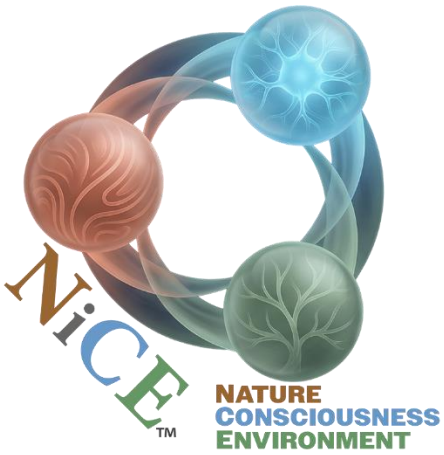

Comprehensive NiCE Diagnosis

Omni-directional Stigma Mechanics

Across All Cohort Pairs in Think.Change

REVISED & EXPANDED

Including MI Constituent Stigma Toward System Agents

Systematic Classification by N-C-E Regime
With Rationales, Implications, and Intervention Targets

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Revision Rationale

The original stigma diagnosis (v0.0.1) examined only unidirectional stigma—system agents' stigma toward people with mental illness. This captured merely one vector of a complex, Omni-directional phenomenon.

The Gap Identified

A comprehensive picture of systemic stigma must include:

- Stigma FROM people with MI TOWARD law enforcement, healthcare, courts, etc. more holistically across Nature, Consciousness, and Environment regimes.
- Inter-cohort stigma among system agents (e.g., law enforcement ↔ mental health providers)
- Intra-cohort stigma (e.g., people with MI toward other people with MI)
- Community stigma toward all system actors, not just toward MI

Why This Matters

Stigma reduction interventions that address only one direction will fail because:

- Omni-directional mistrust creates reinforcing feedback loops
- People with MI's stigma toward helpers reduces treatment engagement
- Inter-agency stigma blocks coordination essential for diversion
- Unaddressed reciprocal stigma undermines coalition formation

Any rational approach to reducing stigma must start with a comprehensive picture of the inter-related problem as it lives within all regimes connected across cohorts.

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Part I: Framework for Omni-directional Analysis

A. The Stigma Matrix

With 7 cohorts, there are 49 potential stigma vectors (7 sources × 7 targets, including self-stigma). This analysis systematically examines each vector, classifying mechanisms by N-C-E regime.

Cohort Definitions

Code	Cohort	System Role
LEO	Law Enforcement	First contact in crisis; arrest/diversion decision authority
DET	Detention Staff	Custody management; daily contact with incarcerated MI population
HCP	Healthcare Providers	Treatment provision; gatekeeping to services
EDU	School/Youth Workers	Early identification; youth development context
JUD	Judiciary/Courts	Disposition authority; sentencing alternatives
COM	General Community	Social context; political will; resource allocation support
MI	People with MI	Service recipients; subjects of system action; also agents with perspectives

B. Reading the Analysis

Each stigma vector is analyzed with:

- SOURCE → TARGET notation (e.g., MI → LEO = MI stigma toward Law Enforcement)
- N-C-E classification with explicit rationale for domain assignment
- Mechanism description: What produces this stigma?
- Expression: How does this stigma manifest behaviorally?
- Implications: What are consequences for system function and intervention design?

Part II: MI Constituent Stigma Toward System Agents

This section addresses the critical gap in v0.0.1: the stigma that people with mental illness hold toward the various system agents they encounter. This Omni-directional stigma is essential to understand because it shapes treatment engagement, crisis behavior, and recovery trajectories.

MI → LEO: People with MI Stigma Toward Law Enforcement

N-Domain Mechanisms

N-MI→LEO-1: Trauma-Conditioned Fear Response

Mechanism: Prior negative encounters with police (arrests, use of force, humiliation) create conditioned physiological fear responses. Amygdala-mediated threat detection triggers fight-flight-freeze upon sight of uniform/badge.

Expression: Autonomic arousal in police presence; defensive/aggressive behavior that escalates encounters; avoidance of help-seeking when police might be involved; physiological inability to comply with commands.

Rationale for N-Classification: Conditioned fear responses are subcortical, automatic, and not subject to conscious override. The person may cognitively 'know' this officer is trying to help while their body prepares for threat.

Implications: De-escalation training for officers must account for trauma physiology in MI population. Crisis response models using non-uniformed responders may reduce N-domain activation.

