Office of the City Manager

CONSENT CALENDAR
December 13, 2022

To: Honorable Mayor and Members of the City Council

From: Dee Williams-Ridley, City Manager

Submitted by: Lisa Warhuus, Director, Health, Housing and Community Services

Subject: Contract: Resource Development Associates Specialized Care Unit and Community Crisis Response Services Program Evaluation

RECOMMENDATION

Adopt a Resolution authorizing the City Manager to execute a contract and any amendments with Resource Development Associates (Contractor) to design and implement an evaluation for program effectiveness of the Specialized Care Unit and Community Crisis Response Services (Bridge Services). Services will begin on January 1, 2023 and extend to June 30, 2025 in an amount not to exceed $150,000.

FISCAL IMPACTS OF RECOMMENDATION

Funding in the amount of $150,000 for the Specialized Care Unit program effectiveness evaluation is available in the FY2023 budget in One-Time fund (Fund 336).

CURRENT SITUATION AND ITS EFFECTS

As the City moves closer to implementing the Specialized Care Unit, there needs to be a robust evaluation of the pilot program to identify necessary operational changes and provide a report on the overall effectiveness of this new program for the Berkeley community. Similarly, an evaluation needs to be conducted for the Community Crisis Response Services (“Bridge Services” to the SCU) which have served community members over the last calendar year.

Given their previous engagement on a variety of SCU activities, the Department of Health, Housing and Community Services (HHCS) recommends entering in to new contract with Resources Development Associates (RDA) for the program evaluation services. In its previous work, RDA has gained expertise in the model chosen, provided excellent services and work products, and developed a high degree of trust among SCU stakeholders in the community.

The evaluation for the SCU and the associated Community Crisis Response Services is a Strategic Plan Priority Project, advancing our goal to champion and demonstrate social and racial equity.

BACKGROUND

In Fall 2020, Resource Development Associates (RDA) was selected through a competitive bid process to provide an extensive research, community engagement, and recommendations to create the framework for the Specialized Care Unit (see Attachments 2-4). This process involved working across multiple Berkeley stakeholder groups, including service utilizers, and in-depth research regarding crisis response systems to best inform a behavioral crisis response model to meet Berkeley's needs.

To oversee and advise on this process, the City formed an SCU Steering Committee consisting of representatives from the Health, Housing, and Community Services Department, the Berkeley Fire Department, appointees of the Mental Health Commission, and community representatives from the Berkeley Community Safety Coalition.

With guidance from the Steering Committee, RDA created three reports. The first report provides detailed information about 37 alternative crisis response models that have been implemented in the United States and internationally. The second report provides information about Berkeley's current crisis response system and also summarizes stakeholder perspectives gathered through a deep community engagement process conducted by RDA; in which input was gathered from utilizers of Berkeley's crisis response services, local community-based organizations (CBOs), local community leaders, and City of Berkeley and Alameda County agencies. RDA's third and final report utilized information gathered in completing the first two reports and makes specific recommendations for an SCU model for Berkeley.

ENVIRONMENTAL SUSTAINABILITY AND CLIMATE IMPACTS

No environmental sustainability and climate impacts directly associated with this recommendation have been identified.

RATIONALE FOR RECOMMENDATION

Resource Development Associates (RDA) has been a significant partner on this project for the past two years and is the only contractor that possesses both extensive knowledge about the SCU design process and program model, and has established important and trusting relationships with key stakeholders who are driving SCU implementation.

Given their community engagement and Berkeley-specific expertise about what constitutes a successful SCU Pilot Program, working with RDA will elicit higher community trust, leading to increased validity of performance measures and outcomes. Additionally, contracting with RDA will allow for more efficient evaluation given their existing strong familiarity with the SCU program.

ALTERNATIVE ACTIONS CONSIDERED

The City could choose to go through another competitive bidding process to identify an evaluator. However, RDA's existing level of knowledge and credibility with stakeholders would be impossible for another firm to match, so this approach is not recommended.

CONTACT PERSON

Lisa Warhuus, Director, Health, Housing and Community Services, 510-981-5404

Attachments:
1: Resolution
2: City of Berkeley Crisis Models Report (Research Development Associates)
3: City of Berkeley Mental Health Crisis Response Services and Stakeholder Perspectives Report (Research Development Associates)
4: City of Berkeley Specialized Care Unit Crisis Response Recommendations (Research Development Associates)

RESOLUTION NO. ##,###-N.S.

CONTRACT: RESOURCE DEVELOPMENT ASSOCIATES EVALUATION FOR SPECIALIZED CARE UNIT AND COMMUNITY CRISIS RESPONSE SERVICES

WHEREAS, the City of Berkeley passed an omnibus package to reimagine public safety, including the establishment of a Specialized Care Unit (SCU) to respond to nonviolent behavioral health calls and

WHEREAS, the City of Berkeley released a Request for Proposals and then awarded a contract to the most qualified applicant, Resource Development Associates (RDA), to conduct extensive community engagement to provide design recommendations for the Specialized Care Unit; and

WHEREAS, the Specialized Care Unit will be implemented using RDA's recommendations and accompanying Steering Committee Analysis; and

WHEREAS, the evaluation of the Specialized Care Unit will require expertise and community trust to create a valid and reliable evaluation of this program.

NOW THEREFORE, BE IT RESOLVED by the Council of the City of Berkeley that the City Manager is authorized to execute a contract and any amendments with Resource Development Associates (Contractor) to design and implement an evaluation for program effectiveness of the Specialized Care Unit and Community Crisis Response Services (Bridge Services). Services will begin on January 1, 2023 and extend to June 30, 2025 in an amount not to exceed $150,000 in One-time Fund (Fund 336) available in the FY2023 budget.

City of Berkeley

Crisis Response Models Report

RDA CONSULTING

CITY OF BERKELEY

City of Berkeley
Specialized Care Unit Model Recommendations
Crisis Response Models Report

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This report was developed by Resource Development Associates under contract with the City of Berkeley Health, Housing & Community Services Department.

Resource Development Associates, September 2021

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Introduction

In response to the killing of George Floyd by Minneapolis police in May 2020 and the ensuing protests across the nation for this and many other similar tragedies, a national conversation emerged about how policing can be done differently in local communities. The Berkeley City Council initiated a broad reaching process to reimagine policing in the City of Berkeley. As part of that process, in July 2020, the Berkeley City Council directed the City Manager to pursue reforms to limit the Berkeley Police Department's scope of work to "primarily violent and criminal matters." These reforms included, in part, the development of a Specialized Care Unit (SCU) pilot to respond to mental health crises without the involvement of law enforcement.

In order to inform the development of an SCU, the City of Berkeley contracted with Resource Development Associates (RDA) to conduct a feasibility study that includes community-informed program design recommendations, a phased implementation plan, and funding considerations. As part of this feasibility study, RDA reviewed the components of nearly 40 crisis response programs in the United States and internationally, including virtually meeting with 10 programs between June and July 2021. This report provides a synthesized summary of RDA's findings, including common themes that emerged from across the programs, how they were implemented, considerations and rationale for design components, and overall key lessons learned. Please see the table below for a list of the programs that RDA reviewed. For the first nine programs listed (in bold and italics), RDA conducted phone interviews with representatives to obtain a further understanding of their program models; these programs are cited more often in this report because RDA had more details about them. For the remaining programs listed, RDA reviewed information that was available online. For a tabular summary of the key components of each crisis response program that RDA reviewed, please see Appendix C at the end of this report.

Additionally, SAMHSA's summary of its National Guidelines for Behavioral Health Crisis Care (released in 2020) is included in Appendix A of this report.

Program Name	Location
B-HEARD (the Behavioral Health Emergency Assistance Response Division)	***New York, NY***
Crisis Assistance Helping Out On The Streets (CAHOOTS)	***Eugene, OR***
Crisis Response Pilot	***Chicago, IL***
Expanded Mobile Crisis Outreach Team (EMCOT)	***Austin, TX***
Mental Health First / Anti-Police Terror Project	***Sacramento and Oakland, CA***
Portland Street Response	***Portland, OR***

Program Name	Location
REACH 24/7 Crisis Diversion	***Edmonton, Alberta, Canada***
Support Team Assisted Response (STAR)	***Denver, CO***
Street Crisis Response Team (SCRT)	***San Francisco, CA***
Albuquerque Community Safety Department	Albuquerque, NM
Boston Police Department's Co-Responder Program	Boston, MA
Community Assessment & Transport Team (CATT)	Alameda County, CA
Community Paramedicine	California (statewide)
Crisis Call Diversion Program (CCD)	Houston, TX
Crisis Now	National model (via SAMHSA)
Crisis Response Unit	Olympia, WA
Cuyahoga County Mobile Crisis Team	Cuyahoga County, Ohio
Department of Community Response	Sacramento, CA
Department of Community Solutions and Public Safety	Ithaca, NY
Downtown Emergency Service Center (DESC) Mobile Crisis Team	King County, WA
Georgia Crisis & Access Line (GCAL)	Georgia (statewide)
Los Angeles County Department of Mental Health – ACCESS Center	Los Angeles County, CA
Los Angeles County Department of Mental Health – Co-Response Program	Los Angeles County, CA
Los Angeles County Department of Mental Health – Psychiatric Mobile Response Teams (PMRT)	Los Angeles County, CA
Mobile Assistance Community Responders of Oakland (MACRO)	Oakland, CA
Mental Health Acute Assessment Team (MHAAT)	Sydney, Australia
Mental Health Mobile Crisis Team (MHMCT)	Nova Scotia, Canada
Mobile Crisis Assistance Team (MCAT)	Indianapolis, IN
Mobile Crisis Rapid Response Team (MCRRT)	Hamilton, Ontario, Canada
Mobile Emergency Response Team for Youth (MERTY)	Santa Cruz, CA
Mobile Evaluation Team (MET)	East Oakland, CA
Psykiatrisk Akut Mobilitet (PAM) Unit, the Psychiatric Emergency Response Team	Stockholm, Sweden

Program Name	Location
Police and Clinician Emergency Response (PACER)	Australia (several locations)
Seattle Crisis Response Team	Seattle, WA
Street Triage	England (several locations)
Therapeutic Transportation Pilot Program/Alternative Crisis Response	Los Angeles City and County, CA
Toronto Crisis Response	Toronto, Ontario, Canada

Crisis Response Models: An Overview

Of the crisis response program models reviewed, almost all specify that they respond to mental health and behavioral health concerns in their communities. Some models additionally specify that they respond to non-emergency calls, crises or disturbances related to substance use, homelessness, physical assault and sexual assault, family crises, and/or youth-specific concerns, as well as conduct welfare checks.

In California, Alameda County has the highest rate of 5150 psychiatric holds in the entire state.[1] Of those Alameda County individuals placed on a 5150 psychiatric hold that were transferred to a psychiatric emergency services unit, 75-85% of the cases did not meet medically necessary criteria to be placed in inpatient acute psychiatric services. This demonstrates an overuse of emergency psychiatric services in Alameda County, which creates challenges in local communities such as having lengthy wait times for ambulance services when these ambulances are tied up transporting and waiting to discharge individuals on 5150 holds at psychiatric emergency service units.

Mental health crises are varied - they affect individuals across their lifespans, manifest in a variety of behaviors, and exist on a spectrum of

[1] INN Plan – Alameda County: Community Assessment and Transport Team (CATT) – October 25, 2018. (2018, October 25). *California Mental Health Services Oversight and Accountability Commission*. http://www.mhsoac.ca.gov/document/inn-plan-alameda-county-community-assessment-and-transport-team-catt-october-25-2018 & https://mhsoac.ca.gov/sites/default/files/documents/2018-10/Alameda_INN%20Project%20Plan_Community%20Assessment%20and%20Transport%20Team_8.6.2018_Final.pdf

severity and risk. A crisis response system ultimately seeks to provide care to individuals in the midst of a mental health crisis, keeping the individual and their surrounding community safe and healthy, and preventing the escalation of the crisis or exacerbating strains to mental and emotional well-being. As such, there are many considerations for the design of a mental health crisis response system that addresses the current shortcoming or flaws in existing models around the country and internationally.

Traditionally, the U.S. crisis response system has been under the purview of local police departments, typically with the support of local fire departments and emergency medical services (EMS), and activated by the local 911 emergency phone line. Over time, communities have responded to the need for a response system that better meets the mental health needs of community members by activating medical or therapeutic personnel in crisis response instead of traditional first responders (i.e., police, fire, EMS).

Term	Definition
Traditional Crisis Response Model	For the purposes of this report, we assume a traditional crisis response model includes having all crises routed through a 911 center that then dispatches the local law enforcement agency (as well as fire department and/or EMS, if necessary) to respond to the crisis.
Co-Responder Model	Co-responder models vary in practice, but they generally involve law enforcement officers and behavioral health clinicians working together to respond to calls for service involving an individual experiencing a behavioral health crisis.
911 Diversion Programs	Programs with processes whereby police, fire, and EMS dispatchers divert eligible non-emergency, mental health-related calls to behavioral health specialists, who then manage crisis by telephone and offer referrals to needed services.
Alternate Model	Emerging and innovative behavioral health crisis response models that minimize law enforcement involvement and emphasize community-based provider teams and solutions for responding to individuals experiencing behavioral health crises.

Like a physical health crisis that requires treatment from medical professionals, a mental health crisis requires responses from mental health professionals. Tragically, police are 16 times more likely to kill someone

with a mental health illness compared to others without a mental illness.[2] A November 2016 study published in the American Journal of Preventative Medicine estimated that 20% to 50% of fatal encounters with law enforcement involved an individual with a mental illness.[3] As a result, communities have begun to consider the urgent need for crisis response models that include mental health professionals rather than police.

In the current national discussion about appropriate crisis response strategies for individuals experiencing mental health crises, the prominent concerns voiced have typically focused on the safety of crisis responders and community members, the funding of such programs, and balancing a sense of urgency to implement new models quickly with the need for intentional planning and preparation. In order to understand the current models that exist, RDA reviewed nearly 40 national and international crisis response programs and specifically interviewed staff from 9 programs about their:

- Program planning efforts, including community engagement strategies, coordinating across city agencies and partner organizations, and program planning, implementation, and evaluation activities;
- Models' key elements, including dispatch, staffing, transport capabilities, follow-up care, and more;
- Program financing;
- Other considerations that were factored into their program planning; and
- Key lessons learned or advice for the City of Berkeley's implementation of its SCU.

Components of Crisis Response Models

While each crisis response program was designed to meet the needs of its local community, there are several overarching components that were common across the programs that RDA explored. The majority of crisis response programs use their community's existing 911 infrastructure for dispatch. Most programs respond to mental health and behavioral health calls where they engage in de-escalation, assessment, referral, and

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[2] Szabo, L. (2015, December 10). People with mental illness 16 times more likely to be killed by police. *USA Today*. https://www.usatoday.com/story/news/2015/12/10/people-mental-illness-16-times-more-likely-killed-police/77059710/

[3] DeGue, S., Fowler, K.A., & Calkins, C. (2016). Deaths Due to Use of Lethal Force by Law Enforcement. *American Journal of Preventive Medicine, 51* (5), S173-S187. https://www.ajpmonline.org/article/S0749-3797(16)30384-1/fulltext

transport. Nearly all programs recognize the need to operate 24/7. Staffing structure varies by the needs of the community, but many response team units are staffed by teams of two to three individuals and can include a combination of mental health professionals, physical health professionals, and peers with lived experience. Many teams arrive in plainclothes or T-shirts with logos in a vehicle equipped with medical and engagement items. Teams typically receive skills-based training in de-escalation, crisis intervention, situational awareness, and communication. Crisis teams will either transport clients themselves or call a third party to transport, depending on the legal requirements and staffing structure of the crisis response team. Programs varied in their inclusion and provision of follow-up care.

Underneath the high-level similarities of the crisis response models that RDA researched are the tailored nuances that each program adapted to its local needs, capacities, and priorities. Below are additional details, considerations, and examples from existing models to further inform the City of Berkeley's development and implementation of its SCU.

Accessing the Call Center

Of the reviewed crisis response programs, the majority use the existing local 911 infrastructure, including its call receiving and dispatch technology and staff. There are several advantages to this approach. The general public is typically familiar with the number and process for calling 911, which can reduce the barrier for accessing services. Also, because 911 call centers already have a triage protocol for behavioral health calls, there can be a more seamless transfer of these types of calls to the local crisis response program. Additionally, some calls might not be reported as a mental health emergency but can be identified as such by trained 911 dispatch staff.

Generally, the administration of 911 varies across the nation. In some locales, 911 is operated by the police department, while in other locales it is administered centrally across all emergency services. Some programs have mental health staff situated in the 911 call center to: a) directly answer calls; b) support calls answered by 911 staff; and/or c) provide services over the phone as a part of the 911 call center's response. In Chicago, in addition to diverting more calls to the crisis response program, the staff of Chicago's Crisis Response Pilot anticipates that having mental health clinicians embedded in their call center to do triage and telemedicine will help them lay the foundation for a smooth transition to 988.

988 is the three-digit phone call for the National Suicide Prevention Lifeline. By July 16, 2022, phone service providers across the country will direct all calls to 988 to the National Suicide Prevention Lifeline, so that Americans in crisis can connect with suicide prevention and mental health crisis

counselors.[4] In California, AB 988 was passed in the State Assembly on June 2, 2021(and is currently waiting on passage by the State Senate) – AB 988 seeks to allocate $50 million for the implementation of 988 centers that have trained counselors receiving calls, as well as a number of other system-level changes.[5] In RDA's research of crisis response models, some programs are actively planning for the upcoming 988 implementation when exploring the functionalities of their local 911 infrastructure and responsibilities; other programs were not differentiating 988 from 911 in the communities. For the purposes of this report, moving forward, we will not differentiate 911 from 988, and will refer to all emergency calls for service as going to 911.

Other programs use an alternative phone number in addition to or instead of 911. These numbers can be an existing non-emergency number (like 211) or a new phone number that goes directly to the crisis response program. Oftentimes a program will utilize an alternative phone number when they believe that people, particularly those disproportionately impacted by police violence, do not feel safe calling 911 because they fear a law enforcement response. Portland's Street Response team & Denver's STAR team use both a non-emergency number and 911, routed to the same call center. This supports community members that are hesitant to use 911 while also ensuring that calls that do come through 911 are still routed to Portland's Street Response team. Overall, designing a system in Portland with both options was intended to increase community members' access to mental health crisis services. Given that Portland's program began on February 16, 2021, not enough time has elapsed for findings to be generated regarding the success of this model. But a current challenge that Portland shared with RDA is that some calls to their non-emergency number have wait times upwards of an hour because their call center needs to prioritize 911 calls.

In other program models, an alternate phone number may have been used in the community for years and, therefore, is a well-known resource. For example, in Canada's REACH Edmonton program, the 211 line is well-used for non-emergency situations, so it is used as the main connection point for its crisis diversion team.

Triage & Dispatch

Once a call is received, dispatch or call center staff will assess whether services could be delivered over the phone or whether the call requires an in-person response, and whether the response should be led by the crisis response team or another entity. Several programs utilize existing

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[4] Federal Communications Commission. (2021). *Suicide Prevention Hotline*. **https://www.fcc.gov/suicide-prevention-hotline** & **https://www.fcc.gov/sites/default/files/988-fact-sheet.pdf**

[5] Open States. (n.d.). *California Assembly Bill 988*. Retrieved September 2, 2021, from **https://openstates.org/ca/bills/20212022/AB988/**

well-used triage tools and/or made modifications to those triage tools based on a renewed emphasis of having non-police responses for mental health crises. Please see Appendix B for sample outlines of types of scenarios for crisis response teams that were shared with RDA. A dispatch's assessment of mental health related calls is dependent on the services provided by the local mental health crisis response team, an assessment of the situation and the caller's needs, who the caller has identified as the preferred response team, and any other safety concerns.

Some programs prioritize staff assignment based on call volume and need, such as programs that have chosen to pilot non-police crisis response teams in specific geographic locations within their jurisdiction. In these programs, the call center must, therefore, determine the location of the requested response when dispatching a crisis response team. For example, Chicago's Crisis Response Pilot has four teams that are assigned to different areas of the city based on their local ties and expertise of community needs; each team, therefore, only responds to calls that come from their assigned area. When programs are able to scale their services and hire more staff, many pilot programs plan to expand their geographical footprints.

Many crisis response teams are dispatched via radio or a computer-aided dispatch (CAD) system, and some have the ability to listen in on police radio and activate their own response if not dispatched. Of the nine programs that RDA interviewed, the Eugene CAHOOTS program allows its team to be self-dispatched, the Denver STAR program allows its team to directly see what calls are in the queue so they can be more proactive in taking and responding to calls, and the San Francisco SCRT program allows its team to respond to incidences that they witness while being out in the streets. Regarding the ability to self-dispatch, San Francisco's SCRT program is currently figuring out the regulatory requirements that might prohibit self-dispatching paramedics because they must be dispatched through a dispatch center.

Having multiple opportunities to engage the crisis response team is important to ensure community members have the most robust access to the service. For example, in Denver, their police, fire, and EMS can call their Support Team Assisted Response (STAR) team directly. Across all incidents that the Denver STAR team responded to in the first six months of its pilot implementation, it was activated by 911 dispatch in 42% of incidents, by police/fire/EMS in 35% of incidents, and self-activated in 23% of incidents.[6] These data from the Denver STAR team demonstrate how, especially in the early stages of a new program's implementation, new processes and relationships are continually being developed, learned, refined, and implemented. For this reason, it is beneficial to have safeguards in place in triage and dispatch processes so that the crisis

[6] Denver STAR Program. (2021, January 8). *STAR Program Evaluation*. **https://www.denverperfect10.com/wp-content/uploads/2021/01/STAR_Pilot_6_Month_Evaluation_FINAL-REPORT.pdf**

response team can be flexible in responding to the various ways in which crisis response calls originate.

Assessing for Safety

The presence of weapons or violence are the most common reasons why a crisis response team would not be sent into the field. Some of the reviewed programs only respond to calls in public settings and do not go to private residences as an effort to protect crisis team staff, though this was the case in a few of the 40 reviewed programs. Calls that are deemed unsafe or not appropriate for a crisis response team will often be responded to by police, co-responder teams, police officers trained in Critical Intervention Team (CIT) techniques, or other units within the police department. Many alternative models have demonstrated that the need for a police response is rare for calls that are routed to non-law enforcement involved crisis response teams. For instance, in 2019, Eugene's Crisis Assistance Helping Out On The Streets (CAHOOTS) team only requested police backup 150 times out of 24,000 calls, or in fewer than one percent of all calls received by the crisis team;[7] this demonstrates that effective triage assessments and protocols do work in crisis response models.

Several of the programs interviewed by RDA mentioned that they are currently evaluating options for their non-police crisis response teams to respond to situations that may involve weapons or violence. These are situations that would otherwise be scenarios that default to a police response. These programs are aware of the risks of police responses to potentially escalate situations that could otherwise be deescalated with non-police involved responses and are trying to find ways to reduce those types of risks.

The types of harm and concerns for safety that should be assessed are not only for crisis response team staff, but also for the individual(s) in crisis and surrounding bystanders or community members. SAMHSA's best practices on behavioral health crisis response underscores that effective crisis care is rooted in ensuring safety for all staff and consumers, including timely crisis intervention, risk management, and overall minimizing need for physical intervention and re-traumatization of the person in crisis.[8] When call center staff deem a call safe and appropriate for the crisis response team, they will assign the call to the crisis response team. There may be multiple calls and situations happening concurrently, in which case the call center staff

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[7] White Bird Clinic. (n.d.). *What is CAHOOTS?*. Retrieved August 29, 2021, from **https://whitebirdclinic.org/what-is-cahoots/**

[8] Substance Abuse and Mental Health Services Administration (SAMHSA). (2020). *Crisis Services – Meeting Needs, Saving Lives*. **https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-08-01-001%20PDF.pdf** (page 32)

prioritize the calls based on pre-established criteria, such as acuity and risk of harm.

Crisis Response Teams Increase Community Safety

New York City's Behavioral Health Emergency Assistance Response Division (B-HEARD) program is being piloted in a region that receives the city's highest number of mental health emergency calls.[9] In the first month of implementation, the program demonstrated:

- Increased rates of people accepting care from the B-HEARD team compared to traditional 911 response teams.
- The proportion of people transported by the crisis response team to the hospital for more care was far smaller than the proportion transported with their traditional 911 response.
- An anticipated increase of 911 operators routing mental health emergency calls to the B-HEARD team.

"A smarter approach to public health and public safety. A smarter use of resources. And the evidence — from Denver to New York — shows that responding with care works."

- U.S. Representative Jamaal Bowman, D-NY

Hours of Operation

Because a mental health crisis can happen at any time, many programs have adopted a 24-hour model that supports the community seven days a week; of the 40 programs that RDA reviewed, 12 have adopted a 24/7 model. Some programs that are in their early phases of implementation have launched with initially limited hours but have plans to expand to 24/7 coverage once they are able to hire more staff for crisis response teams. If a program uses 911 as a point of access for the crisis response team, then there may be a community perception or expectation that the crisis response team also operates 24/7 the same way that 911 operates 24/7.

Other programs with more restricted resources often have limited hours; some offer services during business hours (9am to 5pm, Monday through Friday) while others offer services after-hours. Using historical data to prioritize coverage during times with highest call volumes can help a program adapt to local needs. For example, Mental Health First Oakland currently responds to calls Friday through Sunday from 7pm to 7am

[9] Shivaram, D. (2021, July 23). Mental Health Response Teams Yield Better Outcomes Than Police In NYC, Data Shows. *National Public Radio (NPR)*. https://www.npr.org/2021/07/23/1019704823/police-mental-health-crisis-calls-new-york-city#:~:text=Hourly%20News-,New%20York%20City%20Mental%20Health%20Response%20%20Teams%20Show%20Better%20Results,were%20admitted%20to%20the%20hospital.

because they have found that those times are when mental health services are unavailable but need is high.

Types of Calls

Some crisis response programs only respond to specific call types, such as calls pertaining to mental health, behavioral health, domestic violence, substance use, or homelessness. A fraction of programs only respond to acute mental health situations, such as suicidal behavior, or conversely only non-acute mental health calls, such as welfare checks. And, some crisis response programs respond to any non-emergency, non-violent calls, which may or may not include mental health calls. Every program is unique in the calls that they are currently responding to as well as how agencies coordinate for different types of calls. Additionally, given that many programs are actively learning and adapting their models, what and how they respond to calls is evolving.

The most common types of calls that programs are responding to are calls regarding trespassing, welfare checks, suicidal ideation, mental health distress, and social disorder. Several programs mentioned that their main call type - trespassing - is to move an unwanted person, usually someone that is unsheltered and sitting outside the caller's home or business. While programs provide this service, many advocate for increased public education around interacting with unhoused residents and neighbors without the need to call for a third-party response.

The programs in New York City, Chicago, and Portland shared with RDA that they are keeping their scopes of services small for their current pilot implementations. At a later time, they will learn from the types of calls receive and determinations made in order to determine how they will expand their program to respond to more situations (e.g., including serving more types of crises, more types of spaces like private residences, etc.).

In order to demonstrate the variety of incidents that different programs respond to, below are highlights regarding the types of calls that some of the programs that RDA interviewed respond to:

- New York City's B-HEARD program is currently responding to calls regarding suicidal ideation with no weapons, mental health crisis, and calls signaling a combination of physical health and mental health issues. For calls where weapons are involved or are related to a crime, NYPD is the initial responder. The B-HEARD program provides transport and linkage to shelters, where the shelters then provide follow-up services.
- Chicago's Crisis Response Pilot is determining how they will address "low-level crimes" and crimes related to homelessness, especially if the root cause of the crime is an unmet behavioral health and/or housing need. The program does not have an official protocol or decision tree yet for determining which calls it will respond to. But,

its emphasis is on responding to mental health crisis and mental health needs.

- The Portland Street Response program is currently only responding to calls regarding crises that are happening outdoors or public settings (e.g., storefronts), not in private residences. The majority of their calls are related to substance use issues, co-occurring mental health and substance use issues, and welfare checks. The program cannot respond to suicide calls because of a Department of Justice (DOJ) contract that the City of Portland has that would require the Portland Street Response Program to appear before a judge and renegotiate that contract that the city currently has; this process would take at least two years to happen.
- Denver's STAR program currently responds primarily to calls where individuals have schizophrenia, bipolar disorder, major depression, and/or express suicidal thoughts but have no immediate plans to act upon them. The STAR program also conducts many Welfare checks. The program is currently primarily dealing with issues related to homelessness because its pilot rolled out in Denver's downtown corridor where there is a high number of unsheltered individuals.

Services Provided Before, During, and After a Crisis

The reviewed programs offer a variety of services before, during, and after a mental health crisis. Regarding services provided before crises occur, some programs view their role as supporting individuals prior to crisis, including proactive outreach and building relationships in the community with individuals. Portland's Street Response team contracts with street ambassadors with lived experience (via a separate contract with a local CBO) that do direct outreach to communities; street ambassadors work to explain the team's services and ultimately increase trust. Portland's Street Response team also works with nursing students who provide outreach and medical services to nearby encampments. Mental Health First has a strong cohort of repeat callers who request accompaniment through issues they are facing that the team will go into the field to provide – these services can help them avoid escalating into a crisis. Denver's STAR program initiates outreach with local homeless populations to ensure they have medicines and supplies. These proactive efforts are examples of crisis response teams supporting potential individuals before they are in crisis, and thus also promoting their overall health and well-being.

During a crisis response, most programs offer various crisis stabilization services, including de-escalation, welfare checks, conflict resolution and mediation, counseling, short-term case management, safety planning, assessment, transport (to hospitals, sobering sites, solution centers, etc.), and 5150 evaluations. To engage the individual in crisis, staff will provide supplies to help meet basic needs with items such as snacks, water, and clothing. If there is a medical professional on the team, they can provide

medical services including medical assessments, first aid, wound care, substance use treatment (i.e., medicated-assisted treatment), medication assistance and administration, and medical clearance for transport to a crisis stabilization unit (CSU).

After a crisis, the teams may provide linkage to follow-up care. Some crisis response teams do short-term case management themselves, but most refer (and sometimes transport) individuals to other providers for long-term care. Referrals can be a commonly provided service of a crisis response program. For example, 41% of Denver STAR's services are for information and referrals.[10] Many programs have relationships with local community-based organizations for providing referrals and linkages, while some programs have a specific protocol for referring individuals to a peer navigation program or centralized care coordination services.

[10] Alvarez, Alayna. (2021, July 21). Denver's pilot from police is gaining popularity nationwide. *Axios*. **https://www.yahoo.com/now/denver-pivot-police-gaining-popularity-122044701.html**

Term	Definition
Transport	Placing an individual in a vehicle and driving them to or from a designated mental health service or any other place.
5150	5150 is the number of the section of the Welfare and Institutions Code which allows an adult who is experiencing a mental health crisis to be involuntarily detained for a 72-hour psychiatric hospitalization when evaluated to be a danger to others, or to himself or herself, or gravely disabled.
Peer Worker	A mental health peer worker utilizes learning from their own recovery experiences to support other people to navigate their recovery journeys.
Medication-Assisted Treatment (MAT)	MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of SUDs.
Narcan	Narcan (Naloxone) is a nasal spray used for the treatment of known or suspected opioid overdose emergencies.
Crisis Stabilization Unit	A mental health voluntary facility that provides a short-term stay for individuals needing additional stabilization services following a behavioral health crisis.
Sobering Center	A facility that provides a safe, supportive environment for publicly intoxicated individuals to become sober.

Staffing Crisis Teams

Most teams include a combination of a medical professional (e.g., an EMT or nurse), a mental health clinician (e.g., a psychologist or social worker), and a peer. Having a variety of staff on a team allows the program to respond to a diverse array of calls, meet most needs that a client might have, and gives the client the ability to engage with whomever they feel most comfortable.

The reviewed programs staffed their crisis teams with a variety of medical professionals. There was consensus among interviewed programs that crisis response team EMTs, paramedics, nurse practitioners, or psychiatric nurse practitioner clinicians should have at least three to five years of experience in similar settings, as well as having comprehensive de-escalation and trauma-informed care training and skills. Austin's Extended Mobile Crisis Outreach Team (EMCOT) program cited that a paramedic's ability to address a client's more acute physical health and substance use

needs is a beneficial diversion away from an EMS or police response.[11] However, in many cities, the skills and expertise of paramedics are not heavily utilized, as many mental and behavioral health calls do not require a high level of medical care. However, a medical professional can be an important addition to the team, especially for services like providing first aid, wound care, the administration of single-dose medication, medication-assisted treatment (MAT) for substance use issues, and 5150 transports. Considerations for which medical professionals should be staffed on a crisis team depends on the types of services the model intends to provide, the historical data on the types of calls or service needs, the local rules for which services can be provided by specific professions, and the overall program budget.

All programs had a mental health provider on their crisis response teams. There is variability in the level of formal education, training, and licensure of the type of mental health provider in each program. Some programs have licensed, masters-level therapists and clinicians (e.g., ASW, LCSW), while other programs utilize unlicensed mental health providers. Considering if a program wants or needs to be able to bill Medicaid or other insurance payors, the ability to place a 5150 hold, as well as the direct costs of providers with differing levels of education and training are examples of considerations and decision points that programs have when determining what type of professional they want to provide mental health services.

Across the programs reviewed and interviewed by RDA, there is variability in the current presence of peer support specialists on teams. By definition, peer workers are "those who have been successful in the recovery process who help others experiencing similar situations."[12] Studies demonstrate that by helping others engage with the recovery process through understanding, respect and mutual empowerment, peers increase the likelihood of a successful recovery. While they do not replace the role of therapists and clinicians, evidence from the literature and testimonials given to RDA leave no doubt about their value added on a crisis response team. Peer support specialists are able to connect with clients in crisis in ways that are potentially very different from how mental health clinicians and medical providers are trained to provide their specific types of services.

Although 21 of the 40 reviewed programs were classified as alternative models for mental health crisis response, it is important to note that co-responder programs, which were 11 of the 40 reviewed programs, include a police officer on the response team. A co-responder program will often

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[11] *Expanded Mobile Crisis Outreach Team*. (n.d.). Integral Care Crisis Services. Retrieved August 29, 2021, from **https://www.austintexas.gov/edims/document.cfm?id=302634**

[12] *Who Are Peer Workers?*. (2020, April 16). Substance Abuse and Mental Health Services Administration (SAMHSA) Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). **https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers**

be used for higher acuity calls that involve the risk of violence by the person in crisis or the risk that the person in crisis has a weapon. As co-responders, police may arrive on site before the rest of the crisis team does. Other models treat the police officer as a back-up personnel, allowing the crisis team to evaluate the level of risk or danger of the situation and then, if de-escalation tactics are unsuccessful, call the police for support.

Team structures vary depending on funding, local salary structures for different types of providers, program design, and program administration. For example, 24-hour programs require more teams and staffing while programs with limited hours will likely have fewer shift rotations and therefore fewer teams. San Francisco's Street Crisis Response Team has six teams with three members per team; shifts are 12 hours long with two teams assigned to each shift. Overlap between the shifts has improved coordination between the teams. Programs with unionized staff (e.g., EMTs, paramedics) require regimented 8-, 10-, or 12-hour shifts, which also influences a team's capacity and scheduling.

Training

Training requirements vary based on the staffing structure and services provided by a crisis response program as well as the specific needs of the local community. Across the board, programs train their staff in crisis intervention topics such as de-escalation, mental health intervention, substance use management, and situational awareness. Many teams are trained together as a cohort to build relationships and trust between staff. Most teams are trained for around 40 hours in the classroom and then supervised in the field. In co-responder teams, police officers often receive 40 hours of Crisis Intervention Team (CIT) Training.

Specialized staff also receive specific training relevant to their role. Dispatch staff typically receive separate training focused on risk assessment and triage. In programs with clinicians embedded within the call center, the clinicians often provide training to other dispatch staff on mental health topics. Interviewed programs also recommended the crisis response team's dispatch team learn to assess call risk level by building an intake/eligibility tool, as well as through risk assessment and motivational interviewing. For both Denver's STAR and Portland's Street Response programs, dispatch staff were trained by and then shadowed Eugene's CAHOOTS dispatch team, leveraging the decades of experience of CAHOOTS' established alternative crisis response model.

Specific de-escalation and crisis intervention training in which programs participate include key strategies to mitigate risk in the field, learning effective radio communication, and motivational interviewing skills. Some interviewed programs shared that substance use training should be attended by all crisis response staff, not just clinicians; for example, Narcan administration, tourniquet application, and harm reduction training are critical training skills for all team members when supporting a client during a substance use emergency.

Training on implicit bias was also regarded as essential among interviewed programs. Many interviewed programs agreed that receiving training in team-building and communication strategies, trauma-informed care, cultural competency, and racial equity advances the intention and principles of their alternate response program.

Equipment: Uniforms, Vehicles, and Supplies

Most teams arrive either in plain clothes or a T-shirt with a logo. Interviewed programs attested that casual clothing helps crisis response teams appear approachable and creates a sense of comfort for the person in crisis. In contrast, programs worried that formalizing their uniforms could trigger negative past experiences that community members have had with institutions (e.g., police, psychiatric hospitals, prisons) and, therefore, escalate someone in crisis. However, EMTs or police in a co-responder team do wear their usual uniform so that they are easily identifiable as first responders.

The types of vehicles and equipment needed for each model vary based on the scope of services provided, types of calls to which the team responds, and the team's staffing structure. The majority of programs have a van or fleet of vans with the program logo on it and are stocked with necessary supplies. Some programs use their vehicles for on-site service delivery, while others use them only for transporting a client to an alternate location. Programs situated within fire departments often have EMTs or paramedics on-staff, so those teams ride in ambulances or vans with transport capabilities. Co-responder programs often use police vehicles, either marked or unmarked.

There are several considerations for how the design of the vehicle increases accessibility and safety for clients, as well as supports the security of providers. Vans should be accessible to wheelchairs so that crisis response teams can provide services within the interior of the van (to ensure client privacy) and in the event of a needed transport. Also, vans equipped with lights allow them to park on sidewalks and increase traffic safety. Several interviewed programs mentioned using Eugene's CAHOOTS program's van specifications. One component of this design is a plexiglass barrier between the van's front and back seats, which protects both the driver and anyone riding in the back in the case of an accident; additionally, the barrier keeps clients in the back of the vehicle and protects the driver from any disruption that could decrease safety during the transport. However, some cities are moving away from including the plexiglass barrier between the front and back seats in their vans due to the stigma and lack of trust it communicates to the client.

Many vehicles and teams are equipped with various technologies, including radios with connection to dispatch, cell phones, and data-enabled tablets for mobile data entry. Denver's STAR program has access to the local 911 dispatch queue to understand what calls are being

assessed and which could potentially use the program's response. The STAR program teams also have direct access to an electronic health record (EHR) system where they can look-up an individual's health history or communicate directly with a client's psychiatrist or case manager and thus provide tailored, high quality of care in real-time.

If crisis response teams provide medical services, they often carry items such as personal protective equipment, wound care supplies, a stethoscope, blood pressure armband, oxygen, and intravenous bags. Teams also often carry engagement items to initiate client interactions and meet basic needs, such as food, water, clothing, socks, cigarettes, "mercy beers," tampons, condoms, and hygiene packs. When it is able to go into the field again, the Mental Health First model intends to use an RV instead of a van, so they can invite clients into the RV for more privacy and then supply them with a variety of supplies for their basic needs (e.g., clothing).

Overall, when deciding the types of uniforms, vehicles, and equipment to obtain, programs considered what would be recognizable, establish expertise, support the service delivery, build trust with those whom they serve, and not trigger or further harm individuals in crisis.

Transport

The ways that programs transport clients to a subsequent location varies in many ways, including when the transport is allowed, who is doing the transport, where clients are transported, and who is affected by the transport decision.

While some programs have the capability to transport clients themselves, others call a third party to do the transport. This depends on whether staff are licensed to do involuntary transports, whether the vehicle is able to transport clients, and whether it is deemed safe to provide transport at that time. Oftentimes, programs will only conduct voluntary transports, and they may pre-establish specific locations or allow the client's location of choice. If clients do not want to be transported to another location, some programs will end the interaction. Because Denver's STAR team does not use an ambulance, they can refuse someone's requested transport to a hospital if a lower level of care is appropriate, such as a sobering center. Some programs conduct involuntary holds, either done by program staff or by calling for police backup. Waiting for police can undermine the level of care provided, a delay which poses a threat to the client's safety and well-being. Portland's Street Response program experiences delays of up to an hour when requesting police for involuntary holds; for this reason, the team hopes to have the ability to do 5150 transports themselves, and in a trauma-informed way that gives individuals a sense of control over the situation. Whether a crisis response team can transport clients, initiate involuntary holds, and/or call police for back-up in these situations are all considerations which implicate the continued involvement of law enforcement in crisis response.

In the transport process, clients may be transported to short- or long-term service providers as well as the client's location of choice. Some short-term programs include a crisis stabilization facility, detox center, sobering center, homeless shelter, primary care provider, psychiatric facilities, diversion and connection center, hospital, and urgent care. Long-term programs include residential rehabilitation and direct admission to inpatient units of psychiatric emergency departments. Building relationships at these destinations and with providers is key to successful warm handoffs and ensuring clients in crisis receive the appropriate care. For example, challenges can arise when bringing someone to an emergency room if the hospital is not fully aware of what the crisis response program is, which makes it more difficult to advocate for the client to receive services.

There are many things to consider about client and provider safety when transporting a client. Some programs do not give rides home and only transport the person to a public place. Others have restrictions on when they will transport a client to a private residence. For example, Denver's STAR team will not take a person home if they are intoxicated and if someone else is in the home because they do not want to put the other person in potential harm. Instead, when responding to an intoxicated individual, the STAR team transports them to a sobering center, detox facility, or similar location of choice. In Portland, first responders and crisis response providers use a risk assessment tool that helps them determine if ambulance transport needs to be arranged. Portland's risk assessment tool asks providers to determine if the individual has received sedation medication in the last six hours, had a Code Gray in the last 6 hours, had a history of violence and/or aggression, had a history of AWOL, or are showing resistance to hospitalization; if the answer is yes to any of these five questions, then they will arrange for ambulance transport for the individual in crisis.

Follow-up Care & Service Linkage

Follow-up care and linkage to services are handled in a variety of ways. Some programs include referrals to internal, non-crisis response program staff as a service provided directly by the crisis response team. When community health workers and peer support specialists are staffed on crisis response teams, they often lead the referral and navigation support role. After responding to a crisis, Portland's Street Response team (an LCSW and paramedic) call a community health worker if the client wants linkages or additional follow-up supports. While referrals and linkages are important to client outcomes and prevention, this kind of follow-up care can be challenging for many programs to do because it can be difficult to find individuals in the community, particularly if they are not stably housed or do not have a working phone. Portland's Street Response team often goes to encampments to provide follow-up care, which is a program element that is also effective as proactive outreach into local communities.

Other programs refer individuals to other external teams or organizations not affiliated with the crisis response team whose primary role is to provide follow-up care to individuals who served by the crisis response team. Olympia's Crisis Response Unit specifically identifies repeat clients for a referral to a peer navigation program for linkage to care. Additionally, many programs have relationships with community-based organizations and refer clients there for follow-up services. Newer programs that have yet to fully launch stated this was a focus of their program design, as well. For example, San Francisco's Street Crisis Response Team partners with a centralized Office of Care Coordination within the San Francisco Department of Public Health that provides clients with linkages to other services; the Street Crisis Response Team essentially embeds this handoff in their own processes.

And, there are some programs that do not include follow-up care within the scope of their services. For example, Eugene's CAHOOTS program has a narrower focus on crisis stabilization and short-term care; they do not provide referrals or linkage to longer-term services for their clients.

Program Administration

Across the crisis response models that RDA researched and interviewed, there was variability in how they are each administered. As each program is constructed around their local agency structures, resources, needs, and challenges, how their programs are administered are also just as adaptive.

Administrative Structure

The administrative structure and placement of crisis response programs varies significantly. Some programs are administered and delivered by the city/county government, some programs are run in collaboration between a city/county government and community-based organizations (CBO), while others are entirely operated by CBOs.

The administration and structure of a crisis response program may be affected by the geographic and/or population size of the local region and what stage of implementation the program is in. For instance, consistent and guaranteed funding helps sustain programs for the long-term, so developing a program within the local municipal structure may be an advantage over contracting the crisis response program to a CBO. Some programs found that staff retention was higher for government positions, due to their generally higher wages and increased benefits compared to what CBOs generally offer. Additionally, the use of the existing 911 and dispatch infrastructure may be streamlined for crisis response programs administered by city/county governments because they can be situated within existing emergency response agencies and use existing interagency data sharing and communication processes

more easily. Finally, programs that are situated within a local health system -- such as Departments of Public Health, Behavioral Health, or public hospitals -- may have existing protocols and processes with which to collaborate with CBOs for referral assistance, case management, resourcing, and follow-up service provision.

On the other hand, programs that are primarily administered and staffed through CBOs reported a sense of flexibility and spontaneity in their program design, expansion, and evolution, especially for early-stage pilots that intend to change and grow over time. These programs shared that they experienced reduced bureaucratic barriers that were conducive to community engagement and program redesign. Additionally, most programs that included peer support specialists in their crisis response program had these roles sourced by CBOs – these peer support specialists were either fully integrated into crisis response teams or were referred to by crisis response teams to provide linkage and follow-up services.

Though there is variety in what entity administers crisis response programs, who sources or contracts the crisis responders, and where funds are generated, all programs require cross-system coordination for designing the program and implementing the dispatch, training, funding, and program evaluation/monitoring activities.

Staffing and sourcing a crisis response program entirely by volunteers can also be helpful in reducing barriers for potential providers to enter this professional field, elevating lived experience of staff, addressing community distrust of the police-involved response system, and building a mental health workforce. However, currently, all-volunteer models face challenges in having consistent and full staffing coverage, which limits a program's overall service provision and hours of operation.

Financing

Aside from the health benefits of increasing mental health and medical resources in crisis responses, there are financial benefits, too. For example, in Eugene, the CAHOOTS program's annual budget is $2.1 million. In contrast, the City of Eugene estimates it would cost the Eugene Police Department $8.5 million to serve the volume and type of calls that are directed to CAHOOTS.[13]

Several cities are funding crisis response systems through the city's general fund, which offers a potentially sustainable funding source for the long-term because it demonstrates that city officials are committed to investing in these services with public funds. To generate these funds, Denver added a sales and use tax in 2019 (one-quarter of a percent) to cover mental health services, a portion of which funds the STAR program.

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[13] White Bird Clinic. (n.d.). *What is CAHOOTS?*. Retrieved August 29, 2021, from **https://whitebirdclinic.org/what-is-cahoots/**

Some cities have funded crisis response programs by reallocating other city funds. Chicago's Police Department currently pays the salary of the CIT-officer in Chicago's crisis response pilot program. Chicago's crisis response pilot also receives additional funding from Chicago's Department of Public Health. Austin's EMCOT program is funded by $11 million reallocated from the Police Department. And Eugene's CAHOOTS program is fully funded through a contract by the Eugene Police Department.

Federal or state dollars have also been used for some crisis response programs. Alameda County's Community Assessment and Transport Team (CATT) is funding by California's Mental Health Services Act (MHSA) Innovation funds. Chicago's current crisis response pilot uses Centers for Disease Control and Prevention (CDC) funding. New York City and Los Angeles both plan to bill Medicaid as a funding source for their emerging crisis response programs. The national Crisis Now program bills per service and per diem for mobile crisis and crisis stabilization services, which is reimbursed by Medicaid.

Some programs are able to leverage private funds to support their services. In addition to the allocation of city funds, Chicago receives funding from foundations and corporations to fund its crisis response program. The Mental Health First program is entirely supported by donations, grants, and volunteer time.

These financing mechanisms provide varying levels of sustainability and predictability, which may affect the longevity of a program and, therefore, its overall impacts. Ensuring that programs can be continuously funded ensures resources go into direct service provision and program administration, rather than on development, fundraising, or grant management. Staff recruitment and retention is also more successful when there is long-term reliability of positions.

Program Evaluation

Many crisis response programs use data to monitor their ongoing progress and successes, modify and expand program pilots, and measure outcomes and impact. Standardizing data collection practices (i.e., data collection tools, measures, values for measures, aligned electronic sources for data entry, etc.) across participating teams and agencies within and across cities/locales, especially for regional plans, supports effective program evaluation and reporting. Addressing this consideration is best done early in program planning because it affects the protocols developed for triage and dispatch, the equipment that crisis response teams use to record service delivery notes or accessing clients' EHR records, the way referrals and hand-offs are conducted, whether or how Medicaid billing/financing will be leveraged, and more. Several cities noted that they incorporated data sharing and access into MOUs that outlined the scope of work. The providers in most programs have access to an electronic health record (EHR) system that they are able to enter

their contact notes into – having access to a centralized data collection portal like this can greatly aid a program's evaluation efforts.

