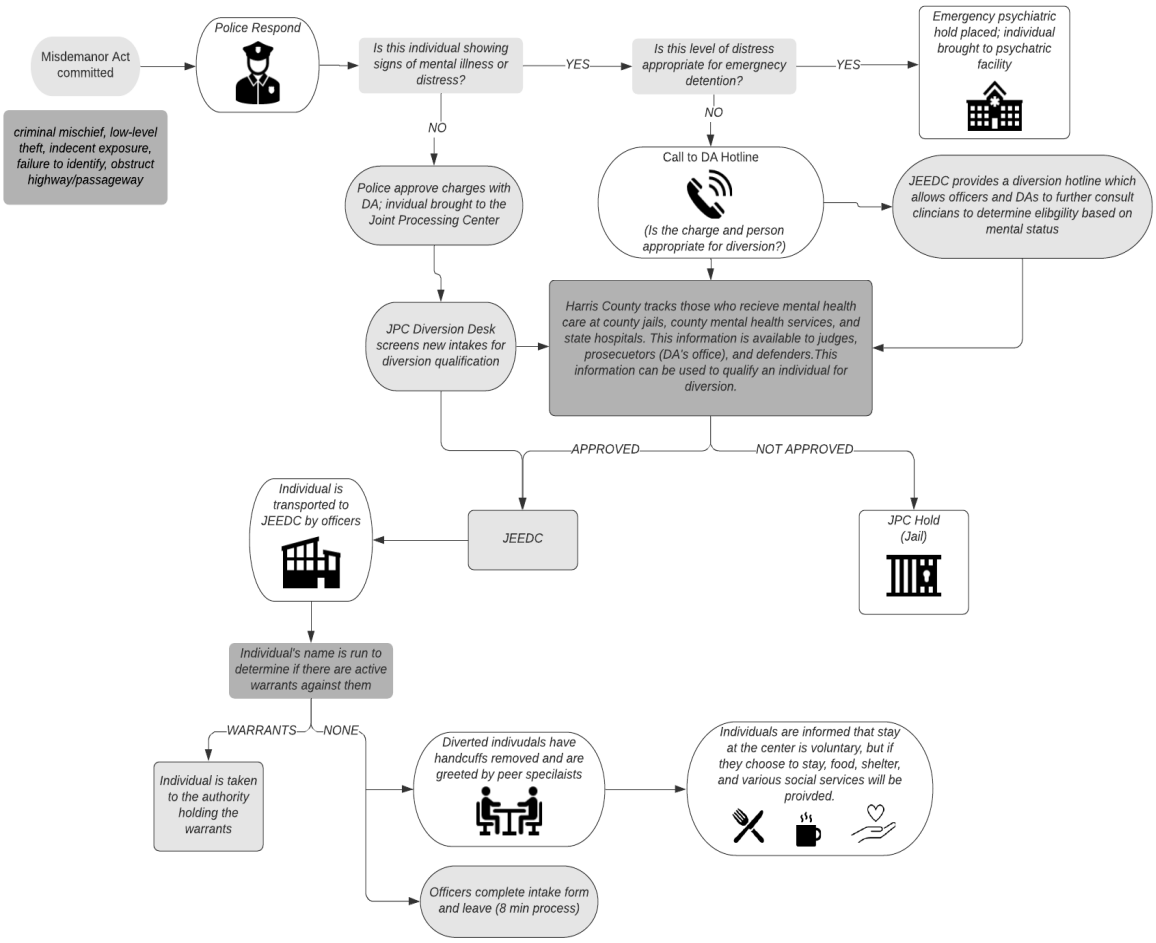
Online Supplement for Psychiatric Services Article

Introduction

Flow Diagram Jail Diversion Intake Process



Methods

Consumer Representation in this Research

We understand the vital importance of including consumer voices in research about the services that are meant to serve them. We planned to interview 12-15 consumers during this project. We understood that it might be difficult to engage in research with pre-booking jail diversion program consumers for several reasons. First, attrition rates in studies of consumers

using *post*-booking jail diversion programs had been high in the past (e.g., Crisanti et al., 2014) even when consumers were in jail. At our research site, a pre-booking jail diversion program, consumers could leave the program voluntarily at any time. Many exercised this right. Second, our research team also included two self-identified peers (although only one in the planning phase) who advised us that gaining client trust and willingness to engage in an interview would be challenging without taking our time—a research process we might also call "slow engagement," which may be an important concept for mental health services research as well. Third, some of the researchers also had prior experience engaging with consumers in ethnographic mental health services research and anticipated that this would take time.