N-MI→LEO-2: Medication-Induced Vulnerability

Mechanism: Psychiatric medications produce side effects (sedation, akathisia, cognitive slowing) that impair capacity to respond to rapid police commands, creating dangerous encounters.

Expression: 'Non-compliance' that is actually physiological incapacity; movements misread as threatening; inability to 'act normal' under scrutiny.

Rationale for N-Classification: Medication effects are biological constraints on behavioral expression, not attitudes or beliefs.

Implications: Officer training must include medication effects education; response protocols should accommodate slower processing.

C-Domain Mechanisms

C-MI→LEO-1: Generalized Distrust Attribution

Mechanism: Accumulated negative experiences generalize to 'all cops are dangerous/unhelpful.' Attribution of malicious intent to police actions, even helpful ones.

Expression: Refusal to engage with police-involved crisis response; interpreting officer behavior through threat lens; reluctance to call 911 during crisis.

Rationale for C-Classification: Generalized attributions are cognitive schemas—interpretive frameworks applied to new encounters based on prior experience.

Implications: Peer co-response models provide trusted intermediary; positive contact experiences can shift attributions over time.

C-MI→LEO-2: Identity-Based Opposition

Mechanism: For some MI individuals, opposition to police becomes part of identity, especially in communities with historical police conflict. 'People like me don't trust cops.'

Expression: Principled non-cooperation; social identity boundary maintenance; resistance as self-expression.

Rationale for C-Classification: Identity and group membership are cognitive/meaning-making phenomena.

Implications: Identity-based stigma requires identity-level intervention; peer specialists from same communities can bridge.

E-Domain Mechanisms

E-MI→LEO-1: Structural Violence History

Mechanism: Documented history of police violence, especially toward MI and marginalized communities, creates rational basis for avoidance. This is not 'bias' but accurate risk assessment.

Expression: Avoidance behavior grounded in statistical reality; teaching children to fear police; community norms of non-cooperation.

Rationale for E-Classification: Historical and ongoing structural violence is an environmental fact, not a cognitive distortion.

Implications: Stigma reduction requires actual change in police behavior, not just MI attitude change; accountability structures matter.

E-MI→LEO-2: System Design Creating Adversarial Contact

Mechanism: When police are primary mental health crisis responders, every MI encounter occurs under adversarial/coercive conditions, preventing trust-building.

Expression: No opportunity for positive contact; all police-MI interaction filtered through crisis/coercion frame.

Rationale for E-Classification: This is system architecture—the way crisis response is organized determines encounter quality.

Implications: Alternative crisis response (988, mobile crisis, peer response) creates non-adversarial contact opportunities.

MI → HCP: People with MI Stigma Toward Healthcare Providers

N-Domain Mechanisms

N-MI→HCP-1: Iatrogenic Trauma Physiology

Mechanism: Prior traumatic healthcare experiences (involuntary commitment, restraints, forced medication, dismissive treatment) create conditioned physiological responses to clinical settings.

Expression: White coat hypertension extending to all clinical contact; avoidance of medical care; panic responses in hospitals; inability to advocate for self in clinical settings.

Rationale for N-Classification: Conditioned fear responses operate through autonomic nervous system, not beliefs.

Implications: Trauma-informed care must include environmental modifications (calm spaces, peer support) that reduce N-domain activation.

N-MI→HCP-2: Medication Aversion from Side Effect History

Mechanism: Severe medication side effects (weight gain, sexual dysfunction, cognitive dulling, tardive dyskinesia) create physiological aversion to treatment.

Expression: Medication non-adherence; avoidance of prescribers; distrust of 'chemical solutions.'

Rationale for N-Classification: Aversion based on actual physiological harm is N-domain, distinct from belief-based resistance.

Implications: Shared decision-making about medications; acknowledgment of legitimate concerns; alternative treatment options.

C-Domain Mechanisms

C-MI→HCP-1: 'They Don't Listen' Attribution

Mechanism: Repeated experiences of being dismissed, not believed, or having concerns minimized create attribution that providers are incapable or unwilling to help.

Expression: Withholding information from providers; superficial engagement; seeking care only in extremis; 'doctor shopping.'

Rationale for C-Classification: This is an attribution about provider competence/motivation—a cognitive schema.

Implications: Provider training in validation and collaborative care; extended appointment times; peer support integration.