Pilot Program Evaluation Highlight: Denver's Support Team Assisted Response (STAR) Program

Denver planned to evaluate the STAR program after an initial six-month pilot phase. For the evaluation, data was collected from both the 911 CAD database and the Mental Health Center of Denver. Data was kept in separate systems to protect health-related information from the law enforcement database. The program evaluation provided data on incident locations, response time, response dispatch source (i.e., 911, police unit, or STAR-initiated), social demographics of consumers served, services provided, location of client transport/drop-off, and more. The use of two data systems also allowed the program to evaluate what the STAR team identified as the primary issue of concern compared to clinical diagnoses from the health data.[14]

As a result of analyzing these data, Denver identified its program successes and impacts and is committed to expanding the funding and scope of the program. This expansion includes purchasing more vans, staffing more teams, expanding the hours of operation, expanding the service area across the City, hiring a supervisor, and investing in program leadership. Additional plans for future evaluation include building a better understanding of populations served and more rigorous data capture, a longitudinal study to understand consumer long-term outcomes, and a cost-benefit analysis to understand the economic impacts of the program.

Once data is collected, a process for analyzing, visualizing, and reviewing data supports the overall effectiveness of program monitoring, thus contributing to changes to a pilot and the overall outcomes achieved by the program. Some programs have developed internal data dashboards to compile and organize their data in real-time, thus allowing them to review their program data on a weekly basis. And, some programs are also planning for an external evaluation to assist them in developing a broader understanding of their program's impacts for their clients and in the larger community.

[14] Denver STAR Program. (2021, January 8). *STAR Program Evaluation*. https://www.denverperfect10.com/wp-content/uploads/2021/01/STAR_Pilot_6_Month_Evaluation_FINAL-REPORT.pdf

Examples of Metrics that Cities Collect, Review, and Publish Data On

- *Call volume*
- *Time of calls received*
- *Service areas*
- *Response times*
- *Speed of deployment*
- *Determinations and dispositions of dispatch (including specific coding for violence/weapons/emergency)*
- *Which teams are deployed across all emergency response*
- *Actual level of service needed compared to the initial determination at the point of dispatch*
- *Number of involuntary holds that are placed*
- *Number of transports that are conducted*
- *Type of referrals made*
- *Priority needs of clients served (housing, mental health)*
- *Frequency of police involvement*

Making data about crisis response programs publicly available is also important for community transparency and public research. For example, New York City is planning to publish B-HEARD program data on a monthly basis. And, Portland has a public data dashboard for its crisis response program that is updated at least once per week.[15] Such data transparency allows local constituents and stakeholders to check on the progress of their local crisis response program and whether it is making a difference. Such transparency can also contribute to public research and dissemination efforts about emerging alternate crisis response models.

Coordinating the Crisis Response System

Given the complexity of a crisis response system -- from its administrative structure and financing, the technical integration of dispatch with responders, the coordination of referrals and linkages, to client case management -- coordination is an essential, ongoing element of any program. This coordination requires investing in staff time and skills to participate in coordination efforts, focusing on de-siloing all components of crisis response, and effective leadership and vision. Coordination affects financing decisions and contributes directly to client outcomes; therefore, coordination implicates every aspect of program planning, implementation, and evaluation. Overall, program administration benefits

[15] *Portland Street Response Data Dashboard*. (n.d.). City of Portland, Oregon. Retrieved August 29, 2021, from **https://www.portland.gov/streetresponse/data-dashboard**

from having coordination done at a high level, ensuring there is a person(s) responsible for holding the program at a birds-eye view.

Coordinating services between the crisis response team and community partners includes ensuring there are open communication channels between various entities at a structural level down to a client case management level. At a structural level, it requires investing in staff time, technology, and protocol development, not just at the initial program launch but on an ongoing basis. Based on the program evaluation and data collection design, system-level coordination can support ongoing data review and inform future decisions made about a program.

For example, the managers of San Francisco's Street Crisis Response Team participate in interagency meetings to ensure strategic coordination of service delivery across San Francisco's Department of Public Health, Fire Department, and Office of Care Coordination. Additionally, when Austin's EMCOT program's call center staff integrated the call center technology and co-located their crisis response services within the city's 911 dispatch, the crisis response program had reduced dropped calls, increased communication around safety and risk assessment during triage, more effective handoffs to mental health clinicians for telehealth, and increased deployment of the crisis response team by dispatch.

System-level coordination also has important downstream effects, such as ensuring that first responders (i.e., police, fire, EMS) can call the crisis response team to respond to a situation if they are dispatched first. At a client level, system coordination can support case management, referrals and linkages, and improved client outcomes. For example, Canada's REACH Edmonton program provides governance support and coordination to a network of CBO providers, including facilitating a bimonthly meeting for frontline workers to discuss shared clients. The program shared that for its most complex cases, this coordination significantly increased positive client outcomes. The program also found that they were able to better leverage the expertise of peer support specialists by having a specified coordinator leading these meetings and ensuring their voice and participation was valued. Service providers within this network all utilize the same EHR for documenting and sharing client notes, though the program has encountered challenges in data sharing. Overall, the REACH Edmonton program shared that system-level coordination must be tightly managed but that most program staff and frontline workers do not have the capacity to do so, so having a centralized governance and coordinating body is essential.

Program Planning Process

Planning the large and small details of a crisis response program is an essential part of a successful launch. Although each city will have a different planning process and timeline based on the local community's needs and administrative designs, some common themes emerged across the crisis response models that RDA reviewed.

Planning across city departments typically includes active involvement from emergency medical services, fire, and police as well as leaders from local public health and mental/behavioral health agencies and CBOs. Many cities stated that having emergency responders involved in the collaborative brainstorming and discussions from the earliest planning stages was essential in garnering buy-in from other city or county departments, including identifying the best resource(s) when responding to mental health needs and crises. Planning also requires engaging other entities; for instance, Portland has to negotiate with the local police union for all services provided by Portland's Street Response program. Some cities shared that they are aware of beliefs of local police departments and unions about potentially losing funding for police services when new crisis response services are added to the local infrastructure. But, cities found that when they focused the conversation about shared objectives between the crisis response program and the police, police began to see the program as a resource to them as mental health professionals could often better handle mental health crises because of their training and backgrounds. This alignment on shared goals and values underpins the reason that the Eugene Police Department funds the city's non-police crisis response program, CAHOOTS. Developing a collective and shared narrative around community health and well-being while reducing harm, trauma, and unnecessary use of force, is essential in promoting any crisis response program.

Program planning allows cities to identify elements to include in the pilot that will be investigated throughout the pilot stages. For instance, the planning process may include heat mapping the highest call-volume areas of the city or discussing preliminary milestones to support scaling or expansion of a pilot program. As an example, New York City's B-HEARD model is currently focused on deploying the B-HEARD team using the existing 911 determination process for identifying mental health emergencies; but, in the future, the program will also assess how those determinations are made to improve the determination and dispatch processes. Their sequencing of planning priorities allowed the program to be launched on a shorter timeline while preparing for an iterative evaluation and design process.

In the future, many learnings can be extrapolated from the ways that crisis response programs are being implemented across the United States and internationally. At this point in time, given that many implementations began within the past two years and are still actively evolving and changing, it is premature to pinpoint common themes in how similar and different jurisdictions and communities (e.g., population size, population density, geography, etc.) are unfolding their emerging crisis response programs.

Planning Timeline

While some cities operated co-responder models for years before moving to a non-police model, other cities are launching non-police models for the first time. Some cities engaged in extensive community engagement

processes while others launched programs quickly and plan to collect feedback for future iterations of their program.

For instance, Denver had a co-responder model from 2016-2020 and launched the STAR program in 2020 for an initial six-month pilot. The program was launched very quickly in 2020, and then it held community forums to hear from community members for input on the expansion. In Chicago, planning began in the summer of 2019 and the mental health advisory commission developed recommendations in October 2019, then planning and funding continued throughout the summer of 2020, with the program launched in the summer of 2021 (two years after initial program planning began).

New York City's B-HEARD program was originally announced in November 2020 with an initial launch target of February 2021, though the launch was delayed until June 2021 (eight months later). San Francisco's Street Crisis Response Team began planning in July 2020 and launched with one team in November 2020 (five months later); the program added a second team and additional hours in January 2021, added four more teams in March 2021, and integrated the local Office of Coordinated Care team for follow-up and linkages in April 2021 (all over a span of four months); the City of San Francisco wanted to move quickly due to its budgeting timeline so it did not conduct much initial community engagement, but rather expected the program design to be an iterative process with future opportunities for community input and evaluation. Additionally, for many pilot crisis response programs, when they are able to scale their services and hire more staff, then they plan to expand their geographical footprints.

Community Engagement

Community engagement is an invaluable element of program design and evaluation that leverages the expertise of the local community members directly impacted by these services. Community engagement activities are conducted to include the perspectives of potential service recipients, existing consumers of the behavioral health and crisis systems, existing coalitions, and/or local community-based service providers in the development and implementation of crisis response programs.

Cities may face barriers in hearing from community members that are the most structurally marginalized, so engaging existing coalitions and networks can support more equitable and targeted outreach. For instance, in Chicago, Sacramento, and Oakland, program planners worked with credible messengers that were connected to networks that the cities were not connected to, such as a teen health council, street outreach teams, homeless advocacy organizations, and disability rights collectives. There was a focus especially on working with mutual aid collectives and other underground groups that do not receive city funding, including voices that may otherwise be neglected in government spaces. This level of outreach and intentionality is essential because, historically, government institutions and other structures have prevented

the full and meaningful engagement of people of color, working class and cash-poor people, immigrants and undocumented people, people with disabilities, people who are cognitively diverse, LGBTQ+ people, and other structurally marginalized people. Engaging community members that are most directly impacted by crisis response programs, such as unsheltered people, will lead to feedback that is informed by direct lived experiences with the prior and existing programs in a given community. Additionally, prioritizing the engagement, participation, and recommendations of community members that are most harmed by existing institutions - such as the disproportionate rates of police violence against people of color[16] - will ensure that systems of inequity are not reproduced by a crisis response program. Instead, intentional community engagement can support the program to address existing structural inequities.

Community engagement can inform program planning, program implementation, and program evaluation in unique ways. When planning for a crisis response program, community engagement can be used to survey existing needs, collect input on priorities, and engage hard-to-reach consumers. To hear directly from community members, Chicago interviewed 100 people across the city to ask about their service needs and how to implement a co-responder or alternative crisis response model. Denver targeted specific community stakeholder groups when collecting feedback for its program design, including perspectives from residents with lived experience, community activists for reimagining policing, a Latinx clinic, and a needle exchange program.

When implementing a crisis response program, engaging the community can identify opportunities for program improvement in real-time and promote community education about the program's services and partners. To collect feedback on key components of its model, Portland worked with a local university to send a questionnaire to service recipients. Denver prioritized community education by working with Business Improvement Districts (BIDs) to educate them on appropriate and inappropriate times to call 911 and how to more effectively and compassionately engage with unsheltered neighbors. Denver also worked to build trust with local CBOs to increase their engagement of the STAR crisis response team. Such community engagement can improve program implementation by increasing community awareness of the program, clarifying existing barriers for community members, and modifying service provision processes and priorities on an ongoing basis.

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[16] Edwards, F., Lee, H., & Esposito, M. (2019). Risk of being killed by police use of force in the United States by age, race-ethnicity, and sex. *Proceedings of the National Academy of Sciences of the United States of America (PNAS), 116*(34), 16793-16798. **https://www.pnas.org/content/116/34/16793**

Lessons Learned

As cities have begun planning, launching, and iterating on a variety of crisis response program models, they shared key lessons learned and recommendations for new cities considering implementing non-police crisis response programs.

Community members are essential sources of knowledge: Co-creating a crisis response model with community members that have directly experienced the crisis system will make the program more accessible and utilized.

Community engagement requires time: Build the engagement and planning time into the overall program development approach and timeline.

Use a pilot approach: Test, modify, and expand specific aspects of each crisis response model based on program successes, challenges, and consumer feedback.

Build trust across the network: Cities must build trust across city agencies and local CBOs to successfully launch and implement a crisis response program.

The 911 dispatch system is complex: Successful implementation of a crisis response program requires sufficient planning, time/resources investment, and buy-in for revising 911 call determination and dispatch processes.

Look to the future: While alternative models are currently focused on crisis response, future models could also support a population's holistic health outcomes and redefine what "safety" means in a community.

Community members are essential sources of knowledge.

Program representatives that spoke with RDA emphasized the many considerations that programs must make to ensure a program is utilized and accessible to community members. The interviewed programs emphasized the importance of co-creating programs with community members because community members have experienced the existing crisis response options, know where the gaps exist, and may have already implemented or witnessed community-based short-term solutions that should directly inform program design. Cities explained that creating a program or model that does not appeal to the consumer, especially in terms of the involvement and presence of law enforcement, will decrease

the reach and impact of the program. Community members must trust the program if they are going to call and engage in services. For example, because they understood that a significant barrier was that the general public was not confident that they could call 911 to engage a non-police response to a mental health or related crisis, the San Francisco's Street Crisis Response Teams have done significant outreach at community events and presentations at CBOs to build relationships and trust.

Community engagement requires time.

Learning from the community requires time, so plans for community engagement should be part of any new program's overall timeline and approach. For example, after their initial implementation began, Denver's STAR teams learned that there is a need to expand their program with multilingual teams, which they have since been effective in making progress towards achieving this. It has been a part of the STAR program's process to prioritize program needs as they arise while planning for expansion.

Use a pilot approach.

Cities also recommended using a pilot approach so that the model can evolve and expand over time. For example, Chicago piloted two crisis response teams with a CIT-officer and piloted two teams without a CIT-officer to determine the role and efficacy of the CIT-officer in a crisis response. New York City designed their pilot to focus on one zone (a geographic subsection of a borough) before broadening the pilot to more of the city. A pilot approach allows a city to learn from implementation successes and challenges, hear from service recipients, and generate buy-in from potentially hesitant stakeholders.

Build trust across the network.

Cities elevated that building trust across city departments and with CBOs was an essential component of their processes. Cities recognize the different cultures and priorities across city departments and agencies as well as CBOs and volunteers. Within a local government, framing this work as a health response helps to align all partners on their shared values. Moreover, emphasizing to the local police departments that taking a responsibility off their plate is a benefit to them, which may help them to see the crisis response teams as assets and resources to them. Additionally, while bringing onboard internal (i.e., city departments and agencies) stakeholders to the table, it is important to ensure that they each have the appropriate degree of weight in decision making for the program. For example, New York City emphasized that law enforcement should not have an imbalance in controlling the conversation or

decisions. Programs also shared examples of opportunities to build trust across staff members: San Francisco's Street Crisis Response Team used all-team debriefs to strengthen communication and establish processes; and Canada's REACH Edmonton used data on their program and outcomes to promote accountability between providers. Ultimately, building and sustaining trust across a network of crisis response teams, first responders, and law enforcement agencies is a type of role that the central coordinating governance structure of a crisis response system should aim to lead and support.

The 911 dispatch system is complex.

The 911 dispatch component of a crisis response model is complex and requires effective collaboration for successful implementation. New York City felt that the dispatch and deployment components of its B-HEARD program took the most time to design well (e.g., diagramming calls, finding existing data), even though the 911 data infrastructure already existed. Similarly, Los Angeles' Department of Mental Health found the call diversion process and decision-making to be the most challenging aspect to align across departments. By being aware of this hurdle from the beginning, a new program can allocate sufficient time and resources as well as identify strategic personnel to support the development of this important component of any crisis response program.

Look to the future.

Finally, cities offered that they are only in their first steps of a longer process of designing alternative models of care in their communities. Planning for a program's next steps can make the initial pilots even more successful and support the transition to future iterations. For instance, Portland's Street Response program is primarily focused on low-acuity crises, though there is a need for a non-police response that can respond to higher acuity calls, including incidences with weapons, in order to achieve Portland's aim of reducing police violence. Mental Health First emphasized that an armed officer does not necessarily provide security and safety to bystanders, providers, or consumers, and so alternative crisis response models are countering a larger system of socialization around notions of safety and the role of 911 in a community. Additionally, these models are operating within larger mental health response systems that must work together to ensure fewer community members are going into crisis in the first place. Programs should always be considering how alternative models of care can support individuals from entering into crises, too. Denver's STAR program shared that they have numerous opportunities for prevention efforts, such as proactive response after encampment sweeps, checking in with consumers in high visibility areas even if there is not a call there, and proactively connecting people to services. By keeping an open mind for what a more holistic crisis response system could look like in their future, cities can plan for their present day,

early-stage pilot programs to be a part of their evolving and innovative models of care.

Appendices

Appendix A. SAMHSA's National Guidelines for Behavioral Health Crisis Care - Best Practice Toolkit Executive Summary[17]

The *National Guidelines for Crisis Care – A Best Practice Toolkit* advances national guidelines in crisis care within a toolkit that supports program design, development, implementation and continuous quality improvement efforts. It is intended to help mental health authorities, agency administrators, service providers, state and local leaders think through and develop the structure of crisis systems. The toolkit includes distinct sections for:

- ✓ Defining national guidelines in crisis care;
- ✓ Implementing care that aligns with national guidelines; *and*
- ✓ Evaluating alignment of systems to national guidelines.

Given the ever-expanding inclusion of the term "crisis" by entities describing service offerings that do not truly function as no-wrong-door safety net services, we start by defining what crisis services are and what they are not. Crisis services are for **anyone, anywhere and anytime.** Crisis services include (1) crisis lines accepting all calls and dispatching support based on the assessed need of the caller, (2) mobile crisis teams dispatched to wherever the need is in the community (not hospital emergency departments) and (3) crisis receiving and stabilization facilities that serve everyone that comes through their doors from all referral sources. These services are for **anyone, anywhere and anytime.**

With non-existent or inadequate crisis care, costs escalate due to an overdependence on restrictive, longer-term hospital stays, hospital readmissions, overuse of law enforcement and human tragedies that result from a lack of access to care. Extremely valuable psychiatric inpatient assets are over-burdened with referrals that might be best-supported with less intrusive, less expensive services and supports. In too many communities, the "crisis system" has been unofficially handed over to law enforcement; sometimes with devastating outcomes. The current approach to crisis care is patchwork and

[17] Substance Abuse and Mental Health Services Administration (SAMHSA). (2020). *National Guidelines for Behavioral Health Crisis Care – Best Practice Toolkit Executive Summary*. https://www.samhsa.gov/find-help/implementing-behavioral-health-crisis-care & https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-services-executive-summary-02242020.pdf

delivers minimal treatment for some people while others, often those who have not been engaged in care, fall through the cracks; resulting in multiple hospital readmissions, life in the criminal justice system, homelessness, early death and even suicide.

A comprehensive and integrated crisis network is the first line of defense in preventing tragedies of public and patient safety, civil rights, extraordinary and unacceptable loss of lives, and the waste of resources. There is a better way. Effective crisis care that saves lives and dollars requires a systemic approach. This toolkit will delineate how to estimate the crisis system resource needs of a community, the number of individuals who can be served within the system, the cost of crisis services, the workforce demands of implementing crisis care and the community-changing impact that can be seen when services are delivered in a manner that aligns with this Best Practice Toolkit. Readers will also learn how this approach harnesses data and technology, draws on the expertise of those with lived experience, and incorporates evidence-based suicide prevention practices.

Core Services and Best Practices

The following represent the *National Guidelines for Crisis Care* essential elements within a **no- wrong-door** integrated crisis system:

1. **Regional Crisis Call Center**: Regional 24/7 clinically staffed hub/crisis call center that provides crisis intervention capabilities (telephonic, text and chat). Such a service should meet National Suicide Prevention Lifeline (NSPL) standards for risk assessment and engagement of individuals at imminent risk of suicide and offer quality coordination of crisis care in real-time;
2. **Crisis Mobile Team Response**: Mobile crisis teams available to reach any person in the service area in his or her home, workplace, or any other community-based location of the individual in crisis in a timely manner; *and*
3. **Crisis Receiving and Stabilization Facilities**: Crisis stabilization facilities providing short-term (under 24 hours) observation and crisis stabilization services to all referrals in a home-like, non-hospital environment.

In addition to the essential structural or programmatic elements of a crisis system, the following list of essential qualities must be "baked into" comprehensive crisis systems:

1. Addressing recovery needs, significant use of peers, and trauma-informed care;
2. "Suicide safer" care;
3. Safety and security for staff and those in crisis; *and*

4. Law enforcement and emergency medical services collaboration.

Regional Crisis Call Hub Services – *Someone To Talk To*

Regional, 24/7, clinically staffed call hub/crisis call centers provide telephonic crisis intervention services to all callers, meet National Suicide Prevention Lifeline (NSPL) operational standards regarding suicide risk assessment and engagement and offer quality coordination of crisis care in real-time. Ideally, these programs will also offer text and chat options to better engage entire communities in care. Mental health, substance use and suicide prevention lines must be equipped to take all calls with expertise in delivering telephonic intervention services, triaging the call to assess for additional needs and coordinating connections to additional support based on the assessment of the team and the preferences of the caller.

Minimum Expectations to Operate a Regional Crisis Call Service

1. Operate every moment of every day (24/7/365);
2. Be staffed with clinicians overseeing clinical triage and other trained team members to respond to all calls received;
3. Answer every call or coordinate overflow coverage with a resource that also meets all of the minimum crisis call center expectations defined in this toolkit;
4. Assess risk of suicide in a manner that meets NSPL standards and danger to others within each call;
5. Coordinate connections to crisis mobile team services in the region; *and*
6. Connect individuals to facility-based care through warm hand-offs and coordination of transportation as needed.

Best Practices to Operate Regional Crisis Call Center

To fully align with best practice guidelines, centers must meet the minimum expectations and:

1. Incorporate Caller ID functioning;
2. Implement GPS-enabled technology in collaboration with partner crisis mobile teams to more efficiently dispatch care to those in need;
3. Utilize real-time regional bed registry technology to support efficient connection to needed resources; *and*
4. Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff to support connection to ongoing care following a crisis episode.

To align with National Suicide Prevention Lifeline (NSPL) operational standards, centers must:

1. Practice **active engagement** with callers and make efforts to establish sufficient rapport so as to promote the caller's collaboration in securing his/her own safety;

2. Use the **least invasive intervention** and consider involuntary emergency interventions as a last resort, except for in circumstances as described below;
3. Initiate life-saving services for attempts in progress – in accordance with guidelines that do not require the individual's consent to initiate medically necessary rescue services;
4. Initiate active rescue to secure the immediate safety of the individual at risk if the caller remains unwilling and/or unable to take action to prevent his/her suicide and remains at imminent risk;
5. Practice active engagement with persons calling on behalf of someone else ("third-party callers") towards determining the least invasive, most collaborative actions to best ensure the safety of the person at risk;
6. Have supervisory staff available during all hours of operations for timely consultation in determining the most appropriate intervention for any individual who may be at imminent risk of suicide; *and*
7. Maintain caller ID or other method of identifying the caller's location that is readily accessible to staff.

True regional crisis call center hub services that offer air traffic control-type functioning are essential to the success of a crisis system. Cracks within a system of care widen when individuals experience interminable delays in access to services which are often based on an absence of:

1. Real-time coordination of crisis and outgoing services; *and*
2. Linked, flexible services specific to crisis response; namely mobile crisis teams and crisis stabilization facilities.

Mobile Crisis Team Services – *Someone To Respond*

Mobile crisis team services offering community-based intervention to individuals in need wherever they are; including at home, work, or anywhere else in the community where the person is experiencing a crisis. For safety and optimal engagement, two person teams should be put in place to support emergency department and justice system diversion. EMS services should be aware and partner as warranted.

Minimum Expectations to Operate a Mobile Crisis Team Services

1. Include a licensed and/or credentialed clinician capable to assessing the needs of individuals within the region of operation;
2. Respond where the person is (home, work, park, etc.) and not restrict services to select locations within the region or particular days/times; *and*
3. Connect to facility-based care as needed through warm hand-offs and coordinating transportation when and only if situations warrants transition to other locations.

Best Practices to Operate Mobile Crisis Team Services

To fully align with best practice guidelines, teams must meet the minimum expectations and:

1. Incorporate peers within the mobile crisis team;
2. Respond without law enforcement accompaniment unless special circumstances warrant inclusion in order to support true justice system diversion;
3. Implement real-time GPS technology in partnership with the region's crisis call center hub to support efficient connection to needed resources and tracking of engagement; *and*
4. Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff in order to support connection to ongoing care.

Essential functions of mobile crisis services include:

- Triage/screening, including explicit screening for suicidality;
- Assessment;
- De-escalation/resolution;
- Peer support;
- Coordination with medical and behavioral health services; *and*
- Crisis planning and follow-up.

Crisis Receiving and Stabilization Services – *A Place to Go*

Crisis receiving and stabilization services offer the community a no-wrong-door access to mental health and substance use care; operating much like a hospital emergency department that accepts all walk-ins, ambulance, fire and police drop-offs. The need to say yes to mental health crisis referrals, including working with persons of varying ages (as allowed by facility license) and clinical conditions (such as serious emotional disturbance, serious mental illness, intellectual and developmental disabilities), regardless of acuity, informs program staffing, physical space, structure and use of chairs or recliners in lieu of beds that offer far less capacity or flexibility within a given space. It is important to fund these facility-based programs so they can deliver on the commitment of never rejecting a first responder or walk-in referral in order to realize actual emergency department and justice system diversion. If an individual's condition is assessed to require medical attention in a hospital or referral to a dedicated withdrawal management (i.e., referred to more commonly and historically as detoxification) program, it is the responsibility of the crisis receiving and stabilization facility to make those arrangements and not shift that responsibility to the initial referral source (family, first responder or mobile team). Law enforcement is not expected to do the triage or assessment for the crisis system and it is important that those lines never become blurred.

Minimum Expectations to Operate a Crisis Receiving and Stabilization Service

1. Accept all referrals;
2. Not require medical clearance prior to admission but rather assessment and support for medical stability while in the program;
3. Design their services to address mental health and substance use crisis issues;
4. Employ the capacity to assess physical health needs and deliver care for most minor physical health challenges with an identified pathway in

order to transfer the individual to more medically staffed services if needed;

5. Be staffed at all times (24/7/365) with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community; including:
    a. Psychiatrists or psychiatric nurse practitioners (telehealth may be used)
    b. Nurses
    c. Licensed and/or credentialed clinicians capable of completing assessments in the region; *and*
    d. Peers with lived experience similar to the experience of the population served.
6. Offer walk-in and first responder drop-off options;
7. Be structured in a manner that offers capacity to accept all referrals, understanding that facility capacity limitations may result in occasional exceptions when full, with a no rejection policy for first responders;
8. Screen for suicide risk and complete comprehensive suicide risk assessments and planning when clinically indicated; *and*
9. Screen for violence risk and complete more comprehensive violence risk assessments and planning when clinically indicated.

Best Practices to Operate Crisis Receiving and Stabilization Services

To fully align with best practice guidelines, centers must meet the minimum expectations and:

1. Function as a 24 hour or less crisis receiving and stabilization facility;
2. Offer a dedicated first responder drop-off area;
3. Incorporate some form of intensive support beds into a partner program (could be within the services' own program or within another provider) to support flow for individuals who need additional support;
4. Include beds within the real-time regional bed registry system operated by the crisis call center hub to support efficient connection to needed resources; *and*
5. Coordinate connection to ongoing care.

The Role of the Psychiatrist/Psychiatric Nurse Practitioner

Psychiatrists and Psychiatric Nurse Practitioners serve as clinical leaders of the multi-disciplinary crisis team. Essential functions include ensuring clinical soundness of crisis services through evaluation of need, continued monitoring of care and crisis service discharge planning.

Essential Principles for Modern Crisis Care Systems

Best practice crisis care incorporates a set of core principles that must be systematically "baked in" to excellent crisis systems in addition to the core structural elements that are defined as essential for modern crisis systems. These essential principles and practices are:

1. Addressing Recovery Needs,

2. Significant Role for Peers,
3. Trauma-Informed Care,
4. *Zero Suicide*/Suicide Safer Care,
5. Safety/Security for Staff and People in Crisis *and*
6. Crisis Response Partnerships with Law Enforcement, Dispatch, and Emergency Medical Services.

Addressing Recovery Needs

Crisis providers must address the recovery needs of individuals and families to move beyond their mental health and substance use challenges to lead happy, productive and connected lives each and every day.

Implementation Guidance

1. *Commit to a no-force-first approach to quality improvement in care that is characterized by engagement and collaboration.*
2. *Create engaging and supportive environments that are as free of barriers as possible. This should include eliminating Plexiglas from crisis stabilization units and minimal barriers between team members and those being served to support stronger connections.*
3. *Ensure team members engage individuals in the care process during a crisis. Communicate clearly regarding all options clearly and offer materials regarding the process in writing in the individual's preferred language whenever possible.*
4. *Ask the individual served about their preferences and do what can be done to align actions to those preferences.*
5. *Help ensure natural supports and personal attendants are also part of the planning team, such as with youth and persons with intellectual and developmental disabilities.*
6. *Work to convert those with an involuntary commitment to voluntary so they are invested in their own recovery.*

Significant Role for Peers

A transformative element of recovery-oriented care is to fully engage the experience, capabilities and compassion of people who have experienced mental health crises. Including individuals with lived mental health and substance use disorder experience (peers) as core members of a crisis team supports engagement efforts through the unique power of bonding over common experiences while adding the benefits of the peer modeling that recovery is possible.

Implementation Guidance

1. *Hire credentialed peers with lived experience that reflect the characteristics of the community served as much as possible. Peers should be hired with attention to common characteristics such as gender, race, primary language, ethnicity, religion, veteran status, lived experiences and age.*

2. *Develop support and supervision that aligns with the needs of your program's team members.*
3. *Emphasize engagement as a fundamental pillar of care that includes peers as a vital part of a crisis program's service delivery system. This should include (1) integrating peers within available crisis line operations, (2) having peers serve as one of two mobile team members and (3) ensuring a peer is one of the first individuals to greet an individual admitted to a crisis stabilization facility.*

Trauma-Informed Care

The great majority of individuals served in mental health and substance use services have experienced significant interpersonal trauma. Mental health crises and suicidality often are rooted in trauma. These crises are compounded when crisis care involves loss of freedom, noisy and crowded environments and/or the use of force. These situations can actually re-traumatize individuals at the worst possible time, leading to worsened symptoms and a genuine reluctance to seek help in the future.

On the other hand, environments and treatment approaches that are safe and calm can facilitate healing. Thus, we find that trauma-informed care is an essential element of crisis treatment. In 2014, SAMHSA set the following guiding principles for trauma-informed care:

1. Safety;
2. Trustworthiness and transparency;
3. Peer support and mutual self-help;
4. Collaboration and mutuality;
5. Empowerment, voice and choice; *and*
6. Ensuring cultural, historical and gender considerations inform the care provided.

Trauma-informed systems of care ensure these practices are integrated into service delivery. Developing and maintaining a healthy environment of care also requires support for staff, who may have experienced trauma themselves.

Implementation Guidance

1. *Incorporate trauma-informed care training into each team member's new employee orientation with refreshers delivered as needed.*
2. *Apply assessment tools that evaluate the level of trauma experienced by the individuals served by the crisis program and create action steps based on those assessments.*

Zero Suicide/Suicide Safer Care

Two transformational commitments must be made by every crisis provider in the nation: (1) adoption of suicide prevention as a core responsibility, and (2) commitment to dramatic reductions in suicide among people under care. These changes were adopted and advanced in the revised *National Strategy for Suicide*

Prevention (2012), specifically via a new Goal 8: "Promote suicide prevention as a core component of health care services" (p. 51).

The following key elements of Zero Suicide or Suicide Safer Care are all applicable to crisis care:

1. Leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care, that includes survivors of suicide attempts and suicide loss in leadership and planning roles;
2. Developing a competent, confident, and caring workforce;
3. Systematically identifying and assessing suicide risk among people receiving care;
4. Ensuring every individual has a pathway to care that is both timely and adequate to meet his or her needs and includes collaborative safety planning and a reduction in access to lethal means;
5. Using effective, evidence-based treatments that directly target suicidal thoughts and behaviors;
6. Providing continuous contact and support; especially after acute care; *and*
7. Applying a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

Safety/Security for Staff and People in Crisis

Safety for both individuals served and staff is a foundational element for all crisis service settings. Crisis settings are also on the front lines of assessing and managing suicidality and possibly violent thoughts or aggressive behaviors, issues with life and death consequences. While ensuring safety for people using crisis services is paramount, the safety for staff cannot be compromised. Keys to safety and security in crisis delivery settings include:

- Evidence-based and trauma-informed crisis training for all staff;
- Role-specific staff training and appropriate staffing ratios to number of clients being served;
- A non-institutional and welcoming physical space and environment for persons in crisis, rather than Plexiglas "fishbowl" observation rooms and keypad-locked doors. This space must also be anti-ligature sensitive and contain safe rooms for people for whom violence may be imminent;
- Established policies and procedures emphasizing "no force first" prior to implementation of safe physical restraint or seclusion procedures;
- Pre-established criteria for crisis system entry;
- Strong relationships with law enforcement and first responders; *and*
- Policies that include the roles of clinical staff (and law enforcement if needed) for management of incidents of behavior that places others at risk.

Providers must establish environments that are safe for those they serve as well as their own team members who are charged with delivering high quality crisis care that aligns with best practice guidelines. The keys to safety and security for

home visits by mental health staff include:

- No mental health crisis outreach worker will be required to conduct home visits alone.
- Employers will equip mental health workers who engage in home visits with a communication device.
- Mental health workers dispatched on crisis outreach visits will have prompt access to any information available on history of dangerousness or potential dangerousness of the client they are visiting.

Implementation Guidance

1. *Commit to a no-force-first approach to care.*
2. *Monitor, report and review all incidents of seclusion and restraint with the goal of minimizing the use of these interventions.*
3. *Remember that barriers do not equal safety. The key to safety is engagement and empowerment of the individual served while in crisis.*
4. *Offer enough space in the physical environment to meet the needs of the population served. A lack of space can elevate anxiety for all.*
5. *Incorporate quiet spaces into your crisis facility for those who would benefit from time away from the milieu of the main stabilization area.*
6. *Engage your team members and those you serve in discussions regarding how to enhance safety within the crisis program.*

Law Enforcement and Crisis Response—An Essential Partnership

Law enforcement agencies have reported a significant increase in police contacts with people with mental illness in recent years. Some involvement with mental health crises is inevitable for police. Police officers may (1) provide support in potentially dangerous situations when the need is assessed or (2) make warm hand-offs into crisis care if they happen to be first to engage.

In many communities across the United States, the absence of sufficient and well-integrated mental health crisis care has made local law enforcement the *de facto* mental health mobile crisis system. This is unacceptable and unsafe. The role of local law enforcement in addressing emergent public safety risk is essential and important. With good mental health crisis care in place, the care team can collaborate with law enforcement in a fashion that will improve both public safety and mental health outcomes. Unfortunately, well-intentioned law enforcement responders to a crisis call can escalate the situation solely based on the presence of police vehicles and armed officers that generate anxiety for far too many individuals in a crisis.

Implementation Guidance

1. *Have local crisis providers actively participate in Crisis Intervention Team training or related mental health crisis management training sessions.*

2. *Incorporate regular meetings between law enforcement and crisis providers, including EMS and dispatch, into the schedule so these partners can work to continuously improve their practices.*
3. *Include training on crisis provider and law enforcement partnerships in the training for both partner groups.*
4. *Share aggregate outcomes data such as numbers served, percentage stabilized and returned to the community and connections to ongoing care.*

Psychiatric Advance Directives

A psychiatric or mental health advance directive (PAD) is a legal tool that allows a person with mental illness to state their preferences for treatment in advance of a crisis. They can serve as a way to protect a person's autonomy and ability to self-direct care. Crisis providers are expected to always seek to understand and implement any existing PAD that has been developed by the individual during the evaluation phase and work to ensure the individual discharges from crisis care with an updated and accurate psychiatric advance directive whenever possible. PAD creates a path to express treatment preferences and identify a representative who is trusted and legally empowered to make healthcare decisions on medications, preferred facilities, and listings of visitors.

Funding Crisis Care

The full *Crisis Services Best Practice Toolkit* document contains specific strategies on how a community can fund each of the core crisis system elements in single and multiple-payer environments. Additionally, recommendations on service coding already being reimbursed by Medicaid in multiple states are made available; including the use of *HCPCS code H2011 Crisis Intervention Service per 15 Minutes* for mobile crisis services and *S9484 Crisis Intervention Mental Health Services per Hour* or *S9485 Crisis Intervention Mental Health Services per Diem* for crisis receiving and stabilization facility services.

Training and Supervision

Many members of the crisis services delivery team are licensed mental health and substance use professionals operating within the scope of their license and training with supervision delivered in a manner consistent with professional expectations of the licensing board. Licensed professionals are expected to strengthen their skills and knowledge through ongoing CEU and CME professional advancement opportunities focused on improving team members' ability to deliver crisis care.

Providers also incorporate non-licensed individuals within the service delivery

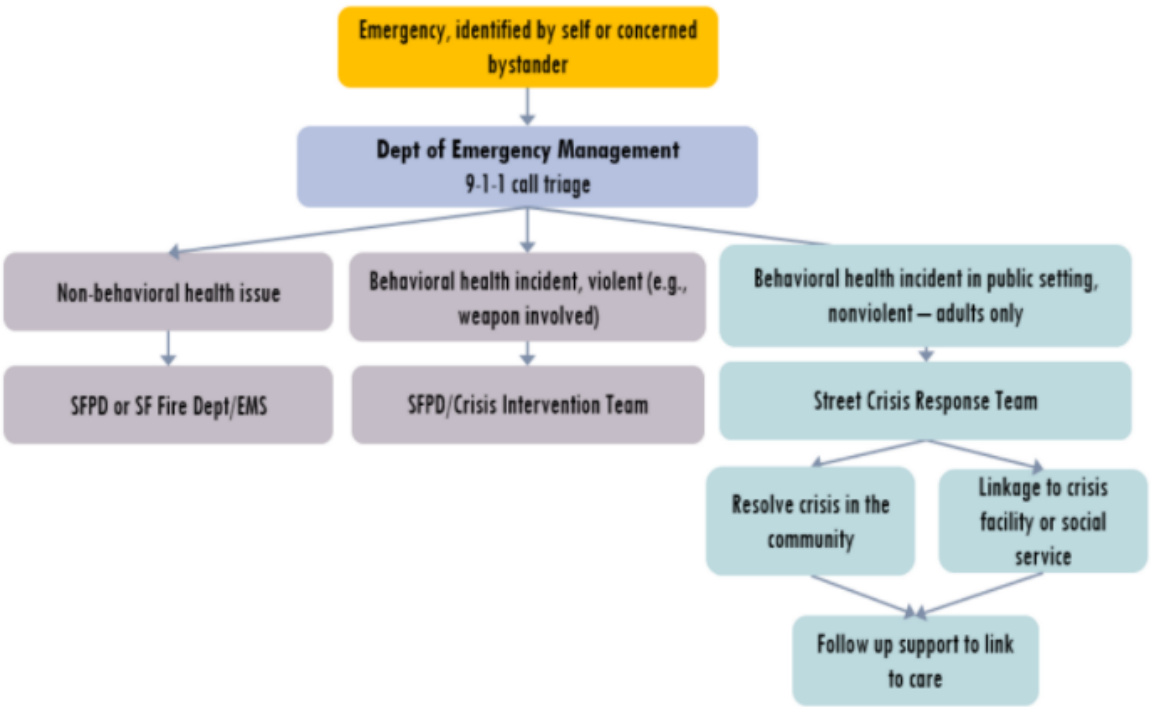
team; creating the need for additional training and supervision to ensure services are delivered in a manner that advances positive outcomes for those engaged in care. Verification of skills and knowledge of non-professional staff is essential to maintaining service delivery standards within a crisis program; including the incorporation of ongoing supervision with licensed professionals available on site at all times. Supervision and the verification of skills and knowledge shall include, but is not limited to, active engagement strategies, trauma-informed care, addressing recovery needs, suicide-safer care, community resources, psychiatric advance directives and role-specific tasks.

Conclusion

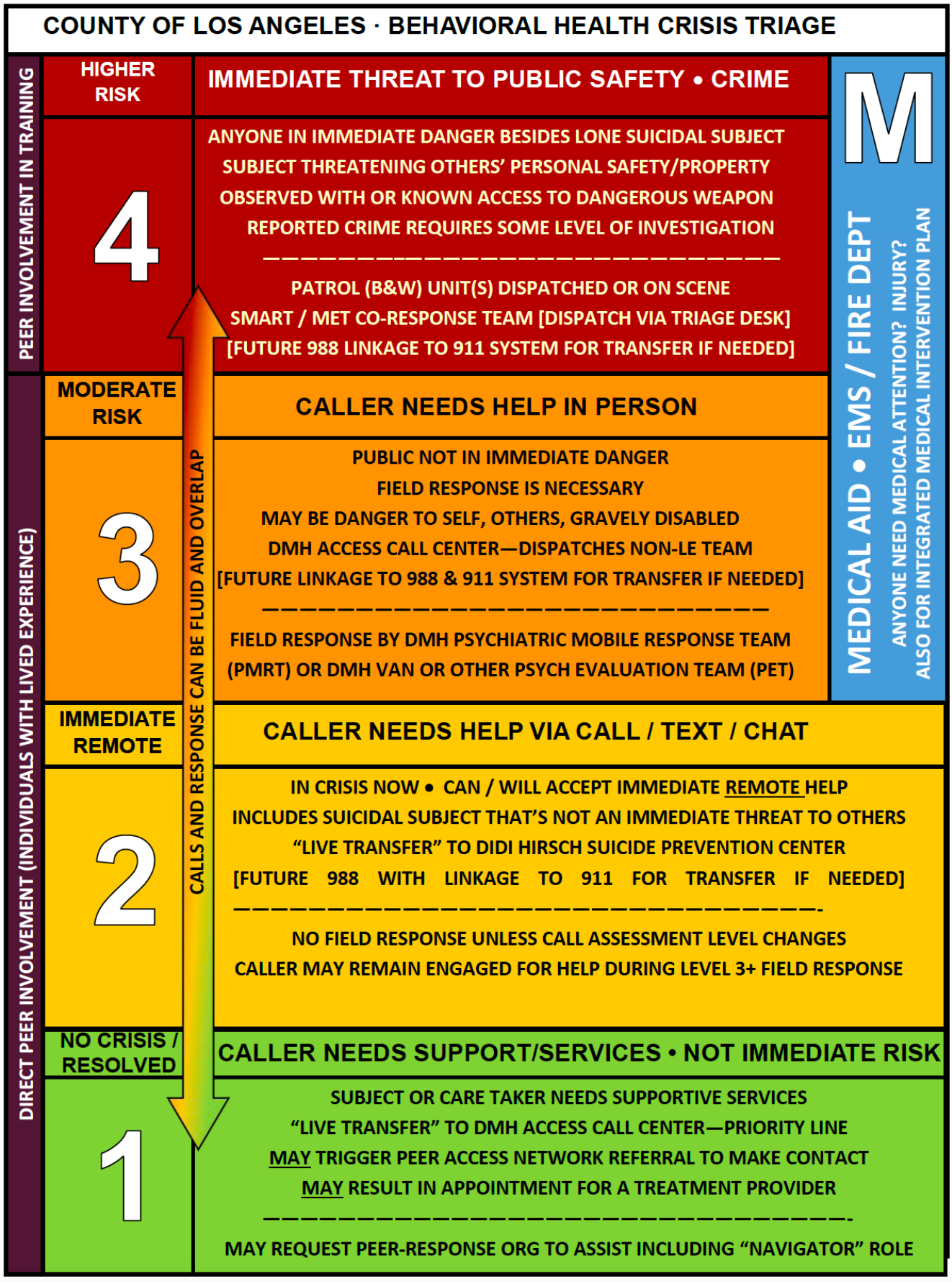
Crisis services must be designed to serve **anyone, anywhere and anytime**. Communities that commit to this approach and dedicate resources to address the community need decrease psychiatric boarding in emergency departments and reduce the demands on the justice system. These two benefits translate into better care, better health outcomes and lower costs to the community. The *National Guidelines for Crisis Care – A Best Practice Toolkit* delivers a roadmap that can be used to truly make a positive impact to communities across the country.