Thus, our original research plan included six, week-long (4-5 hours each day for 5 days), ethnographic visits to the Judge Ed Emmett Jail Diversion Center (JEEDC) so that the same researchers could engage with the same consumers on multiple days in a row, and so try to build a trusting relationship, and *then* respectfully ask if they would like to participate in an interview. Consumers were thus to be consented in two phases—one for the ethnographic research and one for the qualitative interview.

We began the research in January 2020 and were able to complete two of the six planned periods of ethnographic research. Consumers were involved directly in about 13 hours of field observation about which eight pages of field notes specifically about consumers (single-spaced) were recorded. However, we were unable to interview any of the diversion consumers on-site as the flow of intakes was slow and about half of clients left soon after they arrived. There were not many spaces that a researcher could hang out in, either, and most consumers that did stay longer were involved in a structured activity (e.g., art therapy, group therapy), were watching television, or remained in their rooms. A comfortable enough level of engagement with consumers to request an interview had not yet been achieved. The researchers were instead focused on getting to know staff, especially peer staff, to learn more about how to approach and get to know consumers non-intrusively. Unexpectedly, in March 2020, the COVID-19 pandemic

began. Before we could make our visit, non-essential workers were asked to not visit the facility to protect the staff and consumers. The IRB also banned in-person research.

During the lockdown, we attempted to recruit consumers into interviews with help from the staff, including the peer specialists; however, contacting these consumers was difficult. Many lived in group homes or shelters, and despite our efforts to contact them by phone, it was difficult to reach them without the opportunity to visit in person. As time and funding ran out, the pandemic had no end in sight, and research staff moved on to other opportunities, we decided that “slow engagement” was an important concept from the staff perspective that needed to be reported in the literature as soon as possible. However, more research is needed on this concept that includes the consumer perspective. While it is not a supplement for the consumer perspective, we did have three peer specialists in the mental health stakeholder group, and two authors who self-identify as peers on this paper, all of whom advocated for slow engagement.

Diversion Staff Interview Protocol

1. Tell me how you came to be involved with the JEEDC.
2. How would you describe the care and services that the JEEDC offers?
3. In your own words, describe to me what you do for the JEEDC and the participants in this program.
4. Describe to me the population of the clients you serve at JEEDC. [*Probes: who is being served and who isn’t being served, what is their perception or experience of the Center’s populations.]*
5. Draw me a map of how you imagine clients move to, though, and away from the JEEDC. [*Probes: what is the typical trajectory of the clients, what kinds of experiences lead clients to the Center, what kinds of experiences do clients have after they leave, where do they go when they leave the Center.*]
6. How is this kind of care especially innovative compared to other places you have worked [*if applicable*]?

7. If you were listing “best practices” for the JEEDC Center, what would they be? [*Probes: Encourage them to list at least three*.]
8. Can you describe any “lessons learned” or things you might do differently in the future? [*Probes: Encourage them to list at least three*.]
9. If you were offering ideas about what might be done differently to enhance the services provided here what would they be? [*Probes: Encourage them to list at least three.*]
10. Why do you think some diverted clients only stay at the Center for a few hours? What can be done to change this?
11. How do you think “success” should be measured for the JEEDC? Based on what factors that shape the kind of support you can offer?
12. How do you define “success” for people using the JEEDC?
    (Probes: on a general scale, programmatically, more specific to their role)
13. How do you see or envision the JEEDC supporting the lives of people experiencing homelessness?
14. Are there any further resources, services or programs that you wish the JEEDC provided?
15. In an ideal world, what would be the best way to help people who are experiencing homelessness and mental illness avoid getting into trouble with the police?
16. Is there anything else you would like to add?

Thank you for your time! We would like to offer you a $10 gift card as a sign of our appreciation for your time and participation.

Coding Process

We inductively derived multiple codes that captured what defined care at the JEDDC and barriers and facilitators to implementing effective care there, such as “defining the population,” “defining success,” and “engaging multiple stakeholders.” The entire team derived these codes and developed a codebook by reading 9 interviews together and then establishing

codes for patterns that we identified across the data set. Codes were refined, added and deleted by consensus in a series of team meetings across several weeks. Once the codebook was finalized and uploaded into Dedoose, three researchers proceeded to apply the codes to the data set. Two researchers coded each interview initially and then the third checked each interview to make sure that all of the necessary codes were applied to each interview and used correctly. All discrepancies in coding decisions were discussed by the team. Codes were also analyzed for saturation meaning that enough people had mentioned the codes across the data set to warrant their inclusion. One researcher read through all of the tagged text relevant to each theme and selected five quotes from the data set most representative of what the code represented across the data set. Some of these quotes appear in the article.