C-MI→HCP-2: 'Just Want to Drug Me' Belief

Mechanism: Perception that providers view medication as only tool and are not interested in understanding person or context.

Expression: Rejection of biological framing; seeking 'alternative' providers; conflict over treatment plans.

Rationale for C-Classification: Beliefs about provider motivations and competence are cognitive content.

Implications: Integrate psychosocial interventions visibly; explain medication rationale; offer choices.

C-MI→HCP-3: Internalized Inferiority in Clinical Encounter

Mechanism: Power asymmetry in clinical relationship activates internalized stigma; person with MI feels 'less than' and cannot assert needs.

Expression: Passive compliance without genuine engagement; failure to report problems; deference masking disagreement.

Rationale for C-Classification: Internalized status beliefs shape interaction patterns—cognitive/identity phenomenon.

Implications: Peer advocates in clinical encounters; explicit power-sharing; collaborative care models.

E-Domain Mechanisms

E-MI→HCP-1: System Fragmentation Creating Abandonment

Mechanism: Fragmented care systems (multiple providers, poor communication, insurance barriers) create experience of being 'lost in the system.'

Expression: Distrust of 'the system' generalized to individual providers; expectation of abandonment; not investing in therapeutic relationships.

Rationale for E-Classification: Care fragmentation is system architecture, not individual provider behavior.

Implications: Care coordination; patient navigators; integrated care models.

E-MI→HCP-2: Economic Barriers as Perceived Rejection

Mechanism: Being turned away for inability to pay, insurance barriers, or waitlists is experienced as rejection/stigma.

Expression: 'They don't want people like me'; avoidance of seeking care; internalization of economic exclusion as personal rejection.

Rationale for E-Classification: Access barriers are structural/environmental, though experienced personally.

Implications: Sliding scale fees; proactive outreach; elimination of barriers to entry.

MI → JUD: People with MI Stigma Toward Judiciary/Courts

N-Domain Mechanisms

N-MI→JUD-1: Courtroom Anxiety Physiology

Mechanism: Court settings trigger extreme anxiety (formal authority, public scrutiny, high stakes) that impairs cognitive function precisely when clear thinking is essential.

Expression: Dissociation during proceedings; inability to follow or participate; behavior interpreted as disrespect or incapacity.

Rationale for N-Classification: Anxiety response is physiological (HPA activation, prefrontal impairment) not volitional.

Implications: Mental health courts with modified procedures; preparation support; accommodations for anxiety.

C-Domain Mechanisms

C-MI→JUD-1: 'Predetermined Outcome' Belief

Mechanism: Belief that courts have already decided against them; that mental illness label ensures negative disposition regardless of facts.

Expression: Fatalistic non-participation; guilty pleas to 'get it over with'; not pursuing legitimate defenses.

Rationale for C-Classification: Beliefs about court fairness are cognitive schemas shaping behavior.

Implications: Mental health court model with visible alternative outcomes; peer court navigators.

C-MI→JUD-2: Authority Reactance

Mechanism: Reactance against perceived illegitimate authority, especially when court involvement stems from untreated illness.

Expression: Defiance; contempt behavior; refusal to engage with mandated treatment.

Rationale for C-Classification: Reactance is psychological response to perceived freedom threat—cognitive/motivational.

Implications: Procedural justice emphasis (voice, respect, neutrality); explaining rationale; offering choices within constraints.

E-Domain Mechanisms

E-MI→JUD-1: Criminalization Experience

Mechanism: Having mental health crisis treated as crime creates perception of courts as instrument of oppression rather than justice.

Expression: Viewing court as enemy; inability to distinguish supportive court programs from punitive ones.

Rationale for E-Classification: Criminalization is system design choice—structural, not attitudinal.

Implications: Diversion before court involvement; clear separation of treatment court from criminal processing.

MI → DET: People with MI Stigma Toward Detention Staff

N-Domain Mechanisms

N-MI→DET-1: Incarceration Trauma Physiology

Mechanism: Detention environment (confinement, loss of autonomy, unpredictable violence) activates chronic stress physiology and exacerbates MI symptoms.

Expression: Hypervigilance toward all staff; inability to distinguish helpful from harmful staff; physiological deterioration masking engagement capacity.

Rationale for N-Classification: Incarceration effects on HPA axis, sleep, circadian rhythms are biological.