Appendix B. Sample Outlines of Types of Scenarios for Crisis Response Teams

Appendix B-1. County and City of San Francisco's Crisis Response



Appendix B-2. County of Los Angeles' Behavioral Health Crisis Triage



Appendix C. Crisis Response Programs Researched by RDA – Summary of Key Components

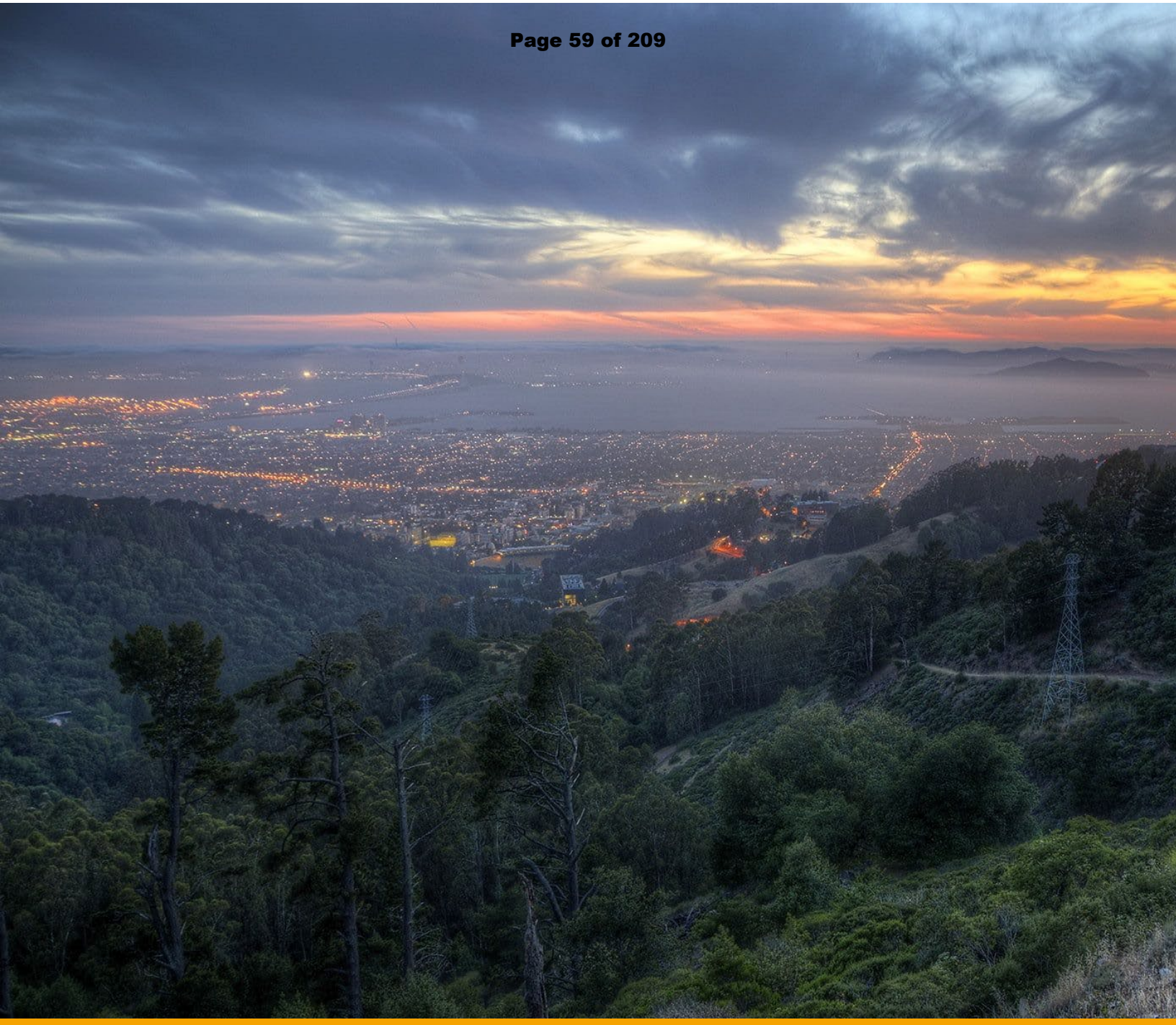
Program	Dispatch	Types of calls	Hours of operation	Crisis team staff	Vehicles	Follow-up process
Albuquerque Community Safety Department – *Albuquerque, NM*	911	Mental health, inebriation, homelessness, addiction	TBD	Clinicians or peers	TBD	TBD
B-HEARD (the Behavioral Health Emergency Assistance Response Division) – *New York, NY*	911 dispatch	Mental health	Daily 16 hours per day	2 EMTs or paramedics + social worker	Non-transport vehicles	Connect with services if transported; heat team does follow-up (clinician and peer for follow-up connection to services)
Boston Police Department's Co-Responder Program **– *Boston, MA***	911 dispatch	Mental health crisis	Unknown	Co-responder (police + clinician)	Police car	Unknown
Crisis Assistance Helping Out On The Streets (CAHOOTS) – *Eugene, OR*	911 calls dispatched on radio	Non-emergency calls	24/7	Unlicensed crisis worker and EMT or paramedic	3 vans with logo	Not currently part of services
Crisis Assessment & Transport Team (CATT) – *Alameda County, CA*	911 dispatch	Mental health	Daily 7am-12am	Licensed clinician + EMT, co-responding with police	Unmarked vehicles, barrier, custom locks and windows, locked storage cabinets	Unknown
Community Paramedicine – *California (statewide)*	911 dispatch	Non-emergency health and mental health calls	Unknown	Paramedics	Unknown	Unknown
Crisis Call Diversion Program (CCD) – *Houston, TX*	911 dispatch	Non-emergency mental and behavioral health calls	Daily, morning and evening shifts	Mental health professional tele-counselors at 911 call center	N/A	Unknown

Program	Dispatch	Types of calls	Hours of operation	Crisis team staff	Vehicles	Follow-up process
Crisis Now – *National model (via SAMHSA)*	Regional crisis call hub	Mental health	24/7	Licensed clinician + behavioral health specialist	Unmarked van	Program staff follows up to ensure connection to a resource
Crisis Response Pilot – *Chicago, IL*	911 dispatch	Mental health	M-F 9:30-5:30	Paramedic, crisis counselor, CIT officer, peer recovery coach	2 vans	Unknown
Crisis Response Unit – *Olympia, WA*	911 or alternate number	Mental health, homelessness	Daily 7am-9pm	Nurse + behavioral health specialist	Van owned by the City	Repeat clients get referred to peer navigation program (Familiar Faces)
Cuyahoga County Mobile Crisis Team – *Cuyahoga County, Ohio*	National Suicide Prevention Hotline	Mental health	24/7	Licensed clinicians	Unknown	Unknown
Department of Community Response – *Sacramento, CA*	911 or alternate number	Mental health, homelessness, youth and family crisis, substance use	24/7	Social workers	6 vans	CBO partner will provide connection to longer term care and follow up services
Department of Community Solutions and Public Safety – *Ithaca, NY*	TBD	Non-violent calls	TBD	Unarmed first responders	TBD	TBD
Downtown Emergency Service Center (DESC) Mobile Crisis Team – *King County, WA*	911 dispatch	Mental health, substance use	24/7	Mental health professional	Unknown	Unknown

Program	Dispatch	Types of calls	Hours of operation	Crisis team staff	Vehicles	Follow-up process
Expanded Mobile Crisis Outreach Team (EMCOT) – *Austin, TX*	911 or alternate number	Mental health	24/7	Field staff: two person teams of clinicians Call center staff: mental health professionals	Unmarked vehicles	Post-crisis services available for up to 3 months after initial contact
Georgia Crisis & Access Line (GCAL) – *Georgia (statewide)*	Alternate number, app	Non-emergency mental health, substance use	24/7	Mental health professionals	Unknown	Unknown
Los Angeles County Department of Mental Health - ACCESS Center – *Los Angeles County, CA*	Alternate number	Mental health	24/7	Unknown	Unknown	Unknown
Los Angeles County Department of Mental Health - Co-Response Program – *Los Angeles County, CA*	911 dispatch	Emergency mental health	Unknown	Co-responder (police + clinician)	Police car	Unknown
Los Angeles County Department of Mental Health - Psychiatric Mobile Response Team (PMRT) – *Los Angeles County, CA*	Alternate number	Mental health crises	Unknown	Psychiatric mobile response team	Unknown	Unknown
Mobile Assistance Community Responders of Oakland (MACRO) – *Oakland, CA*	911 dispatch	Non-emergency calls	24/7	Unlicensed community member + EMT	Vehicle with radios, mobile data terminal, cell phones	Community Resource Specialist to connect to resources
Mental Health Acute Assessment Team (MHAAT) – *Sydney, Australia*	Ambulance Control Center	Acute mental health crises	Unknown	Paramedic + mental health nurse	Ambulance	Contacted within 3 days, follow up with referral facility
Mental Health First / Anti-Police Terror Project – *Sacramento and Oakland, CA*	Alternate number, social media	Mental health, domestic violence, substance use	Fri-Sun 7pm-7am	Peer first responders	Use personal vehicles and meet at the scene; have an RV with supplies	Have relationship with CBOs, staff work to get folks into longer term services
Mental Health Mobile Crisis Team (MHMCT) – *Nova Scotia, Canada*	911 dispatch	Mental health	24/7	Co-responder (police + clinician) and telephone clinician support	Unknown	Unknown

Program	Dispatch	Types of calls	Hours of operation	Crisis team staff	Vehicles	Follow-up process
Mobile Crisis Assistance Team (MCAT) – *Indianapolis, IN*	911 dispatch	Mental health, substance use	M-F, not after hours or overnight	Co-responder (police + clinician + paramedics)	Unknown	Conduct follow up visits to encourage connection to care
Mobile Crisis Rapid Response Team (MCRRT) – *Hamilton, Ontario, Canada*	911 dispatch	Mental health	Unknown	Co-responder (CIT-trained police + clinician)	Police car	Unknown
Mobile Emergency Response Team for Youth (MERTY) – *Santa Cruz, CA*	Alternate number	Mental health calls for youth	M-F 8am-5pm	Clinician + family specialist	Van with wheelchair lift, comfortable chairs, TV, snacks	Continue to provide services until patient connected with long-term services
Mobile Evaluation Team (MET) – *East Oakland, CA*	911 or alternate number	Mental health	Mon-Thurs 8am-3:30pm	Co-responder (1-2 mental health clinicians + police officer)	Unmarked police car	Unknown
Psykiatrisk Akut Mobilitet (PAM) Unit, the Psychiatric Emergency Response Team – *Stockholm, Sweden*	Alarm center	Acute risk of suicidal behavior	Daily 2pm-2am	2 psychiatric nurses and ambulance driver	Ambulance	Unknown
Police and Clinician Emergency Response (PACER) – *Australia (several locations)*	Dispatched by police	Mental health	Varies	Co-responder (police + clinician)	Unknown	Unknown
Portland Street Response – *Portland, OR*	911 or alternate number	Low-acuity mental health, substance use, welfare checks	M-F 10am-6pm	EMT and LCSW dispatched to scene; 2 CHWs called in for follow-up	Van with logo	CHWs connect to services; partnerships with CBOs for outreach in encampments
REACH 24/7 Crisis Diversion – *Edmonton, Alberta, Canada*	Alternate number (211)	Non-violent, non-emergency calls	24/7	2 crisis diversion workers	Have van to transport	Connector role for connection to long-term services

Program	Dispatch	Types of calls	Hours of operation	Crisis team staff	Vehicles	Follow-up process
Seattle Crisis Response Team – *Seattle, WA*	911 dispatch	Mental health, assault/threat/harassment, suspicious circumstance, disturbance	Unknown	Co-responder (CIT + clinician)	Unknown	Clinicians can follow up with clients
Supported Team Assisted Response (STAR) – *Denver, CO*	911 dispatch	Mental health, homelessness, substance use	M-F 10am-6pm	Mental health clinician (SW) + paramedic	Civilian van with amber lights, bucket seats on each side with standard front seat	Can hand off to case managers
Street Crisis Response Team (SCRT) – *San Francisco, CA*	911 calls dispatched on radio	Non-emergency mental health	Daily, 12 hours a day	Social worker/psychologist + paramedic + peer	Van with lights and sirens, currently using old fire department vehicles	Office of Care Coordination provides linkages to other services
Street Triage – *England (several locations)*	Emergency dispatch	Mental health	Varies	Mental health nurse	Unknown	Unknown
Therapeutic Transportation Pilot Program/Alternative Crisis Response – *Los Angeles City and County, CA*	911 dispatch	Mental health crisis	24/7	Mental health experts co-respond or take the lead on MH calls	Plan to have van for transports	Level 1 calls will be referred to non-crisis follow up services, folks can step down from crisis receiving to residential program
Toronto Crisis Response – *Toronto, Ontario, Canada*	TBD	Non-violent, non-emergency calls	TBD	Mental health professionals	TBD	TBD



City of Berkeley

Mental Health Crisis Response Services and Stakeholder Perspectives Report

RDA CONSULTING

CITY OF BERKELEY

City of Berkeley
Specialized Care Unit Model Recommendations

City of Berkeley Mental Health Crisis Response and Stakeholder Perspectives Report

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This report was developed by Resource Development Associates under contract with the City of Berkeley Health, Housing & Community Services Department.

Resource Development Associates, October 2021

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BERKELEY

Table of Contents

Executive Summary

The City of Berkeley contracted with Resource Development Associates (RDA) to conduct a feasibility study to inform the development of Specialized Care Unit (SCU) pilot to respond to mental health crises without the involvement of law enforcement. RDA's feasibility study includes community-informed program design recommendations, a phased implementation plan, and funding considerations. RDA's first report from this feasibility study was a synthesis of crisis response programs in the United States and internationally. This second report details RDA's synthesized findings from speaking with and collecting data from a myriad of City of Berkeley and Alameda County agencies, community-based organizations (CBOs), local stakeholders and community leaders, and utilizers of Berkeley's crisis response services.

This report has two focus areas: 1) describing the City of Berkeley's current mental health crisis response system, including the roles and responsibilities of the various agencies involved and basic quantitative data about the volume of mental health crisis calls received; and 2) sharing key themes from RDA's qualitative data collection efforts across the Berkeley community.

Presently, callers experiencing a mental health crisis typically call 911, Mobile Crisis Team (MCT) phone line, or the Alameda County Crisis Support Services phone line. Depending on the assessment of the call, phone or in-person services are deployed. All these points of access could result in a police response.

In Berkeley, while there are a variety of programs and service provided by Berkeley Mental Health, Berkeley Police, Berkeley Fire, and an array of community-based organizations, there is an overall insufficient level of resources to meet the volume and types of mental health crisis needs across the city. Stakeholder participants urged that the concept and definition of a mental health crisis and crisis services be expanded to include the full spectrum of a mental health crisis, including prevention, diversion, intervention, and follow-up. Through this lens, stakeholders identified strengths and challenges of the existing crisis response system, described personal experiences, and shared ideas for a reimagined mental health crisis response system.

Key Themes from Stakeholder Feedback

Perceptions of the urgent need for a non-police mental health crisis response in Berkeley

Perceptions of varied availability, accessibility, and quality of crisis response services

Perceptions of insufficient crisis services for substance use emergencies

Perceptions of a need for a variety of crisis transport options

Perceptions of a lack of sites for non-emergency care

Perceptions around supporting the full spectrum of mental health crisis needs

Perceptions of a need for post-crisis follow-up care

Perceptions of barriers to successful partnerships and referrals across the mental health service network

Perceptions of needs to integrate data systems and data sharing to improve services

Perceptions of a need for increased community education and public awareness of crisis response options

Participants were asked to share their ideas for alternative approaches to mental health and substance use crises as well as to share community needs for a safe, effective mental health and substance use crisis response. Such perspectives illuminate the perceived gaps in the current system that could be filled by a future SCU. These perspectives are summarized as guiding aspirations for reimagining public safety and designing a response system that promotes the safety, health, and well-being of all Berkeley residents.

Community Aspirations

Stakeholder-identified opportunities to address the root causes that contribute to mental health, homelessness, and substance use crises

Stakeholder-identified opportunities for centering BIPOC communities in crisis response

Stakeholder-identified opportunities for community oversight to ensure equitable and transformative crisis care

Introduction

In response to the killing of George Floyd by Minneapolis police in May 2020 and the ensuing protests across the nation for this and many other similar tragedies, a national conversation emerged about how policing can be done differently in local communities. The Berkeley City Council initiated a broad-reaching process to reimagine policing in the City of Berkeley. As part of that process, in July 2020, the Berkeley City Council directed the City Manager to pursue reforms to limit the Berkeley Police Department's scope of work to "primarily violent and criminal matters." These reforms included, in part, the development of a Specialized Care Unit (SCU) pilot to respond to mental health crises without the involvement of law enforcement.

To inform the development of an SCU, the City of Berkeley contracted with Resource Development Associates (RDA) to conduct a feasibility study that includes community-informed program design recommendations, a phased implementation plan, and funding considerations. RDA's first report from this feasibility study was a synthesized summary of its review of the components of nearly 40 crisis response programs in the United States and internationally. This second report details RDA's synthesized findings from speaking with and collecting data from a myriad of City of Berkeley and Alameda County agencies, community-based organizations (CBOs), local stakeholders and community leaders, and utilizers of Berkeley's crisis response services.

With the guidance and support of an SCU Steering Committee (led by the Director of City of Berkeley's Health, Housing and Community Services Department), RDA conducted a large volume of community and agency outreach and qualitative data collection activities between June-July 2021. The goal of this immense undertaking was to understand the variety of perspectives in the local community regarding how mental health crises are currently being responded to as well as the community's desires for a different crisis response system that would better serve its populations and needs. The City of Berkeley will be implementing an SCU that consists of a team of providers – that does not include law enforcement representation – who will respond to mental health crisis situations in Berkeley. Given that this is happening, RDA's data collection focused on obtaining perspectives that could inform the development of Berkeley's SCU; in contrast, RDA's data collection was not targeted at understanding the validity or utility of having a SCU in Berkeley.

RDA's outreach and data collection efforts yielded a large volume of information. In order to ensure this report is accessible to a wide audience - in both the length and breadth of findings - RDA's analysis of all the information it collected was led by a clear goal of identifying common themes across its many data sources. Additionally, RDA sought to distill all findings into manageable pieces that could be succinctly written about in this report.

This report has two focus areas: 1) describing the City of Berkeley's current mental health crisis response system, including the roles and responsibilities

of the various agencies involved and basic quantitative data about the volume of services provided; and 2) sharing the common themes from RDA's qualitative data collection efforts across the Berkeley community. It is important to note upfront that given the limited quantitative data available about Berkeley's historical mental health crisis response calls – as documented and described in much depth by the Berkeley City Auditor's study (released in April 2021) entitled "Data Analysis of City of Berkeley's Police Response"[1] – this report is focused on qualitative data. That data allows for a better understanding of what this set of stakeholders feels about the current crisis system and their hopes for an improved system. After sharing information about Berkeley's current mental health crisis response services, this report shares information from RDA's qualitative data collection activities with local agencies, CBOs, stakeholders, and utilizers of crisis response services.

Communitywide Data Collection

In order to fully understand the current state of the mental health crisis system in the City of Berkeley, RDA engaged a variety of stakeholders in gathering both quantitative and qualitative data. As this is a community-driven process, much of the data collection was through engaging members of the Berkeley community. These methods will be described below.

Note: Please refer to the following section, ***What is the current mental health crisis call volume in Berkeley?*** *for a description of the project's quantitative methods.*

Community Engagement Planning Process

To bring resident and other stakeholder voices into community planning efforts, RDA worked closely with the SCU Steering Committee[2] to develop a comprehensive, inclusive, and accessible outreach and engagement plan. The goal of this plan was not to reach a group that was "representative" of all Berkeley residents, but rather to hear from those that receive crisis response services, those that call or initiate crisis

[1] https://www.cityofberkeley.info/uploadedFiles/Auditor/Level_3_-_General/Data%20Analysis%20of%20the%20City%20of%20Berkeley's%20Police%20Response.pdf

[2] Berkeley Specialized Care Unit Steering Committee members: Colin Arnold, Paul Kealoha Blake, Jeff Buell, Caroline de Bie, Margaret Fine, Maria Moore, Andrea Pritchett, David Sprague, David McPartland, Marc Staton, Lisa Warhuus, and Jamie Works-Wright.

response, and those whose voices are commonly omitted from city planning efforts. The plan focused on those who are most marginalized by the current system and are most at risk of harm. These groups include, but are not limited to the following:

- Individuals who are frequently targeted by policing, including:
  - Black and African Americans
  - Native Americans
  - Pacific Islander Americans
  - Latinx Americans
  - Asian Americans
  - SWANA (Southwest Asia and North Africa)
- People who have experienced a mental health crisis
- People experiencing or at risk of homelessness
- People who use substances
- Gay, Lesbian, Bisexual, Queer, Transgender and Non-Binary people
- Seniors and older adults
- Transition age youth (TAY)
- People with disabilities
- Survivors of domestic violence and/or intimate partner violence
- People returning to the community from prison or jail
- Veterans
- Immigrants and undocumented residents

RDA and the steering committee also reached out to a wide range of advocates, service providers, and CBOs. In addition to wanting to understand the current state of crisis services from a provider perspective, one of the objectives for reaching out to these advocacy and community organizations was to leverage their community and client connections to reach the target populations.

Once the target groups were identified, RDA and the SCU Steering Committee developed a specific outreach plan and interview guides for each group. The outreach strategy was designed to maximize accessibility by providing multiple opportunities for engagement. Interview guides[3] were customized to each group but followed the same set of four core questions:

1. People's experiences with, and perceptions of, the current mental health and substance use related crisis response options;
2. Challenges and strengths of current mental health and substance use related crisis response options;
3. Ideas for an alternative approach to mental health and substance use related crises; and
4. Needs identified by the community for a safe, effective mental health and substance use related crisis response.

[3] For an example interview guide, see **Appendix A**.

This set of four questions was also used to create a survey distributed to providers unable to attend focus groups, their clients, other service utilizers, and the broader Berkeley community.

It is important to note that mental health crisis affects everyone. RDA purposefully focused engagement efforts on groups that are most often marginalized and at risk of harm from the current crisis system, but in so doing, was an approach that may not have brought in all voices impacted by mental health crisis. The key themes brought out by stakeholders, therefore, may not be fully representative of the broader Berkeley community. Instead, the key themes reflect the perspective of those most impacted by the current system.

Data Sources

All outreach activities occurred between June and July 2021. RDA engaged the community in a variety of in-person and virtual mediums including interviews, focus groups, shadowing, and surveys. In total, RDA conducted 18 focus groups, 51 individual interviews, 1 full day of shadowing dispatch at BPD, and administered 1 online survey.

The CBOs and community members that were targeted for outreach skewed towards either agencies serving unhoused populations in Berkeley or individuals who were unhoused. This was an intentional strategy to reach a population that is generally underrepresented in community-wide data collection efforts. But, as mentioned above, mental health crises can affect anyone, not just those who are unhoused.

Below is a list of groups that were engaged in interviews or focus groups as part of this process.

Type of Group	Organizations/Departments (# individuals)
City of Berkeley & Alameda County	1. Berkeley Fire Department 2. Berkeley Fire Department – Mobile Integrated Paramedic (MIP) 3. Berkeley Mental Health 4. Berkeley Mental Health - Mobile Crisis Team 5. Berkeley Mental Health – Crisis, Assessment, and Triage (CAT) 6. Berkeley Mental Health - Homeless Full Service Partnership 7. Berkeley Mental Health – Transitional Outreach Team (TOT) 8. Berkeley Police Department - Key Informants 9. Berkeley Police Department – Dispatch 10. Berkeley Police Department - Community Services Bureau 11. Berkeley Police Department - Public Safety Officers 12. City of Berkeley - Aging Services 13. Alameda County Behavioral Health Care Services 14. Alameda County Crisis Support Services

Type of Group	Organizations/Departments (# individuals)
Community-Based Organizations	1. Alameda County Network of Mental Health Clients 2. Alameda County Psychological Association 3. Anti Police-Terror Project 4. BACS - Amber House 5. Berkeley Free Clinic 6. Dorothy Day House 7. Harm Reduction Therapy Center 8. LifeLong Medical Care - Ashby Health Center, Behavioral Health 9. LifeLong Medical Care - Street Medicine 10. Needle Exchange Emergency Distribution (NEED) 11. Pacific Center 12. UC Berkeley School of Social Welfare 13. Women's Daytime Drop-In Center
Service Utilizers	1. People's Park 2. Seabreeze encampment 3. Planting Justice

Demographics of Participants of RDA's Data Collection Efforts

RDA was able to reach a large demographic of providers, service utilizers, and community members across these engagement efforts. These data collection efforts were not focused on providers of mental health care, substance use disorder care, or insurance companies like Kaiser Permanente or the Alameda Alliance. This was a purposeful decision to gain the insight of those who are outside of the current system of care. Demographic information was not gathered for City of Berkeley or Alameda County staff.

Overall, RDA received information from more people in the 30-44 range than any other age range. As compared to Berkeley's overall population, service utilizers and providers who identified as Black or African American were overrepresented in RDA's data collection efforts. There were far more cisgender participants than transgender participants overall, though a higher proportion of service utilizer respondents were transgender compared to survey respondents and provider respondents. RDA collected feedback from more than double the number of female-identifying participants than male identifying participants. Overall, there were very few genderqueer or nonbinary participants. The most common zip codes of participants were 94710, 94702, 94703, and 94704. For more a more detailed description of participant demographics, see **Appendix B**.

Impacts of COVID-19 Pandemic on Data Collection

The COVID-19 pandemic made it challenging for this project to engage with participants for data collection. The rise of the Delta variant in August 2021 further complicated matters. Many non-medical social service providers in Berkeley had suspended or limited their in-person services with clients due to the pandemic, so RDA was unable to connect with clients in-person. Invitations were sent to case managers and group/individual counselors to forward to their clients in hopes of interviewing clients, but this did not prove to be effective. Aside from being unable to connect with participants in-person, many providers were overwhelmed with ongoing COVID-19 emergency response and unable to participate in focus groups or the survey. Eleven agencies were in conversation with RDA but were unable to attend any focus groups or submit a survey, and 34 agencies did not respond to attempts to connect. Despite these challenges, RDA found considerable themes and patterns in the data that was collected for this project and feel strongly that the data and perspectives presented here represent the scope of the issues pertinent to mental health crisis response in the City of Berkeley.

Overview of Berkeley Crisis Response

What is the current mental health crisis response system in Berkeley?

To understand where the gaps are in the mental health crisis response system in Berkeley, it is important to understand each component and the surrounding landscape of providers and services. The following section describes the process of a mental health call, key city and county entities involved in the crisis system, and other community-based organizations who provide crisis services. This information was gathered during key informant interviews with city and county staff, CBO provider focus groups, and consulting online materials.

Process of Response to a Mental Health Call[4]

When someone makes a call for a mental health crisis, they will typically call 911, the Mental Health Division's Mobile Crisis Team (MCT) phone line,

[4] See **Appendix C** for a flowchart of this process.

or Crisis Support Services of Alameda County. The caller is often a family member, friend, or bystander.

If the call goes to 911, the staff member at Berkeley dispatch receives the call. They use the Emergency Medical Dispatch (EMD) protocols to assess whom to deploy to the scene: fire, police, or an ambulance. When assessing a call for the presence mental health issues, they consider many factors including the possibility of violence against the caller or others, certainty or uncertainty of violence, whether the person is using substances and what type of substance, the coherence of the person's thoughts or behaviors, and background noises. Callers can specifically request MCT, in which case dispatchers may call MCT on the radio and request an MCT call-back for the caller.

If they determine that services can be delivered over the phone, they can transfer the call to Alameda County Crisis Support Services (CSS). If CSS cannot resolve the crisis, they will send the call back to dispatch for an in-person response. If an in-person response is required, they will transfer the call to the appropriate dispatcher staff. Calls with a potential for violence or criminal activity are transferred to police dispatch. Police can call the Berkeley Mobile Crisis Team (MCT) for backup if it is clear that there is a mental health component to the situation. Calls that involve mental health are sent to police dispatch. Police will then alert the MCT that they are needed on-scene. The police will arrive first to secure the scene, then mobile crisis will provide mental health crisis services while police are still on-scene. If the individual needs to be transported to a secondary location, the police will call for an ambulance. Calls that involve a medical or fire issue are transferred to fire dispatch. If fire staff need to place an involuntary hold on the person, they can call police to place the hold.

If the caller decides to call MCT directly, their call will be sent to a confidential voicemail. An MCT staff member will listen to the voicemail, call the person back, and provide services over the phone. If no further services are required, the call is resolved. If an in-person response is required, MCT will call police dispatch to have police secure the scene. After MCT calls dispatch, they will travel to the scene of the incident. Once the scene is secured, MCT provides services and may call an ambulance through dispatch if transport is needed.

If the caller decides to call CSS directly, staff will first attempt to resolve the crisis over the phone. If they are able to de-escalate the crisis over the phone, they will provide referral services to additional resources or, on rare occasions, contact Berkeley Mental Health for follow-up care. If they are unable to resolve the crisis, they will send the call to 911 dispatch.

After the incident, the Berkeley Transitional Outreach Team (TOT) will follow-up with the client to ensure that options for longer term care have been offered. TOT can provide referrals and linkage to long-term services, bridging the gap between a moment of crisis and ongoing mental health care.

City and County Teams that Respond During a Crisis

There are several teams within the City of Berkeley and Alameda County that provide services to someone experiencing a mental health crisis. These include programs within Berkeley Mental Health, Berkeley Police Department, Berkeley Fire Department, and Alameda County Behavioral Health Care Services. Although, as mentioned later in this report, the community does not see these services as sufficient or linked.

Berkeley Mental Health Crisis Programs:

The City of Berkeley is contracted by Alameda County to deliver mental health services to Berkeley residents. In general, Berkeley Mental Health programs are funded to serve individuals with severe mental health needs who have major impairments in their functioning and are covered by Medi-Cal. However, Crisis Services teams (not including Homeless FSP) can serve any Berkeley resident, regardless of diagnosis or insurance status. It should be noted that residents covered by private insurance are eligible for services through their insurer and are not eligible for most Berkeley Mental Health programs.

The *Crisis, Assessment, and Triage (CAT)* program is a key access point for a wide range of Berkeley residents to get connected to mental health services. They are a team of clinical staff—licensed clinicians, paraprofessionals, peers, and/or family members—that conduct mental health screenings and assessments, mental health planning/consultation, and linkages to county or community-based care. They are also the official entry point for Berkeley Mental Health's Homeless Full Service Partnership (HFSP), Adult Full Service Partnership (AFSP), and Comprehensive Community Treatment (CCT) programs. As previously noted, these programs have strict eligibility requirements driven by their funding. Most callers are referred to non-city resources. They offer both remote as well as in-person, walk-in assessments, and linkages to appropriate care. If someone is in crisis, they can suggest or facilitate linkage to 911, MCT, Amber House, or other crisis resources. CAT can also provide limited outreach and transportation services to people experiencing homelessness or people with disabilities who also want to engage in mental health services.

The *Mobile Crisis Team (MCT)* is a team of licensed clinicians that provide crisis intervention services to people in crisis within the Berkeley city limits. These services include de-escalation and stabilization for individuals in crisis, consultation to hospital emergency personnel, consultation to police and fire departments, hostage negotiation, and disaster and trauma-related mental health services. When fully staffed, MCT can operate 7 days a week from 11:30am-10pm. Due to persistent staff shortages, MCT is currently unable to operate on Tuesdays or Saturdays. They primarily receive referrals from Berkeley Police Department, Berkeley Fire Department, hospital emergency rooms, and directly from residents. Most calls for MCT are received on the police radio directly from BPD for 5150 evaluations. Calls can also come directly through the MCT voicemail.

The *Transitional Outreach Team (TOT)* follows up with individuals after an interaction with MCT. The TOT team consists of one licensed clinician and

one unlicensed peer team member. The function of the TOT team is to offer linkages to appropriate resources and help navigating the system of care after someone has experienced a crisis. TOT assesses the individual's eligibility for services, including insurance status, before making referrals to care. During the pandemic, their services have been mostly limited to phone calls. Pre-pandemic, they regularly connected with service utilizers after they were discharged from the hospital. Most often, TOT connects people with homeless service provider agencies, the CAT team for connection to BMH programs, case management services at other clinics, or any other community provider that would meet the client's needs. Due to a recent division restructuring, TOT and CAT have been combined into one unit to allow more community members to access information and referrals provided by TOT.

The *Homeless Full Service Partnership (HFSP)* is Berkeley Mental Health's newest program. They are a team of two behavioral health clinicians, two social service specialists, one mental health nurse, one part-time psychiatrist (0.5 FTE), and one clinical supervisor. HFSP serves adults who are homeless or at risk of homelessness and have major functional impairments related to a mental health diagnosis. They provide a wide array of services based on the client's needs including support applying for benefits, connection to short-term and long-term housing, harm reduction for substance use, and support with physical health needs.

Berkeley Police Department: The Berkeley Police Department (BPD) is made up of patrol teams, Communications Center (i.e., dispatch) staff, other sworn officers, and non-sworn professional personnel. In total, the 2020 budget included 181 sworn officers and 104.2 professional staff.[1] BPD patrol team duties include responding to emergency and non-emergency calls for service or criminal activity, enforcing the law, responding to community needs, and directing traffic. The role of BPD patrol teams in mental health crises is to assess the situation to determine if there is a threat of public safety, assess how volatile the situation is, and secure the scene. Oftentimes, police officers will then provide crisis intervention services themselves, either because MCT is unavailable or the officer believes they can adequately respond with their experience and skillset. Otherwise, they will bring in another service team, such as MCT or Fire/ambulance to provide additional mental health or medical services. Officers may on-view incidents, but primarily receive assignments from the Communications Center. Officers may also coordinate with the other City Departments on some cases. All officers also receive a minimum of eight hours of advanced officer training in de-escalation and crisis intervention per year; and many officers are trained in a full week CIT-training course. The Department continues to assign

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[1] Berkeley City Auditor. (2021, July 2). *Data Analysis of the City of Berkeley's Police Response*. https://www.cityofberkeley.info/uploadedFiles/Auditor/Level_3_-_General/Data%20Analysis%20of%20the%20City%20of%20Berkeley's%20Police%20Response.pdf

officers to this full week training as staffing allows and course space is available.

BPD's Communications Center is staffed by dispatchers who handle the following: community calls, records checks, fire dispatching, and police dispatching.[2] Call takers receive non-emergency and 911 calls, assess the call (including using the emergency medical dispatch (EMD) protocol, enter data into the computer aided dispatch (CAD) system to be dispatched to either police or fire personnel where appropriate. Other calls may be directed to other City Departments or BPD work units. The dispatchers deploy the appropriate response to the scene and maintain radio contact until personnel arrive at the scene.

Other sworn officers in BPD include area coordinators, a bike unit, detectives and traffic enforcement unit, and other sworn non-patrol officers. Area coordinators are situated within the Community Services Bureau and work with patrol officers in their area and seek to address community needs. Officers on the bike unit are assigned to patrol specific areas, where they address public safety issues and other community safety concerns. Detectives follow up on criminal investigations, conduct search warrants and work with the District Attorney's Office on charging. The traffic enforcement unit responds to traffic related complaints, investigates serious injury and fatal collisions, and analyzes and provides state mandated reporting on collision data. Other sworn, non-patrol officers include special assignments in personnel and training, policy, and police technology.

The remaining staff are non-sworn, professional personnel including community service officers, crime scene technicians, and parking enforcement officers. Community service officers work in jail and as crime scene technicians who collect and document evidence from crime scenes. Parking enforcement officers enforce parking violations and support traffic safety related matters. Many of these functions are also supported by Police Aides and Reserve Police Officers.

Berkeley Fire Department: The Berkeley Fire Department (BFD) is comprised of 7 fire stations, 130 sworn fire suppression personnel and paramedic firefighters.[5] BFD provides 24/7 response to emergencies including fires, medical emergencies, and disasters. The department operates 4 24/7 Advanced Life Support ambulances that are primarily responsible for all emergency medical transport within the City of Berkeley to local emergency departments.

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[2] Berkeley City Auditor. (2019, April 25). *911 Dispatchers: Understaffing Leads to Excessive Overtime and Low Morale*. https://www.cityofberkeley.info/uploadedFiles/Auditor/Level_3_-_General/Dispatch%20Workload_Fiscal%20Year%202018.pdf

[5] City of Berkeley Fire Department. (n.d.). *History of the Berkeley Fire Department*. Retrieved October 5, 2021, from https://www.cityofberkeley.info/Fire/Home/Department_History.aspx

BFD also participates in care coordination for high utilizers of services as part of the Community Accessing Resources Effectively (CARE) Team. This team is a multidisciplinary group of practitioners made up of both staff from community organizations as well as City of Berkeley staff. The group is facilitated by the EMS division of the department and aims to connect residents using high amounts of emergency services to more appropriate and/or long-term care options.

During the COVID-19 pandemic, BFD operated a Mobile Integrated Paramedic (MIP) unit for a six-week pilot. The MIP unit provided community paramedicine as a diversion from hospitals during the early days of the pandemic. This team did proactive street outreach in the community to help meet basic needs and provide referrals to community organizations, based primarily on 9-1-1 callers who ended up not seeking care at an Emergency Department.

For people experiencing a mental health crisis, the City of Berkeley contracts with Falck Ambulance, which is also the private provider for emergency medical transport for Alameda County. Falck provides treatment, stabilization, and transports to hospitals, including voluntary and involuntary psychiatric hospitalizations. BFD firefighters can call Falck directly when an individual needs to be transported for mental health issues, although most transport requests are through requests from Mobile Crisis. The current collaboration with Falck began July, 1 2019, and the contract is overseen by BFD.

Alameda County Behavioral Health Care Services Crisis Programs: Alameda County Behavioral Health Care Services (AC BHCS) operates both crisis and long-term mental health service programs.[6] Some key crisis programs include Crisis Support Services, Acute Crisis Care and Evaluation for Systemwide Services, Mobile Crisis Team, Mobile Evaluation Team, and the Community Assessment and Transport Team.

The Alameda County Mobile Crisis Team, Mobile Evaluation Team, and the Community Assessment and Transport Team do not serve the geographic area of the City of Berkeley; despite this, we include brief information about them below to describe the types of mobile crisis services available to the other cities in Alameda County.

Crisis Services Eligible to Berkeley Residents

Crisis Support Services (CSS) is a county contracted program that provides several services for individuals experiencing a mental health crisis, including a 24-hour crisis phone line, text messaging, therapy groups, therapy services for older adults, school-based counseling, grief therapy,

[6] Alameda County Behavioral Health Care Services. (n.d.). *Acute & Integrated Health Care – Acute & Crisis Services*. Retrieved October 5, 2021, from **http://www.acbhcs.org/acute-integrated-health-care/acute-crisis-services/**

and community education.[7] CSS coordinates closely with mobile crisis teams in Oakland and Alameda County and often refer clients to mobile crisis. They are staffed by trained crisis counselors, both licensed and unlicensed. Most often calls to CSS are direct from someone experiencing a crisis. Berkeley dispatch can transfer calls to CSS for phone support if they deem an in-person response is not required. CSS fields over 40,000 calls annually and spends an average of 25-30 minutes per call.

Acute Crisis Care and Evaluation for Systemwide Services (ACCESS) is the main entry point for Alameda County residents to get connected to acute and longer-term mental health and substance use services.[8] The phone line is staffed by licensed mental health clinicians and administrators who screen and assess the client's needs, provide information about available options, and refer to an appropriate service. Clinicians also screen clients to see if they meet medical necessity criteria for Specialty Mental Health Services (SMHS). Calls that come in after 5pm or on weekends are routed to CSS.

Crisis Services Not Eligible to Berkeley Residents

The Alameda County *Mobile Crisis Team* responds to mental health crisis calls either in-person or over the phone.[9] They are staffed by two licensed clinicians. Calls can come directly to the mobile crisis team, or they can be dispatched by 911 or CSS. The Alameda County Mobile Crisis Team responds in a police co-responder model.

The *Mobile Evaluation Team (MET)* is a co-responder program; one Oakland police officer and one licensed clinician respond to calls in an unmarked police car. They respond to mental health calls that come through 911 dispatch.

The *Community Assessment and Transport Team (CATT)* provides community-based crisis intervention, medical clearance, and transport services. Administered through Bonita House, a licensed clinician and an EMT will be dispatched to a scene where the individual needs to be transported to a higher level of care. CATT currently utilizes a police co-responder model.

Other Service Providers in the Mental Health Crisis Response System: In addition to services provided by the City of Berkeley and Alameda County, there is an array of community-based services and other providers within the mental health crisis response system in Alameda

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[7] Crisis Support Services of Alameda County. (n.d.). *24-Hour Crisis Line*. Retrieved October 5, 2021, from Alameda County Behavioral Health Care Services. (n.d.). *Acute & Integrated Health Care – Acute & Crisis Services*. Retrieved October 5, 2021, from **http://www.acbhcs.org/acute-integrated-health-care/acute-crisis-services/**

[8] Alameda County Behavioral Health Care Services. (n.d.). *ACCESS program*. Retrieved October 5, 2021, from **http://www.acbhcs.org/providers/Access/access.htm**

[9] In this report, the acronym "MCT" is only used in reference to the City of Berkeley's Mobile Crisis Team, not Alameda County's Mobile Crisis Team.

County. These generally fall into four categories: crisis response providers, crisis stabilization units, drop-in centers, and medical service providers.

The agencies listed below are not meant to be a comprehensive list, rather these were the organizations that were mentioned most frequently by focus group participants, interviewees, and survey respondents. There are many organizations and individuals who contribute to crisis prevention and stabilization by addressing other needs such as housing, substance use, ongoing mental health support, or domestic violence. Though not enumerated in this report, the ecosystem of services in Berkeley and surrounding areas help prevent community members from escalating into crisis.

Crisis Response Providers: Crisis response providers accompany individuals while they are experiencing a crisis, work with the client to de-escalate, and connect them to resources to meet their needs. It should be noted that ongoing mental health service providers, such as therapists or clinical case managers, de-escalate and divert mental health crises every day. In this report, we are focusing on providers who respond to acute crisis situations that are outside of long-term supports. The two key crisis response providers mentioned most often by the community are Mental Health First and UC Berkeley.

Mental Health First is a project of the Anti Police-Terror Project (APTP). Based in Oakland, this volunteer-run crisis line provides crisis support, de-escalation, mediation, and connection to resources to anyone who calls. They are available on Friday and Saturday nights, 8pm to 8am, when other crisis services are unavailable. Community members can access services via phone, text, or social media. About half of callers are calling for themselves, while the other half are calls from friends or family members concerned about a loved one. Mental Health First can help people navigate the complicated mental health system and get them connected to services.

When a student is experiencing a mental health crisis on the UC Berkeley campus, *UC Police Department (UCPD)* are often the ones who arrive on scene. UCPD employs a mix of sworn and non-sworn personnel including 49 police officers, 10 dispatch and records staff, 31 security patrol officers, and 12 professional staff.[10] UCPD police officers are currently the ones who respond during a mental health crisis. However, the University has publicly stated plans to phase out involvement of police during a crisis and shift to having its Tang Center counselors respond to mental health

[10] Berkeley UCPD. (n.d.). *Department Demographics*. Retrieved October 5, 2021, from **https://ucpd.berkeley.edu/department-demographics**

calls.[11] They are currently in the process of planning and developing a new mental health response team.[12]

The *UC Berkeley Tang Center* offers health, mental health, and crisis services to all UC Berkeley students, regardless of insurance. Their staff, which include licensed psychologists, psychiatrists, and psychiatric nurses, respond to urgent mental health concerns.[13] They also provide services after a sexual assault or incident of domestic violence and respond to campus crises (e.g., when a student passes away).[14] As of the Fall 2021 semester, students can access these services by calling the Tang Center's urgent phone or after-hours support lines. But as previously mentioned, UC Berkeley is currently redesigning their crisis response model so students can more easily get connected with Tang Center staff during a crisis.

Crisis Stabilization Units and Psychiatric Facilities

Crisis Stabilization Units and psychiatric facilities provide a safe location for people to de-escalate from crisis, receive psychological support, and get connected with mental health services. There are no crisis stabilization units within the City of Berkeley, so Berkeley residents in crisis are often transported or referred to the facilities noted below.

John George Psychiatric Hospital (JGPH, or John George) is a locked facility where patients can receive short-term psychiatric care from doctors, psychiatrists, and counselors. Once a patient receives medical clearance (i.e., they do not have any acute medical needs), they can be transported to JGPH. John George is the main facility that individuals are transported to when they are under an involuntary hold. Many patients are referred and/or transported by emergency services and mobile crisis teams across the County.

Willow Rock Center operates both a 12-16 bed crisis stabilization unit as well as an inpatient unit for adolescents ages 12-17.[15] A team of psychiatrists, nurses, group and individual therapists and counselors provides assessment, counseling, medication administration, group,

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[11] Public Affairs. (2021, August 18). UC Berkeley to shift comes campus services away from UCPD. *Berkeley News*. **https://news.berkeley.edu/2021/08/18/uc-berkeley-to-shift-some-campus-services-away-from-ucpd/**.

[12] Berkeley Business Process Management Office. (n.d.). *Mental Health Response*. Retrieved October 5, 2021, from **https://bpm.berkeley.edu/projects/active-projects/reimagining-uc-berkeley-campus-and-community-safety-program/mental-health**

[13] University Health Services. (n.d.). *Meet the CAPS Staff*. Retrieved October 5, 2021, from **https://uhs.berkeley.edu/mental-health/counseling-and-psychological-services-caps/about-caps/meet-caps-staff**

[14] University Health Services. (n.d.). *Crisis Counseling for Urgent Concerns*. Retrieved October 5, 2021, from **https://uhs.berkeley.edu/counseling/urgent**

[15] Telecare. (n.d.). *Willow Rock Center*. Retrieved October 5, 2021, from **https://www.telecarecorp.com/willow-rock-center**

family, individual therapy, and connections to resources. The locked, inpatient unit is the main transport facility for adolescents under an involuntary hold. Their patients are often referred from Kaiser Permanente, schools, and emergency services. They also accept walk-ins for voluntary services.

Cherry Hill Detoxification Services Program provides services for adults needing to detox from substances.[16] Their sobering unit has 50 beds for patients to stay 23 hours or less. The detox unit has 32 beds for patients to stay 4-6 days. Trained staff screen patients, provide medical services and psychological support, and link patients to services to meet their needs before discharge. Both units often get referrals from emergency services but also can accept self-referrals.

Amber House, operated by Bay Area Community Services (BACS), is a 23-hour mental health crisis stabilization unit (CSU) that provides a quiet environment for clients to receive short-term psychological support and have their basic needs met. The team is a clinician, a nurse, a supervisor, and an on-call psychiatrist, who provide voluntary services for people experiencing an acute mental health crisis. Many of their clients are transported or referred by mobile crisis teams, Oakland's CATT program, and occasionally police. Before a client is discharged, a staff member will provide referrals for long-term mental health care and other resources to meet their needs. Amber House also operates a crisis residential treatment (CRT) program in the same facility (which is Alameda County's only combined CSU and CRT), providing clients the option for a longer stay.

Drop-In Centers

The City of Berkeley has three drop-in centers for residents: the Berkeley Drop-In Center, Berkeley Wellness Center, and the Women's Daytime Drop-In Center. While not all sites have specific services for individuals in crisis, they can be an entry point for mental health services.

The *Berkeley Drop-In Center* is a peer-run, walk-in community center that provides drop-in time, service advocacy, and housing advocacy.[17] Clients can have their basic needs met, find a place to socialize, get connected to benefits, receive a referral for subsidized housing, and get linked to mental health services.

The *Berkeley Wellness Center*, operated by Bonita House, provides art classes, employment services, connection to benefits, primary care, counseling, case management, and evidence-based support groups for

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[16] Horizon Services. (n.d.). *Cherry Hill Detoxification Program Services*. Retrieved October 5, 2021, from **https://www.horizonservices.org/cherry-hill-detoxification**

[17] City of Berkeley. (n.d.). *Berkeley Drop-In Center*. Retrieved October 5, 2021, from **https://berkeleycity.networkofcare.org/mh/services/agency.aspx?pid=BerkeleyDropInCenter_670_2_0**

adults with mental health and co-occurring disorders.[18] The Berkeley Wellness Center serves as an entry point to recovery and supportive services for people with a broad range of mental health needs and co-occurring conditions.

The *Women's Daytime Drop-In Center (WDDC)* provides similar services for homeless women and their children.[19] A small team of case managers, managers, and volunteers provide various services including case management, food, groceries, and hygiene kits. Clients can also receive referrals to additional services that are beyond the scope of WDDC.

Medical Service Providers

Because a mental health crisis and substance use crisis can co-occur, medical service providers play an important role in crisis stabilization and prevention. The two medical outreach teams mentioned by the community were Lifelong Street Medicine and Berkeley Free Clinic's Street Medicine team.

LifeLong Street Medicine is a program contracted by Alameda County Health Care for the Homeless Street Health.[20] Multidisciplinary teams provide street psychiatry and substance use recovery services for people experiencing homelessness in Berkeley. They can also provide connections to primary care, social services, housing, and other resources.

Berkeley Free Clinic's Street Medicine team is a volunteer-run collective where volunteers are trained as medics and provide services in the community.[21] Their services include HIV and STI testing and treatment, first aid, vaccinations, hygiene kit distribution, and substance use supplies and training. The teams regularly do proactive outreach to connect to new clients.

What is the current mental health crisis call volume in Berkeley?

In addition to its deep community engagement process, RDA also reviewed quantitative data on the volume of calls related to mental health issues and who is making those calls. As noted previously, quantitative data from City of Berkeley agencies conducting crisis response (i.e., Mobile Crisis Team, Berkeley Police Department, and Berkeley Fire Department) currently have a variety of limitations. Because

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[18] Bonita House Inc. (n.d.). *Berkeley Wellness Center*. Retrieved October 5, 2021, from **https://bonitahouse.org/berkeley-creative-wellness-center-cwc/**

[19] Women's Daytime Drop-In Center. (n.d.). *Women's Daytime Drop-In Center*. Retrieved October 5, 2021, from **https://www.womensdropin.org/**

[20] Alameda County Health Care for the Homeless. (n.d.). *Street Health*. Retrieved October 5, 2021, from **https://www.achch.org/street-health.html**

[21] Berkeley Free Clinic. (n.d.). *Street Medicine Team*. Retrieved October 5, 2021, from **https://www.berkeleyfreeclinic.org/street-medicine-team**

of these limitations, RDA suspects that the available data is generally an underrepresentation of the true volume of mental health related calls in Berkeley. Given these limitations, RDA explored the available data for trends that can support the community in building its understanding of who is currently utilizing Berkeley's crisis services.

It is important to note that the City of Berkeley has contracted with the National Institute of Criminal Justice Reform (NICJR) to lead the City's current Reimagining Public Safety work. As a part of its current engagement, NICJR collaborated with Bright Research Group (BRG) on a large community engagement effort to better understand the local community's perspectives across a variety of issues pertaining to public safety in Berkeley. NICJR and BRG shared their findings on July 29, 2021 at Berkeley's Reimagining Public Safety Task Force (RPSTF) meeting; the slide deck presentation of key findings can be found online.[22] The overarching findings from this presentation align with RDA's community-wide data collection efforts.

Key Mental Health Call Volume Trends

- MCT has responded to a declining number of 5150s since 2015, in part due to staff vacancies and the pandemic.
- The most frequent incident types of all 5150 calls to BPD were disturbance, welfare check, mentally ill, and suicide.
- Around 40% of BPD's welfare check calls included a mental health related facet to the response, followed by around 20% of disturbance calls, and around 10% of calls regarding suspicious circumstances.
- Falck has been contracted to conduct the large majority of 5150 transports in Berkeley, most often taking service utilizers to Alta Bates Medical Center and John George Psychiatric Emergency Services.
- BFD conducted fewer 5150 transports in Berkeley and only took service utilizers to Alta Bates, Oakland Children's Hospital, and Kaiser Hospital.
- The time required for a 5150 is, in part, determined by geography and the destination of transport.
- Calls for 5150s are most frequent from 10:00am to midnight and least frequent from 2:00am to 8:00am. There are no notable differences in the frequency of calls by day of the week.

For a deeper description of call volume and data, demographics of calls, and methods please see **Appendix D**.

[22] City of Berkeley's Reimagining Public Safety Task Force. (2021, July 29). *Berkeley Reimagining Public Safety – Community Engagement Report*. **https://www.cityofberkeley.info/uploadedFiles/Clerk/Level_3_-_Commissions/CE-presentation-Final.pdf**

Stakeholder Feedback

Mental health crises vary in severity along a spectrum. A crisis can present as someone in immediate danger to themselves or others, someone that needs regular support to address their basic needs, or someone that is generally able to manage their needs but needs occasional support to prevent a future crisis. Many stakeholders expressed that in order to effectively address the challenges of the current system, solutions and changes must engage with the nuance and spectrum of mental health crises.

Many stakeholders shared that by broadening our concept or definition of a mental health crisis, we can better design the mental health crisis response system and related services. Stakeholders provided several examples of the nuance and spectrum of mental health crises:

- Some forms of crisis are readily visible (such as people presenting to hospitals or experiencing a crisis while in public) while others may be unseen (such as a homeless-but-sheltered individual recovering from intimate partner violence).
- Some forms of mental illness or neurodivergence are reported by a bystander as a crisis, but there is not an acute crisis situation and should not result in a forced transport just because of a bystander's concern.
- Some forms of crisis are a result of community members not knowing where to access services even if they are able to identify their needs.
- Some forms of emergency service utilization stem from an ongoing unmet need for basic goods and services, such as a high utilizer that regularly presents at the hospital emergency department because they need food.

Overall, there is wide consensus among interviewed stakeholders that the current mental health, substance use, and homelessness crisis systems in Berkeley are under-resourced and unable to meet both the volume of need and the various ways in which crisis presents.

Expectations for different types of crisis responders varied greatly by stakeholder. Stakeholders shared mixed experiences with BPD's ability to successfully de-escalate situations and respond empathetically to people in crisis, and often attributed the quality of interaction to the traits of an individual officer. Stakeholders often held low expectations for BPD to intervene non-violently and expressed positive perceptions when BPD "didn't do anything." On the other hand, stakeholders shared high expectations for other crisis service providers including MCT responders or county case managers. Negative feedback from stakeholders was often because providers were not meeting these high standards. As a result, understanding stakeholder praise and criticism of crisis responders – such as MCT, BPD, and other CBOs – requires understanding stakeholders' varied expectations.

In discussing their experiences as well as the strengths and challenges of existing crisis response system, interviewed participants and survey respondents also shared ideas for a reimagined mental health crisis response system. The following sections detail key themes that were elevated across stakeholder participants.

Illustrative quotes from survey respondents are included alongside key themes. Due to concerns with anonymity and limitations of data collection, quotes from interviews and focus groups were unable to be included.