Results

Theme 1: Negotiating Success

1. Participant N4: “The goal certainly is to reduce recidivism, their rearrest and...even if they're not arrested or diverted again, to reduce the contact with law enforcement. And to get as many individuals connected with services, to try to get them on a good track, managing their mental health in housing. And just not living the same life that leads them to commit those crimes. That's better for the whole community, for everybody."
2. Participant M3: "I think most officers would say that, and I'm supposing here, that success is the reduction or termination of any calls for service involving that individual and a criminal offense that they are reported to or purported to have caused, right?”
3. Field Notes (1/28/20): “[One CJS]’s agenda is to discuss recidivism within the center. [They are] concerned about the ‘familiar faces’ (everyone is so averse to using the term ‘frequent flyer’) of the center, the people who come many times and who never get help. [They are] not seeing a change in this population, and [are] unhappy about ... picking people up so many times, spending the resources on them. When [one MHS] points out that the cops were picking

these people up just as many times before and taking them to jail…[they say] at least by taking them to jail, those people are arrested and the police can show they did something about it."

4. Participant N4: ""Again, we don't want someone that poses a public safety threat to be diverted...Typically, we would not file charges. We would just do that emergency detention order with the officer. And again, participation is voluntary in the program. And then here are your disqualifications, the crimes that are not eligible for obvious reasons because of public safety issues. So all of your domestic violence cases, any assault, terroristic threat is basically threatening to harm someone. And of course, we look at those cases. If someone is highly intoxicated, in a wheelchair, threatening an officer...Do we take that very seriously as an imminent threat? Not really, okay. But the ex-boyfriend that threatens to kill his ex-girlfriend, we take that seriously...that's just not something that we think is appropriate."

5. Participant O3: "Oh, okay. With the one lady that I can think of, she had been through a rough time...She was running from her husband...and you can tell she's scared. Everything's not gone right, she's had a bad time in life. So then, as you watched the two weeks evolve, you can see a softness coming, and openness for people to help her. So then she ended up getting to go to a house...she got to go to a good house. That sort of stuff. So I think that's really important. Finding the right place for a person."

6. Participant N4: "But it can be challenging to get law enforcement to buy in. When you're talking about a police officer versus a social worker, totally different frames of reference. Right? Very, very different."

7. Participant M3: "[One JEEDC client] was a very sick man, who was very unpleasant to be around. He was almost non-communicative. He had mobility issues, sat in a wheelchair. He would defecate on himself, not bathe himself. And he was a pariah on the street. Going into a business, trespassing, and he'd get arrested and go to jail. We got our clutches into him. And he was difficult. He was horrible to deal with. He really was...as distasteful on the street as he was in our Center and vice versa. The folks at the diversion center, and this wasn't my deputies, I'd

love to be able to say my deputies did that, they did a lot, they definitely put up with a lot but, but really the folks at the diversion center, got his money turned on, got him into a facility and he was actually improving, he was getting healthier. He was clean. And unfortunately he had a...medical issue and he died. So, most people would probably snarl their nose up at me saying, 'this is a success?' But this was a guy that, in his last days, had dignity, in his last days, maybe not loved ones, but had someone there to help care for him, in his last days, hopefully, the pain that he may have felt was abated or lessened. So even though we rescued a guy from the street, just to watch him die. I consider that a success. So, the millions that we spend on stupid, frivolous and I'm, you know I'm a dog lover, and I love dog parks...We spend millions on dog parks and monuments to excess. So even if the millions we spent only save that one guy, I think that's a success."

8. Participant L1: "Yeah...the program is supported by the [District Attorney]. The DA is an elected official and the DA runs on a platform. Mental Health Jail Diversion is part of that platform. You need the buy-in from law enforcement. You need the buy-in from the agency that we work with, and then you have the citizens of Harris County that fund our budget that want some return on their investment. And homelessness, of course, is always a hot topic, especially in neighborhoods and things like that.

9. Participant E1: "Someone who came in here to work from the floor up with nearly nothing, yeah. And then come in here and buy in to what we have to offer and open their mind up to receive the help that's being presented. And actually get everything they needed done here: ID, goal card, food stamps, transitional living. if they have a mental disorder, get stabilized on medication, if they got a drug and alcohol issue you know, staying sober, and then leaving here and going to a transitional facility and the follow up that we do with them over there-- them still doing what they're supposed to do, still complying, still taking in information, still taking care of your business. And then, eventually get into the transition- into the housing piece. When someone transitions to an apartment we help him out with getting started with basic needs:

dishes, a broom, that type of stuff. Seeing someone actually start in here with nothing and then get to that point, you know, becoming stable, whether it's getting employment, whether it's getting a disability [income] started, whatever the case may be, but seeing someone actually stable and independent on their own--that's what success is to me."