Implications: Mental health units with modified environment; continuity of psychiatric care; reduced punitive responses to symptoms.

C-Domain Mechanisms

C-MI→DET-1: 'They're All the Same' Generalization

Mechanism: Negative experiences with some staff generalize to all detention personnel; inability to form working relationships even with supportive staff.

Expression: Uniform hostility or withdrawal; not seeking help when needed; misinterpreting helpful actions.

Rationale for C-Classification: Generalization is cognitive process of category formation.

Implications: Consistent positive contact with designated staff; peer mentors within facility.

E-Domain Mechanisms

E-MI→DET-1: Total Institution Dynamics

Mechanism: Jail structure inherently creates adversarial relationship; staff control all resources; any positive relationship is constrained by structural power asymmetry.

Expression: Inability to trust staff even when individuals are trustworthy; everything filtered through power lens.

Rationale for E-Classification: Total institution dynamics are structural features, not individual characteristics.

Implications: Fundamental reform of carceral approach; therapeutic community models; external advocacy access.

MI → EDU: People with MI Stigma Toward School/Youth Workers

C-Domain Mechanisms

C-MI→EDU-1: School Trauma Attribution

Mechanism: Educational settings where MI symptoms emerged or were mishandled create lasting negative associations with school personnel.

Expression: Adults with MI avoid educational re-engagement; distrust of school-based services for their children; expectation of judgment.

Rationale for C-Classification: Attributions about school personnel based on past experience are cognitive schemas.

Implications: Trauma-informed school practices; peer parent advocates; alternative educational pathways.

C-MI→EDU-2: 'They'll Label My Kid' Fear

Mechanism: Parents with MI fear school identification of their children's mental health needs will lead to stigma and tracking.

Expression: Concealment of family MI history; resistance to evaluation; conflict with school over services.

Rationale for C-Classification: Anticipatory stigma fears are cognitive/belief content.

Implications: Confidentiality protections; strength-based framing; parent education about IDEA protections.

E-Domain Mechanisms

E-MI→EDU-1: Discipline-Based School Response

Mechanism: When schools respond to MI symptoms with discipline rather than support, they become adversarial institutions.

Expression: Distrust of school as extension of punitive system; school avoidance; adversarial parent-school relationships.

Rationale for E-Classification: Discipline-first policies are structural/environmental.

Implications: Restorative practices; PBIS implementation; mental health first response.

MI → COM: People with MI Stigma Toward General Community

C-Domain Mechanisms

C-MI→COM-1: Anticipated Rejection Schema

Mechanism: Expectation of rejection by 'normal' community members based on prior experiences and internalized stigma.

Expression: Social withdrawal; self-isolation; reluctance to disclose; avoidance of community participation.

Rationale for C-Classification: Anticipated rejection is cognitive prediction shaping behavior.

Implications: Supported community integration; peer-led social activities; graduated exposure.

C-MI→COM-2: 'They Could Never Understand' Belief

Mechanism: Belief that people without MI cannot understand MI experience, creating perceived unbridgeable gap.

Expression: Exclusive engagement with MI community; dismissal of support from non-MI others; isolation as identity.

Rationale for C-Classification: Beliefs about others' capacity for understanding are cognitive content.

Implications: Family psychoeducation; community education; contact-based interventions that demonstrate understanding.

E-Domain Mechanisms

E-MI→COM-1: Housing/Employment Discrimination Experience

Mechanism: Documented discrimination in housing and employment creates rational basis for distrust and concealment.

Expression: Not disclosing MI in any community context; parallel life (MI community vs. 'normal' world); exhaustion from concealment.

Rationale for E-Classification: Discrimination is structural/environmental reality, not cognitive distortion.

Implications: Anti-discrimination enforcement; supported employment/housing; peer disclosure role models.

MI → MI: Intra-Cohort Stigma Among People with MI

C-Domain Mechanisms

C-MI→MI-1: Diagnostic Hierarchy

Mechanism: People with certain diagnoses stigmatize those with 'worse' diagnoses (e.g., depression stigmatizing schizophrenia; anxiety stigmatizing personality disorders).

Expression: Distancing from more stigmatized diagnoses; 'at least I'm not...' comparisons; exclusion within MI community.

Rationale for C-Classification: Diagnostic hierarchy is cognitive schema for maintaining relative status.