Key Themes from Stakeholder Feedback

Perceptions of an urgent need for a non-police mental health crisis response in Berkeley

Perceptions of varied availability, accessibility, and quality of crisis response services

Perceptions of insufficient crisis services for substance use emergencies

Perceptions of a need for a variety of crisis transport options

Perceptions of a lack of sites for non-emergency care

Perceptions around supporting the full spectrum of mental health crisis needs

Perceptions of a need for post-crisis follow-up care

Perceptions of barriers to successful partnerships and referrals across the mental health service network

Perceptions of needs to integrate data systems and data sharing to improve services

Perceptions of a need for increased community education and public awareness of crisis response

Stakeholder perceptions of the urgent need for a non-police mental health crisis response in Berkeley.

"I think a carceral approach creates more trauma and fear. I have been traumatized by being in jail. I do not wish to be incarcerated when all I need is support."

- SCU Survey Respondent

Overall, there was a strong sense of urgency for a change in the response to mental health crises in Berkeley. Service providers indicated that they routinely use creative interventions and provide services for clients multiple times and consider calling the police a last resort. Service providers shared that if there were an SCU, they would prefer to use a non-police option for crisis response.

Service providers and crisis responders expressed a sense that the current system is "broken," that they see the same service utilizers on a frequent basis. Providers shared examples of clients unable to access existing services, not engaged in services they are enrolled in, or not willing to receive offered treatment for a variety of reasons. Stakeholders felt that most people need support accessing resources in addition to immediate crisis response or de-escalation. However, they believe the existing crisis response system often relies on police to respond to calls. This is not the specialty of the police, nor are they able to provide a full range of follow-up linkages and referrals to trauma-informed social services.

There is strong consensus across city staff, service providers, service utilizers, and survey respondents that police do not best serve the needs of those who are experiencing a mental health or substance use crisis. Stakeholders emphasized that a mental health crisis should not be equated with violence, though there is often the misconception that any display of mental illness is violent or a threat to public safety.

*"My perception is that mental health issues, substance use, and homelessness are *rampant* in Berkeley - now more than ever - and police are simply not the right people to deal with these issues."*

- SCU Survey Respondent

Stakeholders shared that there are scenarios in which the presence of police can increase the danger for service utilizers or bystanders. In the context of intimate-partner and domestic violence, there is often a fear of retaliatory violence if the police are called in to respond to the abused partner seeking help. Stakeholders shared examples police presence and visible weapons escalating a mental health crisis, causing an increase in erratic or unpredictable client behavior. Particularly for service utilizers with traumatic histories from interactions with police officers, they felt the presence of police can escalate a crisis or emergency. Service providers shared stories of clients that have suffered through immense psycho-social harm and/or medical complications before reaching out to 911 due to their fear of the police.

Survey respondents and service providers shared the perception that sometimes police think a weapon is present on an individual when it is not, and felt that police use unnecessary violence and force, which overall decreases their sense of safety. **Stakeholders felt that this context results in an environment in which they do not call for emergency help because of**

a fear of police, leaving community needs for crisis support unmet. Service providers also elevated that there are ways to disarm someone without using force or weapons which would improve the safety for both service utilizers and providers alike.

For these reasons, Crisis Support Services of Alameda County (CSS) crisis line providers shared that they prepare callers for interactions with the police by telling them what to expect when the police arrive and providing options to keep themselves safe (e.g., stepping outside, double checking that there are no weapons or illicit substances on their person, and closing their front door). However, they did mention that service utilizers using substances or experiencing a break with reality may not be able to follow close directions and are at increased risk of police violence due to the heightened probability of misunderstanding or miscommunication.

"I desperately needed help for a friend who was experiencing a mental health crisis. She was adamant that I not call police because she is scared of them and feared that they would be violent with her. There were no alternatives available in Berkeley. I have watched police respond to people in crisis many times. Some cops are aware that their presence can escalate people. Some of the cops are oblivious of how they impact a situation and make it worse."

- SCU Survey Respondent

Stakeholders shared a few strengths of police involvement in the existing crisis response system. They shared that police may provide a useful resource for people who need documentation of a crime for future legal reference. A police report with these details can later be used in a court setting or provided as proof to an insurer. Additionally, many service providers indicated police presence can protect the safety of crisis responders and bystanders when weapons are present. Some stakeholders elevated that the presence of police can be supportive when community members or service providers are attempting to de-escalate a crisis.

The overwhelming importance and immediacy of changing the mental health crisis response system was emphasized in stakeholders' references to the violence committed against a woman killed by BPD during a mental health crisis in 2013 and a man shot by BPD during a mental health crisis in 2021. Stakeholders shared that providing a non-police mental health crisis response option could increase the acceptability and accessibility of crisis response by addressing this fear, thereby promoting the safety and well-being of community members and service utilizers.

There were differing perspectives of whether police should have any involvement in crisis response. The expressed perspectives included: there should be no police involvement; police should be called as back-up only if SCU de-escalation efforts were unsuccessful; police should be called as back-up only if the presence of weapons was confirmed; or police should be involved through a co-responder model like MCT.

Stakeholders offered important considerations for police involvement. Some stakeholders suggested that police should be dressed in plain clothes to avoid their presence further escalating a community member in crisis. Other stakeholders shared that if police are involved in the SCU model of crisis response, then they should be in uniform; they elevated that community members should understand who they are speaking to, given that a police officer can arrest, detain, and/or incarcerate them. Additionally, because community members expressed that they have the right to identify a police officer's badge number and last name -- which is particularly important if a community member needs to report any

misconduct -- police should be in uniform. Furthermore, stakeholders elevated their fear of being targeted by certain police officers as someone that experiences mental health emergencies and/or someone who uses drugs; for this reason, stakeholders shared that it is important for police to remain in uniform to mitigate the criminalization of mental health crises and drug use and for public awareness.

"I have had police response in an emergency crisis. It only made the crisis more terrifying and traumatic."

- SCU Survey Respondent

Stakeholders shared considerations for protecting and enhancing the safety and well-being of crisis responders, service utilizers, and community bystanders alike. The presence of weapons is a primary safety consideration for many stakeholders. Stakeholders reported concerns about determining and dispatching the appropriate intervention team in order to prevent injury or assault to crisis responders, especially when there are weapons present. Many stakeholders also emphasized that the safety of the person in crisis must be protected too.

Stakeholders provided many ideas for how a non-police crisis response system could best support Berkeley residents. Community members and providers suggested a crisis response team include mental health practitioners such as peer workers, therapists, direct patient care specialists, social workers, medical providers and/or psychiatrists. They also suggested several trainings that would support crisis responders to better meet the needs of people in crisis, such as trainings on trauma-informed care, de-escalation, and crisis neutralization. Finally, given the types of crises service providers and service utilizers most often experience, stakeholders elevated specific technical knowledge that crisis responders should be prepared to employ, including basic first aid, domestic-violence crisis response training, and specific knowledge on DSM-5 mental health diagnoses, and co-occurring drug-induced states.

Additional Perspectives from the SCU Survey

"The police response here is among the most professional that I have seen in any jurisdiction in the nation - yet the bottom line is requiring police to respond to crisis situations in which they do not have the requisite training is a disservice to both the officers and those on the other side of the response."

"I don't feel unsafe in the community. My homeless neighbors are much more unsafe than I am because they are consistently interacting with people who hate them, with some bad cops including the campus cops."

"There is a huge crisis in our city of homelessness and mental health and the police only ever make things worse. Sweeps, seizures of possessions, harassment and intimidation of unhoused residents is all too common. The violent detention of mentally ill people seems to be a day to day reality. Heavy restraints and spit hoods being used in the place of de-escalation and care. The Berkeley police shot a man in crisis through the mouth this year and that is beyond unacceptable!!!"

"I need to know that if I, or someone I love, is experiencing a mental health crisis that there is a trained mental health professional that I can call who will come, without a gun, and that I will receive care, not a cop, and that I will not end up dead. Knowing I won't be shot dead by a cop for the "crime" of living with mental illness, for being poor, or for having a substance use disorder would help me to feel safe."

Stakeholder perceptions of varied availability, accessibility, and quality of crisis response services

Perceived Strengths

- MCT provides quality services
- Positive experiences with individual BPD officers
- BFD created a resource list to better provide referrals

Perceived Challenges

- Lack of 24/7 crisis services
- Requiring service utilizers to keep appointments
- Slow response times for MCT due to limited staffing
- Long waitlists for services
- Few options for de-escalation or non-emergency care
- Poorer quality of services provided to people of color and unsheltered people

Stakeholder Ideas

- Proactively communicate service availability & hours of operation
- Increase 24/7 service options
- Increase training on racial justice, cultural sensitivity, harm reduction, and de-escalation

"Berkeley MCT is only open on weekdays during certain hours. I have never had an incident where I needed help with a client coincide with their open hours."

- SCU Survey Respondent

Stakeholders identified a few strengths of the availability, accessibility, and quality of crisis services. Many reported that there is general knowledge of the existing crisis response options in Berkeley. Some providers reported positive experiences with police, and many reported positive experiences with MCT. Another strength shared by stakeholders is that BFD's ability to refer and link service utilizers to resources has increased since they created a list of CBOs and local programs.

A common challenge elevated by stakeholders is the lack of 24/7 response options. A mental health crisis can happen at any time, but many crisis programs operate during standard business hours. The limited hours of operation of MCT were elevated by stakeholders as a significant challenge that increased the risk of police interaction with service utilizers who call 911 when MCT is not staffed.

Stakeholders frequently mentioned limited MCT staffing as a major barrier to accessing quality crisis response services. For the last two years, two of four crisis staff positions have been vacant. Because MCT responds to calls in pairs, only one team is available to respond at a time. This can result in long wait times if the team is responding to another call. Additionally, if there is a high call volume, MCT will prioritize high acuity calls where someone is showing imminent signs of crisis or distress. The reduction in staffing also led to a reduction in hours. This has caused confusion among providers and service utilizers. Service providers elevated this as a source of uncertainty and distrust that can reduce the likelihood of someone accessing services in the future.

"Mobile Crisis folks are good. It's just that they always come with the cops, and sometimes they can't come for many hours because they're busy."

- SCU Survey Respondent

"It's a revolving door (with Santa Rita, John George, etc.) where crises are sometimes averted, but almost no one is truly healed and set on a good path of recovery or even stability."

- SCU Survey Respondent

Stakeholders believe these challenges and barriers to accessing services or ensuring the availability of services are ultimately challenges to the overall safety and well-being of potential service utilizers, community bystanders, and service providers.

A Berkeley City Auditor's report in 2019 elevated that the understaffing of the 911 Communications Center has led to staffing levels that cannot meet the call volume and increased call wait times.[23] Increased call wait times have negative implications for the safety and well-being of service utilizers and community members, as well as the service providers and crisis responders that are responding to a potentially more advanced state of crisis. Additionally, inadequate staffing levels have caused BPD to rely on overtime spending to fund the Communications Center, which increases the cost of the entity.

There was consensus among participants that many facets of the crisis response system feel understaffed, which can lead to decreased service availability and slower responses. Under-resourcing can create challenges to service availability across the providers and programs throughout Berkeley and Alameda County. Service utilizers and community members reported long waiting lists for permanent supportive housing units, a key stabilizing factor that could reduce the incidence of mental health crises overall. There was also a perception among stakeholders that service utilizers are faced with long waits to access healthcare, case managers, and temporary congregate shelters.

Some CBOs also identified a need for more multilingual services, especially Spanish-speaking providers. They also indicated that a fear of ICE or 911-corroboration with ICE is a barrier for undocumented community members to call 911, especially for undocumented residents that are unhoused. Service providers suggested that more culturally competent services would increase the likelihood of someone seeking services when they are experiencing a crisis.

Stakeholders believe that these challenges to availability and accessibility can reduce the quality of available services. When police must respond to a mental health crisis because it is outside MCT business hours, community members do not feel the response was adequate or of the highest quality. Crisis responders expressed that they frequently provide medical solutions when the service utilizers they encounter have mental health needs and are most affected by broader societal problems.

When MCT is not operating, CSS indicated that they do more de-escalation over the phone prior to calling for police support to prepare

[23] Berkeley City Auditor. (2019, April 25). *911 Dispatchers: Understaffing Leads to Excessive Overtime and Low Morale*. https://www.cityofberkeley.info/uploadedFiles/Auditor/Level_3_-_General/Dispatch%20Workload_Fiscal%20Year%202018.pdf

the service utilizer and reduce their risk of harm; however, they shared that phone support may not always be sufficient for every mental health crisis.

Overall, there was consensus among stakeholders that there is a lack of successful linkages and connection to follow-up services beyond John George Psychiatric Hospital. Many participants felt that hospitalization may not be appropriate care for everyone experiencing a mental health crisis. Crisis responders and providers reported service utilizers requesting to not be sent to John George, but that as service providers they do not feel they have other options. For service utilizers, trauma histories can be re-triggered by congregate shelters, psychiatric care or hospitals, and police interactions. Stakeholders elevated a need for increased options for where people can be transported during a crisis.

"The resources we have are helpful, but we need more. We especially need affordable housing units. The mobile street medicine teams have been very helpful. Shelters are ok for some people, but often exclude people with disabilities who need assistance the most."

- SCU Survey Respondent

Finally, there is a perception that the quality of the City's first responder crisis response services is inhibited by a lack of training that sufficiently addresses harm reduction, racial justice and cultural sensitivity training, and successful de-escalation. Service providers shared examples of clients' needs not being taken seriously, such as instances of individual EMTs not responding to unsheltered clients and/or clients of color. These examples demonstrate how stigma, dehumanization, and racism decrease quality of services.

Given the constraints of how the existing crisis system is funded and resourced currently, stakeholders elevated that any changes to program hours of operation, locations, staffing, phone numbers, and/or other logistical/programmatic decisions be shared regularly and distributed to the partnership network in order to improve availability, accessibility, and quality of service provision. They felt that the ideal alternative crisis response options would include 24/7 mental health crisis response and should address the desired competencies of harm reduction, racial justice and cultural sensitivity, and de-escalation to increase community safety and promote health and well-being.

Additional Perspectives from the SCU Survey

"They tend to exist in ways that are the most convenient for the service providers, not for the person in need. Mental Health Services don't really happen outside of their offices. How can disordered, homeless people be expected to make and keep appointments at some unfamiliar address? The drug epidemic is complicating things and I have seen no evidence that this city wants to commit to rehab on demand which is what we need. We need to be able to offer help when it is needed- not when it is convenient."

"I've been doing outreach work for more than a year in Berkeley now and access to mental health crisis support is almost nonexistent. It is highly needed as many individuals are experiencing some level of mental health issues."

"… My experience with the police response has been that the City of Berkeley crisis team has been understaffed or not working the day that I phoned, or my report of the need for crisis support was minimized, and it was explained that the person "wasn't breaking any law." Crisis doesn't often intersect with law breaking, nor does an individual always meet the criteria for a 5150. There are trained individuals who can help with this, and police often offer heavy handed threats of arrest, or physical violence, in attempt to stop a behavior."

Stakeholder perceptions of insufficient crisis services for substance use emergencies

Perceived Strengths

- EMTs respond well to substance overdoses
- EMTs are well-trusted by many unsheltered communities and encampments

Perceived Challenges

- Not enough SUD training for clinicians providing complex mental illness care
- High rates of transport to emergency facilities for substance use emergencies
- Infrequent referrals to substance use management services
- Too few resources to meet high volume of substance use emergencies and management needs

Stakeholder Ideas

- Incorporate harm reduction framework into all crisis response
- Distribute NARCAN
- Distribute harm reduction supplies (e.g., sharps disposal, clean needles, etc.)

"Decriminalization is key to "illegal" drug use and harm reduction methods of dealing with addiction and drug use save lives and alleviate the stigma."

- SCU Survey Respondent

Stakeholders explained that mental health crises often include substance use emergencies, but they felt that variety and uniqueness of substance use emergencies is often overlooked and not adequately served in the existing crisis response. Stakeholders described many examples of physical and psychosocial health needs related to substance use that do not involve an overdose. Service providers shared that substance use emergencies and mental health crises are often co-occurring as substance use is common among people with histories of trauma and is used as a form of self-medicating.

Substances can alter someone's mental state and contribute to or exacerbate what is perceived as a mental illness. Stakeholders elevated that when a person is in distress, providers should assume that something is triggering that distress, be it an event or intoxication. **One of the most frequently and emphatically emphasized points by service providers was the need to address mental health and substance use in tandem.**

In the event of a substance overdose, stakeholders felt that Berkeley EMTs are well-trained, follow protocols, and administer effective treatment for users that have overdosed. Stakeholders reported that EMTs are well-trusted by marginalized substance-using communities, including homeless encampments. Seabreeze encampment residents shared that they avoid calling 911 for any emergencies except to specifically request an EMT during an overdose.

"The people with mental illness should get treatment. In crisis, they should be housed with treatment. those with substance abuse should have treatment available. Being homeless probably makes people mentally ill. I think I would be mentally ill if homeless."

- SCU Survey Respondent

Stakeholders described many challenges to how the system currently addresses substance use emergencies. They felt that the physical health and mental health needs of a service user experiencing a substance use emergency are treated as separate needs. Service providers explained that whichever presents as more immediately pressing often dictates the classification for the call; they felt that this results in inadequate service provision during a crisis.

Community-based providers elevated that when seeking care for clients with complex trauma or chronic mental illness, they are rarely put in contact with a provider that has SUD training. **Service providers expressed a need for an integrated approach to substance use emergencies, with providers working together to tend to both the psychological and physical health needs of their clients.**

Substance users reported frequent transport to hospitals and sobering centers when emergency providers respond to crises. Interviewed substance users shared that they were only informed of other substance use management options when other case managers shared those options (not emergency services personnel prior to transport).

Stakeholders suggested ways that the current crisis response system could better address the needs of substance use emergencies, including incorporating a Harm Reduction framework into first responder's approach to drug use, distributing Narcan, and distributing harm reduction supplies such as clean needles, pipes, and safe sharps disposal kits.

Additional Perspectives from the SCU Survey

"I am a Nurse Practitioner... Some camps in Berkeley have agreements internally not to call the police on each other. If someone does, there is retaliation, sometimes in the form of lighting the person's tent on fire. This means people do not call 9-11 when there is a mental health emergency. While I completely understand why the mobile crisis unit has police officers, it is not used as often as it could be because of that fact...Many unhoused folks we meet use meth in part to stay up all night so they will not get raped or robbed during the night. This is of course not the only reason folks use meth and other drugs--there are mental health issues, addiction, etc. But until people are housed, it is very, very hard for them to cut down or quit, because the risks can outweigh the benefits in their minds."

"...Offering safe use and drug checking sites, so we can reduce harm that comes from unsafe drug use. Creating accessible, affordable, and temporary housing for each phase of a person's recovery from crisis. Ensuring people have access to food, safe shelters, and access needs are met."

Stakeholder perceptions of a need for a variety of crisis transport options

Perceived Strengths

- Transport is provided to emergency sites during medical emergencies

Perceived Challenges

- High rates of involuntary transports (5150s) do not align with service needs
- Lack of options for transport to non-emergency sites
- Ambulances and emergency services can be cost-prohibitive for service utilizers

Stakeholder Ideas

- Provide voluntary transport to non-emergency sites
- Provide services and supplies during transport process

"With all the services available, as a firefighter, all we can really do is take someone to the ER, which is not definitive care for homelessness. Mobile support of homeless services would be a game changer, much the way mental health comes out into the field."

- SCU Survey Respondent

Crises can vary in levels of acuity, and not everyone calling in to report a mental health emergency needs transport to a psychiatric facility, hospital emergency department, or inpatient setting. Both EMTs and police shared that they provide free transport to a medical facility, which is important in the event of medical health emergencies. However, Alameda County has the highest rates of 5150s per capita in California.[24] Service providers described full emergency departments and service utilizers not being admitted upon arrival. There are also financial implications for being transported in an ambulance, which providers suggested may deter service utilizers from requesting emergency services. **Stakeholders felt that there are few to no options for service utilizers to request transport to a different, non-medical facility or location.** Stakeholders did provide some examples of CBOs and non-emergency programs that provide transportation to their clients, though they shared that these services are not for the general public and barriers to transportation persist.

Given the need for addressing a variety of transport needs, stakeholders elevated the importance of an SCU team to have the ability to provide voluntary transport services to any secondary location, such as a sobering center or a public location. Service providers and community members suggested that the transport vehicle should have available supplies to provide care during a transport, such as one-off doses of psychiatric medicines, food, and water. There was a shared sense that providing

[24] California Department of Health Care Services. (2017, October). *California Involuntary Detentions Data Report; Fiscal Year (FY) 2015-2016*. https://www.dhcs.ca.gov/services/MH/Documents/FMORB/FY15-16_Involuntary_Detentions_Report.pdf

transport options that meet the mental health needs at varying levels of acuity has important implications for the safety and well-being of crisis responders and service utilizers.

Additional Perspectives from the SCU Survey

"...Another challenge is the lack of options for people in crisis either hospitalization or nothing which is very harmful. Another issue are people who feel terrible but are not exactly in crisis but because there are not enough mental health providers they are forgotten or left to their own devices."

"I need to know that if I call for help, a compassionate response will arrive and be able to take a person to a humane location, respite of some kind. Not forcing them into a hospital where they are stripped of agency, but giving them a place where they can stabilize without adding to their feeling of trauma and powerlessness."

Stakeholder perceptions of a lack of sites for non-emergency care

Perceived Strengths

- Drop-in centers, day centers, sobering sites, and respite centers provide essential non-emergency services

Perceived Challenges

- No drop-in site for mental health emergencies or crises in Berkeley
- Too few drop-in sites for non-emergencies to meet the volume of need
- Lack of support for people released from a psychiatric hold

Stakeholder Ideas

- Offering drop-in sites with counselors and Peer Specialists, a phone line, and no service/time limits
- Offering office hours and/or relationship-building opportunities between the SCU and service utilizers

Stakeholders shared examples of sites that can support non-emergency care and felt that they are effective for mitigating further crises. These examples include drop-in centers, day centers, sobering sites, and respite centers. Services providers believe that such spaces allow individuals to meet their basic needs – including access to restrooms, showers, clothing, food, and rest – as well as have a safe space for self-regulation and self-soothing**. Stakeholders, particularly service providers, feel that these types of resources are essential for harm reduction, crisis intervention, health promotion, and crisis prevention.** Stakeholders shared that these sites can be a safe and trusted source for someone to access so that a primary caregiver can have a break, such as a parent that provides an adult child behavioral health support and care. Participants mentioned other CBOs

that operate drop-in sites, such as the Women's Drop-In Center or Berkeley Drop-In Center, **but service providers indicated that there is still an unmet need for more sites that serve sub-acute needs**. Because there is not a drop-in center for emergencies, service utilizers and community service providers described relying on either 911 or the CSS 24/7 phone line. Similarly, stakeholders felt that the availability of non-emergency drop-in centers for individuals to have non-emergency, indoor downtime is too limited to meet the volume of need. CBO service providers as well as crisis responders described situations of individuals being released from psychiatric holds without adequate support upon their release. They felt that these individuals would greatly benefit from the availability of additional drop-in centers.

Service utilizers and community-based service providers emphasized that it would be useful for the SCU to have an office available for community members to develop relationships with the team, like Aging Services' Senior Centers. They suggested that a drop-in site could have a social worker or peer counselor to accept and direct phone calls, answer questions, and support those accessing the drop-in site.

Additional Perspectives from the SCU Survey

"…addressing the connection to community in the long term - spaces for people to gather publicly without needing to pay money, so we can get to know our neighbors."

"… We need wrap-around services, a halfway house or drop-in center for people being released from a psychiatric hold, to ease them back into their lives and connect them with ongoing services."

Stakeholder perceptions around supporting the full spectrum of mental health crisis needs

Perceived Strengths

- Relationship building is important in crisis response

Perceived Challenges

- Wages, retention, and union agreements may affect type of staff on crisis response team
- Crisis response lacking sufficient supplies and expertise for SUD treatment, de-escalation, and system navigation
- Crisis responders are not often representative of service utilizers

Stakeholder Ideas

- Incorporate clinicians, social workers, and peer counselors on crisis response team
- Increase compensation for Peer Specialists and non-clinical staff

"A response team targeted at de-escalation and risk reduction would be best; it would be best staffed by those who can actually connect people in need to resources rather turning a crisis into a criminal matter, such as police do."

- SCU Survey Respondent

Stakeholders shared many strengths of crisis responders across a spectrum of non-clinical and clinical background and expertise, emphasizing the importance of empathy and building trusting relationships. For instance, TOT staff received positive feedback across stakeholder groups for their follow-up work post-crisis, especially due to their diverse staff and rigorous training in preparation for field work. Service providers emphasized the importance of Peer Specialists to support service utilizers by reassuring them from their own background of lived experience, especially during transport or if the team applies physical restraints.

Crisis responders and service utilizers shared that the pre-existing relationships paramedics have with community members, particularly those that repeatedly need crisis response services, allows paramedics to deliver better care. Some CBOs have observed similar success when incorporating Nurse Practitioners on their street outreach teams. Overall, stakeholders believe that the ability for the same personnel to be providing crisis response services over an extended period can lead to positive outcomes of relationship building and knowing a client's background.

However, stakeholders raised some potential challenges that must be considered when deciding how to staff a crisis response team. Crisis responders explained that paramedics often have a higher salary than other crisis responders and their skills can be under-utilized during a mental health crisis. They felt that this could make staffing a crisis response

program with paramedics less financially efficient. On the other hand, they shared that other crisis responders, such as peer specialists, can be underpaid for their level of contribution, which they suggested might make retention a challenge. One additional consideration shared by crisis responders is that staff can have different union agreements that restrict the number of hours that can be worked per shift, which would affect the program's overall staffing model and schedule.

"I think professionals who are trained to resolve these crises non-violently is key. For example, social workers."

- SCU Survey Respondent

Stakeholders felt that some of the services most important for mental health are not always standard practice among current crisis response teams. The types of clinical services that stakeholders reported as most important for mental health crisis response include prescribing psychiatric medicines, administering single-dose psychiatric medicines, quick identification of a substance overdose and/or the need for Narcan intervention, as well as a nuanced understanding of drug-psychosomatic interactions. The types of non-clinical services that stakeholders reported as most important for mental health crisis response included de-escalation, resource linkages and handoffs, system navigation, providing perspective from providers with shared identities or experiences, building ongoing relationships with frequent utilizers, and overall building trust and rapport with the community.

Given the considerations around the types of needs that various specialties can address during crises, as well as the implications for financial feasibility, stakeholders elevated additional ideas for how to staff crisis response teams. Stakeholders expressed support for a crisis response team with a medical provider (e.g., advanced practice nurses, psychiatric mental health nurse practitioners, EMTs, or paramedics), social workers, and especially peer counselors. Stakeholders expressed that non-clinical staff are equally valuable to clinical staff in a crisis response team, a value which should be reflected in their salaries.

Additional Perspectives from the SCU Survey

"We need a crisis response team with trained social workers, case managers, and clinicians trained in de-escalation techniques. This team should be able to connect people in crisis with emergency shelter and other services."

"I do not believe that the police are trained to respond to the needs of an individual, homeless, or otherwise, experiencing a crisis. Mental health, substance use, and homelessness related crisis are best responded to by someone who has been trained to work with these issues, or a peer who, along with a trained professional, can provide support and most importantly, follow up."

Stakeholder perceptions of a need for post-crisis follow-up care.

Perceived Strengths

- Positive experiences with existing referral services (i.e., TOT and CAT)

Perceived Challenges

- Existing programs do not meet the volume of need
- Difficulty contacting service utilizers for follow-up care
- Lack of warm handoffs to follow-up providers
- Limited long-term service availability
- Strict missed appointment policies

Stakeholder Ideas

- SCU provides follow-up care
- SCU builds relationships to support before, during, and after a crisis
- Providers should be familiar with case history, triggers, etc.

"I think police officers already deal with so much, there's often an acute need they're responding to when in fact these individuals need long-term care."

- SCU Survey Respondent

For crisis services provided by the City of Berkeley, the Transitional Outreach Team (TOT) is the primary resource for post-crisis follow-up care. **Service utilizers and community-based service providers elevated many strengths about the TOT team**, including their ability to connect service utilizers to longer-term care options and social services when interested.

At the same time, stakeholders uplifted a need for additional follow-up care after a mental health emergency. TOT staff and Berkeley Mental Health leadership described many challenges TOT face in meeting the level of need across the crisis spectrum. The team is not adequately staffed to meet the current demand for their services. TOT is a team of only two staff with limited business hours for providing linkage to care. TOT staff also shared that the service provider that responds during a crisis (i.e., MCT) is not the same provider that makes follow-up connections (i.e., TOT), and that there are many potential providers to provide ongoing, long-term care (e.g., Berkeley Mental Health, Alameda County Behavioral Health, or private providers). They felt that this can create challenges for them to provide successful referrals and handoffs to post-crisis follow-up care, sharing background information on clients, and building trust and establishing rapport.

TOT staff also shared many challenges they face in reaching clients, particularly those leaving an inpatient or emergency facility, such as John George or Alta Bates Hospital. They explained that clients are sometimes discharged prior to their connection with TOT, often outside of TOT's hours of operation. They find it particularly difficult to connect with service utilizers that do not have a cell phone or a consistent residence, which they explain is common among high-utilizer community members, such as those with severe mental illness or those experiencing homelessness.

We need clean, safe shelters for people to spend the night if they're homeless and/or under threat. Kicking them out of shelters doesn't make the problem go away.

- SCU Survey Respondent

In general, many people that experience mental illness or mental health crises require or are recommended to long-term therapy or extended sessions**. However, it is the perception of stakeholders that services are primarily devoted to high-acuity and short-term and service utilizers are unable to access long-term therapy.** Stakeholders felt that the providers who do offer therapy or counseling are unable to meet the volume of weekly appointment needs of service utilizers due to budget and billing constraints. Therapy is not only a form of post-crisis care but also a pre-crisis prevention tool; service providers suggested brief intervention therapy in non-emergency settings (such as a service utilizer walking in during a crisis) to augment the existing crisis response system.

Outside of Berkeley Mental Health services, there are often strict policies around missing appointments, largely tied to insurance and billing requirements, that result in service disruption or termination for service utilizers. **Service providers and service utilizers feel that these strict missed appointment policies are inaccessible to many low-income service utilizers and often result in the discontinuation of services.** Stakeholders described some barriers that service utilizers may face in maintaining their appointments, including working more than one job (especially during standard business hours), having a reliable cell phone, having access to a calendar, and/or having a reliable mode of transportation.

The importance of follow-up care was elevated by all stakeholder groups as a priority for the SCU. Service providers argued that there may be benefits to having the same people providing care before, during, and after a mental health crisis, to build relationships, establish trust, and understand an individual service utilizer's care history, behaviors, triggers, and needs.

Additional Perspectives from the SCU Survey

"I would like for the police to be removed from crisis services and to have a rapid response available when I call...I would like for there to be more connection to services and follow up as part of the planning. There is often not a resource available for the person, and living on the streets is stressful, so repeated contact is essential. It can't be a one and done and often would mean an increase in FSP teams."

"Alternative trained individuals, such as social workers or mental health professionals as part of this time, increased community-based mental health care services, social and rehabilitative services that highlight social reintegration, such as Supported Housing, Supported Employment, and Supported Education."

Stakeholder perceptions of barriers to successful partnerships and referrals across the mental health service network

Perceived Strengths

- Providers know the referral options available for their clients

Perceived Challenges

- Limited coordination and information sharing between providers of shared clients
- BPD engages with many high utilizers but is not connected to the network of providers
- Lack of trust and understanding across service providers

Stakeholder Ideas

- Engage providers in discussions on system improvement
- Increase collaboration between cities, counties, and providers
- Address systemic factors of crises
- Increased outreach and care coordination of referrals

"A 24-hour crisis line/team or at least a team more available than currently. Police and that team should attend the regular city coordination meetings with the current teams that are doing outreach."

- SCU Survey Respondent

There was consensus among stakeholder groups that the existing mental health and crisis service network is complex, involves many providers, and can be a challenge for both clients and providers to navigate. Across these entities, establishing partnerships and referral pathways can be done informally (such as knowing which organization provides which types of services) or can be formalized (such as holding regular case management meetings for shared clients). Among community-based service providers, interviewees shared that they typically do know the scope of options available to their clients.

In general, stakeholders elevated a perceived lack of coordination between service entities in Berkeley. For example, a single client might receive emergency services from John George or Highland Hospital, but also have a primary care provider, have engaged frequently with the LifeLong Street Medicine Team, and have a case manager at the Women's Drop-In Center for wraparound services. Stakeholders shared that there is not active collaboration across all these entities or an established infrastructure to facilitate an understanding of all the touch points between providers and a service utilizer. **Ultimately, stakeholders feel that this obstructs the visibility of how a service utilizer moves through various points in the system.** Some providers explained that they may not share the full case history or behavior details of a client with other service providers initially because they fear the client will be rejected or denied service, particularly for violent behaviors. They feel that this prevents informed and well-placed referrals and service provision.

TOT staff shared that service coordination is lacking between hospitals and TOT for post-crisis follow-up care. To connect with an MCT service

utilizer at the hospital, TOT explained that they must rely on the discharging facility to contact them and coordinate the release of the shared client. TOT staff reported needing to spend time in hospitals to establish relationships with new case managers, front desk staff, nurses, and orderlies to facilitate this information sharing and warm handoff of clients; they described a lack of standardized protocol for such coordination.

BPD also reported feeling disconnected from the care continuum and lacking coordination with trusted CBOs and behavioral healthcare providers around shared clients. BPD routinely engages with frequent crisis service utilizers and sometimes carries supplies like food and clothing, though there is not an existing pathway for BPD to identify, contact, and coordinate with a case manager. **BPD elevated that these frequent utilizers would be better served by a case manager.**

Service providers also reported that BPD does not routinely bring service utilizers to their locations for support, and some questioned whether BPD know that their programs and services exist. Still, others felt that police presence at their sites is disruptive and may prevent potential service utilizers from coming if they witness police officers around the premises.

Stakeholders offered possibilities to enhance the referral pathways and partnerships across the crisis response network at both structural and provider levels. At a structural level, stakeholders suggested having a regular convening of local care providers to discuss opportunities to improve the mental health crisis system. Stakeholders also suggested having more inter-county and inter-city coordination on systemic issues related to housing and healthcare. Stakeholders suggested that the crisis response system should be expanded and augmented to include more non-mental health related service provision on the spot and not only connections or linkages to resources. Additionally, stakeholders expressed a desire for more outreach and partnerships with long-term care to enhance coordination and referrals across the service network.

At a provider level, stakeholders suggested having more coordination between providers and outreach teams. Service providers also expressed an interest in having regular meetings with the SCU to discuss shared clients, which could improve care coordination as well as client outcomes.

Additional Perspectives from the SCU Survey

"The challenge is, and has been, to have adequate staffing to provide services to those in crisis, with severe mental health diagnosis and/or dual diagnosis in the moment and following a crisis response. Successful efforts have been proven by street health teams to engage and provide treatment on the street, which often include de-escalation. The struggle lies on helping folks transition into care in the clinics, recovery programs, or a combination of both: with adequate staffing to provide long term services. So, challenges would fall under budget & funding to expand staffing and programming, including crisis residential, and Board and Care Homes...The City appears open and willing to try an approach that will better meet the needs of its citizens."

Stakeholder perceptions of needs to integrate data system and data sharing to improve services

Perceived Strengths

- Some medical clinics use the same EHR
- Some agencies use a shared Alameda County Community Health Record

Perceived Challenges

- Limited data integration across providers inhibits care coordination

Stakeholder Ideas

- Expand data integration across providers and provider access to case history
- Increase care coordination across providers
- Notify case managers after discharge from hospital

"I would also feel safe knowing that the City and County were working together to identify ways to increase funding for mental health services in conjunction with housing to meet the mental health/substance use recovery needs of the community."

- SCU Survey Respondent

Service providers feel that better system integration and data sharing across the service provider network can support providers in meeting the needs of service utilizers. Stakeholders feel that system integration and data sharing are strongly related to the successes and challenges of partnerships, referrals, and connectivity across the service network.

The numerous entities that span the mental health, substance use, and homelessness service network include CBOs and government agencies across the City of Berkeley, Alameda County, and other cities and counties. **Service utilizers also move across these regions, accessing services in multiple cities or counties. As a result, system integration could happen at many levels.**

Fortunately, subsets within the service network do have data integration and sharing capabilities. For instance, providers shared that all federally-qualified health centers (FQHCs) are on the same network as hospital Emergency Departments.

Some program directors also discussed a recent effort at the county level to integrate data into one Community Health Record for service utilizers.[25] This system integrates medical, mental health, housing, and social service data into one platform. There are currently over 30 organizations within

[25] Alameda County Care Connect. (n.d.). *Why AC Care Connect? Why Now?* Retrieved October 11, 2021, from **https://accareconnect.org/care-connect/#faq-item-5**

Alameda County who are using the community health record, with a goal of every agency being onboarded onto the system.[26]

Until then, the current multitude of agency data systems are not yet fully integrated. Providers explain that they are unable to identify shared clients or high utilizers of multiple systems, track those service utilizers' touchpoints across the service network, or view patient history across those service touchpoints. Case managers share that they are not notified when a client is discharged from a medical facility or community provider of care. **Service providers feel that this lack of data integration affects collaboration, referrals, and, ultimately, client outcomes.** The limited visibility of a service utilizer's prior history was raised by service providers as a challenge to supporting safety when trauma histories, triggers, and recent mental health crises cannot be incorporated into care planning.

"…But we need more training in mental health, de-escalation and interagency training and coordination. We have a lot of great people working these issues, we just need a little more cross pollination of effort."

- SCU Survey Respondent

Additionally, except for diagnosis and treatment purposes, HIPAA privacy regulations require service utilizers to give consent and Release of Information (ROI) to providers for external case managers' names, information, and service documentation to be included in medical records. This limits the collaboration between case managers and other providers on a case-by-case basis.

Stakeholders elevated that it would be ideal to have all service providers, including an SCU, utilizing the same data platform. They also indicated that non-medical CBO providers and case managers should have contact with the client's health home (if established), especially for substance use management and medication management. Case managers could then be notified when a service utilizer is engaged or discharged from care. Service providers emphasized the importance of understanding someone's medical and social history to provide appropriate care and anticipate what could trigger or escalate them. Service providers also warned to not overburden the SCU with documentation requirements.

Additional Perspectives from the SCU Survey

"…Secondly, we need significantly greater inter-municipal and inter-county collaboration in order to tackle structural problems that homeless and mentally ill clients face…Increasingly, our clients are more mobile, have longer commutes, and with gentrification and sprawl, landscapes of poverty and wealth are shifting. We need to be able to be responsive to clients across municipalities and communities, as people who seek services in Berkeley, particularly homeless and low-income clients, often no longer have the means themselves to be able to live in Berkeley."

[26] Raths, D. (2021, October 4). Alameda County's Social Health Information Exchange Expands. *Healthcare Innovation*. https://www.hcinnovationgroup.com/interoperability-hie/health-information-exchange-hie/article/21240807/alameda-countys-social-health-information-exchange-expands

Stakeholder perceptions of a need for increased community education and public awareness of crisis response options

Perceived Strengths

- 911 is well-known by the general public as a crisis response option

Perceived Challenges

- Lack of clarity that MCT responds with police, undermining trust
- Limited knowledge around services and availability
- Distrust of system can prevent people from calling 911
- Incidents of unnecessary use of 911

Stakeholder Ideas

- Launch a public awareness campaign for new SCU and clearly distinguish it from MCT
- Work with partners and service providers to advertise SCU
- Increase community education on use of 911 and techniques for conflict resolution

"In the past, I have witnessed unsafe situations or people who look like they could use support, but I am too afraid to call the police in those situations, for fear that they could show up and harm or kill the person."

- SCU Survey Respondent

A common perspective among stakeholders is that the general public is unclear around when police will or will not be involved in a response. Many service providers and service utilizers do not know the current options and availability of services in Berkeley to support during a mental health crisis. Overall, stakeholders share that there is a lack of understanding of what services are available and which entity provides those services. They feel that this undermines a sense of safety and contributes to distrust of the current mental health crisis response system.

One common challenge raised by many stakeholders has been the lack of understanding of MCT's co-responder model. Many providers shared that they have contacted the MCT line specifically to avoid calling 911 and were surprised when MCT was accompanied by police. Many providers, therefore, stopped calling MCT because of its collaboration with BPD. Similarly, service utilizers shared that there is a lack of trust that MCT can manage a crisis without police presence. Service utilizers are concerned that their safety is endangered in these instances and that they may experience retaliation or police surveillance after requesting service provision from MCT, especially when they request help during substance use emergencies.

Stakeholders spoke to the importance of promoting community education and public awareness to address these challenges. They feel that the success of an SCU would be contingent on community education and public awareness around whether there would be police involvement in an SCU response. Service providers shared that connecting with local CBOs, leveraging existing partnerships, and building trust will be essential for an SCU to have buy-in among service providers to call a new

"More trained & well-compensated and insured crisis response staff, especially at night, around the full moon, or public events, & other times of increased disturbances, & more info put out there about what they do to help."

- SCU Survey Respondent

service that they have not used before. **Service providers are interested in understanding more closely how services will be provided, the techniques that will be used for de-escalation and crisis intervention, and the SCU's relationship with the police.**

Stakeholders also shared challenges around the general public's use of 911 and ideas for how to increase responsible use of 911. Stakeholders shared many instances of inappropriate use of 911, such as during disputes among neighbors or because a housed person or business does not want an unhoused neighbor to be near them. For these reasons, stakeholders emphasized the importance of a community education campaign around appropriate uses of 911. Stakeholders suggested that such a campaign could include strategies and techniques for managing conflicts and disputes without calling for crisis responders as an additional form of promoting community safety through methods that do not require law enforcement.

Additional Perspectives from the SCU Survey

"Merchants in the shopping districts should not be able to call the cops like they're calling customer service when a homeless person is not breaking any laws. It would be great if crisis services were more friendly and less coercive (cops), if the mental health delivery system was more robust, if crisis teams could respond in a timely way, if clinicians didn't use police radios on mobile crisis calls, if actual risk assessments were done on calls where no one would ever need a cop (when the person is willingly ready to go to the hospital), if hospitals would actually keep and treat the most ill patients rather than turning them away after 24 hours in a waiting area, if there were more mental health respite beds run by people who aren't ready to call the police if someone is agitated."

Community Aspirations

Throughout stakeholder engagement, participants were asked to share their ideas for alternative approaches to mental health and substance use crises as well as to share community needs for a safe, effective mental health and substance use crisis response. These perspectives help illuminate the gaps in the current system that could be filled by a future Specialized Care Unit.

The following perspectives provide guiding aspirations for reimagining public safety and designing a response system that promotes the safety, health, and well-being of all Berkeley residents.

Community Aspirations

Stakeholder-identified opportunities to address the root causes that contribute to mental health, homelessness, and substance use crises

Stakeholder-identified opportunities for centering BIPOC communities in crisis response

Stakeholder-identified opportunities for community oversight to ensure equitable and transformative crisis care

Stakeholder-identified opportunities to address the root causes that contribute to mental health, homelessness, and substance use crises

"Berkeley should decriminalize the use of all drugs, it needs to create housing for the chronically mentally disturbed, it needs to have very well-trained people responding to crises. Berkeley together with Alameda County, should be providing wraparound services for the mentally disturbed and substance abusers. It needs to stop criminalizing people who are homeless.

- SCU Survey Respondent

Stakeholders unanimously pointed to the context surrounding the conversation on mental health crises: there are intersecting, state-wide crises of homelessness due to the lack of affordable housing[27] and the opioid epidemic. When reflecting on alternative ideas and community needs, stakeholders expressed desires for addressing the root causes that manifest in the present-day rates of mental illness, homelessness, and substance misuse and abuse. **Stakeholders discussed possibilities for shifting funding away from the criminal system and policing to overall community infrastructure (such as jobs, housing, and education) and increasing preventative healthcare to address the root causes of mental health, homelessness, and substance use emergencies more adequately.**

Stakeholders also emphasized how stigma and criminalization of drug use and/or mental illness continue to exacerbate crises. Stigma and criminalization are barriers to accessing care and addressing these crises at both the individual and structural levels. At the individual-level, stakeholders identified that internalized stigma around mental illness, homelessness, or substance use, can prevent individuals from seeking care and that service providers can reinforce stigma through their actions and/or withhold care. They described instances of criminalization of mental illness, homelessness, and substance penalizing individuals who do seek care, preventing or terminating employment or housing, and consequently perpetuating a cycle of these experiences. At a structural level, stakeholders emphasized that stigma and criminalization shape the prioritization of funding and budget allocations away from quality healthcare, affordable housing, and evidence-based harm reduction approaches that promote community safety and health. **Stakeholders also identified that the gaps in the existing crisis response system are because the crisis response system was designed around the stigma and criminalization of these experiences rather than designed to provide care and promote well-being.**

[27] In 2019, Berkeley passed a resolution calling on the Governor to declare homelessness a state of emergency. https://www.cityofberkeley.info/Clerk/City_Council/2019/02_Feb/Documents/2019-02-19_Item_10_Declaring_a_California_Homelessness.aspx

Additional Perspectives from the SCU Survey

"As with every other part of the United States, we too are dealing with a rather poorly run medical care delivery system. We are also dealing with the war on drugs which is a total failure and has criminalized for too many people for a drug related problem, which is a public health issue and should never have been a criminal justice issue."

"Honestly we need more than just mental health crisis teams. We need a holistic approach. One that considers not just the crisis but also everything before. We need to address the underlying cause - child abuse, domestic violence, individualism and lack of community."

"The system is overwhelmed. It has been extraordinarily difficult to link clients to shelter or mental health consistently in Berkeley. The problems that most clients suffering from mental illness in the region face are primarily systemic in nature, and there is an extreme lack of resources available in the way of permanent housing, shelter, or frontline community mental health services. Furthermore, for clients who are low-income, learning disabled or struggle with executive functioning, or homeless, engaging in the kind of time-intensive, linear, multi-step bureaucratic processes necessary to enter into the shelter and mental health systems is often all but impossible without intensive agency advocacy and persistency. Homeless clients in particular struggle with agency-based barriers to care, often move between counties and municipalities, lack targeted outreach, and experience outreach primarily as criminalization, a tragedy given that cost of living, region-wide housing shortages, and past failures of criminal justice policy are disproportionately responsible for endemic homelessness in the Bay Area."

"Firstly, funding priorities need to shift. We need to address the root causes of mental illness, substance use, and homelessness - trauma, often created or exacerbated by decades of failed criminal justice policy and lack of investment in community infrastructure and social services, criminalization of drug users as opposed to investment in substance use counseling and harm reduction programs, and the legacy of a suburbanized and disjointed approach to regional housing policy and governance. We need to shift funding priorities in Berkeley and the region towards funding social services, especially mental health and substance use rehabilitation, education, parks and transit infrastructure, and encourage policies that protect renters and the working poor, especially families. We need to not only shift towards social workers and mental health responders as the primary agents in engagement with clients suffering from mental illness, and not only increase homeless outreach - we also need to acknowledge the history of homeless-led political engagement in Berkeley and the region, and employ a model that politically values the voices of homeless clients themselves…"

Stakeholder-identified opportunities for centering BIPOC communities in crisis response

Stakeholders emphasized that people of color, particularly Black or African American people, are most often harmed by police. They also named that in Berkeley, the structures that put people at risk of homelessness disproportionately affect Black residents, which results in Black Berkeley residents disproportionately experiencing homelessness.[28]

Some service providers also shared incidences of racial bias and discrimination by BPD against their Black clients. For example, at a CBO provider of non-emergency services, case managers reported calling 911 because MCT was closed; the case managers reportedly gave specific instructions that a young White woman was threatening staff and refusing to leave the premises. Yet, upon arrival, BPD harassed and threatened to arrest a Black client.

Black service utilizers and service providers alike elevated their own experiences navigating systems with entrenched racism, including interactions with police and medical facilities. For example, one Black clinician shared the important and unique ways that Black personnel promote a sense of safety, security, and trust for Black service utilizers. The provider shared that the comfort and reassurance of a shared identity increases the opportunities to be more honest, especially during medical or mental health crises.

Stakeholders shared that reducing contact between police and Black residents, especially Black unsheltered residents, is important to public safety. Stakeholders also shared that Black residents and other community members of color should provide input and feedback as an SCU is designed and implemented in Berkeley.

Additional Perspectives from the SCU Survey

"less arrests and escalation by police, I worry because the homeless population is mostly African American."

"…The proportion of folks who are Black among those homeless in Berkeley is much higher than the general population. We know that police interacting with POC is a dynamic that all too often leads to harm."

[28] City of Berkeley. (2019). *City of Berkeley Homeless Count & Survey – Comprehensive Report.* Retrieved October 11, 2021, from https://everyonehome.org/wp-content/uploads/2019/09/2019HIRDReport_Berkeley_2019-Final.pdf

Stakeholder-identified opportunities for community oversight to ensure equitable and transformative crisis care

Due to system distrust and the current climate around Berkeley's Reimagining Public Safety efforts, **stakeholders expressed a desire and need for ongoing community input and oversight of crisis response, especially by those most impacted by crisis services**.

Stakeholders suggested leveraging the Mental Health Commission, which they feel is currently underutilized. They also expressed the importance of ensuring that engagement and oversight opportunities are accessible for the most structurally marginalized residents and residents utilizing SCU and crisis response services.