10. Field Notes (1/15/20): "R1 mentions a '24 hour threshold' - if they can get people to stay the night and stay for 24 hours, that's when it seems like they can get to people and start helping them in a more profound way."

11. Participant G1: Some clients I look at as a success, if, say, the first time around they didn't even want to stay 24 hours. Now, next time, they stay two days. So, it's kind of starting to work on them. We're not the police or anything like that. That's one of the biggest things; trying to get them to see that this is just help. Of course there are rules, but ... A lot of the barriers are a lot of these clients don't like a structured setting, but everything has to have structure. But we still try to make it a relaxed structured setting, you know?"

12. Participant A1: "We know when they come in, they come in acutely psychotic, they do, we stabilize them on their medications. And you start gradually seeing the stabilization once they take their medications. And I think if you see a patient that gets a little more stable, I mean, they're still psychotic, delusional, but they had more moments of lucidity and by time they leave here, they can talk, and carry on a conversation. I think those are little small triumphs every day, especially seeing the stability arising."

Theme 2: Identifying and Addressing Perceived Barriers to Engagement

13. Participant P1: "Oh, yeah. We've had gang members here. We've had people that have been on the streets since they were kiddos, and now they're adults. It's all they know. So that's their safety. That's their family. That's how they survive. And so being here is like a fish out of water. It is. To us, it's nice--we're gonna feed you and wash your clothes and make sure you have toothpaste and just those little things...They didn't have that out there. Or they're used to kind of struggling. Right? [...] First of all, they don't trust you. They have no idea what that's

about. Because they've been nothing but abused out where they've been. And I'm being kind to them. They know, they don't know anything about kindness. We had a guy that was like, turning 30 something, early 30s. And we got cupcakes for him for his birthday, just regular cupcake next. He had never experienced that. He was so touched [...] And it was because he was a rugged guy. And, um, that cupcake meant everything to him. But that's the engagement piece; engagement comes in so many ways."

14. Participant B1: "So there's a certain consumer that's out there, that says 'I want no responsibility,' right, 'I can go over here. I can go get my breakfast. Okay, I can go to [a food pantry]. I can get my clothes over here. I can get food over here, I can get drinks over here[...] I have all these places that I can go. Okay? And get all my needs met, including my dope. Okay, I get all my needs at--the liquor store is over here. If I clean up a parking lot over here I get a pint. Okay, so once I have my infrastructure all done, and I'm good with it,I'll never have to come back here'. And there is a certain amount of consumer that is out there that will not come back. They like their lives."

15. Participant U4: "I think many of the folks that we serve are living independently in the streets and homeless. Many of them, the very nature of their mental health issue causes them to lack some insight into the nature of the problem that they're experiencing...I think all those things oftentimes combined [result in], 'I don't want to stay here.' Many people have spent many years intentionally avoiding systems just like [this one], right? They don't want to be a part of it. They've tried hard to not be engaged. And so there's a natural resistance or hesitance. And in some cases, some of it may be based on their previous experience. I don't want to be dismissive of their experiences, it could be that they've had experiences that they don't perceive as positive with other systems. They don't trust organized or formal systems."

16. Participant I1: "Oh, yes. I mean not the police presence. Because of course we need them, in case we have something go on. But we try to say, 'Hey, they're not... The police aren't even dealing with you. They're just there just kind of like I guess for support in some kind of way.' But

I guess because of them carrying a gun. I don't know. They just actually look like police. I don't know whatever the police did sometimes when they have brought the client here. Maybe that's something that's triggering in their mind. You never know. I've heard that.

17. Participant C1: “Well, see, when they come in, one of the first thing they see is the police officer [...] And I have to remind them ‘hey, you’re not under arrest.’ [laughs]. Do you see them sitting there? You’re not under arrest. He’s here for our protection.”

18. Participant G1: We're not the police or anything like that. That's one of the biggest things; trying to get them to see that this is just help. Of course there's rules, but it ... A lot of the barriers is a lot of these clients don't like a structured setting, but everything has to have structure. But we still try to make it a relaxed structured setting, you know?

19. Participant I1: Again, I've had two, personally, that will leave, because they just wanted to go get a cigarette...I was like, "Really?" He's like, "I just have to leave....I just got to go. I gotta smoke. They won't allow us to smoke here." And I'm like, try to encourage them. "It's just 14 days." But I guess, it's just hard. I'm not a smoker, so I don't know that feeling. You know?”