Implications: Cross-diagnostic peer support; challenging hierarchy in recovery communities; emphasis on shared experience.

C-MI→MI-2: Recovery Status Judgment

Mechanism: People in recovery may stigmatize those who are 'not trying' or 'not doing recovery right.'

Expression: Judgment of medication use or non-use; criticism of coping strategies; exclusion from recovery communities.

Rationale for C-Classification: Judgments about others' recovery are cognitive evaluations.

Implications: Multiple pathways to recovery emphasis; non-judgmental peer support training; harm reduction integration.

C-MI→MI-3: Internalized Stigma Projection

Mechanism: Internalized stigma projected onto others with MI; distancing from MI identity by stigmatizing those more visibly symptomatic.

Expression: 'I'm not like them'; avoidance of MI-identified spaces; stigmatizing language about other MI individuals.

Rationale for C-Classification: Projection is defense mechanism operating through cognitive/identity processes.

Implications: Internalized stigma interventions; community building emphasizing solidarity; visible high-functioning role models.

E-Domain Mechanisms

E-MI→MI-1: Resource Competition

Mechanism: Scarce mental health resources create competition among MI individuals; hostility toward those perceived as 'taking' limited services.

Expression: Gatekeeping behavior; judgment of others' 'deservingness'; hostility in service settings.

Rationale for E-Classification: Resource scarcity is environmental condition producing competitive dynamics.

Implications: Expanded service capacity; advocacy for resources rather than competition for crumbs; community solidarity framing.

Part III: Inter-Cohort Stigma Among System Agents

System agents hold stigmatizing attitudes toward each other, not only toward people with MI. These inter-agency stigmas impede coordination essential for effective diversion and treatment.

LEO ↔ HCP: Law Enforcement and Healthcare Provider Mutual Stigma

LEO → HCP: Police Stigma Toward Mental Health Providers

C-Domain: 'Soft' and 'Naive' Attribution

Mechanism: Police who perceive MH providers as naive about danger, unwilling to make hard decisions, and focused on 'feelings' over safety.

Expression: 'They don't understand the real world'; dismissing clinical recommendations; reluctance to consult MH professionals.

Implications: Joint training emphasizing mutual expertise; ‘ride-alongs’ for clinicians; clinical presence in police settings.

E-Domain: Territorial Jurisdiction

Mechanism: Unclear boundaries between law enforcement and mental health authority create turf conflicts.

Expression: Resistance to MH 'interference' in police work; refusing to share information; undermining MH recommendations.

Implications: Clear protocols delineating authority; co-responder models with defined roles; shared success metrics.

HCP → LEO: Healthcare Provider Stigma Toward Police

C-Domain: 'Brutal and Insensitive' Attribution

Mechanism: Clinicians view police as insensitive to MI needs, excessively forceful, and part of the problem rather than solution.

Expression: Reluctance to involve police; not sharing information that might aid police; advocacy framed as 'protecting' patients from police.

Implications: Exposure to positive police-MI interactions; CIT success stories; clinician involvement in CIT training.

E-Domain: Different Accountability Structures

Mechanism: Police and healthcare operate under different accountability systems (departmental vs. licensing/malpractice), creating mutual incomprehension of constraints.

Expression: Judging other profession by own standards; frustration at 'bureaucratic' or 'protocol-driven' behavior.

Implications: Cross-training on institutional constraints; shared case conferences; mutual appreciation exercises.

LEO ↔ JUD: Law Enforcement and Judiciary Mutual Stigma

LEO → JUD: Police Stigma Toward Courts

C-Domain: 'Revolving Door' Frustration

Mechanism: Police perceive courts as releasing dangerous individuals who police must repeatedly re-arrest.

Expression: 'Why bother arresting?'; cynicism about court outcomes; reduced investment in quality cases.

Implications: Feedback loops showing court outcomes; involvement in specialty court planning; acknowledgment of police perspective.

JUD → LEO: Court Stigma Toward Police

C-Domain: 'Excessive Force' Attribution

Mechanism: Judges view police as trigger-happy, bringing cases that should have been handled differently.

Expression: Dismissing cases; critical judicial comments; requirements for alternative response evidence.

Implications: CIT officer testimony; data on diversion efforts; judicial ride-along programs.