Additional Perspectives from the SCU Survey

"Crisis response that reaches out to the community to ask what they want; particularly communities of color, and enlist this community in the creation of the programs…"

Thoughtful, constructive ways for integration and engagement of the challenged community with the community of Berkeley residents and workers."

Appendices

Appendix A. Sample Interview Guide

CBO Staff Focus Group Guide

Focus Group Details

Date	
Facilitator	
Community groups in attendance	

Overview

[Introduce facilitator and notetaker]

We are gathering information about mental health and substance use crisis response in the City of Berkeley, including by contacting (211, 911, BMH crisis triage line, etc.) and who responded (if at all): social workers, medics/EMT, fire and/or police in our city. We are interested in hearing specifically about your experiences, and/or your perceptions of, mental health and substance use crisis response in the City of Berkeley. We are gathering this information to inform the development of a Specialized Care Unit (SCU) for the City of Berkeley as a non-police crisis response to mental health and substance use calls.

At the end of the discussion, if you feel like you didn't get to share something, or you think of something else you want to share later, feel free to visit our website for additional ways to provide feedback. https://sites.google.com/rdaconsulting.com/city-of-berkeley-scu/

This focus group will last approximately 90 minutes. If possible, please leave your video on and keep yourself muted when you are not speaking. You may respond to our questions verbally or in the chat, whichever you prefer.

Our goal for today is to understand your experiences as providers and advocates and do not expect you to share private details of your clients' experiences. Your own responses will be kept confidential and will be de-identified in any report back to the City of Berkeley.

We understand that some experiences with the current crisis response may have been harmful to you and/or your clients; if you would like to take a break or leave the focus group, please do so at any time.

Does anyone have any questions before we begin?

Questions

Warm-up

To get us started, we would like to do some introductions.

1. Please introduce yourself to the group by sharing your name, group or organization you are representing, your role, how long you've been there, and a word or phrase that comes to mind when you think about "mental health and substance use crisis services".

Experience with and perceptions of mental health and substance use crisis response

Now I would like to ask you some questions about your experience with and perceptions of the mental health and substance use crisis response options in the City of Berkeley.

2. What do you know about the existing mental health and substance use crisis response options in the City of Berkeley?
    a. What kinds of crises do these services respond to?
    b. What is missing?
3. How do the services your organization or program provides intersect with mental health and substance use related crisis services?
4. Are individuals referred to your program after experiencing a mental health or substance use related crisis?
    a. If so, what services do you typically provide
    b. How are those clients connected to your program?
5. Where would your clients go/who would they call if they were experiencing a mental health or substance use related crisis?
    a. If, as a provider, a client was experiencing a mental health or substance use related crisis is there a program that you would call for support?
        i. If so, who would you call? How do you decide who to call?
        ii. How effective has the response been?
        iii. Please share an example of a situation where you needed to contact someone to support a mental health or substance use related crisis for a client.
            1. Do you feel that the service was helpful? If so, how?
            2. If not, what could have been done differently?
6. Do you feel comfortable/safe calling for support from the existing mental health or substance use related crisis service options? Why or why not?
    a. Do you feel that the existing mental health or substance use related crisis response options are helpful to clients? Why or why not?
7. Are there times that you have chosen not to call for mental health or substance use related crisis response services? Why or why not?
    a. What did you do instead?
    b. What might have made you feel more comfortable calling for support when a client was experiencing a mental health or substance use related crisis?
8. What do you feel that your clients typically need when they are experiencing a mental health or substance use related crisis?
    a. Where might you refer a client if your program or organization can't provide the help they need during a mental health or substance use related crisis?
9. Are there local organizations or groups that you collaborate with that are maybe not considered part of the "system"?
    a. If so, who are they and what kinds of support do they provide?
        i. Do you think they would want to talk with us? *[if yes, get contact info for follow up]*

Strengths and challenges of the current mental health or substance use related crisis response options

In this section we will be discussing what the system is doing well and what the system is not doing so well.

10. In your opinion, what are some of the strengths of the current mental health or substance use related crisis response options?
    a. If your clients have experienced a mental health or substance use related crisis, were they able to get help? How so?

11. In your opinion, what are some of the weaknesses of the current mental health or substance use related crisis response options?
    a. Why do you think things aren't working?
    b. Do you think mental health or substance use related crisis response services are difficult for your clients to access? How so?
    c. What are some of the gaps related to mental health or substance use related crisis response options?

12. Do you feel that some people are served better than others by the current crisis system?
    a. If so, who is left out?
    b. Are people treated differently based on their race, gender, culture, sexuality, or disability? If so, how?

Ideas for alternative model

In this section I'm now going to ask you for your ideas for an ideal response for someone experiencing a mental health or substance use related crisis.

13. What would an ideal mental health or substance use related crisis response look like for you and the people you serve?
    a. What kind of response would best meet the needs of your clients?
    b. What would make it more likely for you to reach out to a crisis team for support?
    c. What would make it less likely for you to reach out?
    d. Who should, and should not, be involved in a mental health or substance use related crisis response? (i.e., Police, EMT, clinicians, peers, social workers, others?)
    e. What do you consider to be essential features of an effective mental health or substance use related crisis response that is responsive to, and respectful of, the clients you serve?

14. What do you feel needs to be included in a new mental health or substance use related crisis response for you to feel safe calling for or providing those services?

Wrap up

We are hoping to talk to people one on one who are less likely to attend a focus group, but who have lived experience and would like to provide feedback on the development of a Specialized Care Unit. We are asking you to think about the people your program serves and consider if there are individuals who might want to share their experience with us in an interview either in person or over the phone.

15. What do you think are the best ways to engage your clients in this process?
    a. How can we make sure that everyone's voice is heard?
    b. Who is the best person to interview them?

c. Would they be comfortable talking with someone from RDA or is there another person who might be more suited to talk with them?
d. [Note contact information for follow up if applicable]

16. Is there anything else that you didn't get to share today that is important for us to know?

Closing

Thank you for your participation. We genuinely appreciate the time you took to speak with us today. We will be conducting interviews with other organizations and community members over the next few months and compiling a report based on the feedback, which will be shared with you and the community. If you would like to share any additional information with the City of Berkeley, feel free to visit https://sites.google.com/rda consulting.com/city-of-berkeley-scu/.

Appendix B. Demographics of Community Engagement Participants

As a reference point, it is important to understand the demographics of the Berkeley population. Table 1 below shows the demographics of Berkeley's overall city population (in July 2019) and the Medi-Cal recipient population (FY 2019-2020). Medi-Cal population demographics are included because the majority of City of Berkeley ongoing funded mental health services are restricted to this population, due to funding requirements. Relative to Berkeley's overall population, Black or African American residents are overrepresented in the City's Medi-Cal population, while Whites and Asians are underrepresented.

Table 1. Berkeley Population and Medi-Cal Recipient Demographics (2019)

	City Population (July 2019)[29]	Medi-Cal Recipients (FY 2019-2020)
Population Size	121,363	18,548
Race Ethnicity (%)		
White	53.3%	26%
Black/African American	7.9%	22%
Hispanic/Latino	11.4%	12%
Asian/Pacific Islander	21.5%	10%
American Indian/Alaska Native	0.5%	0%
Other (including 2+ races)	7.5%	33%
Gender (%)		
Female	50.5%	51%
Male	49.5%	49%

In the charts shown below, "provider participants" are those who were interviewed by RDA as part of CBO interviews and focus groups. "Service utilizer participants" are clients of CBOs or encampment residents who were interviewed by RDA. And "survey participants" are individuals who responded to RDA's online survey; these respondents could be a mix of providers, servicer utilizers, and/or other Berkeley residents or stakeholders.

[29] United States Census Bureau. (2019). *QuickFacts – Berkeley city, California*. https://www.census.gov/quickfacts/berkeleycitycalifornia

Figure 1 below shows the age distribution of the individuals that participated in this process. Overall, RDA received information from more people in the 30-44 range (39%) than any other age range.

Figure 1. Participants by age (n = 122 individuals)

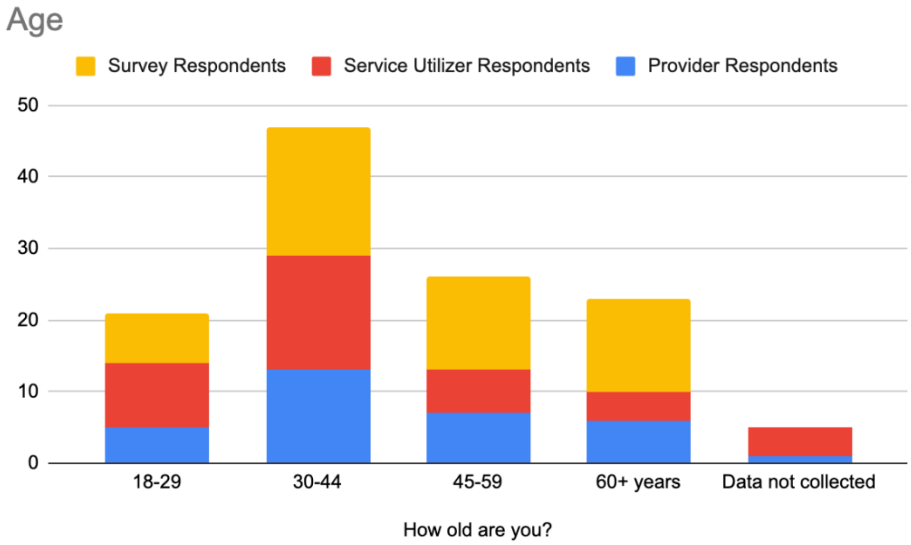


Figure 2 below shows the racial and ethnic distribution of participants in RDA's data collection.[30] Participants were asked to note all races/ethnicities that they identified with, so these are duplicated counts; for this reason, specific percentages should not be interpreted from this data. A large proportion of participants were white, especially among the survey respondents who participated. Most of the Black or African American participants contributed their perspectives via RDA's in-person focus groups or interviews. As compared to Berkeley's overall population, service utilizers and providers who identified as Black or African American were overrepresented in RDA's data collection efforts, (see Table 1).

[30] 13 participants selected more than one racial or ethnic identity, so these numbers are duplicated. For example, if a participant selected White and Black or African American, they are counted in both the White and African American categories.

Figure 2. Participants by race/ethnicity (n = 122 individuals)

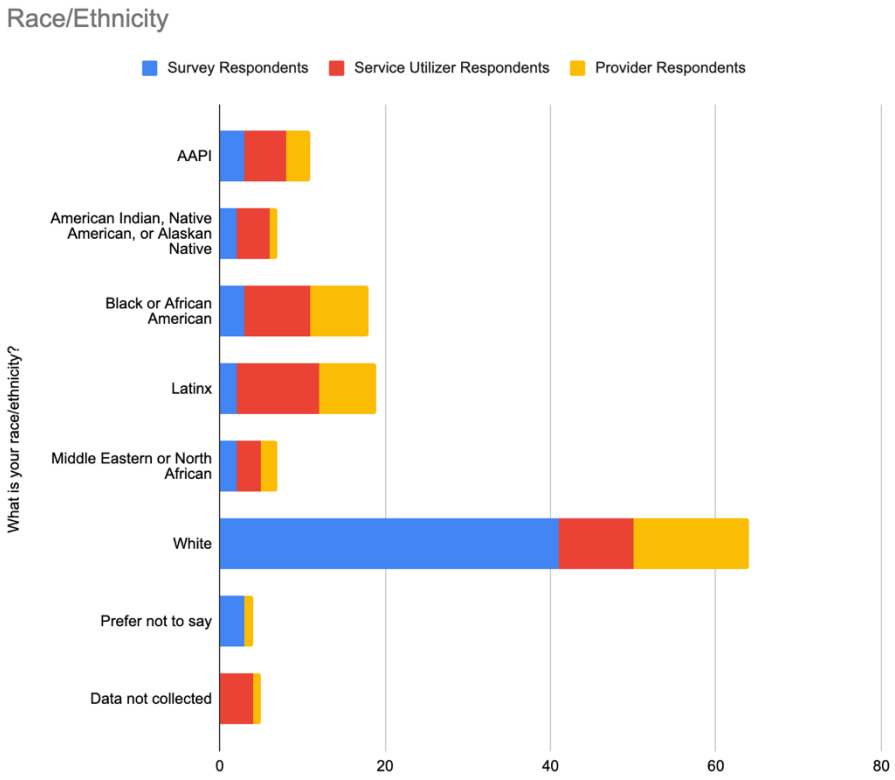


Figure 3 below shows the number of transgender and cisgender participants of RDA's data collection. Overall, there were far more cisgender participants than transgender participants. However, a higher proportion of service utilizer respondents (13%) were transgender, while less than 4% of survey respondents and 3% of provider respondents were transgender.

Figure 3. Participants by transgender/cisgender (n = 122 individuals)

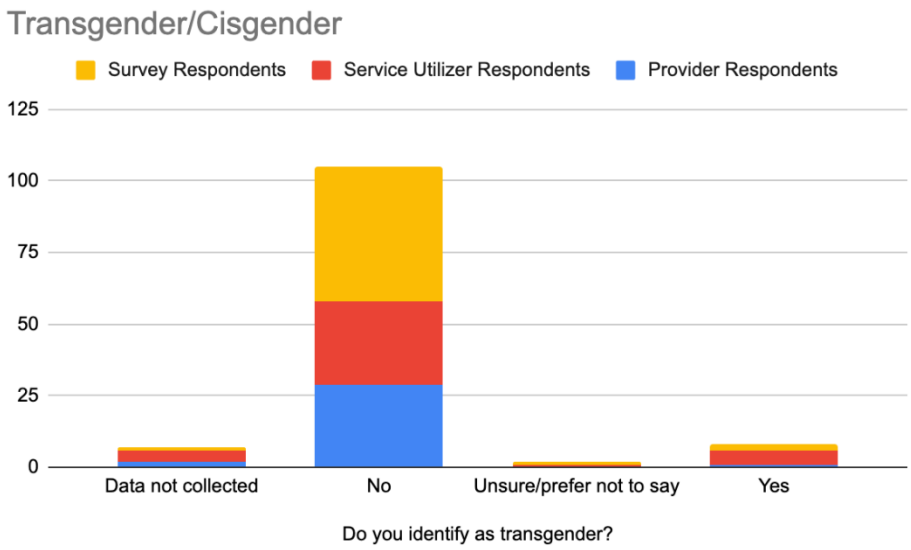


Figure 4 below shows the gender identity distribution of participants to RDA's data collection. RDA collected feedback from more than double the number of female-identifying participants (72) than male identifying participants (31). There was an even distribution among service utilizer respondents (41% female and 41% male) compared to survey respondents (67% female vs. 20% male) and provider respondents (69% female, 16% male). Overall, there were very few genderqueer or nonbinary participants (<1% and 6% respectively).

Figure 4. Participants by gender identity (n = 122 individuals)

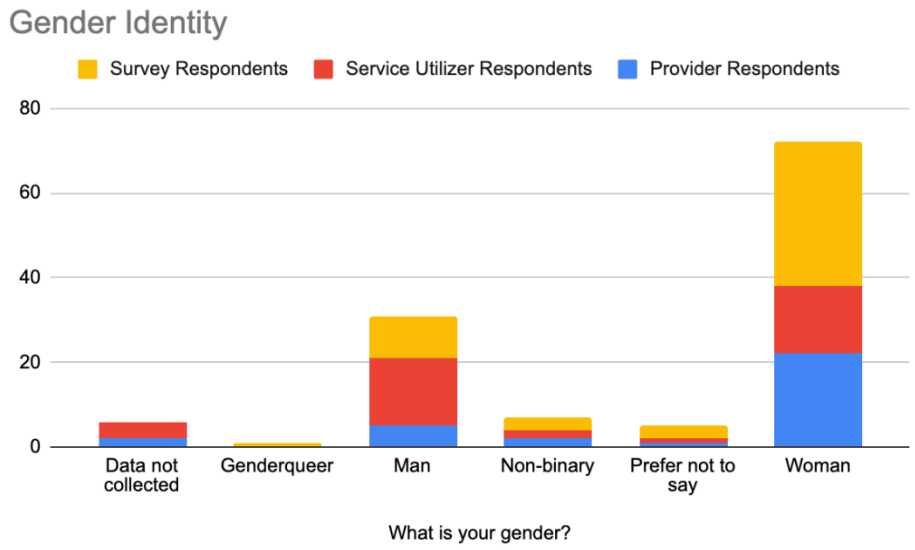


Figure 5 below shows the sexual orientation of participants of RDA's collection. Over one third (35%) of participants identified as heterosexual or straight, while over one fourth (28%) identified as LGBTQ+. The remaining participants did not share their sexual orientation or it was not asked of them. Over half of survey respondents (57%) identified as straight, while only 31% of provider respondents and 10% of service utilizer respondents identified as straight.

Figure 5. Participants by gender identity (n = 122 individuals)

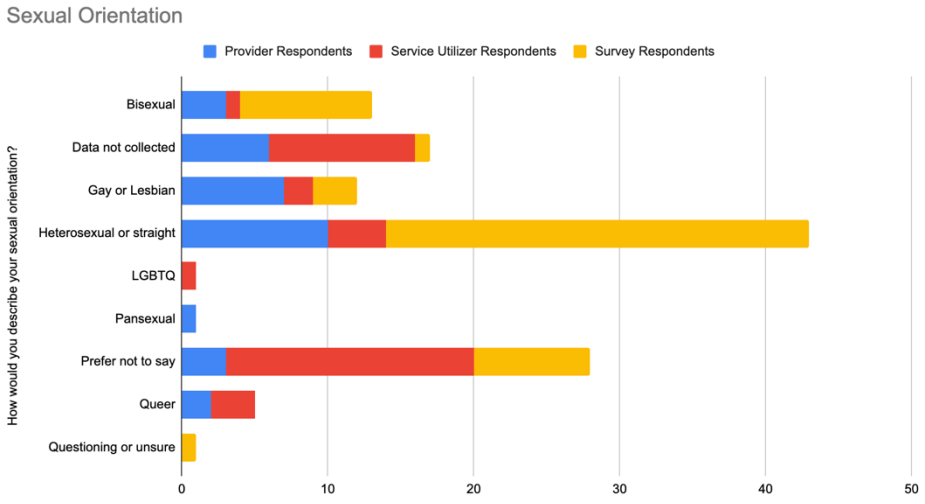
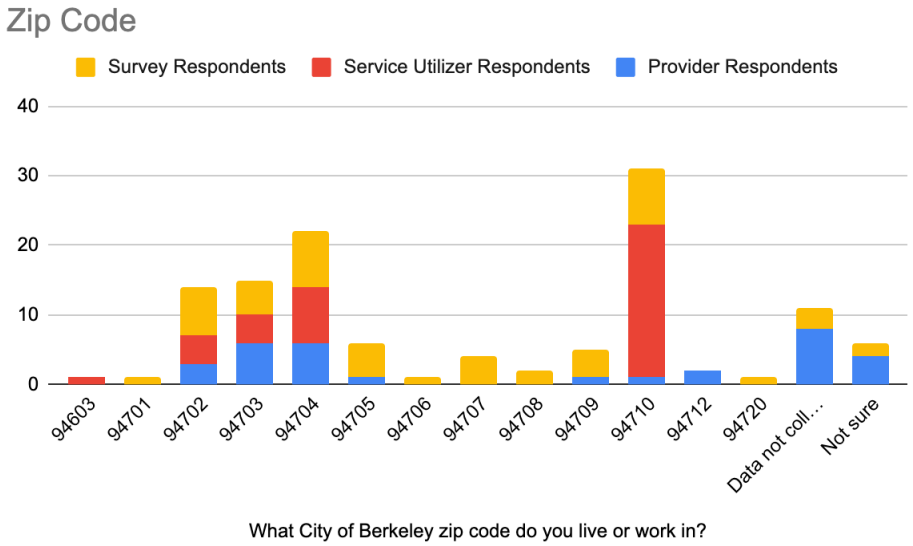
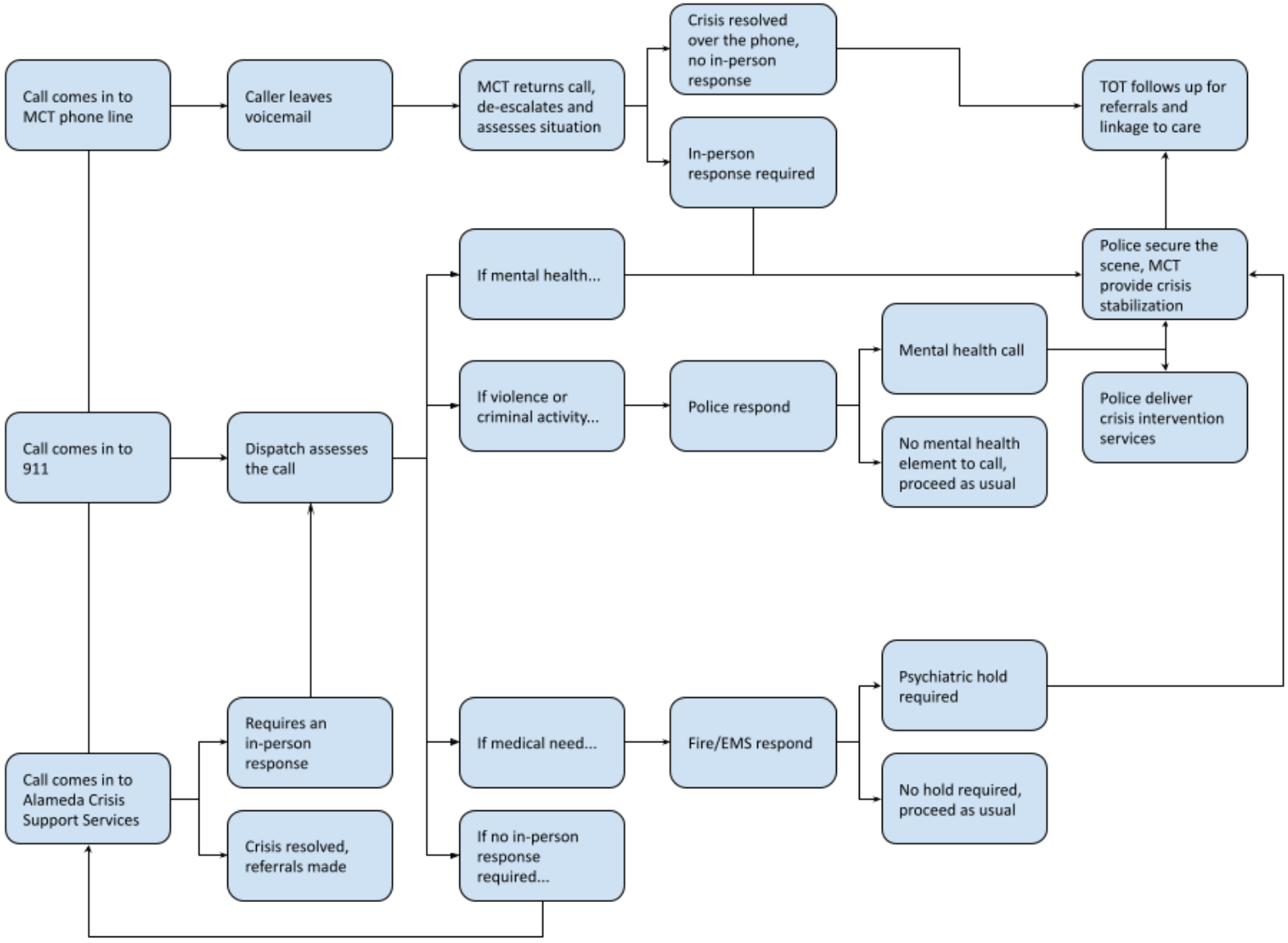


Figure 6 below shows the geographical distribution of participants of RDA's data collection. The most common zip code of participants was 94710 (25%), in large part due to the number of Seabreeze encampment residents that participated in this process. Closely following were the Berkeley ZIP codes of 94702, 94703, and 94704 with 11%, 12%, and 18% of participants, respectively.

Figure 6. Participants by ZIP code (n = 122 individuals)



Appendix C. Process of a Mental Health Call



Appendix D. Mental Health Call Responses – Call Volume and Demographics

Data Collection Methods and Challenges

Early on in this project, RDA submitted requests to Berkeley Mental Health's Mobile Crisis Team (MCT) and the Berkeley Fire Department (BFD) to receive data on responses to all mental health related calls. MCT shared basic service-level data of their responses for FYs 2015-2020. BFD shared data from BFD and Falck (the city's contracted ambulance services provider for mental health crises) that was limited to responses to 5150 calls in Berkeley between calendar years 2019-2021.

RDA did not submit a data request to the Berkeley Police Department (BPD) for two reasons. First, from another evaluation project that RDA currently has with the Berkeley Mental Health Division, RDA already had basic service-level data from BPD regarding their responses to calls originating for 5150s, for the period of CYs 2014-2020. Second, in April 2021, the Berkeley City Auditor released a comprehensive report on its extremely in-depth data analysis of BPD's responses. For the purposes of RDA's project regarding the Specialized Care Unit (SCU), there was no need to replicate any of the work and findings that came from the Berkeley City Auditor. Please see the Berkeley City Auditor's report for a detailed description of its methods, findings, data limitations, and data recommendations for BPD.[31] The findings that are shared in this report from the Berkeley City Auditor's study are extrapolated directly from the data about BPD calls (from CYs 2015-2019) that was included in the Auditor's report.

In general, RDA's analysis of MCT, BFD, Falck, and BPD call data yielded high-level summary plots about subject/patient demographics and call volume. The general limitations of all available data prevented a more in-depth analysis of the data. More detailed tabular findings are not shared in this report for two reasons: 1) given that all of the quantitative data are under representations of the true volume of crisis responses and callers in Berkeley, only the trends about the volume of mental health related calls and caller demographics should be interpreted from this data, not the specific numbers; and 2) in order to protect the privacy of the few individuals who populated some of the specific categorizations of this data, RDA cannot disclose data which includes small sample sizes.

There were limitations to the quantitative datasets that RDA received. Of greatest impact is that the data entry practices across each agency were not consistent with each other, thus limiting which data could be pulled for analysis as well as which findings could be compared between agencies. For example, due to data limitations, RDA was unable to present a total call volume across agencies or the unmet need for mental health intervention during 5150 transport. Though estimates on call volume and unmet need are relevant to understanding crisis response options, inconsistent data collection and reporting across agencies would make this calculation inaccurate and misleading.

[31] Berkeley City Auditor. (2021, July 2). *Data Analysis of the City of Berkeley's Police Response*. **https://www.cityofberkeley.info/uploadedFiles/Auditor/Level_3_-_General/Data%20Analysis%20of%20the%20City%20of%20Berkeley's%20Police%20Response.pdf**

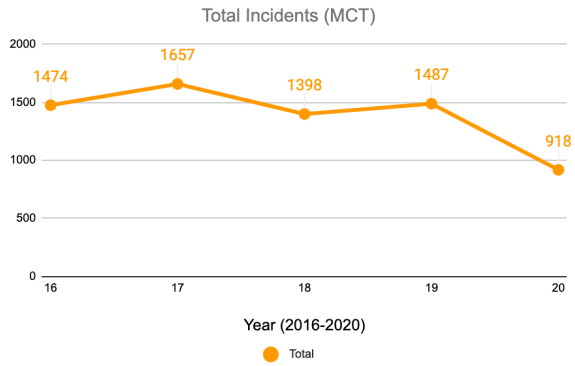
The data challenges that RDA encountered were very similar to those faced by the Berkeley City Auditor; please refer to the Berkeley City Auditor's report of its findings of Berkeley's Police Response for a thorough description of their data challenges.[32]

Mental Health Call Volume

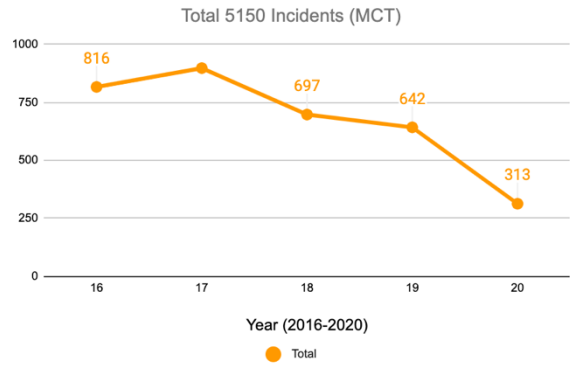
Mobile Crisis Team: From the call data that MCT shared with RDA, findings are limited to only showing the total volume of calls that MCT responded to during 2015-2020. Due to missing data and data elements across the various years, there were not any consistent elements for which findings could be determined over the full five-year period. Figure 7 below shows the volume of MCT's total incidents and which of those incidents resulted in a 5150 for each year between 2015-2020.

Figure 7. Mobile Crisis Team (MCT) Incidents in 2015-2020 - Total

Total Incidents



5150s Only

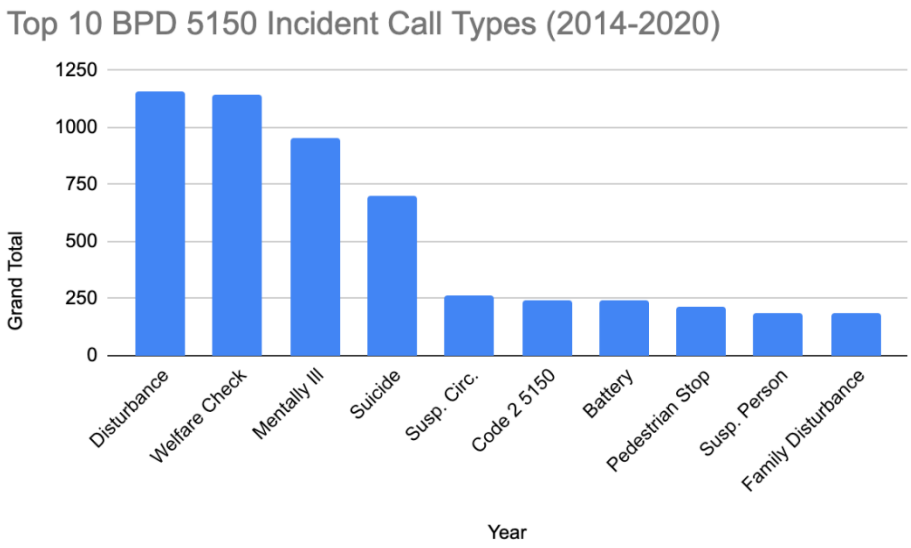


Since 2015, there has been a gradual decline in the number of total and 5150 incidents that MCT responded to in Berkeley due to staff vacancies as well as the COVID-19 pandemic.

Berkeley Police Department: For the period of 2014-2020, RDA received data from BPD that included all calls initially coded by BPD as needing a 5150 response. This was the only type of designation that could be queried in BPD's data for mental health related calls. From this dataset, RDA identified the variety of other types of incidents that were coded alongside "5150" for each call. Figure 8 below shows the top ten incident types for all the 5150 calls that BPD responded to in 2014-2020.

Figure 8. Top 10 Berkeley Police Department (BPD) 5150 Incident Call Types, 2014-2020

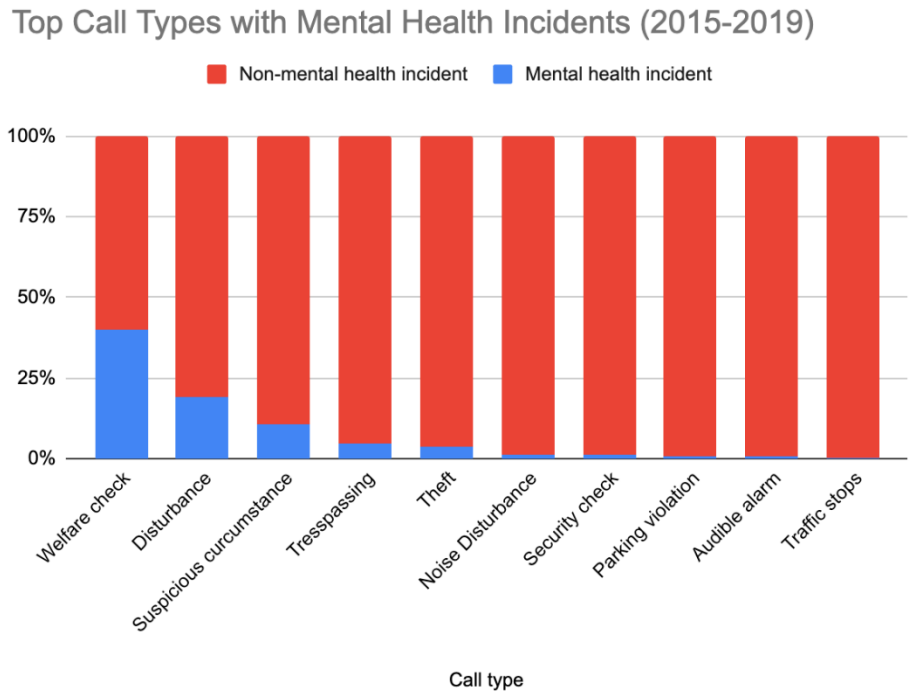
[32] Berkeley City Auditor. (2021, July 2). *Data Analysis of the City of Berkeley's Police Response*. https://www.cityofberkeley.info/uploadedFiles/Auditor/Level_3_-_General/Data%20Analysis%20of%20the%20City%20of%20Berkeley's%20Police%20Response.pdf



Disturbance, welfare check, mentally ill, and suicide were the most frequent incident types of all 5150 calls to BPD.

The Berkeley City Auditor conducted a qualitative analysis of its BPD call response data to explore the differences between calls that were or were not mental health related. Because BPD's data does not have an explicit variable that denotes whether each call is mental health related or not, the Berkeley City Auditor did a keyword search for mental health related terms in the open narrative fields of BPD's call entries. Figure 9 below shows the differences in mental health related and non-mental health related calls that BPD responded to between 2015-2019, stratified by call type.

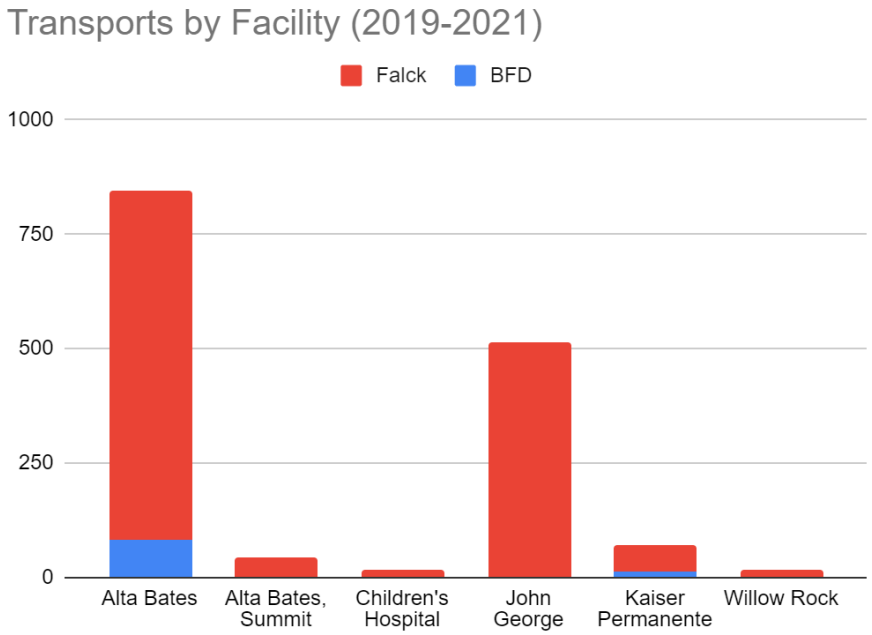
Figure 9. Berkeley Police Department (BPD) Call Types, 2015-2019



Around 40% of BPD's welfare check calls included a mental health related facet to the response, followed by around 20% of disturbance calls, and around 10% of calls regarding suspicious circumstances.

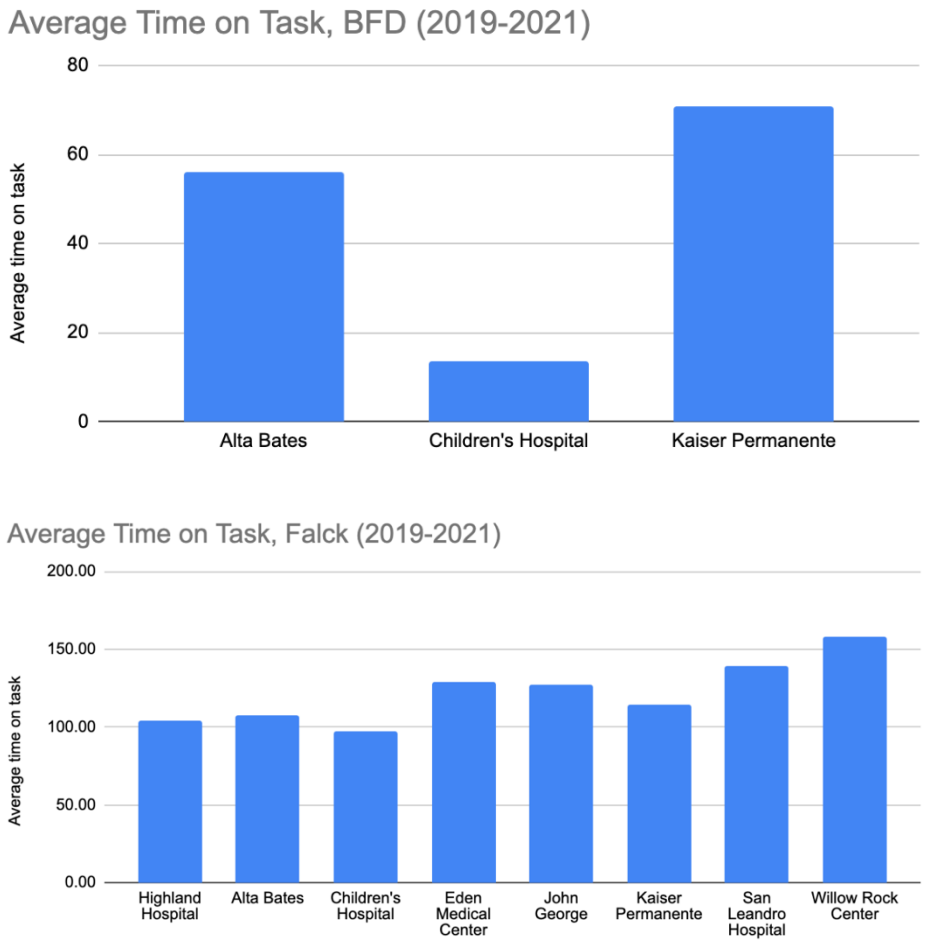
Berkeley Fire Department: The data that BFD shared with RDA (which included data from BFD and Falck) included information on the facilities that BFD and Falck transported 5150 cases to between 2019-2021. Falck conducted the large majority of 5150 transports in Berkeley. Most 5150 transports were to Alta Bates Medical Center and John George Psychiatric Emergency Services. BFD only transported 5150 cases to Alta Bates, Oakland Children's Hospital, and Kaiser. As contracted, Falck conducted 5150 transports to all the agencies noted below.

Figure 10. BFD and Falck 5150 Transports by Destination, 2019-2021



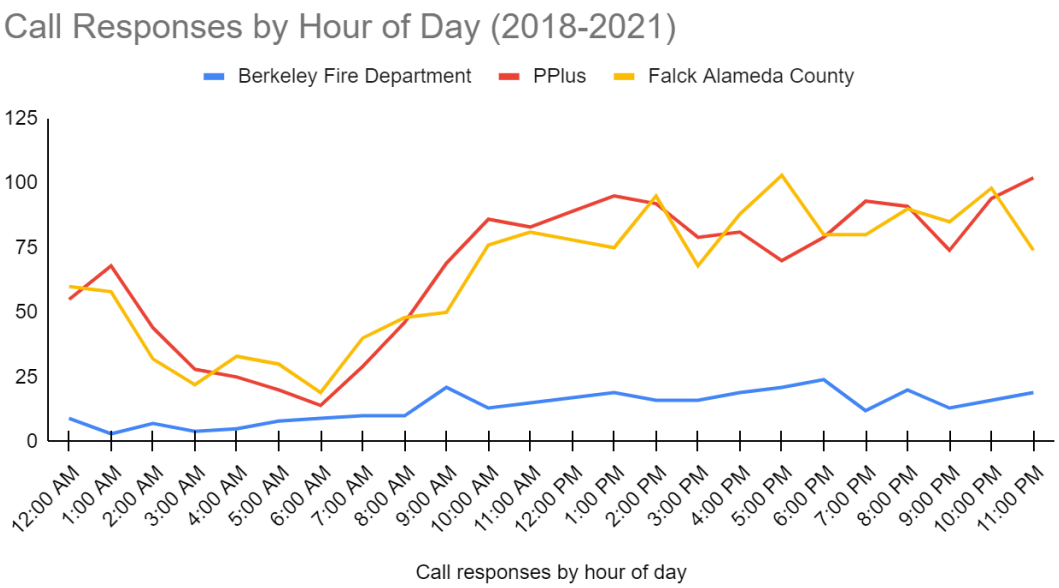
BFD also shared data regarding their and Falck's time on task for each 5150 response and transport. Time on task represents the time from which BFD or Falck arrive at the scene to the point in which they complete the transport of the patient to the destination. Of the 95 5150 transports that BFD conducted between 2019-2021, BFD's average time on task was 20 minutes. Of the 1,523 5150 transports that Falck conducted between 2019-2021, Falck's average time on task was 115 minutes. This is because Falck is the designated ambulance provider who is transporting 5150 cases around Alameda County. These calls can take more time and can be to farther locations. Figure 11 below shows the average time on tasks for BFD and Falck.

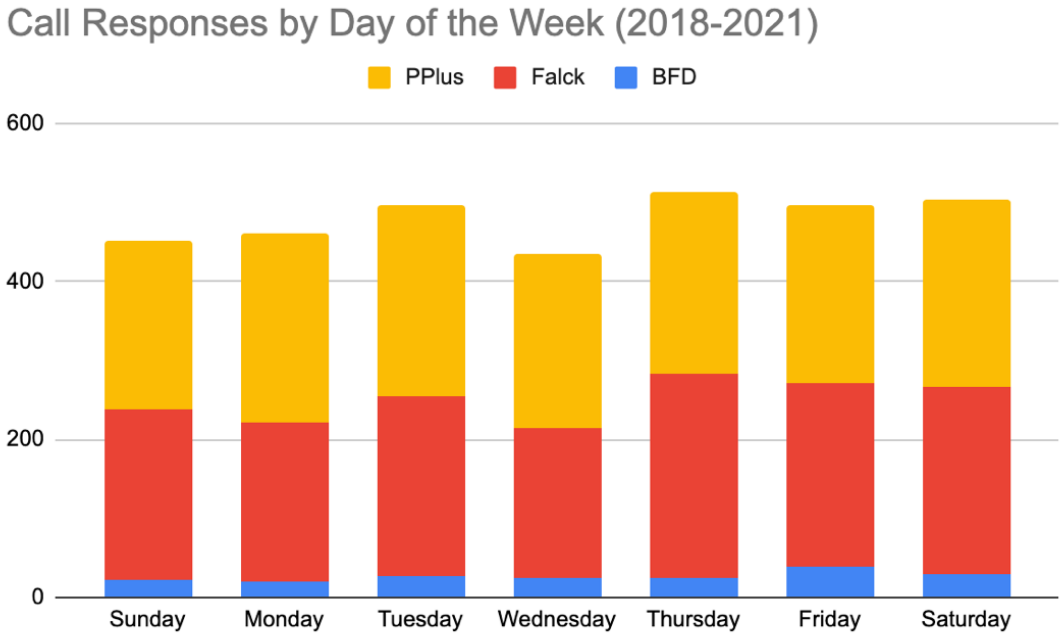
Figure 11. BFD and Falck Time on Task for 5150 Transports, 2019-2021



BFD, Paramedics Plus (or PPlus, the contracted ambulance provider prior to Falck), and Falck's data on their 5150 call responses also included information on the day of the week and time that each 5150 call was initiated. RDA analyzed this data to search for any notable trends regarding when 5150 calls originate. Figure 12 below shows when each agency's 5150 call responses occurred; this data spans the years 2018-2021. From this data, it appears that 5150s are least frequent during the very late-night and early-morning hours (2:00-8:00am), and the most frequent between 10:00am – midnight. There is no noticeable difference in the frequency of 5150s across the seven days of the week.

Figure 12. BFD, PPlus, Falck 5150 Transports by Time of Day and Day of Week, 2018-2021



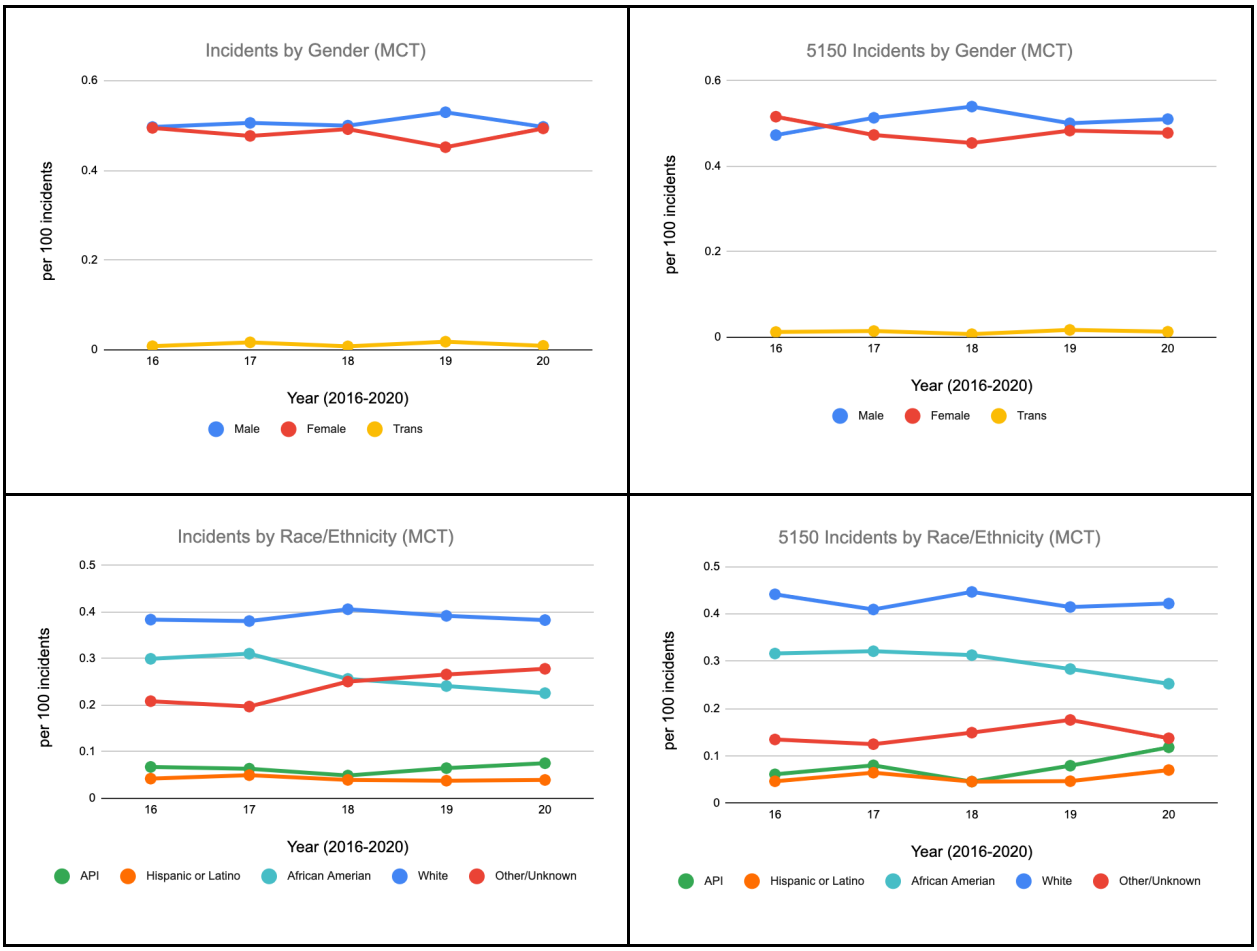


Demographics of Mental Health Call Responses

Mobile Crisis Team: For the five-year period of FY 15/16 through FY 19/20, the Berkeley Mental Health Division's Mobile Crisis Team (MCT) shared data about both their overall volume of responses as well as those pertaining specifically to 5150 calls. Figure 13 below includes four figures that show MCT's incidents by gender (first row), and then incidents by race/ethnicity (second row) by each fiscal year.

Figure 13. Mobile Crisis Team (MCT) Incidents in 2015-2020 - Gender, Race/Ethnicity

Total Incidents	5150s Only



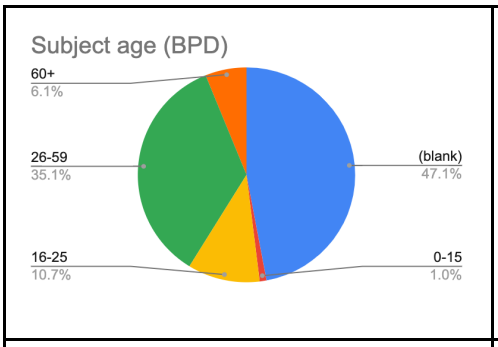
MCT incidents were with slightly more males than females, and very few trans individuals. And, regarding race/ethnicity, MCT cases were most often White, followed by African American, other/unknown, Asian Pacific Islander, and Hispanic or Latino. Given that African Americans comprise only 7.9% of Berkeley's population (see Table 1), they are very overrepresented in MCT's service utilizer population.