20. Participant G1: “I would do a designated smoking area. If it was up to me, what's going to be more beneficial here? This is the reason why clients are leaving. I'd just give a smoking area. You know?”

21. Participant U4: “I think you combine this kind of fierce independent streak with sometimes a limited ability to understand how their mental illness might be impacting their circumstances. I think you also combined with that, on occasion, substance use disorders, then the need to, you know, obtain or use drugs to continue, you know, avoiding withdrawal or experiencing difficulties of, you know, being sober. I think all those things oftentimes combine to these kind of anecdotal pressures, that I get, “I don't want to stay here.”

22. Participant P1: “So, just my humble observation, okay? The biggest deal is train your staff, train, train, train, and train them in mental health and substance abuse. Have them trained, because the people that I see leave here, it's due to reaction, a lot of times based on how they

were talked to or presented to by staff...it's not a prison. So the mentality, we can't treat them like that...Training is key because it's just the most important thing and to address the dual diagnosis as opposed to just focusing on one."

Theme 3: Engaging Slowly

23. Participant T1: "They just keep coming back, some of them, which we really feel like, we wish they would get it and just stay and let us help them with the best of our ability. But you know, that comes with a person who wants to be motivated and wants to change. So we can be the change agent, but you have to want to make the change...Some people stay, some people don't. And then when they finally make up their mind, they come back, they're gonna stay here. They really know they need to stay. Then they'll stay. You'll see the benefits of staying. Interviewer: Do you think they're almost more committed to saying than other people when they come and go?

Participant T1:: Yes...Well, when they're tired. They say 'I'm gonna stay this time.'"

24. Participant U4: "[M]y frequent retort is,'they have been arrested 80 times? Give me at lesat 80 shots at connecting with them before you decide our approach doesn't work.' All that said, there is significant expectation for the team to always engage – both initial visits, throughout a visit, and in subsequent visits."

25. Participant L1: "You need to have staff that is willing to work with this population, and that is not bothered about being around them. I think those two are the biggest assets. For best practices, I think you have to have people that actually care, and people that actually listen."

26. Participant M3: "I think that there are people that are very resistant. And they're, those are that, that smaller percentage of the small percentage, right? That, that are very difficult customers that may never be reached. Right? The ones that leave, the ones that stay. I think we have people that will stay because they truly want help. And I think we have people that stay sometimes because the right staff member talked to them at the right time and was able to, you know, derail their thought process, right, or redirect their thought process to get them to stay. I

think that some folks that leave mid- program, they probably live a very hard life. And this is pure speculation. They probably lived a very hard life and have not developed the skill set, coping mechanisms to deal with stressors. And the only tools that they have are to leave and seek drugs, seek refuge alone somewhere, seek the great, wide open."

27. Participant C1: "I want to be there for our consumers. You know? I try to get to them on their level. I go down, I go down in the little dining area and I just try to interact with them. You know sometimes I'll sit and play dominoes and cracking jokes with them, making them laugh, try to lift them up, you know, "why you looking so sad today" you know? Just try to you know, pull them to the side. "Hey, you need to talk? What's going on?" Or, I just sit at the table with them, like "what we watching?" I'll sit there, I'll just go…and then they'll go…like they might just wanna stare at you and say "[Staff name], what's wrong with you?" "I'm just trying to see if you're alright." "Yeah I'm fine, why you looking at me like that?" "I don't know, I might've just wanted to stare at you." "[Staff name], you crazy!" But that's how I get them to kind of open up, and then the next time I come in, they might stare at me. I try, I've always been silly like that."

28. Participant P1: "I think what happens is their tolerance level, their ability to stay engaged. There's sometimes a disconnect... And that's why I say engagement can happen the whole time. And it can be small little things. It does not have to be a big, Oh, I just engaged this person in small little things like just respect. So I think they leave sometimes that's because of that, because they don't understand what's happening so they get frustrated."

29. L1: "As long as I get them in an apartment everybody's happy, correct? Like yay, they're off the street. But that doesn't make them a whole person. And maybe that's the social worker talking in me, but you have to look at these people, at any person as a holistic view. So, for my aftercare workers that was also a difficult concept in the beginning because it's like, "What are you talking about? We got them in an apartment. What do you want from us?" It's like, "Okay, so what are these people going to do now the whole day?" So, how do you give them credit for that? I don't know, or the program."

References

Crisanti, A.S., Case, B.F., Isakson, B.L., & Steadman, H.J. (2014). Understanding study attrition in the evaluation of jail diversion programs for persons with serious mental illness or co-occurring substance use disorders. *Criminal Justice and Behavior*, *41*(6), 772-790.