HCP ↔ JUD: Healthcare and Judiciary Mutual Stigma

HCP → JUD: Clinical Stigma Toward Courts

C-Domain: 'Punitive Not Therapeutic' Attribution

Mechanism: Clinicians view courts as interested in punishment, not treatment; as coercive rather than therapeutic.

Expression: Reluctance to engage with court-mandated treatment; viewing forensic work as 'not real therapy'; minimal investment in court-involved patients.

Implications: Mental health court models demonstrating therapeutic outcomes; integration of clinical voice in court design.

JUD → HCP: Court Stigma Toward Clinicians

C-Domain: 'Excuse-Making' Attribution

Mechanism: Courts perceive clinicians as providing excuses for behavior, undermining accountability.

Expression: Skepticism of clinical testimony; preference for prosecution narrative; dismissing MI as mitigating factor.

Implications: Clinical education on legal standards; expert testimony training; collaborative court-clinic relationships.

Additional Inter-Cohort Stigma Vectors

DET ↔ HCP: Detention and Healthcare

DET → HCP: 'They don't understand jail reality'; clinicians seen as impractical idealists who don't appreciate security constraints.

HCP → DET: 'Correctional officers are cruel'; detention seen as inherently anti-therapeutic environment.

Implications: Embedded clinical staff in detention; cross-training; shared metrics for health outcomes.

EDU ↔ HCP: Schools and Healthcare

EDU → HCP: 'Clinicians are inaccessible'; MH system seen as unavailable when schools need support.

HCP → EDU: 'Schools just want to medicate difficult kids'; educators seen as wanting clinical labeling for behavior problems.

Implications: School-based mental health services; clear communication protocols; collaborative treatment planning.

COM ↔ All System Agents

COM → LEO: Distrust of police varies dramatically by community; ranges from support to opposition.

COM → HCP: 'Mental health system is broken'; providers seen as unavailable or ineffective.

COM → JUD: 'Courts are unfair'; especially in communities with justice system involvement history.

All → COM: System agents may view community as ignorant, obstructionist, or 'NIMBYist.'

Implications: Community engagement in system design; transparent accountability; responsive governance.

Part IV: Macro Level Stigma Matrix

The following matrix summarizes primary stigma mechanisms for all 49 potential vectors (7×7). Shading indicates intensity: dark = strong/pervasive, medium = moderate, light = minimal or context-dependent.

FROM↓ TO→	LEO	DET	HCP	EDU	JUD	COM	MI
LEO	—	Minimal	'Soft/naive'	Minimal	'Revolving door'	Context-dep	Threat/danger
DET	Solidarity	—	'Impractical'	N/A	'Soft'	Misunderstood	Dehumanize
HCP	'Brutal'	'Anti-theraputic'	—	'Want labels'	'Punitive'	'Uneducated'	'Non-compliant'
EDU	Fear/respect	N/A	'Unavailable'	—	Distant	'Don't support'	'Disruptive'
JUD	'Excessive'	'Warehousing'	'Excuse-making'	N/A	—	Procedural	'Responsible'
COM	Mixed	'Inhumane'	'Unavailable'	'Failing'	'Unfair'	—	'Dangerous'
MI	Fear/distrust	Fear/distrust	'Don't listen'	Trauma-based	'Predetermined'	Anticipated rej.	Hierarchy

Key: Dark red = strong/pervasive stigma; Light red = moderate stigma; Orange = context-dependent; Gray = minimal/N/A

Part V: Omni-directional Feedback Loops

Stigma vectors do not operate independently. They form feedback loops that amplify and perpetuate stigma across the system.

Loop 1: MI ↔ LEO Escalation Spiral

- MI fear of police (MI→LEO) → defensive/avoidant behavior in encounters
- Defensive behavior interpreted as threat by officers (LEO→MI stigma confirmed)
- Threat response increases coercive police behavior
- Coercive encounter reinforces MI fear → cycle continues

Intervention point: Non-police crisis response breaks the cycle by providing non-threatening initial contact.

Loop 2: MI ↔ HCP Disengagement Spiral

- MI distrust of providers (MI→HCP) → superficial engagement, non-disclosure
- Provider sees 'non-compliant' patient (HCP→MI stigma activated)
- Provider gives less attention/worse care
- Poor care confirms MI distrust → cycle continues

Intervention point: Peer specialists as bridge; extended intake; trauma-informed engagement.