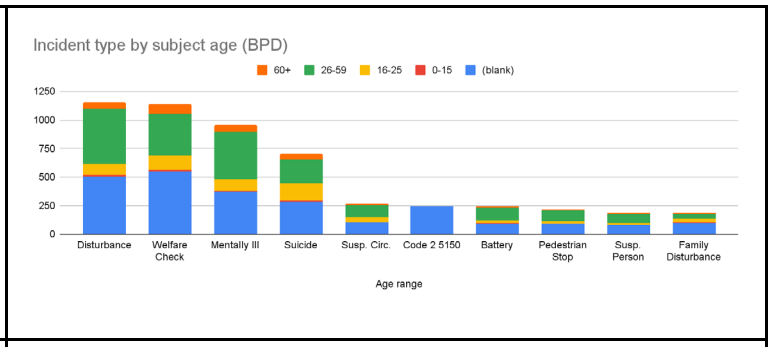
Berkeley Police Department: For the six-year period of CY 2014 through CY 2020, the Berkeley Police Department (BPD) shared data regarding demographics (age, race, and sex) for each of its calls that were originated as designated 5150 responses. Since 2019, the majority of 5150 responses were conducted by Falck - an ambulance services provider contracted by BFD - because Falck is the designated entity (between the two agencies) to conduct 5150 transports in Berkeley. Figure 14 below includes six figures that show: 1) the summative demographics of BFD's 5150 subjects, and 2) the incident types stratified by subject demographics.

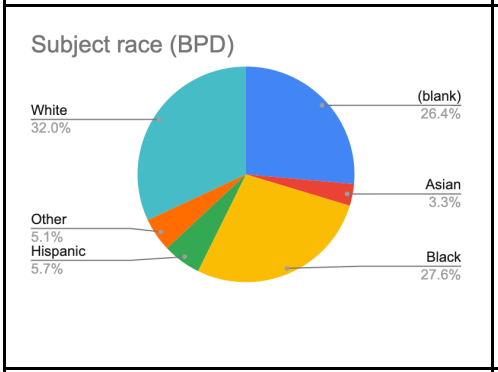
Figure 14. Berkeley Police Department (BPD) 5150 Subjects in 2014-2020 - Demographics and Incident Types[33]

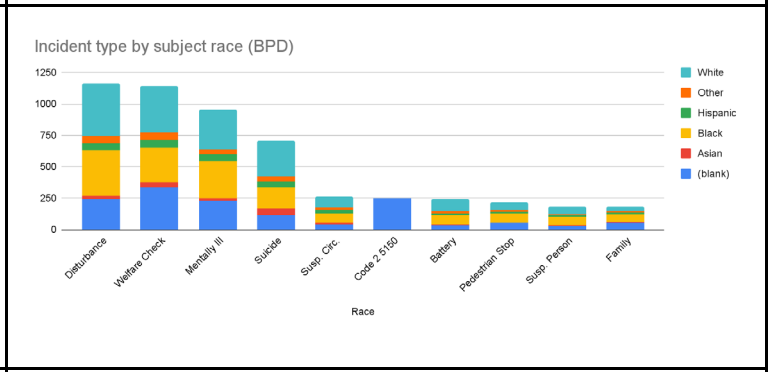
Subjects by Demographics	Incident Types by Demographics

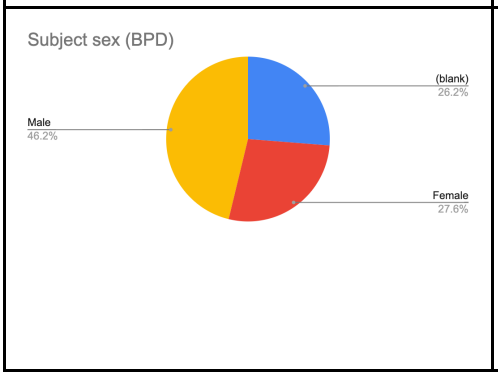
[33] Data noted as (blank) represent data points where data were missing.

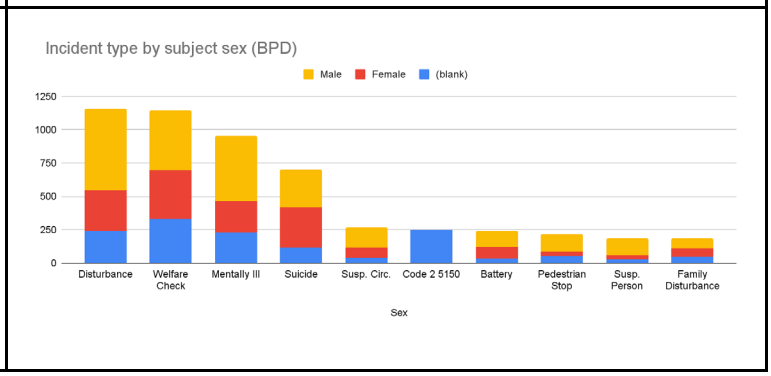










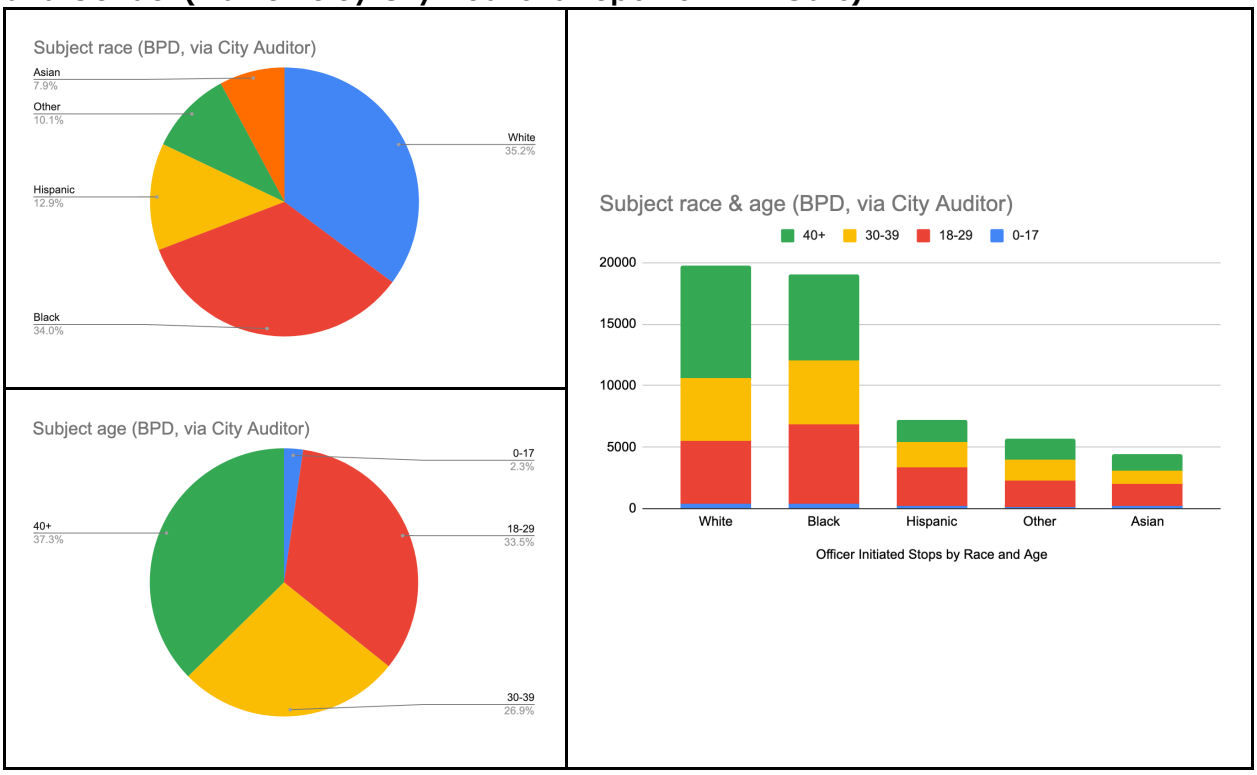


Of the BPD 5150 calls that had demographic variables coded, most responses were with individuals between ages 26-59, White, or male. Liked noted above with MCT's service utilizer population, given that African Americans comprise only 7.9% of Berkeley's population (see Table 1), they are also very overrepresented amongst BPD's 5150 population. Most BPD 5150 calls were also coded as disturbance calls, welfare checks, mentally ill individuals, and suicide. Each incident type is not mutually exclusive, so any particular incident could have one or multiple more incident type logged towards it in addition to being a 5150.

The Berkeley City Auditor's report (released in April 2021) on BPD call responses included a variety of tables with data on the demographics of the subjects of their officer-initiated stops by race and age; please refer to the Berkeley City Auditor's Report in Figure 19: Officer-Initiated Stops by Race and Age, 2015-2019.[34] RDA took the data shared in that figure to produce different visual representations of all subjects that BPD responded to between 2015-2019; this data includes responses to non-mental health related calls, as well.

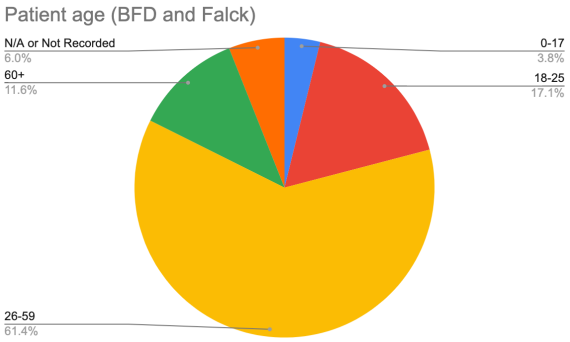
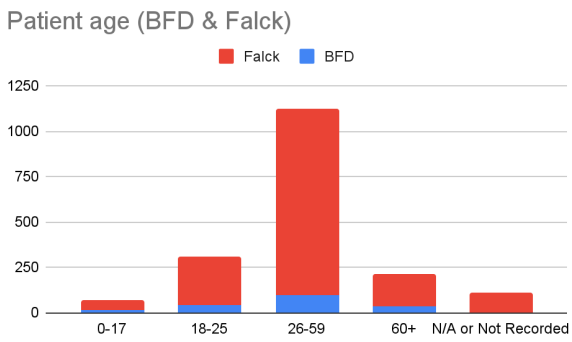
[34] Berkeley City Auditor. (2021, July 2). *Data Analysis of the City of Berkeley's Police Response*. https://www.cityofberkeley.info/uploadedFiles/Auditor/Level_3_-_General/Data%20Analysis%20of%20the%20City%20of%20Berkeley's%20Police%20Response.pdf

Figure 15. Berkeley Police Department (BPD) Officer-Initiated Calls in 2015-2020 - Race and Gender (via Berkeley City Auditor's Report on BPD Calls)



Berkeley Fire Department: For the three-year period of CY 2019 through CY 2021, the Berkeley Fire Department (BFD) shared data regarding demographics (age, race, and gender) and incident type for each of its calls that were originated as designated 5150 responses. Figure 16 below includes six figures that show: 1) the summative and combined demographics of BFD and Falck's 5150 patients, and 2) the differences in volume of BFD and Falck 5150 responses stratified by patient demographics. Figure 17 below shows the total combined 5150 responses by BFD and Falck, first grouped by gender by race, then by race by gender.

Figure 16. Berkeley Fire Department (BFD) and Falck 5150 Patients in 2019-2021 - Demographics

Patients by Demographics	**Transport Agency by Demographics**
	

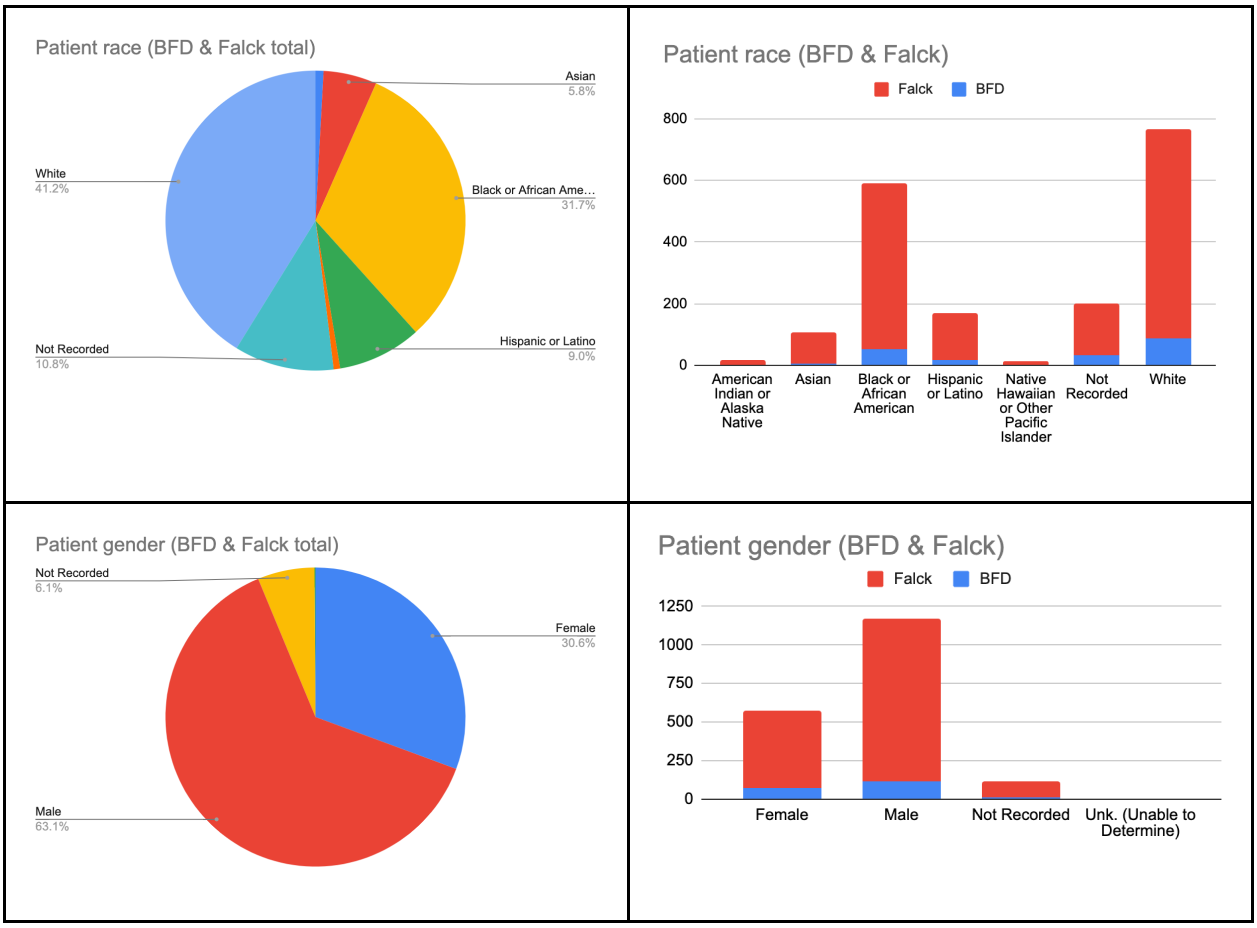
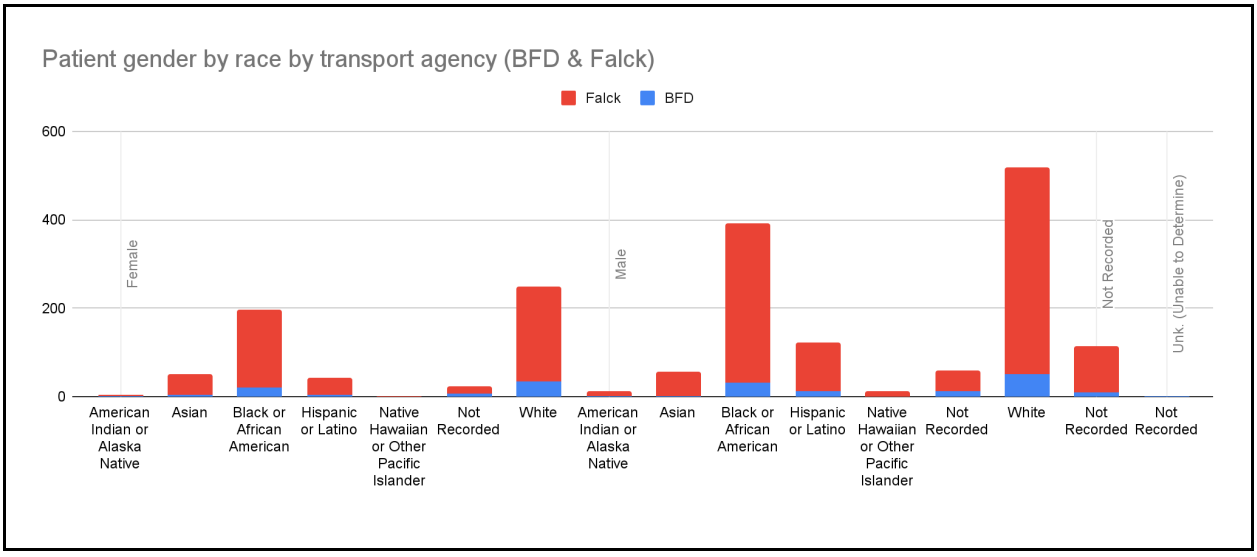
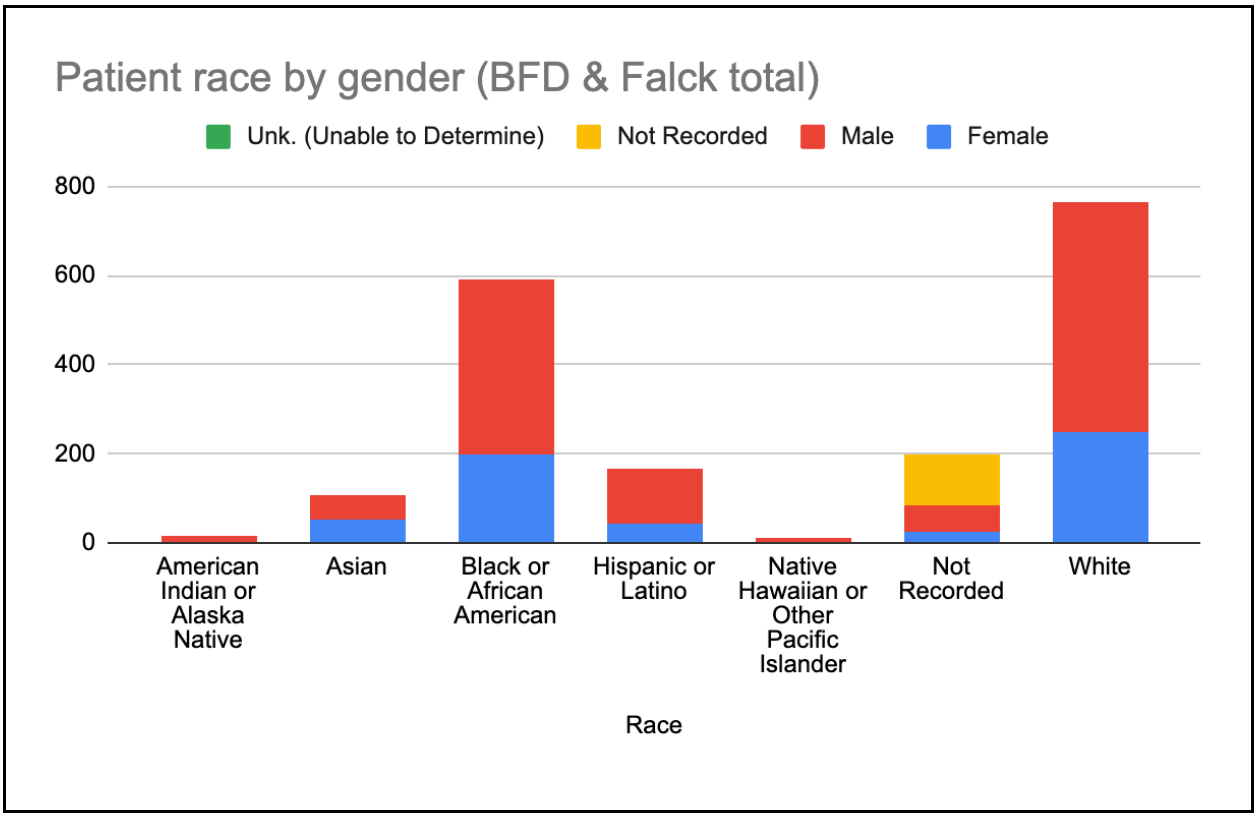


Figure 17. Berkeley Fire Department (BFD) and Falck 5150 Patients in 2019-2021 - By Gender and Race





Similar to the incidents that MCT responded to, the 5150 patients that BFD and Falck responded to are mostly between ages 26-59, White, or male. Falck also conducted a large majority of the 5150 transports in Berkeley, as compared to BFD.

City of Berkeley

Specialized Care Unit

Crisis Response Recommendations

RDA CONSULTING

CITY OF BERKELEY

City of Berkeley

Specialized Care Unit (SCU) Crisis Response Recommendations

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This report was developed by Resource Development Associates under contract with the City of Berkeley.

RDA CONSULTING

CITY OF BERKELEY

Table of Contents

Executive Summary

As part of the larger effort to Reimagine Public Safety, the City of Berkeley contracted with Resource Development Associates (RDA) to conduct a feasibility study for a Specialized Care Unit (SCU), an alternative mental health and substance use crisis response model that does not involve law enforcement.

This is the third of three distinct reports for this effort. The first report ("**Crisis Response Models Report**") presents a summary of crisis response programs in the United States and internationally. The second report ("**Mental Health Crisis Response Services and Stakeholder Perspectives Report**") is the result of engagement with stakeholders of the crisis system, including City of Berkeley and Alameda County agencies, local community-based organizations (CBOs), local community leaders, and utilizers of Berkeley's crisis response services, and presents a summary of key themes to inform the SCU model.

This third report is intended to guide implementation of the SCU model and includes:

- Core components and guiding aims of the SCU model;
- Stakeholder and best practice-driven design recommendations;
- Considerations for planning and implementation;
- A phased implementation approach;
- System-level recommendations; and
- Future design considerations.

Each recommendation put forth in this report is deeply rooted in the stakeholder feedback included in the two previous reports. This report presents RDA's recommendations based on this year-long project, which the City of Berkeley may adapt and adjust as necessary.

Key Recommendations

1. The SCU should respond to mental health crises and substance use emergencies without a police co-response.
2. The SCU should operate 24/7.
3. Staff a three-person SCU mobile team to respond to mental health and substance use emergencies.
4. Equip the SCU mobile team with vans.
5. The SCU mobile team should provide transport to a variety of locations.
6. Equip the SCU mobile team with supplies to meet the array of clients' needs.
7. Clearly distinguish the SCU from MCT.
8. Participate in the Dispatch assessment and planning process to prepare for future integration.
9. Ensure the community has a 24/7 live phone line to access the SCU.
10. Plan for embedding a mental health or behavioral health clinician into Dispatch to support triage and SCU deployment.
11. Fully staff a comprehensive model to ensure the success of the SCU mobile team, including supervisory and administrative support.
12. Operate one SCU mobile team per shift for three 10-hour shifts.
13. SCU staff and Dispatch personnel should travel to alternative crisis programs for in-person observation and training.
14. Prepare the SCU mobile team with training.
15. Contract the SCU model to a CBO.
16. Integrate the SCU into existing data systems.
17. Collect and publish mental health crisis response data publicly on Berkeley's Open Data Portal.
18. Implement care coordination case management meetings for crisis service providers.
19. Implement centralized coordination and leadership across city agencies to support the success of mental health crisis response.
20. Continue the existing SCU Steering Committee as an advisory body.
21. Solicit ongoing community input and feedback.
22. Adopt a rapid monitoring, assessment, and learning process.
23. Conduct a formal annual evaluation.
24. Launch a public awareness campaign to promote community awareness and education about the SCU.
25. The SCU mobile team should conduct outreach and build relationships with potential service utilizers.

Introduction

Project Background

In response to the killing of George Floyd by Minneapolis police in May 2020 and the ensuing protests across the nation for this and many other similar tragedies, a national conversation emerged about how policing can be done differently in local communities. The Berkeley City Council initiated a wide-reaching process to reimagine safety in the City of Berkeley. As part of that process, in July 2020, the Council directed the City Manager to pursue reforms to limit the Berkeley Police Department's (BPD) scope of work to "primarily violent and criminal matters." These reforms included, in part, the development of a Specialized Care Unit (SCU) to respond to mental health crises without the involvement of law enforcement.

In order to inform the development of an SCU, the City of Berkeley contracted with Resource Development Associates (RDA) to conduct a feasibility study that includes community-informed program design recommendations, a phased implementation plan, and funding considerations.

The Need for Specialized Mental Health Crisis Response

Just as a physical health crisis requires treatment from a medical professional, a mental health crisis requires response from a mental health professional. Unfortunately, across the country and in Berkeley, police are typically deployed to respond to mental health and substance use crises.

Without the proper infrastructure and resources in place, cities are unable to adequately meet the needs of people experiencing a mental health and/or substance use crisis. Relying on police officers to respond to the majority of mental health 911 calls endangers the safety and well-being of community members. Tragically, police are 16 times more likely to kill someone with a mental illness compared to those without a mental illness.[1] A November 2016 study published in the American Journal of Preventative Medicine estimated that 20% to 50% of fatal encounters with law enforcement involved an individual with a mental illness.[2] As a result, communities have begun to consider the urgent need for crisis response models that deploy mental health professionals rather than police. An analysis found that the 10 largest police departments in the U.S. paid out nearly 250 billion dollars in settlements in 2014, much of which were related to wrongful-

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[1] Szabo, L. (2015). People with mental illness 16 times more likely to be killed by police. *USA Today.* **https://www.usatoday.com/story/news/2015/12/10/people-mentalillness-16-times-more-likely-killed-police/77059710/**

[2] DeGue, S., Fowler, K.A., & Calkins, C. (2016). Deaths due to use of lethal force by law enforcement. *American Journal of Preventive Medicine*, 51(5), S173-S187. **https://www.ajpmonline.org/article/S0749-3797(16)30384-1/fulltext**

death lawsuits of people in a mental health crisis.[3] Law enforcement should not be the primary responders to mental health crises.

A 2012 Department of Justice report outlines that policing in the U.S. does not necessarily keep people safer but instead, militaristic policing causes more harm than good and disproportionately impacts communities of color. The report further assessed that over-policing requires more resources without producing benefits to public safety, draining resources that could otherwise be used for more effective public safety strategies.[4]

Nationally, the negative impacts of policing and police violence have been declared a public health issue.[5] Extensive data shows that aggressive policing is a threat to physical and mental health: inappropriate stops are associated with increased anxiety, depression, PTSD, or long-term health conditions like diabetes. In 2016, at least 76,440 nonfatal injuries due to law enforcement were reported and at least 1,091 deaths were reported. However, due to insufficient monitoring and surveillance of law enforcement violence, these statistics are underestimated.[6]

The impacts of policing disproportionately harm people of color, especially Black Americans, making policing an issue of racial justice. Police disproportionately stop, arrest, shoot, and kill Black Americans. Other marginalized populations, such as people with mental illness, people who identify as transgender, people experiencing homelessness, and people who use drugs, are also subjected to increased police stops, verbal and sexual harassment, and death.[7]

In California, Alameda County has the highest rate of 5150 psychiatric holds in the entire state,[8] which may indicate inadequate provision of mental health crisis services. Of those individuals placed on a 5150 psychiatric hold in Alameda County and transferred to a psychiatric emergency services unit, 75-85% of the cases did not meet medical necessity criteria to be placed in inpatient acute psychiatric care. This demonstrates an overuse of emergency psychiatric services in Alameda County. Such overuse creates challenges in local communities such as lengthy wait times for ambulance services which are busy

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[3] Elinson, Z. & Frosch, D. (2015). Cost of police-misconduct cases soars in big U.S. cities. *Wall Street Journal.* **https://www.wsj.com/articles/cost-of-police-misconduct-cases-soars-in-big-u-s-cities-1437013834**

[4] Ashton, P., Petteruti, A., & Walsh, N. (2012). Rethinking the blues: How we police in the U.S. and at what cost. *Justice Policy Institute, U.S. Department of Justice.* **https://www.ojp.gov/ncjrs/virtual-library/abstracts/rethinking-blues-how-we-police-us-and-what-cost**

[5] American Public Health Association. Addressing law enforcement violence as a public health issue. Policy number: 201811. 2018. **https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2019/01/29/law-enforcement-violence**.

[6] Ibid.

[7] Ibid.

[8] INN Plan – Alameda County: Community Assessment and Transport Team (CATT) (2018, October 25). *California Mental Health Services Oversight and Accountability Commission.* **https://mhsoac.ca.gov/sites/default/files/documents/2018-10/Alameda_INN%20Project%20Plan_Community%20Assessment%20and%20Transport%20Team_8.6.2018_Final.pdf**

transporting and discharging individuals on 5150 holds. The overuse of involuntary psychiatric holds can be traumatizing for people experiencing crisis, as well as for their friends and family.

The overuse of involuntary psychiatric holds is also an issue of racial justice. Police and ambulance workers have been found to bring Black patients with psychoses to psychiatric emergency service more frequently than non-Black patients with psychoses. [9] For example, in San Francisco, Black adults are overrepresented in psychiatric emergency services, relative to overall population size.[10]

Based on 911 call data from 2001 to 2003 in San Francisco, a study found that neighborhoods with higher proportions of Black residents generate relatively fewer mental health-related 911 calls. The authors suggest that underutilization of 911 by the Black community can result in delayed treatment, therefore increasing the risk posed to the health and safety of people in crisis and their communities. The study highlights the common distrust of law enforcement among communities of color. Such distrust and fear of law enforcement may mean that people of color do not trust that mental health-related calls will be handled appropriately if they seek support for a mental health crisis through 911. The study reinforced that "law enforcement officers' role in the disposition of calls makes them de facto gatekeepers to safety net services for persons with mental disorders."[11]

It is within this context that many Berkeley community members are calling for a more just, equitable, and health-focused crisis response system, in part due to the distrust of institutions of policing or those closely intertwined with police. A variety of stakeholder groups, including the Berkeley Mental Health Commission and the Berkeley Community Safety Coalition, have long advocated for a community-designed 24/7 crisis care model and to reduce the role of law enforcement in crisis response.

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[9] Kessell, E.R., Alvidrez, J., McConnell, W.A. & Shumway, M. (2009). Effect of racial and ethnic composition of neighborhoods in San Francisco on rates of mental health-related 911 calls. Psychiatric Services, 60(10), 1376-1378. **https://ps.psychiatryonline.org/doi/pdf/10.1176/ps.2009.60.10.1376**

[10] Ibid.

[11] Kessell, E.R., Alvidrez, J., McConnell, W.A. & Shumway, M. (2009). Effect of racial and ethnic composition of neighborhoods in San Francisco on rates of mental health-related 911 calls. Psychiatric Services, 60(10), 1376-1378. **https://ps.psychiatryonline.org/doi/pdf/10.1176/ps.2009.60.10.1376**

In a concurrent project for the City of Berkeley's Reimagining Public Safety initiative, the National Institute for Criminal Justice Reform found that among many Berkeley residents, there is a lack of trust in and satisfaction with the Berkeley Police Department. They found that:[12]

- Non-White respondents were more likely to indicate that the Berkeley Police Department is not effective at all compared to White respondents;
- 17.1% of Black respondents and 7.6% of Latinx respondents reported that police had harassed them personally in comparison to only 4.3% of White respondents;
- Respondents are less likely to call 911 during emergencies related to mental health or substance use crisis (57.9%) in comparison to an emergency not involving mental health or substance use (86.2%); and
- Substantially more Black respondents indicated extreme reluctance to call 911 as compared with other groups.

Additionally, the report shared that across all respondents, 65.9% indicated a preference for trained mental health providers to respond to mental health and substance use emergencies "with support from police when needed" and 14.9% indicated a preference "with no police involvement at all." In total, 80.8% of respondents indicated a preference for trained mental health providers to respond to calls related to mental health and substance use.[13]

Clearly, there is an urgent need for a more racially just, equitable, and health-focused mental health crisis response system. The SCU could be well poised to address these inequities by providing specialized mental health crisis intervention, de-escalation, and stabilization without the presence of law enforcement.

Inputs to the Recommendations

This report includes core components and guiding aims of the SCU model, considerations for planning and implementing the SCU model, a phased implementation approach, stakeholder-driven design recommendations, system-level recommendations, and next steps and future design considerations. Each recommendation that RDA puts forth in this report is deeply rooted in the following sources of input:

- Crisis Response Models Report (Report 1 of this series of 3)
- Mental Health Crisis Response Services and Stakeholder Perspectives Report (Report 2 of this series of 3)
- Ongoing engagement with the SCU Steering Committee and the City's Health, Housing & Community Services Department (HHCS)

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[12] National Institute for Criminal Justice Reform (2021). Reimagining public safety: Draft final report and implementation plan. **https://www.cityofberkeley.info/uploadedFiles/Clerk/Level_3_-_Commissions/Draft%20Final%20Report%20and%20Implementation%20Plan%20FNL%20DRFT%2010.30.21.pdf**

[13] Ibid.

- Learnings from the simultaneous Reimagining Public Safety initiative
- Best practices research

The recommendations presented in this report are directly informed from the strengths, challenges, gaps in services, and lessons learned from crisis response programs around the country. Those considerations, however, must be uniquely tailored to the Berkeley community based on the existing crisis response system and the needs and perspectives of Berkeley residents. Together, the recommendations and implementation approaches presented here are informed by findings from the robust community engagement and citywide processes of the past year.

Crisis Response Models Report

As part of this feasibility study, RDA reviewed the components of nearly 40 crisis response programs in the United States and internationally, including virtually meeting with 10 programs between June and July 2021. A synthesized summary of RDA's findings, including common themes that emerged across the programs, how they were implemented, considerations and rationale for design components, and overall key lessons learned can be found in the **Crisis Response Models Report**.

Mental Health Crisis Response Services and Stakeholder Perspectives Report

With the guidance and support of the SCU Steering Committee, facilitated by the Director of City of Berkeley's Health, Housing and Community Services Department (HHCS), RDA conducted a large volume of community and agency outreach and qualitative data collection activities in June and July 2021. Because BIPOC, LGBTQ+, unhoused, and other communities are disproportionately represented in public mental health and incarceration systems—particularly ones designed for punishment and sentencing to prisons—their input was sought to advance the goal of achieving health equity and community safety.

Crisis response service users described their routes through these systems, providing their perspectives about their experiences and how these experiences impact their lives in a way that other stakeholders are not able or qualified to do. The goal of the immense amount of outreach and qualitative data collection was to understand the variety of perspectives in the local community regarding how mental health crises are currently being responded to as well as the community's desire for a different crisis response system that would better serve its population and needs. Such perspectives are necessary to improve the quality of service delivery and, moreover, to inform structural changes across the crisis response system.

The synthesis of the City of Berkeley's current mental health crisis system and themes from qualitative data collection can be found in the **Mental Health Crisis Response Services and Stakeholder Perspectives Report**

The SCU Model: Planning & Implementation

Core Components

The recommendations presented in this report represent a model that is responsive to community needs, but as planning continues throughout 2021 and into 2022, new considerations and constraints may arise. As dynamics evolve and more information is obtained and assessed, the model must be flexible and adaptable. There are several components that should, however, remain core to the SCU model:

- The SCU responds to mental health and substance use crises.
- The SCU responds with providers specialized in mental health and substance use.
- The SCU model does not include police as a part of the crisis response.
- The SCU is not an adjunct to nor overseen by a policing entity (e.g., Police, Fire, or CERN[14]).

With these core components in mind, the SCU model and phased approach were designed to address the challenges, gaps in services, and community aspirations shared by numerous stakeholders throughout Berkeley. The SCU model seeks to:

- Address the urgent need for a non-police crisis response.
- Disrupt the processes of criminalization that harm Black residents and other residents of color, substance users, people experiencing homelessness, and others who experience structural marginalization.
- Increase the availability, accessibility, and quality of mental health crisis services.
- Provide quality harm reduction services for substance use emergencies.
- Strengthen collaboration and system integration across the crisis and wraparound service network.
- Be responsive to ongoing community feedback and experiences.
- Build and repair trust with community members and increase public awareness of newly available services.

A System-wide Change Initiative

The development of a mental health crisis response model as a component of the City of Berkeley's emergency services should be understood as a systemwide change initiative of great magnitude. Developing a shared narrative around community health and well-being while reducing harm, trauma, and unnecessary use of force may build collective support for the SCU model across City of Berkeley agencies and departments. Other cities implementing non-police crisis response models found that garnering buy-in from other

[14] Community Emergency Response Network (CERN) is a model recommended by the National Institute for Criminal Justice Reform through the Reimagining Public Safety process.

city or county departments requires collaboration from the earliest planning stages. Cities shared that when they focused these conversations about shared objectives between the crisis response program and the police, police began to see the program as a resource to them, as mental health professionals could often better handle mental health crises because of their training and backgrounds. Alignment on shared goals and values may support leadership across the City of Berkeley to identify and advance the best resource(s) for responding to mental health needs and substance use crises. An effective systemwide change initiative will also require all involved leaders to communicate and champion the shared vision.

The SCU model requires not only collaboration, but also structural changes and integration across other entities. For one, the SCU's ability to respond to crises relies in large part on the 911 Communications Center ("Dispatch"). However, in 2019, a Berkeley City Auditor's report[15] elevated that the understaffing of Dispatch has led to staffing levels that cannot meet the call volume of residents and has increased call wait times. Increased wait times for 911 callers have negative implications for the safety and well-being of service utilizers and community members. Increased wait times also have negative implications for service providers and crisis responders that are responding to a potentially more advanced state of crisis. Additionally, inadequate staffing levels rely on overtime spending to fund Dispatch, which increases the cost of the entity.

The Auditor's report also recommended increased training for Dispatchers to manage and respond to mental and behavioral health crisis calls, including the management of suicidal callers and persons with mental illness. The well-being and stress of call takers are also of concern. In all, if they are not addressed, such resource shortages and unmet training needs could have a significant impact on the SCU's success.

Other entities that will be affected by the implementation of the SCU model include Berkeley Fire, who responds to crises through Dispatch, and the Mobile Crisis Team (MCT), who provide mental health crisis services in partnership with the Berkeley Police Department. These entities, in addition to Dispatch and the SCU, will have to establish new working relationships and protocols to effectively serve the community together.

Dispatch is an immensely complex system. Integrating the SCU into such a system, while addressing staff capacity and training needs, will take significant planning and coordination, as well as funding. For these reasons, the recommendations for the planning and implementation of the SCU model are laid out in a phased implementation approach to allow for sufficient preparation of Dispatch while providing urgently needed mental health crisis response to community members.

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[15] Berkeley City Auditor. (2019, April 25). 911 Dispatchers: Understaffing Leads to Excessive Overtime and Low Morale. **https://www.cityofberkeley.info/uploadedFiles/Auditor/Level_3_-_General/Dispatch%20Workload_Fiscal%20Year%202018.pdf**

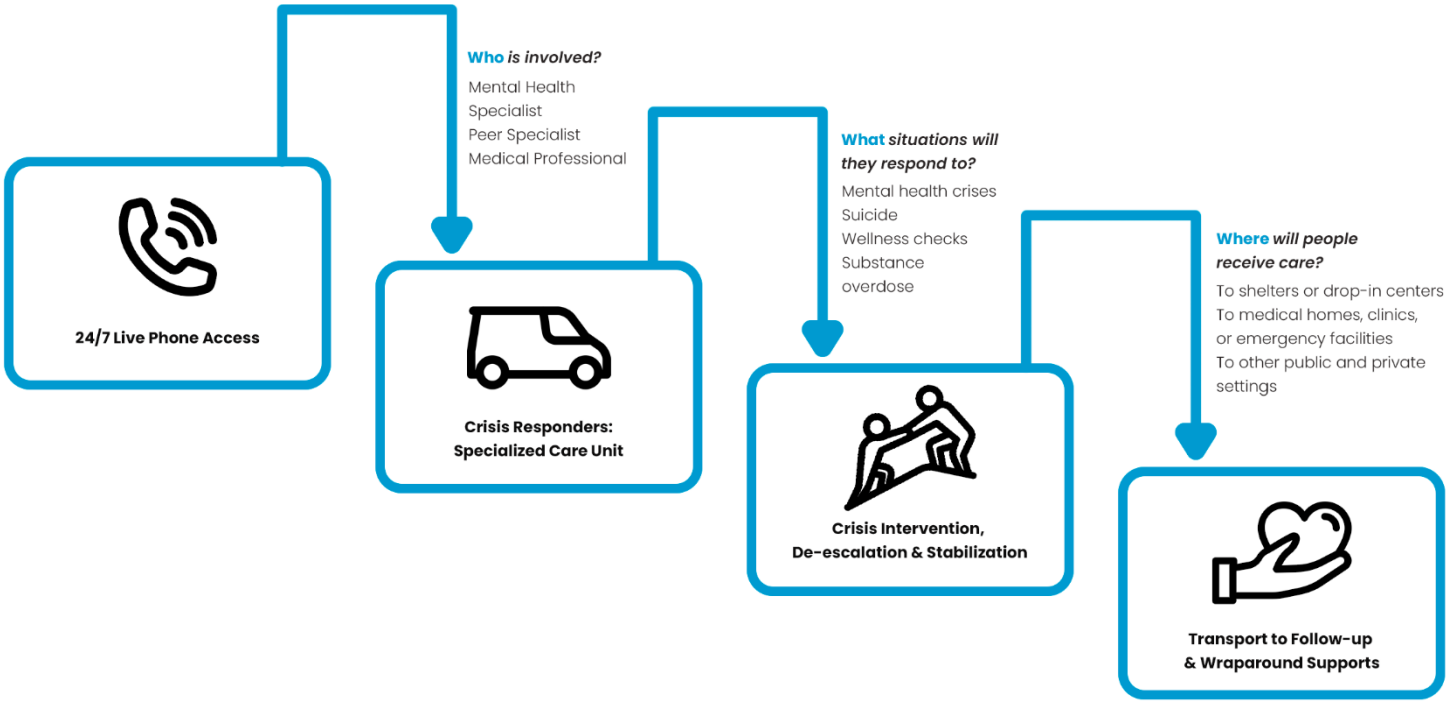
Recommendations

Overview

This report presents recommendations that address what is required for SCU model. Figure 1, below, provides an overview of the specialized care unit's response. Figure 2 shows the many components required for a comprehensive 24/7 SCU model.

The Specialized Care Unit: Crisis Response

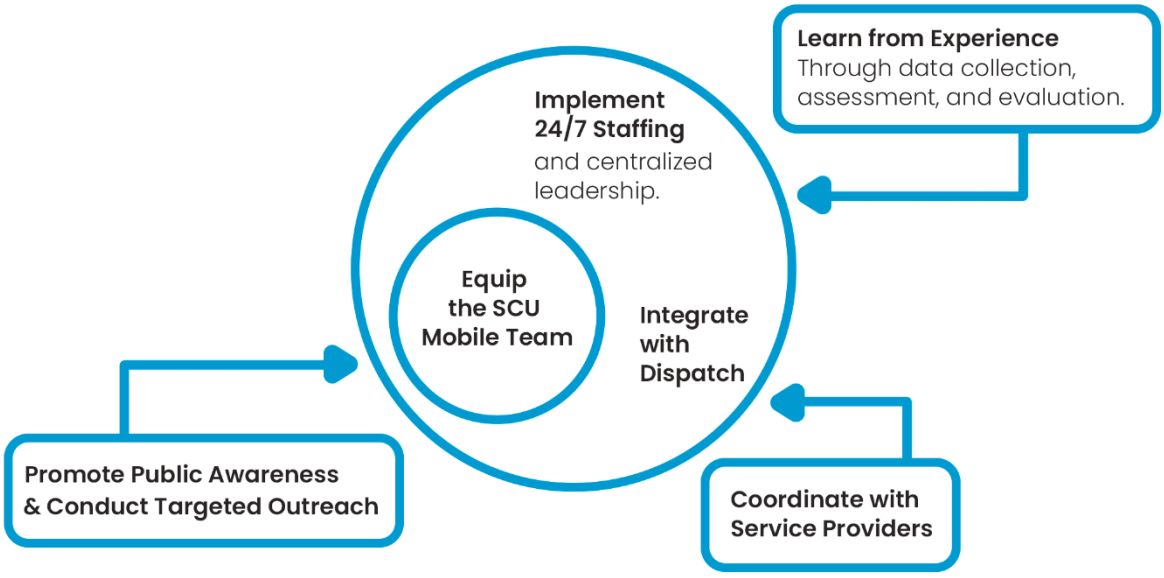
Figure 1: An overview of the SCU crisis response.



Community members experiencing or witnessing a mental health or substance use crisis will be able to call the SCU through a 24/7 live phone line, from which the SCU mobile team will be deployed to the crisis. The SCU mobile team will include specialists who support a person in crisis with intervention, de-escalation, and stabilization techniques. If necessary, the SCU will also be able to transport a person in crisis to locations that promote the person's safety and care.

The SCU Model: A Comprehensive 24/7 Crisis Response

Figure 2: An Overview of the comprehensive 24/7 SCU model.



The SCU is not solely a mobile team that delivers specialized care during mental health and substance use crises, but rather requires a comprehensive model. This model includes clinical and administrative staff to ensure 24/7 live access to the phone line and SCU mobile team. The model also requires centralized leadership and system integration to realize systemwide changes. As this new model is implemented, it will require ongoing data collection, assessment, and iteration to ensure it is meeting the needs of the community. And, the model requires that community members know that they can call a non-police, specialized mental health and substance use crisis team.

Phased Implementation

A phased approach will support a successful rollout of the SCU model while planning for integration across city agencies. These timelines may be ambitious given the magnitude of this systems-change initiative and the dependencies of the various model components. While the phased implementation approach represents an ideal timeline and is responsive to the urgent need for specialized mental health and substance use crisis response in Berkeley, it may need to be adjusted to realize the success of the SCU.

Refer to **Appendix A** for a complete phased implementation roadmap.

Figure 3: An overview of the phased implementation approach.

PHASE 0	PHASE 1		PHASE 2
Nov 2021 - Aug 2022	Sept 2022 - Aug 2023	Sept 2023 - Feb 2024	Feb 2024+
• Engage SCU Steering Committee & community stakeholders on RFP; launch RFP • SCU staff: Contracting, hiring, training • Dispatch: Planning & assessment • Establish preliminary triage criteria, workflows and protocols • Launch public awareness campaign	• SCU implements crisis response services • Dispatch implements integration or components based on Phase 0 planning • Conduct rapid assessment, monitoring, and iteration • Engage centralized leadership in coordination	• Review annual evaluation and rapid assessments • Prepare for Phase 2	• Implement changes based on evaluation and community need

SCU Mobile Team

The goal of the SCU is to provide specialized care during mental health crises and substance use emergencies, including crisis intervention, de-escalation, and stabilization. This specialized care does not require a police response but instead should be a three-person team of medical and behavioral health specialists. The SCU will need to be equipped to address the nuanced variety of crisis needs across mental health and substance use emergencies.

By providing 24/7 SCU services, the City of Berkeley asserts that mental health crisis response is of the same importance as other crisis services and limits the need to use the police to respond to such crises. Overall, the SCU model aims to disrupt the criminalization of substance use and mental illness and advance racial justice in the City of Berkeley. There are several considerations for how to most effectively promote the safety of crisis responders, persons in crisis, and general community members.

The following recommendations are aligned to best practices and emerging alternative models, while being rooted in community-driven recommendations. Each recommendation is tailored to the City of Berkeley and provides key considerations to support planning and implementation:

Key Recommendations

1. **The SCU should respond to mental health crises and substance use emergencies without a police co-response.**
2. **The SCU should operate 24/7.**
3. **Staff a three-person SCU mobile team to respond to mental health and substance use emergencies.**
4. **Equip the SCU mobile team with vans.**
5. **The SCU mobile team should provide transport to a variety of locations.**
6. **Equip the SCU mobile team with supplies to meet the array of clients' needs.**
7. **Clearly distinguish the SCU from MCT.**

Recommendation #1

The SCU should respond to mental health crises and substance use emergencies without a police co-response.

The goal of the SCU is to provide specialized care during mental health crises and substance use emergencies. Below are suggested guidelines of when the SCU should and should not respond to a call.

Types of calls SCU **should** respond to:

- Suicide
- Drug overdose
- Welfare check
- Suspicious circumstance
- Complaint of an intoxicated person
- Social disorder
- Indecent exposure
- Trespassing
- Disturbance

Types of calls SCU should **not** respond to:

- Confirmed presence of firearm, knife, or other serious weapon
- Social monitoring and enforcement (e.g., of unsheltered residents in public spaces)
- Calls that Dispatch already deems do not need an in-person response (e.g., argument with a neighbor, minor noise violation)

Location of calls SCU should respond to:

- Public settings (e.g., parks, sidewalks, vehicles)
- Commercial settings (e.g., pharmacies, restaurants)
- Private settings (e.g., homes)

Note: These guidelines and types of calls will need to be further explored to develop triage criteria that adequately reflect all the considerations for when the SCU will respond to crises.

Why isn't the SCU responding with police?
Stakeholders consistently emphasized the need to provide non-police mental health crisis response options, noting that police are primarily trained in issues of imminent public safety threats, not mental health care. Rather than duplicating the MCT's model, the SCU model provides a new option for those better served by a non-police response. A dedicated response unit for mental health, behavioral health, and substance use emergencies will also help to build community trust and increase the likelihood that someone will call for help when they are in a crisis.

Why is the SCU responding to calls at public and private locations? Is that safe?
A mental health crisis can happen anywhere, so the SCU must be able to respond to mental health and substance use crises in both public and private settings. Any variables around the safety of responding to a crisis in a private setting should be assessed before deploying the SCU team (e.g., the presence of a serious weapon).

How were the types of calls decided?

Research from alternative models in other cities, community stakeholders' perceptions of existing needs in Berkeley, and input from crisis responders in the City of Berkeley all indicate that these call types may be well suited for behavioral health and mental health specialists instead of police. The nuances within any of these call types will be further planned for throughout Phase 0.

Considerations for Implementation

Safety & Weapons:

- Not all weapons pose the same risk to crisis responders, so triage and deployment protocols should be aligned to best practices and standards of practice. The SCU may be able to respond to some calls where a weapon is present. The criteria for this safety precaution should be evaluated and planned for during Phase 0.
- If there is a mental health or substance use emergency where a weapon is present, then MCT-Police co-response should be deployed rather than the SCU.
- If the SCU mobile team is on scene but feels their safety is in imminent danger, they should have the ability to call in the MCT-Police co-response as backup support.

Coordinating with Other Entities

- Mobile Crisis Team: The types of calls, triage criteria, and workflows will need to be differentiated for deploying MCT versus SCU.
- Berkeley Police Department: When BPD is on scene and MCT is not available, BPD and SCU will need clear processes for whether police can bring the SCU to support. Similarly, BPD and SCU will need clear processes for when/how SCU leaves if they call the BPD to a scene.

Recommendation #2

The SCU should operate 24/7.

The SCU mobile team should be available to respond to a crisis in person 24 hours per day, 7 days per week. Not having services available 24/7 was the most common challenge expressed by stakeholders about the current mental health crisis response system. In contrast, other crisis services like Fire and Police are available 24/7. By operating the SCU 24/7, the City of Berkeley asserts that mental health crisis response is of the same importance as other crisis services and negates the need to use police to respond to such crises. The need for 24/7 service is supported by national trends, as although some cities have implemented alternative crisis models with limited hours, many of them shared that they plan to expand to 24/7 to meet community needs.

Why does the SCU need to be available 24/7? Why can't it operate only during peak hours?
A mental health or substance use crisis can happen at any time. Stakeholders stressed the importance of having mental health crisis response services available 24 hours per day and 7 days per week. If community members are to trust in the SCU as an ongoing and authentic alternative to police involvement, services need to be available whenever someone calls.

Considerations for Implementation

All other supporting elements described throughout this report will need to accommodate 24/7 availability, such as:

- Phone access to the SCU
- Certain personnel roles, like a Clinical Supervisor
- Staffing structure that allows redundancy of personnel to cover each shift
- Equipment and infrastructure including the number of vans for the mobile team

Recommendation #3

Staff a three-person SCU mobile team to respond to mental health and substance use emergencies.

The array of mental health, behavioral health, and substance use services offered by the SCU require staff with varying professional specialties. The following roles are necessary to adequately provide these services:

1. **A Mental Health Specialist**
   This role will be the primary provider of mental health services with the ability to conduct 5150 assessments, and therefore need to be licensed. They should have significant training in mental health and behavioral health conditions and disorders, crisis de-escalation, and counseling.

   - Recommended position: Licensed Behavioral Health Clinician
   - *Possible positions: Licensed Clinical Social Worker (LCSW), Associate Clinical Social Worker (ASW), SUD or AOD Counselor, psychologist*

2. **A Peer Specialist**

   This role should have lived experience with mental health crises and systems, substance use crises or addiction, and be equipped to support system navigation for a person in crisis.

   - Recommended position: Peer Specialist
   - *Other possible positions: Community Health Worker, Case Manager*

3. **A Medical Professional**
   This role should be able to identify physical health issues that may be contributing to or exacerbating a mental health crisis, including psychosomatic drug interactions. They should be able to administer single-dose psychiatric medicines and have training in harm reduction theory and approaches. They can also assess and triage for higher levels of medical care as needed.
   - Recommended position: Psychiatric Nurse Practitioner (Psych-NP)
   - *Other possible positions: Nurse Practitioner (NP), EMT, Paramedic*

Why a three-person team?
These three distinct roles create a team that can effectively provide the necessary range of specialized services and can engage in organic collaboration to address each crisis. Cities who have implemented similar models spoke to the advantage of team members taking different roles in each scenario based on each client's needs and preferences.

Why is the mental health specialist conducting 5150 assessments?
The SCU's aim is to reduce the overall number of involuntary holds through effective crisis intervention, de-escalation, and stabilization. However, ensuring the SCU has the ability to conduct 5150 assessments and involuntary holds rather than calling in the police to do the assessment can reduce interactions between people experiencing mental health crisis and police. Additionally, enabling the SCU to conduct the 5150

assessment is a more trauma-informed model because it eliminates the need for a person in crisis to interact with multiple teams and reduces the time it takes to respond to a crisis from start to finish.

Why is there a peer on the team?

The peer is a critical member of the crisis team. Other systems shared that a person in crisis may be most responsive to a peer who has gone through a similar experience and that, at times, peers' unique training and skills allow them to engage that person more effectively than other specialties. Berkeley stakeholder participants emphasized the invaluable contributions of peer specialists, noting that they may be best equipped to lead the de-escalation before the mental health specialist or medical professional steps in to administer care because a person in crisis may be most responsive to someone that has similar lived experience.

Why is there a medical professional on the team? Why a Psych-NP?

Mental health and physical health needs often co-present, with physical needs ranging from basic first aid (e.g., wound care, dehydration) to reactions to substances, such as overdoses or drug interactions. A medical professional, such as a Psych-NP, brings the clinical expertise to understand how physical ailments, chronic medical conditions, and psychiatric conditions affect a service utilizer (e.g., someone with hypertension and schizophrenia using methamphetamines). Other medical professionals, such as NPs, may also have sufficient training to meet the mental health and substance use needs of service utilizers. These situations do not require the expertise of a paramedic or doctor who are trained to respond to emergencies and deliver life-saving care.

Considerations for Implementation:

- The number of mobile teams required will be based on multiple variables including community needs, call volume, and budget (for a more in-depth description, *refer to recommendation #12*).
- There may be challenges in staffing the SCU mobile team with these specific roles, such as the Psych-NP. The SCU model may need to allow for a variety of specialists to fill each of the three main roles.
- Across these roles, the SCU mobile team should have the following competencies:
    - Lived experience of behavioral health or mental health needs, homelessness, addiction or substance use, and/or incarceration
    - Emphasis on dual diagnosis (mental health and substance use) training, psychosomatic interactions, substance use management, and harm reduction
    - Identities reflective of those most harmed by the current system of care and/or those who are most likely to use or benefit from the SCU services
    - Multilingual
- Across these roles, the SCU mobile team will need to be trained on a variety of topics (for a full list, *refer to recommendation #14*). These may be desirable prerequisite skills, such as:
    - Disarming without the use of weapon
    - Motivational interviewing
    - Naloxone administration
    - Harm reduction
    - Trauma-informed care

Recommendation #4

Equip the SCU mobile team with vans.

Based on the scope of services, the SCU mobile team will need a vehicle to arrive at each call, carry equipment and supplies, and transport clients to another location. A well-equipped van should be both welcoming and physically accessible to clients and easily maneuverable by staff.

SCU vans should include:

- Wheelchair accessible features
- Lights affixed to the top of the van, allowing for sidewalk parking
- Locked supply cabinets
- Rear tinted windows for client privacy
- Rear doors not operable from the inside
- Power ports to charge laptops, tablets, and phones
- Comfortable seating
- SCU logo on the side of the van so the community can easily identify the team

SCU vans should **not** include:

- Sirens
- A plexiglass barrier between the front and back seats

Why not use an ambulance?

There are a several reasons why an ambulance is not the appropriate vehicle for the SCU:

- Ambulances must transport to a receiving emergency department when transporting from the field (a call for service from a community member), which may not always be the most appropriate end point for the level of care required (*refer to recommendation #5*).
- Ambulances require a special license to drive and would require the inclusion of an EMT or paramedic on staff and would therefore increase the expense of the SCU.
- Ambulances are more expensive to purchase and maintain than a van.
- A van is potentially less stigmatizing and traumatizing for a person in crisis.

Why were these specific features chosen?

All van specifications are based on lessons learned from alternative crisis response programs in other cities and experiences and insight shared by the Berkeley Fire Department. Many van features, such as locked supply cabinets and locked rear doors, are designed to increase the safety of both crisis responders and a person in crisis. Other van features support the SCU mobile teams to provide a variety of services.

Why shouldn't the van have sirens or a plexiglass barrier?

Sirens can draw unnecessary public attention, thereby reducing privacy for a person in crisis, while both sirens and plexiglass barriers can exacerbate the stigmatization, traumatization, and criminalization of mental health and substance use crises.

Considerations for Implementation

The number of vans required will be based on the number of SCU mobile teams and shift structure/overlap (*refer to recommendation #12*).

Recommendation #5

The SCU mobile team should provide transport to a variety of locations.

The SCU should provide a level of care appropriate to each specific crisis with the aim of de-escalating crises, preventing emergencies, and promoting well-being. The SCU will transport service utilizers in the SCU van (*refer to recommendation #4*) unless there is a medical need that requires the SCU to request an ambulance for transport.

The SCU will transport service utilizers to:

- Inpatient units of psychiatric emergency departments
- Primary care providers, psychiatric facilities, or urgent care
- Crisis stabilization units, detox centers, or sobering centers
- Drop-in centers and other CBOs
- Shelter or housing sites
- Domestic violence service sites
- Long-term programs including residential rehabilitation sites
- Requested public locations (e.g., parks)
- Requested private locations (e.g., home)

Considerations when deciding transport location:

- Transport can be voluntary or involuntary, based on a 5150 assessment
- The SCU should be able to deny the request of a person in crisis for transportation based on their assessment of the appropriate level of care
- The SCU will need to assess safety or liability concerns for the service utilizer or other bystanders based on transport location (e.g., not transporting an intoxicated person home where another person is present at the home)

Why should the SCU transport service utilizers to so many different locations?

The SCU model aims to support diversion of people experiencing crises away from jails and hospitals and into the appropriate community-based care and resources. Some crises can be resolved on scene, while others will require transport to another location. Even if a crisis is de-escalated on scene, service utilizers may benefit from being transported to another location for additional care or resources. Throughout this project, stakeholder participants emphasized that the level of need outweighs the available resources and providers in Berkeley and Alameda County. Providing transport to a variety of locations and resources allows the SCU to provide the level of care appropriate to each specific crisis and increases the possibility of providing care in an overwhelmed service network. *Refer to Section V for long-term recommendations for addressing the needs of the service network*.

Considerations for Implementation

- Established, trust-based relationships with community partners and warm handoff procedures will improve overall quality of care and can reduce the amount of time required when dropping off a client.
- Staff at emergency facilities will need to be familiar with the SCU, including the van, logo, and uniforms, to be prepared to receive transported clients in a timely and responsive manner, reducing "wall time."
- Triage criteria and workflows should support the SCU in assessing where and how to transport a person in crisis.
- Triage criteria and workflows for transport should address the safety implications for both the person in crisis and other community members.

Recommendation #6

Equip the SCU mobile team with supplies to meet the array of clients' needs.

The SCU will be responding to a variety of calls, each with their own specific needs. The supplies needed will vary depending on the call. Below is a suggested list of supplies the SCU should carry, generated from the input of stakeholders and other alternative crisis response programs. These supplies will facilitate a harm reduction approach and directly contribute to the health and well-being of the person in crisis.

Medical supplies	• First aid kit • Personal protective equipment • Wound care supplies • Stethoscope • Blood pressure armband • Oxygen • Intravenous bags • Single-dose psychiatric medications
Client engagement items	• Food and water • Clothing, blankets, and socks • Transportation vouchers • "Mercy beers" and cigarettes • Tampons and hygiene packs
Community health supplies	• Safe sex supplies and pregnancy tests • Naloxone • Clean needles and glassware • Sharps disposal supplies
Technology	• Cell phones • Data-enabled tablets • Computer Aided Dispatch (CAD) • Police radio
Uniforms	• Casual dress: polo or sweatshirt with the SCU logo

Why does the SCU need to carry client engagement items?
These items can help initiate an interaction while also meeting the basic needs of clients while they are experiencing a crisis.

Why does the SCU need to carry community health supplies?
These supplies can help address an underlying physical health need or provide harm reduction for substance use crises.

Why does the SCU need technology and uniforms?
The team needs cell phones and data-enabled tablets for mobile data entry. The tablets should be preloaded with an electronic health record (EHR) application so staff can access client history to provide more effective, tailored care. Wearing a casual uniform can help the team appear more approachable to clients and be easily identifiable. Uniforms that look more like traditional emergency response uniforms can be triggering for clients who have had traumatic experiences with emergency responders.

Considerations for Implementation

- The need for basic provisions among service utilizers is often significant and therefore affects the model's budget. To effectively plan for the program budget, San Francisco's Street Crisis Response Team shared that they budgeted for $20 in supplies per client contact but quickly exceeded their $10,000 annual budget. Denver's STAR program noted that these supplies were in high demand and the budget was supplemented with donations.
- Staff should track which supplies are used most often and which supplies are requested by clients that the SCU does not carry.

Recommendation #7

Clearly distinguish the SCU from MCT.

Once the SCU model is implemented, there will be two teams responding to mental health crisis calls in the City of Berkeley: the Specialized Care Unit and the Mobile Crisis Team. It will be necessary to clearly distinguish the role of these two teams so that the proper response is deployed for each situation. The general public will also need to be informed regarding the two teams, how to access them, and why.

Suggested scenarios when MCT and Police should be deployed instead of the SCU:

- If there is a confirmed presence of a serious weapon during a mental health crisis, the police and MCT would be deployed.
- If the police request mental health support during a crisis, MCT will be deployed as a co-response.
- If the SCU is on a call and needs backup or cannot successfully intervene, they would call for an MCT-police co-response.

If there's an SCU, why should the MCT still exist?
When the police respond due to the presence of a weapon or other element outlined above, a joint response that includes clinical staff to support the intervention is a best practice and community asset, delivering a trauma-informed response focused on de-escalation. This is especially true for a person in crisis with past traumatic experiences with the police. The MCT remains an important resource that can reduce the negative impacts of police presence during situations where a mental health crisis intersects with issues of imminent public safety.

Why is it important to distinguish MCT from the SCU?
Trust & Acceptability of SCU: MCT responds to the majority of their calls with police backup. Because SCU is a non-police crisis response option, clearly distinguishing the two models will be essential in establishing and maintaining community trust to increase utilization of the SCU, particularly among groups most at risk of harm from police violence.

Logistics for Deploying the Right Team: Dispatch will need tools and training to clearly differentiate the teams' roles to effectively deploy the right team for each mental health crisis call.

Considerations for Implementation

- All triage criteria and workflows need to be reflective of the differentiation between SCU and MCT. This includes the triage criteria and workflows for Dispatch and/or the alternative phone line and Alameda County's Crisis Support Services (CSS) (*refer to recommendation #9*).
- The distinction between MCT and the SCU, particularly around availability and police involvement, should be emphasized in the public awareness campaign (*refer to recommendation #24*).
- Tracking the acuity levels of calls, as well as whether MCT and police were called in for backup, can help refine the Dispatch process and ensure that the right team is deployed.

Accessing the SCU Crisis Response: Dispatch & Alternative Phone Number

Implementing the SCU as a 24/7 mental health and substance use crisis model requires that community members have reliable and equitable access to the team. By integrating the SCU crisis response into 911 and Dispatch's processes, mental health crisis services will be elevated to the same level of importance as Fire and Police when calling for emergency services, thus promoting community access to specialized crisis care. To reach this goal, the SCU model, City of Berkeley leadership, and Dispatch will need to work together during assessment and planning processes.

The need to develop and implement the SCU model is urgent. Yet Dispatch is a complex, under-resourced, and overburdened system. To achieve structural change that ensures sustainability, significant planning and coordination is essential.

There are several possibilities for how to advance the SCU-911 integration aligned to the phased implementation approach. The following recommendations are aligned to best practices and emerging alternative models and responsive to the needs and concerns expressed by community stakeholder participants. Each recommendation should be further explored, assessed, and discussed across City of Berkeley leadership:

Key Recommendations

8. **Participate in the Dispatch assessment and planning process to prepare for future integration.**
9. **Ensure the community has a 24/7 live phone line to access the SCU.**
10. **Plan for embedding a mental health or behavioral health clinician into Dispatch to support triage and SCU deployment.**

Recommendation #8

Participate in the Dispatch assessment and planning process to prepare for future integration.

Ultimately, the SCU should be integrated into 911 and Dispatch protocols. To reach this goal, the SCU model, City of Berkeley leadership, and Dispatch will need to work together during assessment and planning.

Dispatch, through the Berkeley Fire Department, has conducted a Request for Proposal process and selected a consulting firm to support enhancements to the deployment of Fire and EMS/Ambulance services. That assessment and planning process should integrate SCU implementation, preparing for the SCU to be a mental health emergency response on par with police and fire emergency calls.

If this is a non-police response model, why is Dispatch involved?
An effective mental health crisis response that increases community safety, well-being, and health outcomes relies on the SCU actually being deployed to community members in crisis. Dispatch has established infrastructure and technology that could effectively and safely deploy the SCU mobile team. Moreover, 911 is a well-known resource to the general public, which many people do seek during crises. In 2017, Dispatch received 256,000 calls.[16] For these reasons, integration of the SCU into 911 and Dispatch's processes is an important method for deploying the SCU team to people experiencing a mental health or substance use crisis.

Will another assessment and planning process delay the launch of the SCU?
Dispatch's expertise and experience are a critical asset to lead the assessment, planning, and implementation of revised 911 procedures that include the SCU. The Dispatch assessment and planning project is slated to begin in 2022; by incorporating assessment and planning for the SCU into an existing project, it will initiate the process several months sooner than if a separate and new project were to be initiated. Additionally, integrating both projects will ensure consistent and simultaneous efforts rather than disjointed efforts that require backtracking or undoing of work and decisions.

Considerations for Implementation

- A systems-change initiative of this magnitude will need identified shared aims and goals.
- A systems-change initiative of this magnitude will need Dispatch leadership to champion the effort and communicate early, often, and positively about the upcoming changes.
- By participating in Dispatch's assessment and planning processes, the SCU model can identify opportunities early on that support the integration, such as using aligned terminology and data collection processes.
- A Dispatch representative should join the SCU Steering Committee (*refer to recommendation #20*).
- Dispatch leadership should join the model's centralized coordinating body (*refer to recommendation #19*).

[16] Berkeley City Auditor. (2019, April 25). 911 Dispatchers: Understaffing Leads to Excessive Overtime and Low Morale. https://www.cityofberkeley.info/uploadedFiles/Auditor/Level_3_-_General/Dispatch%20Workload_Fiscal%20Year%202018.pdf

Recommendation #9

Ensure the community has a 24/7 live phone line to access the SCU.

Implementing the SCU as a 24/7 mental health and substance use crisis model requires a 24/7 live phone line to ensure community members have reliable and equitable access to mental health crisis response. The 24/7 availability is essential for community members to feel confident in the availability of the mental health crisis response, as stakeholders reported that MCT's alternative phone number—which is not live and relies on voicemail and callbacks—does not feel like a reliable resource during crises.

The need to develop and implement the SCU model is urgent and at the same time must achieve structural change to ensure sustainability. Implementing a process for the short-term that must be undone would be an inefficient use of funds and may confuse the public and exacerbate distrust. For these reasons, the following three options should be further considered and assessed for how to most effectively ensure 24/7 live access to the SCU crisis response:

1. Option A: Use the existing 911 Communications Center ("Dispatch") to deploy the SCU.
2. Option B: Contract to a CBO that can staff and implement an alternative number phone line as part of the SCU model.
3. Option C: Use the 988 National Suicide Prevention Lifeline to receive, triage, and assess all mental health crisis calls.

Table 1 below highlights several factors to consider related to timeline and staff capacity, funding, safety, system integration, and public awareness. Based on these factors, it appears that Option A (using the existing 911 Communications Center to deploy the SCU) would be the best option for the City of Berkeley. However, these factors should be further discussed by City of Berkeley leadership across HHCS and Dispatch with careful consideration of the phased implementation approach and timeline.

Table 1: Options and factors to assess when planning for the community to have 24/7 live phone line access to the SCU.

	Option A **Recommended Option**	Option B	Option C
	Use 911 and existing Communications Center ("Dispatch") to deploy the SCU.	**Contract to a CBO that can staff and implement an alternative number phone line as part of the SCU model.**	**Use the 988 national phone line to receive, triage, and assess all mental health crisis calls.[17]**
Timeline & Staff Capacity	Assess Dispatch's ability to recruit, hire, and train new staff on a timeline aligned to the phased implementation approach. Consider the amount of resources and time required for Dispatch to train existing staff on new protocols. Consider Dispatch's capacity to support the SCU adoption and integration in addition to the current accreditation process.	Assess whether a CBO can realistically implement both the SCU model and an alternative phone number (i.e., call center), including recruiting, hiring, and training all new personnel.	Monitor the alignment of national, state, and county timelines for 988 implementation. Assess whether the 988 call center will be staffed appropriately for the additional call volume brought in by requests for SCU.
Funding	Estimate the additional funds required for Dispatch to recruit new personnel (i.e., a recruitment team) and manage the Human Resource capacity to support additional staff.	Estimate the cost to create and operate an independent 24/7 live alternative phone line.	Explore the amount of funding and resourcing available for 988 to assess whether the funds sufficiently support the 24/7 SCU.

[17] Gold, J. (2021). How will California's new 988 mental health line actually work? *U.S. News.* **https://www.usnews.com/news/health-news/articles/2021-10-12/how-will-californias-new-mental-health-hotline-actually-work**

		Option A (Recommended)	Option B	Option C
Safety	**Promotes Safety**	Evaluate and compare each option's ability to establish protocols or infrastructure to support the safety of crisis responders and community members.		
		Dispatch already has established protocols and technology to track the crisis responder's location/position through CAD. Dispatch already has established protocols and technology to maintain radio communication between Dispatch and crisis responders, especially during rapid changes in a situation. Dispatch already has established protocols and technology to streamline the handling and transfer of calls so that a person in crisis does not have to repeat their story multiple times, thereby reducing the number of dropped calls.	Assess the resources and timing required for a CBO to ensure sufficient training on the use of the CAD system and radio communication. Assess workflows and processes that would affect the number of times a caller must repeat triage/assessment; estimate whether there will be an increase in dropped calls. Consider if a non-911 entity will more effectively reduce police-community interactions during mental health and substance use crises.	Assess the ability for existing Alameda CSS and 988 technology to integrate with Dispatch's CAD system and radio communication. Evaluate the effectiveness of existing processes to transfer calls between Alameda CSS and Dispatch. Consider if the 988 entity will more effectively reduce police-community interactions during mental health and substance use crises.
	Risks to Safety	Evaluate and compare the potential risks to the safety of crisis responders and community members across each option.		
		Consider whether Dispatch will be more likely to deploy the police than the SCU during initial model implementation. Evaluate whether community members' fear of a police response, will reduce the utility, acceptability, and accessibility of the SCU.	Consider whether alternative phone line personnel will be more likely to deploy the SCU than transferring calls to 911. Evaluate whether community members will be more likely to call an alternative phone number than 911 if they are experiencing a mental health or substance use crisis.	Consider whether community members will be confused about 988 and may believe it is only for suicide prevention rather than the full spectrum of mental health and substance use crises, and therefore be less likely to call 988.

	Option A (Recommended)	Option B	Option C
System Integration	N/A *(911 is already integrated with Berkeley Fire, Falck, and Alameda County CSS)*	Explore the process for a CBO to assess and prepare callers if they need to transfer the call to 911, such as if the presence of weapons is confirmed. Evaluate the effects, such as a slowed response time or increased risk of a dropped call. Consider whether the transfer of calls to 911 (i.e., calls ineligible for SCU) will undermine community trust in the alternative phone line. Determine the feasibility of integrating a CBO's technology to allow for the transfer of calls between Alameda CSS and Dispatch. Determine the feasibility of a CBO's technology to receive calls from Fire and Falck if they request the SCU.	Determine whether Alameda County will be able to deploy a Berkeley-specific team (the SCU) for only Berkeley residents as a component within the larger 988 model. Assess what will be required for a county system to deploy a model administered by a CBO, such as additional contracts, MOUs, or staff licensure requirements.
Public Awareness	Consider what will be required of a public awareness campaign to build community trust in 911 to deploy the SCU as a non-police response.	Consider what will be required of a public awareness campaign to inform Berkeley residents both about the SCU as a non-police crisis response and promote an alternative phone number to access the SCU.	Assess the public awareness and education planned for 988. Assess whether the Alameda County 988 public awareness campaign can be adjusted for Berkeley to communicate the availability of the SCU through 988.

Why consider different options for phone access to the SCU?
The numerous factors that should be assessed to determine the best option for phone access to the SCU will require a significant amount of collaboration and detailed planning across city leadership, which requires time throughout Phase 0. The general public is familiar with 911 as a crisis response resource. As a result, 911 could be an important method of ensuring mental health and substance use crises are routed to the SCU mobile team. However, stakeholders, especially residents of color and Black residents, consistently shared that the fear of physical violence, criminalization, or retaliation by police in response to mental health and substance use emergencies is a barrier to calling 911. Therefore, a non-911 option may support community members to feel confident in the SCU as a non-police mental health crisis response. Considering and assessing the full array of options will ensure the best approach for a reliable and equitable access to 24/7 mental health crisis response.

Why is Option A elevated as the recommended option?
Overall, Option A is recommended because it appears to be a better fit for the SCU model. It will most likely be the more cost-effective option, will allow for the SCU mobile team to be launched soonest, and will align to the phased implementation approach and the future integration of the SCU into 911.

By pursuing Option A, preparation with Dispatch can begin sooner than the other options, thus allowing for additional time to plan and prepare. This additional planning time can be used to address concerns regarding safety, community trust, and public awareness. Integrating the SCU into 911 from the initial phases of implementation may also support a streamlined and efficient integration. In contrast, Option B will likely require significantly more funding to create an entirely new call center, which may become obsolete once 988 is implemented, nationally. The feasibility and expense of standing up an entirely new call center (option B) may be prohibitive. Option C will require significant coordination with Alameda County and has many implications that are outside of the control of the City of Berkeley, which could cause delays or challenges to the implementation of the SCU model.

Additionally, 911 has established technology and infrastructure for receiving and triaging phone calls, deploying crisis responders, tracking the crisis response to promote responder safety, and collecting data that is essential for monitoring, evaluation, and follow-up. Moreover, for the public awareness campaign, it may be easier to communicate the SCU as a non-police response through 911 than it is to both communicate the SCU as a non-police response and to publicize an alternative phone number.

Why might the model implement an alternative phone number? (Option B or Option C)
First, due to existing community distrust of policing systems, it is important to establish the SCU response as a non-police response. By implementing the alternative phone number first, community members may be encouraged to utilize the SCU. Second, the existing Dispatch system is complex, overburdened, and underfunded. In order to have a successful integration of the SCU within 911, it may require more time for planning for a sustainable integration that ensures community safety. Third, lessons learned from other cities implementing alternative models may indicate this order would support SCU success. For example, the Portland Street Response team can be accessed through both 911 and a non-emergency phone number connected to Dispatch. However, they found that calls from 911 were prioritized rather than calls from the alternative line when deploying the team. Berkeley will need to establish clear prioritization and triage protocols so that the highest-acuity calls receive adequate responses, rather than the response being determined by the source of the call.

Do other cities use multiple phone numbers?
From the reviewed models, at least seven use two or more lines for emergency crisis calls:

- Olympia, WA: Crisis Response Unit
- Sacramento, CA: Department of Community Response
- Austin, TX: Expanded Mobile Crisis Outreach Team (EMCOT)
- Oakland, CA: Mobile Evaluation Team (MET)
- Portland, OR: Portland Street Response
- Eugene, OR: Crisis Assistance Helping Out on the Streets (CAHOOTS)
- Denver, CO: Supported Team Assisted Response (STAR)

If the model uses an alternative phone line, what happens if people still call 911 when they are having a mental health crisis?
Dispatch should have the option to forward calls to the SCU alternative phone line, where those staff can triage the call and deploy the SCU. Establishing these protocols will be part of the assessment and planning process. It is also important that a public awareness campaign promotes access to the SCU team (*refer to recommendation #24*).

Additional Considerations for Implementation:

- The phone line will require dedicated office space and equipment to process calls and deploy the SCU.
- The phone line will need technology and protocols to ensure data collection and integrity to support monitoring and evaluation (*refer to recommendations #22 and #23*).
- The phone line will require enough staff to maintain a 24/7 live response including staff to receive calls and supervisory staff. This team will need to be sufficiently staffed to account for shift overlap, sick leave, and vacation time.
- Additional data collection and planning will be required to determine the adequate number of call takers and fully implement the phone line.
- Option A may require that Dispatch makes more gradual changes to triage criteria, deploying the SCU to a more limited scope of call types with a gradual increase in SCU deployment through Phase 1 implementation.
- Either option B or option C would still require the phone line entity to collaborate with Dispatch to develop types of calls, triage criteria, and workflows to allow for future integration of SCU into Dispatch.
- The future structure of the 911 Communications Center within Berkeley Police Department should be evaluated (*refer to Section V*).

**Please note: Dispatch uses specific terminology that may not be accurately represented here. The language in these recommendations should be understood from a lay perspective rather than rigid technical language (e.g., call takers versus dispatchers, assessment versus triage versus decision-trees).*

Recommendation #10

Plan for embedding a mental health or behavioral health clinician into Dispatch to support triage and SCU deployment.

Embedding a mental or behavioral health clinician within the Dispatch represents a new process for Berkeley's Dispatch and broadens Dispatch's lens from being solely a Police entity to an entity that includes clinical specialists. Dispatch must be involved in planning for this additional team member.

Why should Dispatch have a clinician in the call center?
Embedding a mental health clinician in emergency call centers is an emerging best practice, though only a few cities nationally report staffing their call centers with clinicians. The few cities that have included mental health clinicians in their call centers have found them to be a useful resource. Where implemented, clinicians provide specialized training for call takers to handle behavioral health crisis calls, receive transferred behavioral health crisis calls, and provide guidance.[18]

How does having a clinician in Dispatch promote community or crisis responder safety?
Berkeley Dispatch is deeply committed to the safety of crisis responders. In interviews for this project, Austin's EMCOT program[19] shared that embedding a clinician within their call center increased communication around safety and risk assessment during triage, including increased deployment of the crisis response team. They also shared that this integration improved handoffs for telehealth conducted by the clinician. Berkeley should plan for embedding a clinician in Dispatch to support with de-escalation and determinations because it could promote safety.

Why does the clinician need to be part of planning in Phase 0 if implementation is in Phase 1?
This change represents a structural shift for Dispatch, incorporates new roles for a specialized skillset, and changes several workflows. As a result, having a clinician participate in planning in Phase 0 will support successful implementation in future phases. Additionally, given the current significant understaffing and under-resourcing of Dispatch, the clinician can augment staff capacity without Dispatch having to acquire a new, specialized skillset.

Considerations for Implementation:

- Calls that do not require an in-person response should continue to be sent to Alameda County CSS for phone support.
- Staffing structures will need to be adapted, such as determining which roles supervise the clinician and which roles the clinician supervises.
- The clinician may be able to provide training and ongoing professional development to support call takers to identify and address mental health calls.
- There may be a need for multiple clinicians depending on their role and the call volume.
- This recommendation will need to be adapted based on how recommendations #8 and #9 are implemented.

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[18] Velazquez, T & Clark-Moorman, K. (2021). New research suggests 911 call centers lack resources to handle behavioral health crises. *ResearchGate.* **https://www.researchgate.net/publication/355684339_New_Research_Suggests_911_Call_Centers_Lack_Resources_to_Handle_Behavioral_Health_Crises**

[19] Read more about the EMCOT program here: **http://www.austintexas.gov/edims/pio/document.cfm?id=348966**

Implement a Comprehensive 24/7 Mental Health Crisis Response Model

There are many considerations for realizing the full implementation of a 24/7 model including hiring personnel, establishing clear roles, and providing office space and required materials. Staffing a comprehensive model should seek to address the perceived challenges of existing crisis response systems throughout Berkeley, such as not having 24/7 availability or sufficient staff capacity.

The following recommendations are designed to leverage the lessons learned from other cities implementing non-police crisis response models and be responsive to the needs and concerns expressed by community stakeholder participants. Each recommendation should be further explored as launch and implementation progresses:

Key Recommendations

11. **Fully staff a comprehensive model to ensure the success of the SCU mobile team, including supervisory and administrative support.**
12. **Operate one SCU mobile team per shift for three 10-hour shifts.**
13. **SCU staff and Dispatch personnel travel to alternative crisis programs for in-person observation and training.**
14. **Prepare the SCU mobile team with training.**

Recommendation #11

Fully staff a comprehensive model to ensure the success of the SCU mobile team, including supervisory and administrative support.

In addition to the three-person SCU mobile team (*recommendation #3*), the 24/7 live phone line (*recommendation #9*), and the clinician in Dispatch (*recommendation #10*), the SCU will require supervisory and administrative support roles. These roles will support the day-to-day services and operations of the SCU mobile team. They also will participate in case management meetings (*recommendation #18*), rapid assessment and monitoring (*recommendation #22*), and model evaluation (*recommendation #23*).

Recommended Personnel Roles & Types of Responsibilities[20]:

Program Manager

- Review data from implementation, lead rapid assessment process, support changes and iteration to model
- Liaise with city, Dispatch, and central leadership around implementation, rapid assessment, and coordination
- Manage contract and budget
- Manage scheduling and shifts

Clinical Supervisors

- Oversee and support SCU mobile team, provide consultation for medical and mental health services
- Plan and lead training and professional development for SCU mobile team
- Collaborate with peer specialist supervisor on how to best support SCU mobile team
- Share client and staff feedback to program manager for rapid assessment and monitoring

Peer Specialist Supervisor

- Oversee and support peer specialists on SCU mobile team with an emphasis on emotional support for peers
- Plan and lead training and professional development for SCU mobile team, with an emphasis on utilizing peer specialists and other forms of team communication and support (e.g., advocacy, equal value, communication)
- Collaborate with clinical supervisor

Call Takers / Call Center *(pending implementation of recommendations #8-10)*

- Receive calls from the 24/7 live phone line; triage calls and deploy SCU mobile team, as required
- Receive calls from Dispatch
- Transfer calls that do not require in-person services to Alameda County CSS
- Participate in case management care coordination meetings, as relevant

[20] Refer to **Appendix B** for the number of personnel, availability, shifts, and a sample shift structure

Considerations for Implementation

Availability or shift structure for roles:

- The program manager and peer specialist supervisor roles should be available during traditional business hours.
- The clinical supervisor role should be available 24/7 and will require redundancy in hiring.
- The call center will need to be staffed to ensure a 24/7 live phone line. If Option B is pursued (*refer to recommendation #9*), the call center should be situated within the SCU model rather than a separate CBO. This could promote morale and team identity and will increase the quality and efficiency of communication.

Office & Equipment Needs:

- The SCU model will need an office space that accommodates all personnel and their roles, such as daily huddles, desks, and equipment.[21]
- Stakeholders suggested that the SCU would benefit from developing relationships with service utilizers and their families. If these opportunities are pursued as part of the SCU's function, then office space could also accommodate service utilizer and family consultations and/or open "office hours" for relationship building.

[21] Refer to **Appendix C** for the budget and additional office equipment needs, such as computers, phones, printers, etc.

Recommendation #12

Operate one SCU mobile team per shift for three 10-hour shifts.

In order to staff a crisis response model that operates 24/7, the SCU should staff one mobile team per shift for three 10-hour shifts. We estimate that the SCU would respond to three to six incidents per 10-hour shift, with each incident requiring 20 to 120 minutes for response and closure. This should generally be manageable by one SCU mobile team.[22]

Why 10-hour shifts?
Based on feedback from those operating similar models as well as from community stakeholders, 10-hour shifts are common in residential settings and tend to work well for clinical and mental health staff. There are often labor union protections for shifts longer than 10 hours. Three 10-hour shifts would provide 24/7 coverage while allowing for some overlap before and after each shift.

Why should shifts overlap?
The SCU mobile team shifts should overlap so that the team can conclude engagement with a person in crisis before their shift ends. The next shift would be able to respond to a crisis call that comes in towards the end of the preceding team's shift. The overlap also supports team huddles for care coordination. The shift structure and overlap should include time for the required paperwork at the end of the shift so that there is not an expectation that paperwork is completed during off hours.

Will one SCU mobile team be sufficient?
This estimate is comparable to the call and incident volume reported by Denver's STAR pilot, Portland's Street Response pilot, and Eugene's CAHOOTS program. Though the city population of Denver and Portland are 5.8 and 5.3 times larger than Berkeley's population, respectively, their pilots are restricted to smaller geographic units of the city; Denver and Portland both operate only 1 mobile crisis response team per shift. Eugene's city population is 1.4 times the population of Berkeley, and Eugene operates 1 crisis team per shift, with an additional team during peak hours of 10am-12pm and 5pm-10pm.[23]

Considerations for Implementation

- Staffing structure will require redundancy to allow for personnel to take vacation and sick days, and in anticipation of periodic vacancies.[24]
- Staffing structure may need to plan for on-call or floater shifts.

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[22] Estimates for SCU call volume are based on analysis of call and service volume by MCT from 2015 to 2019, the Auditor's Report and analysis of Berkeley Police Department's call and service volume from 2015 to 2019, and analysis of Berkeley Fire's and Falck's transport volume and time on task from 2019 to 2021. Please refer to **Appendix D** for more specific analysis and estimates.

[23] The City of Eugene (2019-03240). **https://www.eugene-or.gov/DocumentCenter/View/56579/2019-03240-White-Bird-CAHOOTS-Services---SIGNED**

[24] Refer to **Appendix B** for the number of personnel, availability, and a sample shift structure.

Recommendation #13

SCU staff and Dispatch personnel should travel to alternative crisis programs for in-person observation and training.

Although Berkeley's SCU model will be uniquely designed and tailored for the Berkeley community, there are many opportunities to learn from successes and challenges of other models that have implemented non-police mental health crisis response programs. For example, the Denver STAR team shared that their Dispatch team benefited greatly from traveling to Eugene, OR to observe and learn about the CAHOOTS model and plan their deployment protocols.

Options for city programs to visit:

- CAHOOTS: Eugene, OR
- STAR: Denver, CO
- EMCOT: Austin, TX

Recommended personnel to attend:

- Dispatch: Supervisor
- SCU: Clinical Supervisor and Program Manager
- Phone line staff, as relevant (refer to recommendation #9)

Potential program components to observe during site visit:

- Triage criteria and workflows
- Assessing for risk and safety
- Working with the mental health clinicians embedded in Dispatch
- Coordinating and prioritizing calls between 911 and an alternative phone number
- SCU mobile team services and team coordination
- Role clarification

Why should Dispatch and SCU staff travel to these sites together?

This training opportunity would support the collaboration between the SCU and Dispatch in planning for the phased integration. By traveling to the sites together, SCU and Dispatch will not only hear the same questions and answers but can ideate and collaborate on adaptations for the Berkeley SCU model. Finally, this is an important opportunity for relationship building between SCU staff and Dispatch, which is essential to this systems-change initiative.

Considerations for Implementation

- Travel costs will need to be included in the initial budget; estimates for consulting fees from the sites are already included.[25]

[25] Refer to **Appendix C** for the estimated SCU model budget.

Recommendation #14

Prepare the SCU mobile team with training.

The SCU will require training in a set of specific skill areas to be best equipped to provide mental health crisis response. The personnel hired should already have demonstrated their specialized skill set in previous employment settings; training will therefore support the team to align on how to implement their skills. Training also supports teams to work together and with other entities effectively, such as Dispatch, which is essential in crisis response.

The SCU mobile team should be trained in the following topics:

- General de-escalation techniques
- Disarming without use of weapon
- Substance use management
- Naloxone administration
- Harm reduction theory and practice
- First aid
- Situational awareness and self-defense
- Radio communication
- Motivational interviewing
- Implicit bias, cultural competency, and racial equity
- Trauma-informed care
- Training on data collection protocols and data integrity (refer to recommendations #17 and #18)
- Compliance with confidentiality and HIPAA when interacting with Police and/or Dispatch

How long will it take to train staff?

Eugene's CAHOOTS program includes at least 40 hours of classroom training and 500 to 600 hours of field training for all new staff.[26] This equates to 12.5 to 15 weeks of training when calculated on a full-time basis.

What informed these suggested training topics?

These training topics were generated from a variety of alternative model program recommendations and input from Berkeley service providers and community stakeholders.

Considerations for Implementation:

- The phased approach timeline incorporates an estimate aligned to CAHOOTS' model, with room for adaptation.
- Training should be provided to all new SCU staff as they are added to the team, regardless of start date.
- Additional training topics may be identified by the SCU team.

[26] Beck, J., Reuland, M., & Pope L. (2020). Case Study: CAHOOTS. *Vera*. **https://www.vera.org/behavioral-health-crisis-alternatives/cahoots**

Administration and Evaluation

There are many considerations for effectively administering and monitoring implementation of a new, 24/7 mental health crisis response model. Effective implementation includes ongoing collaboration and decision-making at both the structural and provider levels.

At a structural level, the SCU model will require cross-system coordination for implementing new processes and therefore will require leadership across the City of Berkeley and SCU to collaborate around ongoing program monitoring, data review and transparency, and system integration. At a provider level, the SCU model will require collaboration and communication to support care coordination and case management for people that have experienced crisis as well as to elevate emerging challenges and successes.

Moreover, the community can—and must—provide essential advisory capacities. The community should be actively engaged to provide input and feedback throughout the planning and implementation of the SCU, including through the SCU Steering Committee and ongoing opportunities for the general public.

The following recommendations were informed by the lessons learned from other cities implementing alternative crisis models and aim to be reflective of the perspectives shared by the project's stakeholder participants. Each recommendation should be a starting point to promote cross-sector collaboration, adjusting to accommodate the evolution of the SCU:

Key Recommendations

15. **Contract the SCU model to a CBO.**
16. **Integrate the SCU into existing data systems.**
17. **Collect and publish mental health crisis response data publicly on Berkeley's Open Data Portal.**
18. **Implement care coordination case management meetings for crisis service providers.**
19. **Implement centralized coordination and leadership across city agencies to support the success of mental health crisis response.**
20. **Continue the existing SCU Steering Committee as an advisory body.**
21. **Solicit ongoing community input and feedback.**
22. **Adopt a Rapid Monitoring, Assessment, and Learning process.**
23. **Conduct a formal annual evaluation.**

Recommendation #15

Contract the SCU model to a CBO.

The administrative structure of crisis response systems across the country varies significantly. Some are administered by government agencies, some are run in collaboration between a government agency and CBO, and some are entirely operated by CBOs. There are several reasons why the SCU model should be contracted to a CBO, at least through Phase 2 of the phased implementation approach.

The SCU crisis response model would benefit from being contracted to a CBO for several reasons:

- **Supports a quick launch:** CBOs are often able to move more nimbly than government agencies, especially as it relates to hiring; adequately staffing the SCU mobile crisis team is a critical element in timely implementation. Given the urgent need, the ability to launch the SCU quickly and provide non-police mental health crisis response services is critical.
- **Established relationships with community members:** Stakeholders made it clear that CBOs have developed strong relationships with service utilizers accessing mental health support, homelessness resources, street medicine, and system navigation and referrals. CBOs in Berkeley have expertise in the community that can be leveraged
  to advance the SCU's crisis response efforts.
- **Referral networks and partnerships:** A CBO with established networks and partnerships would be well positioned to support service utilizers with referrals as well as transport to community-based resources. Additionally, these relationships can support warm handoffs at transport locations.

Considerations for Implementation

- To contract with a CBO, the City of Berkeley will have to issue a Request for Proposals (RFP). The RFP process will need to evaluate a CBO's capacity to develop and implement a model of this size on this timeline.
- The City should identify a backup plan if no qualified CBOs respond to the RFP.
- The CBO's practices should align to the values and principles of the SCU. The City may need to use contracts and MOU specifications to require:
  - Adequate and equitable wages for all SCU staff and crisis responders, especially peer specialists and peer specialist supervisors.
  - A representative and equitable hiring process that prioritizes staff who are reflective of those most marginalized and harmed by existing crisis response options and the criminal legal system.
  - Necessary data and metrics to collect and report as well as ensuring sufficient technological systems to meet these needs.
- CBOs may face challenges inherent in the contract structure, which should be evaluated and protected against as these challenges can undermine sustainability and longevity.
  - Short-term funding: only funding the SCU in one-year increments can reduce staff retention and inhibit investments in operations (*refer to Section V*).
  - Overhead costs: allocate enough funds for overhead costs (e.g., salary, training, and office equipment), which are critical to SCU success.
  - Contract monitoring: data collection, monitoring, and evaluation are essential to the success and iteration of the SCU but should not be prohibitive to the work.
- There may be additional needs or considerations around data and system integration (*refer to recommendation #16*) and the collaboration across administration and leadership if a CBO implements the SCU; these may need to be included in the contract.
- All recommendations are written with a contracted CBO in mind; additional implications may arise during planning and Phase 0.

Recommendation #16

Integrate the SCU into existing data systems.

Having access to patient data will support the SCU to provide tailored, informed, and equitable services for those experiencing mental health and substance use crises. Access to existing data systems, such as an EHR, will not only ensure that the SCU has access to relevant patient information, but also that other providers are aware when, how, and why their client might be interacting with crisis response. Finally, integrating the SCU into existing data systems will ensure aligned and consistent data collection, which is essential for the rapid assessment monitoring (*refer to recommendation #22*) and evaluation (*refer to recommendation #23*).

There are many factors outside of the purview of the SCU, HHCS, or even that City of Berkeley that affect whether data and system integration can be achieved. These factors include patient privacy and legal protections (i.e., HIPAA), technological capabilities, available funding, logistics across private and government entities, and more. As a result, this recommendation is included as an aspiration that should be planned for in future phases and may not be realized during Phase 1 of implementation.

- Bidirectional, live data feeds should be integrated between the SCU and other data sources, including but not limited to:
  - EHRs used by major medical systems and Federally Qualified Health Centers (FQHC)
  - Alameda County's Community Health Record (CHR)
  - Alameda County's YellowFin

Why does the SCU need to access service utilizers' records, such as EHRs?
Access to an EHR allows crisis responders to make informed decisions based on a service utilizer's health history. This access also enables crisis responders to communicate directly with a service utilizer's existing support team, such as psychiatrists or case managers, when providing crisis response or referring the service utilizer for follow-up care.

Is it common for crisis responders and clinicians to have access to service utilizer records?
Many other crisis response programs enable access to these sources of data. For example, the Alameda County Community Assessment and Transport Team (CATT) has access to the county's CHR. Providers at FQHCs, including programs like Lifelong's Street Medicine Team, have access to an integrated EHR. Berkeley Mental Health (BMH) is already integrated with the county's YellowFin reporting system. Other city models, such as Denver STAR, enable their crisis responders to access existing data systems.

Why should the data feeds be bidirectional?
Not only do crisis responders need to access service utilizer medical history, but the data they collect during a crisis response should be entered into the centralized data systems so that a service utilizer's existing support team has an updated and complete case history. The county's CHR has live data feeds from many providers and so the SCU's data should also have bidirectional capabilities when possible.

Considerations for Implementation

- The Berkeley City Attorney and IT have signed onto the county's CHR, and many CBOs and medical providers have also already signed onto the CHR, which could facilitate the SCU's integration into this system.
- The SCU will need access to EHRs and the CHR to participate in client case management meetings (*refer to recommendation #18*).
- SCU team members will need training and support to accurately enter data into these platforms, which is essential to data integrity.
- Legal protections for confidentiality and consent will have to be carefully assessed to determine the feasibility of this recommendation and implementation approach.
- Many health conditions can be criminalized and prosecuted. The SCU data must be separate from Dispatch and CAD data because Dispatch is situated within Berkeley Police Department. Presently, Dispatch does not have access to EHRs or the CHR, and in the future, this separation should continue.

Recommendation #17

Collect and publish mental health crisis response data publicly on Berkeley's Open Data Portal

Data collection is essential to monitoring and evaluation and spans across the SCU mobile team and supporting personnel, Dispatch and/or the alternative phone line, and central leadership. Given how many different personnel and agencies will be collecting and reviewing data, it is essential that data collection be planned for early in Phase 0 to ensure alignment, accuracy, and data integrity.