Loop 3: LEO ↔ HCP Coordination Failure

- Police see MH providers as unhelpful ('soft') → don't consult
- Providers don't receive information needed for treatment
- Treatment fails; person returns to crisis
- Police see treatment failure as confirming provider incompetence → cycle continues

Intervention point: Co-responder models; shared case conferences; visible coordination successes.

Loop 4: System ↔ Community Political Will

- Community sees system failure → withholds political/financial support
- Reduced resources → system performs worse
- Worse performance confirms community judgment → cycle continues

Intervention point: Transparent outcome reporting; quick wins demonstrating improvement; community involvement in governance.

Part VI: Implications for Intervention Design

A. Multi-Directional Intervention Requirement

Effective stigma reduction must address all significant vectors simultaneously. Unidirectional intervention produces:

- Unchanged feedback loops that regenerate stigma
- Asymmetric relationships that breed resentment
- Partial gains that decay when reinforcing stigma continues

B. Domain-Specific Intervention Strategies

N-Domain Interventions (Both Directions)

- Trauma-informed crisis response reducing N-domain activation for MI population
- Officer physiological regulation (HRV, sleep) enabling non-threat response
- Medication management reducing side effects that generate stigma
- Environmental modifications reducing stress physiology in all cohorts

C-Domain Interventions (All Vectors)

- System mechanics education for community and MI (understanding structural constraints)
- Attribution retraining for system agents (MI behavior as constrained, not chosen)
- Attribution retraining for MI (system agent behavior as constrained, not malicious)
- Inter-professional respect building (mutual expertise recognition)
- Identity interventions (guardian vs. enforcer; collaborative vs. adversarial)

E-Domain Interventions (Creating Affordances)

- Crisis receiving center creating non-coercive contact opportunity
- Peer co-response providing trusted bridge
- Incentive alignment across agencies (shared outcome metrics)
- Resource expansion reducing scarcity competition
- Policy/legal reform changing default responses

C. Prioritization Framework

Given resource constraints, prioritize interventions that:

- Break highest-impact feedback loops (MI ↔ LEO escalation)
- Address structural (E) preconditions that block other changes
- Enable quick wins demonstrating new dynamics
- Build coalition across cohorts through shared benefit

D. Success Metrics

Comprehensive stigma reduction requires metrics across all vectors:

- MI stigma toward agents: Treatment engagement, crisis help-seeking, court compliance
- Agent stigma toward MI: Behavioral measures (diversion rates, use of force, care quality)
- Inter-agent stigma: Coordination metrics, information sharing, cross-referral rates
- Intra-MI stigma: Peer support participation, disclosure rates, recovery community cohesion

Conclusion

Summary

This more comprehensive diagnosis expands the original NiCE unidirectional analysis to capture the full Omni-directional stigma matrix across all cohort pairs in the Think.Change system. Key findings include:

- MI stigma toward system agents is substantial, grounded in real experiences, and produces treatment-interfering behavior
- MI stigma toward police and healthcare is particularly consequential for engagement and outcomes
- Inter-cohort stigma among system agents impedes coordination essential for effective diversion
- Intra-cohort stigma among people with MI fragments recovery communities
- Feedback loops amplify and perpetuate stigma, requiring multi-vector intervention
- Structural (E-domain) changes can reduce stigma by removing functional need and providing positive alternatives

Framework Value

The NiCE Framework's triadic structure enables systematic classification of stigma mechanisms regardless of direction. By applying N-C-E analysis to all 49 potential vectors, this diagnosis reveals the full complexity of stigma dynamics and identifies leverage points for comprehensive intervention.

Implications for Think.Change

Current MHFA/CIT training addresses one vector (system agent → MI) through one domain (C: knowledge/attitudes). This comprehensive analysis reveals why such unidirectional, single-domain intervention will produce limited results. Effective stigma reduction requires:

- Omni-directional intervention (also addressing MI → system agent stigma)
- Multi-domain intervention (N, C, and E simultaneously)
- Inter-cohort coordination building (reducing agent ↔ agent stigma)
- Feedback loop interruption through structural change

Any rational approach to reducing stigma must start with a comprehensive picture of the inter-related problem as it lives within all regimes connected across cohorts. This analysis provides that comprehensive picture and the NiCE framework for targeted intervention design.

— END OF COMPREHENSIVE DIAGNOSIS —