- Types of data that should be collected and published:
  - Call volume
  - Time of calls received
  - Service areas
  - Response times
  - Speed of deployment
  - Determinations and dispositions of Dispatch (including specific coding for violence, weapons, and emergency)
  - All determinations and deployed teams from Dispatch
  - Percentage of calls responded to by SCU of all calls sent to SCU
  - Type or level of service needed compared to the initial determination at the point of Dispatch
  - Service utilizer outcomes
  - Number of 5150 assessments conducted
  - Number of 5150s confirmed and involuntary holds placed
  - Number of transports conducted
  - Location of transport destinations
  - Type of referrals made
  - Priority needs of clients served (housing, mental health)
  - Number of requests for police involvement
  - Racial demographics of service utilizers
  - Other relevant characteristics of service utilizers, such as homelessness status or dementia

  Note: not an exhaustive list.

- Examples of public data dashboards from alternative crisis models:
  - Portland's Street Response data dashboards
  - NYC's B-HEARD monthly data reports

How does data collection promote community safety and health?

Nationally, many emergency call centers lack consistent data collection and internal sharing and review, suggesting city administrators and leaders are unable to effectively use data to understand the scope of behavioral crisis and response in their communities.[27] Collecting data in a way that can be used among program administrators will be essential in supporting the success of the SCU and positive outcomes for the community. Moreover, during this project, it was impossible for RDA to conduct an "apples-to-apples" analysis between data from any of the contributing agencies (Police, Fire and Falck, MCT, Dispatch/Auditor's Report) because the data entry practices across each agency are inconsistent. Specifically, the variables that each agency records for each call response are not the same. In instances where there were similarities in the types of variables used between agencies, the values that they each used to enter or code their data were not comparable.

Why does publishing data publicly matter?

Publishing data through Berkeley's Open Data Portal could promote transparency around crisis response services, address community stakeholders' distrust of the system, and keep the community informed about the SCU and the city's crisis response services.

Considerations for Implementation

- Multiple agencies are likely to engage in data collection that contributes to the SCU model. All data variables and definitions should be aligned to ensure system integration and data integrity, including:
    - CAD data
    - Additional 911 and Dispatch data (as applicable)
    - Alternative phone number data (as applicable)
    - SCU mobile team data
    - EHR data
    - CHR data
- Personnel will need ample training on data collection, including variable definitions and data entry processes, to ensure a high degree of data integrity.
- Staff will need adequate technology to collect and report on data (*refer to recommendation #6*).

[27] Velazquez, T & Clark-Moorman, K. (2021). New research suggests 911 call centers lack resources to handle behavioral health crises. *ResearchGate.* **https://www.researchgate.net/publication/355684339_New_Research_Suggests_911_Call_Centers_Lack_Resources_to_Handle_Behavioral_Health_Crises**

Recommendation #18

Implement care coordination case management meetings for crisis service providers.

Service utilizers often receive care across multiple agencies and individual service providers, but transparency and visibility of service utilizers that move in and out of these agencies is a challenge. Regular case management coordination meetings across organizations and providers could help to address the perceived lack of coordination across different services and to improve the care coordination for service utilizers, such as those discharged from inpatient facilities.

Who should participate:

- SCU mobile team
- Service providers and case managers identified through CHR and EHRs
- Partners and those receiving referrals at CBOs
- A designated meeting coordinator (e.g., SCU program manager, city staff)

What the meetings should achieve:

- Discuss care for shared service utilizers
- Discuss needs of high service utilizers, services provided
- Discuss successes or challenges with warm handoffs and referral pathways

How is care coordination relevant to crisis response?

Care coordination supports providers in making informed decisions about the services to provide and can prevent future crisis. Throughout the project's qualitative data collection, service providers in Berkeley commonly provided the idea of care coordination meetings between the SCU and providers; they expressed that if their clients access SCU crisis services, they would benefit from collaborating with the SCU. The REACH Edmonton program also shared that meetings for frontline workers to discuss shared clients increased positive client outcomes. Finally, Berkeley's Transitional Outreach Team (TOT) shared challenges they have encountered when providing follow-up care after MCT responds to an incident, especially communicating with the many external providers that interact with a single service utilizer.

Why is there a coordinator role in these meetings? Who is that?

Based on the lessons learned from other cities implementing alternative crisis response models, such as the REACH Edmonton and Denver STAR programs, care coordination meetings will require a centralized coordinator or leader from the SCU. Frontline workers do not have the capacity to manage these meetings, which includes scheduling, note taking, preparing data, following up on items as necessary, and other duties. The care coordinator may be an administrative staff member of the SCU, such as the program manager, or a staff member from the City of Berkeley who oversees many of the relevant contracted providers (beyond the SCU).

Considerations for Implementation:

- These meetings will require a clear owner to manage meeting topics, prepare data, identify non-urgent items for follow-up, and ensure equitable power and time talking, especially for peer specialists. The SCU program manager may be best poised for this role.
- Integrated data systems that allow for sharing data and reviewing case history across providers would enhance care coordination and case management (*refer to recommendation #16*).
- There may be a benefit to call takers joining these meetings if they identify and document who is in crisis.

Recommendation #19

Implement centralized coordination and leadership across city agencies to support the success of mental health crisis response.

Overall, programs benefit from ensuring there are one or more people responsible for coordinating the program at a birds-eye view. As a new mental health crisis response initiative, the SCU model will require cross-system coordination for implementing new processes, training, monitoring, and evaluation. Moreover, because these initiatives span across Dispatch and/or an alternative phone number, the SCU mobile team, and other referral entities like Fire, Police, MCT, TOT, and mental health and social service providers, a centralized coordinating body will be essential to the success of this far-reaching initiative.

Who should participate:

- Berkeley Dispatch
- Berkeley Department of Public Health
- Berkeley Mental Health (BMH)
- Berkeley Health, Housing & Community Services Department (HHCS)
- SCU Program Manager
- Berkeley Fire Department
- Berkeley Police Department
- Other relevant parties as the project evolves

What the meetings should achieve:

- Progress along the phases of implementation
- Lead the rapid assessment processes and regularly review data
- Review SCU Steering Committee feedback
- Review service utilizer and stakeholder feedback
- Prioritize issues
- Make decisions

Additional outcomes:

- Increase open communication across city agencies
- Build trust across crisis responders and city departments
- Align all partners on shared values for increasing community health and well-being

Why is the Berkeley Police Department involved in this leadership body if the SCU is a non-police response?
Because the police currently respond to all mental health calls received through 911, any decision about shifting specific call and service types from police to SCU will require BPD buy-in, communication, and planning. Moreover, Dispatch is currently situated within BPD, and therefore, BPD leadership will be required to assess and approve changes to Dispatch. For instance, to ensure that all SCU data is kept confidential and separate from police, BPD will need to support planning for CAD data to integrate with SCU in a compliant manner. Finally, police may be able to request SCU deployment, so these types of protocols will need BPD's input.

Considerations for Implementation:

- These meetings will need a clear owner to schedule meeting times, prioritize agenda topics, prepare data, identify non-urgent items for follow-up, and coordinate follow-up communication to relevant stakeholders.
- A data dashboard will support data review and rapid assessment processes.
- Some agencies may have strong bargaining presence or positional power, such as BPD. It is important that these meetings uphold equitable power and weight in making decisions.
- Throughout Phase 0 and Phase 1, this group may need to meet on a weekly basis.
- Additional stakeholders may need to be added to this group (permanently or ad hoc for specific topics), such as representatives from emergency departments, John George Psychiatric Hospital, or other city or county stakeholders.
- As the model progresses, this group may discuss opportunities to improve the mental health crisis system at a broader scale, beyond the scope of the SCU's crisis response, such as more inter-county and inter-city coordination on systemic issues related to housing.

Recommendation #20

Continue the existing SCU Steering Committee as an advisory body.

Presently, the SCU Steering Committee has representatives with ties to community groups and stakeholders. The SCU Steering Committee should continue as an advisory body to incorporate into decision-making spaces the perspectives that may otherwise be neglected in government spaces.

The SCU Steering Committee should continue to advocate for marginalized communities in the SCU model design and delivery by taking on an advisory role through Phase 0 and Phase 1 of implementation, at a minimum.

The current participants should remain, if they choose, including:

- Berkeley Community Safety Coalition
- Representatives from the Mental Health Commission
- HHCS staff
- BMH staff
- Berkeley Fire

Additional participants should be added, including:

- Relevant staff from the SCU or administrative CBO, such as the program manager or clinical supervisor
- Dispatch personnel, particularly someone in a leadership position who can both promote change and holds expertise relevant to implementation

Considerations for Implementation

- HHCS staff should maintain the role of coordinating the SCU Steering Committee, even if a contracted CBO leads the SCU, because HHCS will lead other aspects of oversight including contract management.
- Additional participants may be added to the SCU Steering Committee at different times. For example, Dispatch personnel should join earlier in Phase 0 of implementation, while SCU personnel will join once that team is fully staffed in Phase 1.

Recommendation #21

Solicit ongoing community input and feedback.

Governments often face barriers in hearing from community members that are the most structurally marginalized. However, engaging existing coalitions and networks designed to represent marginalized service users' perspectives can support more equitable engagement. Intentional outreach for these opportunities is essential because, historically, government institutions and other structures have prevented the full and meaningful engagement of Black people, Indigenous people, people of color, working class and low-income people, immigrants and undocumented people, people with disabilities, unhoused people, people who use drugs, people who are neurodivergent, LGBTQ+ people, and other structurally marginalized people. Prioritizing the engagement, participation, and recommendations of the community members most harmed by existing institutions, including those most harmed by police violence, will ensure that systems of inequity are not reproduced by a crisis response model.

Instead, community engagement can support the SCU to address structural inequities. In addition to the SCU Steering Committee, ongoing opportunities for the community to provide input to decisions as well as feedback about their experiences will be valuable to the SCU model throughout Phase 1.

Suggested methods to receive community input and feedback:

- Focus groups
- Town halls or community forums
- On-site outreach
- Questionnaire
- Online feedback "box"

Encourage participation among:

- Service utilizers
- Community members with mental health and behavioral health needs who have not yet engaged with the SCU
- Service providers at CBOs, especially those receiving SCU transports and referrals

Modalities should ensure equitable access to participation:

- Online and in person
- Large groups, small groups, and one-on-one
- Anonymous
- Written and verbal
- Translation and interpretation

Address structural barriers to participation by:

- Using convenient, accessible, and geographically diverse locations
- Offering events at varying times to accommodate different schedules
- Providing financial compensation
- Providing childcare

Why is more community engagement needed if community input informed the model?
The robust community engagement that contributed significantly to the development of this model demonstrates the valuable perspective and knowledge held by community members about the types of services needed and how to make them more accessible and acceptable. Soliciting ongoing feedback once the SCU is launched will provide insight to how well the model is meeting community members' needs and where barriers to crisis care persist, servicing both quality improvement and evaluative needs.

Why should ongoing community engagement be conducted?
Community input and feedback should not be limited to the end of Phase 1 as part of a summative evaluation, but instead be ongoing to account for the changing landscape of SCU model implementation and the needs of both service utilizers and the broader community. It will also support ongoing iteration of the SCU throughout Phase 1, while planning for more complex modifications in Phase 2.

Considerations for Implementation

- The opportunities for community input and feedback should be held regularly, such as monthly, or quarterly.
- Frequent service utilizers, perhaps identified during the SCU's first three months of implementation, could be the primary recruitment base for feedback.
- Address barriers to equitable participation in feedback, such as by providing childcare, transportation vouchers, or financial compensation for time.
- Community feedback should be evaluated as essential data points that directly inform the rapid assessment processes (*refer to recommendation #22*).

Recommendation #22

Adopt a rapid monitoring, assessment, and learning process.

Many crisis response programs use data to monitor their ongoing progress and successes, modify and expand program pilots, and measure outcomes and impact to inform ongoing quality improvement efforts. Data collection, data system integration, centralized coordination across city leadership, the SCU Steering Committee, and ongoing input and feedback from community members and service utilizers (*recommendations #16, #17, #19, #20, and #21*) should all contribute to the monitoring that supports ongoing implementation, assessment, and iteration.

A rapid assessment process will likely need to:

- Develop a shared vision for the SCU model.
- Develop goals for the SCU model.
- Create assessment questions to guide the monitoring and learning process.*
- Define indicators or measures.
- Use a mixed-methods approach, including quantitative programmatic data and feedback from service utilizers, staff, and other stakeholders.

All model components will benefit from assessment, including:

- Availability of the team, accessibility of Dispatch and/or alternative phone line, response time
- Services provided, expertise of mobile team, training
- Equipment, vehicles, and supplies
- Transport, service linkages and handoffs, partnerships with CBOs
- Case management meetings and centralized leadership coordination
- Data collection, data integration, data integrity, and data transparency
- Public awareness campaign

Consider using the Results-Based Accountability (RBA) framework[28] to assess SCU performance aligned to:

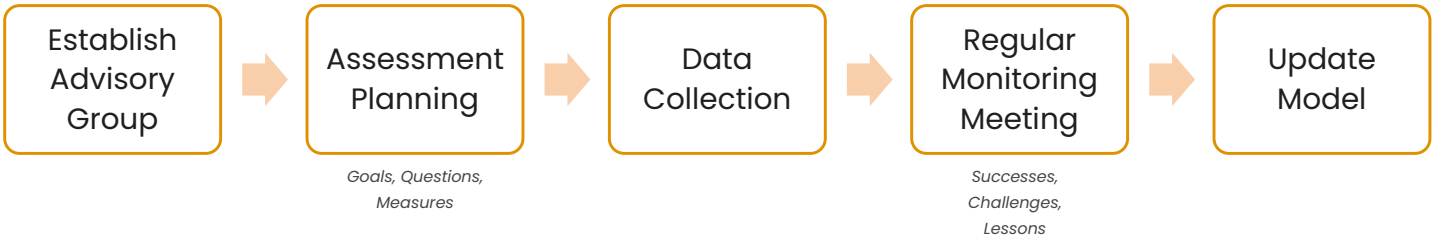
- Quantity of SCU services
- Quality of SCU services
- The impact or outcome of SCU services

*From the shared vision, create assessment questions to use throughout the duration of Phase 1, such as:

- Is there a need to scale and increase services?
- Are resources being used efficiently in the pilot? Will they be used efficiently with an increase in services?
- How effective is the current approach? Will it be effective with an increase in services?
- Is the current approach appropriately tailored to the Berkeley community? Is it appropriate for the Berkeley community?

[28] The City of Berkeley is using RBA for performance monitoring efforts and therefore may benefit from using RBA for the SCU model too.

Figure 4: Rapid Monitoring, Assessment, and Learning Process



A rapid monitoring, assessment, and learning process can happen in multiple venues. Some questions may be assessed on a quarterly basis, while others can happen on a monthly or weekly basis.

Considerations for Implementation:

- The rapid assessment process will need to establish clear roles for leading the meetings and decision-making, especially between the SCU program manager and central coordinating leadership.
- The rapid assessment process will benefit from clear timelines and processes for reviewing data, discussing changes and adaptations, and sharing findings across relevant stakeholders.
- The rapid assessment process may have multiple processes or venues based on specific data points or meeting frequencies. Clarify who should be attending, such as Dispatch, the alternative phone number (if applicable), the SCU mobile team, HHCS leadership, and others.

Recommendation #23

Conduct a formal annual evaluation.

Several components of the SCU - including the model's services, the SCU mobile team's training, the deployment determinations of Dispatch and/or the alternative phone line, and impacts and outcomes for service utilizers - offer potential for demonstrating the success of the model through formal evaluation. The evaluation should measure whether the SCU model is progressing towards the intended outcomes, as well as suggest opportunities for modifications and expansion. Design of a formal, annual evaluation is best done early in program planning.

Evaluation may define:

- A Theory of Change or Logic Model
- Short-term and medium-term goals

Evaluation could measure:

- Fiscal analysis, especially evaluation of progress towards the City's aim of reducing BPD's budget by 50%
- Systems change effectiveness, including evaluation of progress towards City's goal of reducing the footprint of BPD to criminal and imminent threats
- Program efficacy/effectiveness, quality of service
- Service utilizer outcomes
- Ongoing barriers and challenges that Phase 2 can address
- Effectiveness of public awareness campaign, whether community members know about it
- Impacts aligned to a Racial Equity Impact Assessment[29]

Evaluation should include:

- Qualitative and quantitative data
- Perspectives from SCU personnel
- Perspectives from service utilizers
- Perspectives from adjacent organizations, staff, and SCU Steering Committee

How is the proposed evaluation different than rapid monitoring?

Evaluation and rapid monitoring, or quality improvement, are complementary and should inform each other. Rapid monitoring is intended for more immediate quality improvement and occurs on more frequent cycles to guide iterative implementation of specific model elements. Evaluation asks broader questions from a greater degree of distance to guide adjustments to the model that will support ongoing effectiveness and sustainability. Staff are typically central to rapid monitoring to facilitate ongoing improvements, but an evaluation is generally conducted by an outside team that has some distance from day-to-day operations.

Considerations for Implementation

- If the City of Berkeley intends to contract out the evaluation, then the RFP and contracting process should be initiated early in Phase 0 to allow for adequate planning.

[29] To learn more about Racial Equity Impact Assessments, visit: https://www.raceforward.org/sites/default/files/RacialJusticeImpactAssessment_v5.pdf

Promoting Public Awareness

Promoting public awareness of the SCU and its aims will be essential to the SCU's success. Public education efforts should be advanced through a variety of methods, including a far-reaching campaign and targeted outreach. These efforts should emphasize that the SCU is a non-police crisis response service and promote how to access the SCU (i.e., which phone number to call). Overall, promoting public awareness is essential to building trust and addressing fears or reluctance that might inhibit people to call for support during a mental health or substance use crisis.

Promoting awareness and establishing relationships with other providers in the response network is also important, especially staff at emergency facilities who may interact with the SCU during the transport of a person who has experienced a mental health or substance use crisis. This type of relationship-building and education can streamline processes to promote positive outcomes for people in crisis.

The following recommendations should be adapted and implemented to advance public education and awareness about the SCU model:

Key Recommendations

24. **Launch a public awareness campaign to promote community awareness and education about the SCU.**
25. **The SCU mobile team should conduct outreach and build relationships with potential service utilizers.**

Recommendation #24

Launch a public awareness campaign to promote community awareness and education about the SCU.

For the community to be able to call for an SCU response, they must know that it exists. Stakeholder input throughout this project has indicated that community members must trust that the SCU provides a crisis response without the use of law enforcement for the SCU to be a viable and sought-after crisis response option. For these reasons, promoting public awareness of the SCU and its aims will be essential to the SCU's success.

Aims of the campaign:

- Emphasize the SCU as a non-police mental health and crisis response option
- Distinguish the roles and responses of SCU, MCT, and police
- Promote how to access the SCU (i.e., through 911, an alternative number, or 988)
- Describe when SCU will not respond (e.g., social monitoring, weapons) and when it will (e.g., types of services).
- Emphasize the community engagement that informed the model
- Share the availability of Berkeley Open Data
- Promote opportunities for ongoing stakeholder input and feedback

Why is it important to launch a public awareness campaign?

To inform the community of this new resource and to distinguish the SCU as a non-police response. Stakeholder input throughout this project has indicated that community members must trust that the SCU provides a crisis response without the use of law enforcement for the SCU to be a viable and sought-after crisis response option.

How do other cities promote their crisis response model?

Other cities provided examples of promoting awareness outside of mass media. For example, Portland's Street Response team contracts with street ambassadors with lived experience (via a separate contract with a local CBO) who perform direct outreach to communities and work to explain the team's services and ultimately increase trust with potential service utilizers.

Considerations for Implementation

- The methods of the campaign may need to be tailored to the targeted stakeholder groups and may include:
    - Mass media, billboards, advertisements on public transportation, radio announcements, local newspaper announcements, updates to the city's social media and websites, updates to service providers' and CBOs' social media.
    - Business cards with contact information for potential service utilizers.
    - "Meet-and-greets" that the SCU mobile team hosts with service providers at CBOs and emergency facilities.
- The public awareness campaign may have multiple phases, such as first promoting awareness of the SCU and how to access it, and then promoting opportunities for stakeholder feedback.

Recommendation #25

The SCU mobile team should conduct outreach and build relationships with potential service utilizers.

In addition to a public awareness campaign that promotes the SCU as a community resource, shares how to access the SCU, and emphasizes the non-police design, many service utilizers may still be reluctant to engage with a new entity. As a result, to most equitably meet the needs of potential service utilizers and especially substance users, the SCU may need to conduct in-person outreach. This outreach should be targeted to specific groups who are most likely to call the SCU with the aim of establishing trusting relationships and sharing more about their harm reduction approaches.

Targeted sites for relationship building with potential service utilizers:

- Encampments
- Safe parking RV lots
- Drop-in centers
- Downtown Berkeley
- People's Park
- Emergency department waiting rooms

Why might service utilizers be reluctant to engage in services with the SCU?

Many community members have personally experienced the criminalization of substance use and mental health emergencies, whether through their own experiences or having witnessed the experiences of family, friends, or community members. Such carceral approaches include involuntary psychiatrist holds and unnecessary transport to hospitals. In particular, unsheltered residents and substance users may be more distrustful of a new team and be less likely to call during a crisis. In interviews, unsheltered residents shared that not all of their substance use management are being adequately addressed by current crisis responders and they experience high rates of transport to emergency departments. Many also shared that they fear police retaliation for their substance use. In general, there are several reasons why community members may be hesitant about engaging crisis responders, which could be addressed by individual, relational outreach.

Why would relationship building improve utilization of the SCU?

Despite many service utilizers reporting overall distrust of first responders, they also shared that EMTs have developed trusting relationships and strong rapport for handling overdoses. Because of this relationship, service utilizers are more willing to call for an EMT to respond to an overdose. Similarly, having strong relationships built on trust will be key to the success of the SCU.

Considerations for Implementation

- If there are periods of low call volume, the SCU may use those times as opportunities to build relationships in communities of potential service utilizers and proactively provide services.
- This outreach may also be implemented based on data and findings or in preparation for Phase 2 expansion and changes.

System-Level Recommendations

The development of a mental health crisis response model as a component of the City of Berkeley's emergency services should be understood as a systems-change initiative of great magnitude. There are several critical factors that must be attended to in order to realize the full implementation of the SCU and to progress towards its intended outcomes.

Addressing the Needs of Dispatch

There is an urgent need for a 24/7 mental health and substance use crisis response model that does not rely on law enforcement to provide specialized mental health care. To provide this service, crisis responders must be connected to those in crisis. Thus, the role of Dispatch is essential.

Dispatch needs a full assessment and planning process to address the complexity of the 911 response system. This assessment and planning, though urgent, cannot be done hastily. The SCU will benefit if Dispatch is able to:

- Address the understaffing, under-resourcing, and identified training needs of call takers.
- Plan for a sustainable integration.
- Plan for a variety of scenarios to ensure crisis responder and community safety.
- Participate in the SCU phased-implementation approach and ongoing collaboration with SCU leadership.
- Establish trusting relationships and rapport with the SCU so that call takers are confident in deploying the SCU for scenarios they previously would have deployed MCT or Police.

A Sufficient Investment of Resources

A lack of sufficient resources is not only a challenge for Dispatch, but is a common challenge expressed by service providers in Berkeley and in other locales. Within the City of Berkeley, both TOT and MCT have challenges meeting the needs of community members because their hours of operation are limited, and they do not have enough staffing and resources to provide 24/7 services. This results in the perception of slow or delayed response times and can decrease the likelihood that callers continue to seek that service. Efforts in other cities, such as the Mental Health First and MACRO initiatives in Oakland and the Street Crisis Response Team in San Francisco, have also had to restrict their hours of availability and services due to a lack of sufficient funding.

Mental health crisis response could be essential in promoting health equity in the City of Berkeley. However, if it is not sufficiently resourced to provide 24/7 crisis response without long wait times, it will not achieve trust, and will become utilized less often and will therefore not achieve the desired systems-change results. This resourcing includes not only the SCU mobile crisis team, but the entirety of the model and related infrastructure, from the call center to program manager. Sufficient resourcing also includes dedicated time by city leadership to support coordination, collaboration, and problem-solving.

The Role of Trust

Trust was one of the most discussed factors across stakeholder engagement and will be a critical ingredient to the success of this system-wide change initiative. The public awareness campaign and all Phase 0 planning processes must address the concerns and doubts that could undermine trust across community stakeholders, the service provider network, and city leadership.

Trust will shape whether community members utilize the SCU. Community members must trust that the SCU:

- Is a non-police crisis response.
- Is accessible and available 24/7.
- Is responsive to emerging needs and ongoing community input and feedback.
- Provides competent harm reduction and non-carceral approaches to mental health and substance use crisis intervention.

Trusting relationships affect the quality of referrals, warm handoffs, and service linkages across the service provider network. Service providers emphasized that trust plays a role in:

- Whether they will refer a client to another provider.
- The amount and type of information they disclose about a shared client.
- Whether systems will choose to share and integrate data.

- The quality of collaboration and communication during warm handoffs, care coordination, or at client discharge.

Trusting relationships are essential to centralized coordination and collaboration among city leadership. The SCU model will require a variety of agencies and departments to work together in new ways and toward new ends. Other cities implementing alternative crisis models shared that trust was enhanced across leadership by:

- Aligning on shared values and commitment to improving health outcomes for people in crisis.
- Recognizing and adapting to the varied cultures of city departments, agencies, and CBOs.
- Ensuring decision-making power is allocated in alignment with the aims of the crisis model, such as ensuring that law enforcement does not have an unaligned or inequitable of voice or power in making decisions.
- Reviewing data to promote accountability and celebrate successful outcomes.
- Planning for sufficient time to prepare and participate in collaboration.

Conclusion: Next Steps & Future Considerations

This report presents recommendations for a model that is responsive to community needs. Still, there were numerous questions, issues, needs, and considerations that surfaced that were beyond the scope of the project. Decisions around those factors could significantly shape the types of services the SCU provides as well as how it is coordinated and administered across agencies. Such considerations are pertinent to the future of the SCU, crisis response, and the mental health service system in Berkeley, and therefore should continue to be discussed by city leadership and those implementing the SCU.

Long-Term Sustainable Funding

The SCU model requires long-term sustainable funding. A sound fiscal strategy must recognize the robustness of costs associated with the SCU and plan for institutionalizing and sustaining those costs. There are a number of potential funding sources for the SCU model, including Medi-Cal reimbursement, Medi-Cal opportunities through CalAIM, and DHCS grants. However, these funding streams are unlikely to sustain a crisis response model on their own. Other funding and resources may need to be braided into the SCU to effectively implement this model.

While braiding allows for maximizing funding resources, it also requires clear and separate tracking of services based on funding sources and requirements. With multiple funding streams, the target populations, reporting requirements, eligibility criteria, and performance measures can vary greatly. A braided funding model, therefore, requires knowledgeable administrators as well as dedicated time to manage. This can be especially resource-intensive for a CBO implementing the SCU. The SCU model will need to be very clear about the funding requirements and develop an appropriate system for ongoing tracking and reporting.

Different financing mechanisms provide varying levels of sustainability and predictability, considerations which should inform the development of a fiscal strategy for the SCU model. Unfortunately, these recommendations may not be fully realized if there is not a long-term sustainable fiscal strategy. Modifications to the SCU model could negatively impact the quality of service delivery or lessen the population impact.

Across the country, some cities have used a sales tax to fund their alternative crisis response models while others have redirected funds away from police departments. Rather than identifying new or short-term grant awards, a primary consideration for the City of Berkeley should be to look to dollars that can be reinvested from the Berkeley Police Department, in alignment with the Reimagining Public Safety initiative, to develop a sustainable and comprehensive SCU model.

Continue Planning for 24/7 Live Phone Access to the SCU

Significant planning will be required to fully realize the 24/7 live phone access to the SCU (*refer to recommendations #8, 9, and 10*). Reaching out to existing call centers—such as Alameda County CSS—or to other cities implementing similar crisis models could support the development of the phone access to the SCU. Additional planning is needed to determine, at a minimum:

- Equipment and technology needs
- Staffing requirements for the estimated call volume
- Recruitment, hiring, and training
- Workflow and protocol development
- Cost and funding availability

The Location of 911 Dispatch Within the Berkeley Police Department

The 911 Communications Center is currently operated by the Berkeley Police Department. This structure affects how Dispatch is funded and who makes decisions. As the role of Dispatch is broadened to coordinate a greater variety of responses to emergencies, there may be advantages to moving Dispatch outside of the Berkeley Police Department, such as improved communication and coordination across relevant agencies. For instance, it has been expressed that Dispatch call takers are currently more comfortable deploying the police than other crisis responders given their long tenure and rapport with police officers, so call takers' ability to establish rapport with the SCU team is needed for them to be comfortable deploying the SCU. Structural changes like this may also align to several of the Reimagining Public Safety initiative's aims. This consideration can be explored as part of the assessment and planning processes of the phased implementation approach.

Preventing Social Monitoring: Clarifying the SCU's Guiding Principles

The SCU model is designed to ensure that mental health specialists respond to people experiencing mental health crises. However, there is significant and justified concern that the SCU could be co-opted to support the social monitoring and enforcement of unsheltered residents. Clarifying the SCU's guiding principles could support in reifying the intentions of the model to ensure that all practices are aligned with those principles.

There are several elements within the model design where data, ongoing conversation, and service utilizer feedback can ensure that the SCU lives out its intention. One such example is whether and how the SCU would be deployed with the police and/or how the SCU is distinguished from MCT. For example, if a caller reports an unsheltered neighbor is residing on their sidewalk or driveway, this may not qualify for an SCU response. However, if that call is deployed to the police, then the response effectively criminalizes unsheltered Berkeley residents. Such scenarios should be explored as the SCU model is implemented, refined, and expanded.

Address the Full Spectrum of Mental Health and Substance Use Crisis Needs

Mental health and substance use crises vary in severity along a spectrum. A crisis can present as someone in immediate danger to themselves or others, someone who needs regular support to address their basic needs, or someone who is generally able to manage their needs but needs occasional support to prevent a future crisis.

Throughout this project, many stakeholders expressed that in order to effectively address the challenges of the current system, solutions and changes must engage with the nuances and spectrum of mental health crises:

- Some forms of crisis are readily visible while others are not.
- Some forms of neurodivergence are reported as a mental illness or crisis, but they are not.
- Some forms of crisis occur because the person is unable to access services to meet their needs.
- Some forms of emergency service utilization stem from ongoing unmet basic needs such as food and affordable housing.

Stakeholder participants urged that the concept and definition of a mental health crisis and crisis services be expanded to not only support crisis intervention but also prevention, diversion, and follow-up. The following two considerations should be further explored because they may support the SCU model. Both considerations represent a form of

reimagined public safety and may be realized with additional resources, such as funds divested from Berkeley Police Department:

Expand the SCU Model to Include a Follow-up Care and Coordination Team

There will likely be a need for a team to receive referrals from the SCU mobile team and connect with service utilizers for follow-up care. Follow-up care could include referrals, system navigation, and case management support. This team may also need to conduct outreach to make contact with service utilizers and address barriers to care as needed. For example, some service utilizers may be unable to follow through with a referral if they do not have reliable access to transportation or experience challenges maintaining scheduled appointments. This team could potentially be funded by the 988 funding allocated to dedicated follow-up teams deployed from 988 crisis call centers.[30]

There are many lessons that should be learned from the existing Transitional Outreach Team (TOT), such as challenges they face with adequate staffing and funding or constraints and limitations with who they can serve. Any initiatives around follow-up care should augment rather than duplicate the TOT.

Increase the Number of Sites for Non-emergency Care for Berkeley Residents

Throughout this project, stakeholder participants emphasized the need for sites for non-emergency care, such as drop-in centers, day centers, sobering sites, and respite centers. These services are important for harm reduction and crisis prevention, and as such would support the outcomes of the SCU model. There may be opportunities in Phase 0 or Phase 1 to reserve beds at a shelter or similar care facility as a temporary measure, ensuring persons in crisis have access to these beds after engaging with the SCU. However, increasing the overall number of sites for non-emergency care would require a longer-term investment

[30] Santos, M (2021). New suicide prevention hotline aims to divert callers from police. *Crosscut.* **https://crosscut.com/politics/2021/07/new-suicide-prevention-hotline-aims-divert-callers-police**

Appendix

Appendix A: Launch Timeline & Phased Implementation Approach

Phase 0 - Launch Timeline

Nov 2021 - May 2022

System-Level: Planning, Launch, Implementation		HHCS	Steering Committee	Dispatch	Contracted CBO
Dec	Engage community on feedback to SCU Model recommendations	x	x		
	Engage community on SCU RFP requirements	x			
	Dispatch leadership communicates and champions (internally) the SCU change-initiative			x	
	Plan for Dispatch assessment (e.g., determine if RFP needed)	x		x	
Jan	Make decisions about 24/7, live phone line to SCU (option A, B, C)	x	x	x	
Feb	Issue RFP for SCU	x			
	Issue RFP for SCU alternative phone line (TBD)	x			
Mar	RFP Deadline				
	Review all RFPs	x	x		
	Select awardee for SCU	x	x		
	Begin planning for site visits	x		x	x
Apr	Contract process for SCU	x			
May	Hire SCU personnel (mobile team, supportive and administrative roles, Dispatch/phone staff)				x
	Hire mental health clinician to support Dispatch assessment & planning	x		x	
	Build relationships across all new personnel	x	x	x	x
June - Aug	*Plan & Implement Recommendations: Refer to Phase 0 Implementation Approach*				

Phased Implementation Approach		Phase 0 Nov 2021 - Aug 2022	Phase 1 *Implementation* Sept 2022 - Aug 2023	Phase 1 *Planning for Phase 2* Sept 2023 - Feb 2024	Phase 2 Feb 2024+	Future, *Beyond Phase 2*
SCU Mobile Team Recommendations						
1	The SCU should respond to mental health crises and substance use emergencies without a police co-response	Clarify specific factors and codes for all suggested SCU call types Develop triage criteria and workflows across all SCU call-types and services. Coordinate with other entities (BPD, MCT, UCPD) for differentiation and/or collaboration.	*SCU mobile team goes live, providing services*		Consider additional types of calls for service that they can respond to where armed police officers are not needed or aligned to a reimagined definition of public safety, such as: - Completing documentation while providing crisis services where a traditional "police report" is needed, such as in cases of sexual assault, sexual harassment, and rape - Petty theft - Nonviolent conflicts, such as neighbor disputes or youth behavioral issues - Minor assaults, with no weapons present - Proactive support at events that may trigger a crisis (e.g., during an encampment sweep)	Integrate other SCU model elements (e.g., follow-up care team [Report Section V])
2	The SCU should operate 24/7					
3	Staff a 3-person SCU mobile team to respond to mental health and substance use emergencies					
4	Equip the SCU Mobile Team with vans	Procure vans				
5	The SCU Mobile Team should provide transport to a variety of locations	Introduce SCU to emergency facility staff at all transport destinations				
6	Equip the SCU mobile team with supplies to meet the array of clients' needs	Procure supplies				
7	Clearly distinguish the SCU from MCT	Develop clear roles and parameters for SCU and MCT teams by collaborating across Dispatch, the SCU Steering Committee, the current MCT team, and other relevant leadership *Note: These decisions are essential for developing triage criteria and workflows and for communicating to the general public in a public awareness campaign.*		Evaluate the role of MCT and the efficacy of having both teams. Make recommendations for Phase 2, such as changes to each team's scope or processes.	Communicate to general public and relevant service providers about changes relevant to the distinguished roles of MCT and SCU	

Phased Implementation Approach	Phase 0 Nov 2021 - Aug 2022	Phase 1 *Implementation* Sept 2022 - Aug 2023	Phase 1 *Planning for Phase 2* Sept 2023 - Feb 2024	Phase 2 Feb 2024+	Future, *Beyond Phase 2*
Accessing the SCU Crisis Response					
8 Participate in the Dispatch assessment and planning process to prepare for future integration	Decide the most effective method for 24/7, live phone access to the SCU (Option A, B, C) Dispatch makes investments in staffing and technologies, as needed SCU model discusses with Dispatch the necessary data (variables, definitions, timelines, privacy, etc.) to be collected during each Phase of implementation Dispatch begins planning for changes to CAD or other data systems	Dispatch makes investments in staffing and technologies, as needed *Dispatch implements Phase 1 protocols, as determined by Phase 0 planning (Option A, B, C)*	Implement new triage criteria and workflows		
9 Ensure the community has a 24/7 live phone line to access the SCU	Implement and adapt 24/7, live phone line access to SCU (Option A, B, C) Adapt protocols for other Berkeley crisis responders (Fire, EMS/Falck, MCT, Police) to request SCU support through the alternative phone number Dispatch and HHCS/SCU identify opportunities for Phase 1 implementation (based on Option A, B, C), such as: - Phase 1 call types for SCU deployment OR preliminary calls that Dispatch will transfer to the alternative phone line in early Phase 1 (e.g., welfare checks) - Dispatch supports alternative phone line to develop aligned triage criteria and workflows to support future integration	<u>If Option B or C:</u> *Plan for how calls will be triaged and prioritized from the two separate sources (alternative number and 911) in deploying the SCU mobile teams in Phase 2*	Determine if the SCU should respond to crises by sight ("proactive" deployment and intervention) Determine if the SCU should self-deploy by listening to the police radio (based on other models: Eugene's CAHOOTS, Denver's STAR, and San Francisco's Street Crisis Response Team)	<u>If Option B or C:</u> *Integrate SCU into 911*	
10 Plan for embedding a mental health or behavioral health clinician(s) into Dispatch to support triage and SCU deployment	Dispatch hires one clinician to support the Dispatch assessment process and to support triage criteria and workflow development for calls routed to SCU Clinician attends trainings and site observations with Dispatch and SCU Clinician(s) supports planning for triage criteria, call-types, etc. *(as relevant: Option A, B, C may affect timing of this)* <u>If Option A:</u> Dispatch prepares for fully embedding clinician(s), including clarifying their roles and supervision structure *<u>If Option B or C: implement this in Phase 2</u>*	Clinician(s) support Dispatch based on the assessment findings and next steps, such as: - supervises call-takers triaging mental health crisis calls - provides trainings to call-takers based on 2019 Auditor's Report and ongoing assessment			Assess whether clinician(s) can provide services beyond SCU deployment, including basic telemedicine and psychiatric screenings or psychiatric crisis assessment

Phased Implementation Approach		Phase 0 Nov 2021 - Aug 2022	Phase 1 *Implementation* Sept 2022 - Aug 2023	Phase 1 *Planning for Phase 2* Sept 2023 - Feb 2024	Phase 2 Feb 2024+	Future, *Beyond Phase 2*
Implement a Comprehensive, 24/7 Mental Health Crisis Response Model						
11	Fully staff a comprehensive model to ensure the success of the SCU mobile team, including supervisory and administrative support roles for SCU					
12	Operate one SCU mobile team per shift for three 10-hour shifts					
13	SCU staff and Dispatch personnel should travel to alternative crisis programs for in-person observation and training	~~Incorporate into RFP and hiring timelines to allow for~~ these periods of travel and training. *Note: City of Berkeley and/or the contracted CBO may need to reach out to the other cities and programs to solidify travel and training plans prior to the hiring of any individual personnel.* Allot time after the site visit(s) for debriefing, reflecting on lessons learned, and discussing how to integrate key takeaways into the SCU model. Include in debrief and planning conversations personnel that traveled for site observations, HHCS staff, additional Dispatch leadership, and Steering Committee members as needed.				
14	Prepare the SCU mobile team with training, informed by community needs	Plan the training schedule based on community needs, ongoing assessment and planning, and prerequisite skills and experiences of hired personnel				

Phased Implementation Approach	Phase 0 Nov 2021 - Aug 2022	Phase 1 *Implementation* Sept 2022 - Aug 2023	Phase 1 *Planning for Phase 2* Sept 2023 - Feb 2024	Phase 2 Feb 2024+	Future, *Beyond Phase 2*
Administration and Evaluation					
15 Contract the SCU Model to a CBO			*Extend contract and provide funding for Phase 2, as applicable*		Determine if the SCU can be administered through the City of Berkeley, elevating it to the status of Police and Fire as an essential citywide emergency service and ensuring long-term sustainability
16 Integrate SCU into existing data systems	Assess feasibility of data integration across various systems and sources: assess system capacity needs to realize integration, seek consultation on legal issues surrounding patient protections and sharing health data across providers Evaluate implications for Recommendation 18 (care coordination case management meetings) based on feasibility and adaptations from this recommendation (Recommendation 16) Maintain and strengthen data privacy before SCU is integrated with Dispatch (given that Dispatch is situated within Berkeley Police and that many health conditions can be criminalized and prosecuted)		*Continue: Assess feasibility of data integration across various systems and sources: assess system capacity needs to realize integration, seek consultation on legal issues surrounding patient protections and sharing health data across providers* Coordinate with Alameda County Care Connect to plan for bi-directional data feeds with the Community Health Record (CHR) Plan for access to EHRs and other relevant data systems		
17 Collect and publish mental health crisis response data publicly on Berkeley's Open Data Portal	Coordinate with City of Berkeley to add new data to Portal Plan for how regularly data will be refreshed/updated on Portal	*Publish data regularly*			
18 Implement care coordination case management meetings for crisis service providers	Involve all relevant agencies in planning to define, align, and adjust data definitions, variables, and collection practices. (e.g., 911-Dispatch, MCT, BPD, BFD, Falck, HHCS, SCU, etc.) Engage potential participates to plan for Phase 1 implementation of care coordination case management meetings (identify and confirm participants, confirm meeting intervals, set meeting times, etc.)	*Convene and implement care coordination meetings*			
19 Implement centralized coordination and leadership across city agencies to support the success of mental health crisis response	Engage potential participates to plan for Phase 1 implementation of centralized coordination and leadership meetings (identify and confirm participants, confirm meeting intervals, set meeting times, etc.)	*Convene and implement centralized coordination and leadership meetings*			

Phased Implementation Approach	**Phase 0** Nov 2021 - Aug 2022	**Phase 1** ***Implementation*** Sept 2022 - Aug 2023	**Phase 1** ***Planning for Phase 2*** Sept 2023 - Feb 2024	**Phase 2** Feb 2024+	**Future, *Beyond Phase 2***
Administration and Evaluation (continued)					
20 Continue the existing SCU Steering Committee as an advisory body	Identify additional Steering Committee members Invite and engage new members Adapt processes, group norms and agreements, and/or meeting schedules, as relevant	*Hold regular meetings of SCU Steering Committee; incorporate decision-making processes across other Recommendations*			
21 Solicit ongoing community input and feedback	Decide on methods and intervals for collecting community input and feedback during Phase 1 Develop a plan to communicate the opportunities for community and feedback; incorporate into public awareness campaign	*Solicit ongoing community input and feedback; incorporate decision-making processes across other Recommendations*			
22 Adopt a rapid monitoring, assessment, and learning process					
23 Conduct a formal, annual evaluation	Plan for the evaluation and rapid assessment processes to use overlapping data and be mutually-supportive and streamlined Plan for all data definitions and collection processes to be aligned across rapid assessment and evaluation aims.	Ensure that the evaluation findings are available for the latter six-months of Phase 1 to support planning for Phase 2	Review evaluation findings Plan for Phase 2		
24 Launch a public awareness campaign to promote community awareness and education about the SCU	Plan for public awareness campaign, including targeted modalities, targeted audiences, and/or phased timing Launch public awareness campaign	*Continue public awareness campaign, as necessary*			
25 The SCU mobile team should conduct outreach and build relationships with potential service utilizers	Conduct targeted outreach and establish trusting relationships between SCU and community members, promoting utilization of SCU	*Continue targeted outreach and build relationships as necessary*			

Appendix B: Sample Shift Structure & Redundancy Needs

Model Component	Phase	Staffing Needs	Shift Type	M	T	W	Th	F	Sa	Su		No. of shifts (week 1)	*No. of shifts (week 2)*	No. of staff per unit	No. of units	No. of FTE needed	Notes	
SCU	Phase 1	Shift 1	10-hour shift	mobile unit A	mobile unit A	mobile unit A	mobile unit B	mobile unit E	mobile unit E	mobile unit E	mobile unit a	3	*4*	3	6	18	Assumes one mobile unit per shift	
		Shift 2	10-hour shift	mobile unit B	mobile unit B	mobile unit B	mobile unit C	mobile unit F	mobile unit F	mobile unit F	mobile unit b	4	*3*	3			Assumes a three-person mobile unit	
		Shift 3	10-hour shift	mobile unit C	mobile unit C	mobile unit C	mobile unit D	mobile unit D	mobile unit D	mobile unit D	mobile unit c	4	*3*	3			Six clinicians, six peers, six therapists	
											mobile unit d	4	*3*	3				
											mobile unit e	3	*4*	3				
											mobile unit f	3	*4*	3				
SCU	Phase 1	Shift 1	10-hour shift	clinical supervisor A	clinical supervisor A	clinical supervisor A	clinical supervisor B	clinical supervisor E	clinical supervisor E	clinical supervisor E	clinical supervisor A	3	*4*	1	6	6		
		Shift 2	10-hour shift	clinical supervisor B	clinical supervisor B	clinical supervisor B	clinical supervisor C	clinical supervisor F	clinical supervisor F	clinical supervisor F	clinical supervisor B	4	*3*	1				
		Shift 3	10-hour shift	clinical supervisor C	clinical supervisor C	clinical supervisor C	clinical supervisor D	clinical supervisor D	clinical supervisor D	clinical supervisor D	clinical supervisor C	4	*3*	1				
											clinical supervisor D	4	*3*	1				
											clinical supervisor E	3	*4*	1				
											clinical supervisor F	3	*4*	1				

SCU	Phase 1	shift business	8-hour shift	program manager	program manager	program manager	program manager	program manager	-	-	program manager	5	*n/a*	1	1	1	Assumes mobile unit peers are supervised by clinical supervisor during shift; this specialist is for other professional supports for Peer Specialists
		shift business	8-hour shift	peer supervisor	peer supervisor	peer supervisor	peer supervisor	peer supervisor	-	-	peer supervisor	5	*n/a*	1	1	1	
Alternative Phone Line	Phase 1	Shift 1	12-hour shift	call team A	call team A	call team A	call team B	call team D	call team D	call team D	call team a	3	*4*	2	4	8	Assumes two call receptionists per shift
		Shift 2	12-hour shift	call team B	call team B	call team B	call team C	call team C	call team C	call team C	call team b	4	*3*	2			
											call team c	4	*3*	2			
											call team d	3	*3*	2			
Dispatch	Phase 0	shift business	8-hour shift	BH/MH triage clinician	BH/MH triage clinician	BH/MH triage clinician	BH/MH triage clinician	BH/MH triage clinician	-	-	BH/MH triage clinician	5	*n/a*	1	1	1	
	Phase 1	Shift 1	12-hour shift	BH/MH triage clinician A	BH/MH triage clinician A	BH/MH triage clinician A	BH/MH triage clinician A	BH/MH triage clinician C	BH/MH triage clinician C	BH/MH triage clinician C	BH/MH triage clinician A	4	*3*	1	4		Assumes one clinician per dispatch shift

	Shift 2	12-hour shift	BH/MH triage clinician B	BH/MH triage clinician B	BH/MH triage clinician B	BH/MH triage clinician B	BH/MH triage clinician D	BH/MH triage clinician D	BH/MH triage clinician D	BH/MH triage clinician B	4	*3*	1				
										BH/MH triage clinician C	3	*4*	1				
										BH/MH triage clinician D	3	*4*	1				

Appendix C: Budget

Salaries, wages, benefits	FTE	Salary	Cost/Year	Notes	Source
BH Licensed Clinician / Psych-NP	6	$ 178,000.00	$ 1,068,000.00	*JobsEQ "Nurse Practitioner"*	*JobsEQ Mean Annual Wages for San Francisco-Oakland-Bay Area*
Mental Health Peer Specialist	6	$ 77,500.00	$ 465,000.00	*JobsEQ "Health Education Specialists"*	*JobsEQ Mean Annual Wages for San Francisco-Oakland-Bay Area*
BH Licensed Therapist / LCSW	6	$ 85,800.00	$ 514,800.00	*JobsEQ "Mental Health and Substance Abuse Social Worker"*	*JobsEQ Mean Annual Wages for San Francisco-Oakland-Bay Area*
Clinical Supervisor	6	$ 178,000.00	$ 1,068,000.00	*JobsEQ "Nurse Practitioner"; unable to find accurate salaries for a supervisory position*	
Peer Specialist Supervisor	1	$ 85,800.00	$ 85,800.00	*unable to find accurate salary range; using LCSW range*	
Program Manager	1	$ 105,000.00	$ 105,000.00		
Phase 0 Dispatch MH/BH Clinician	1	$ 105,782.00	$ 105,782.00	*"SUPERV PUBLIC SFTY DISP"*	https://www.cityofberkeley.info/uploadedFiles/Human_Resources/Level_3_-__General/ClassificationAndSalaryListingByTitle.pdf
Subtotal			$ 3,412,382.00	*Total FTE Salary*	
Subtotal			$ 853,095.50	*Fringe Benefits, 25%*	
Total Salary + Benefits			**$ 4,265,477.50**		
Ongoing materials and services			**Cost/Year**	**Notes**	
Evaluation			$ 185,000.00	*Used cost of RDA feasibility study as estimate*	
Vehicle maintenance	4	$ 20,000.00	$ 80,000.00	*Estimate provided by Berkeley Fire*	
Advertisement & PR	12	$ 2,000.00	$ 24,000.00	*Includes community education workshops, advertising, outreach and engagement*	
Small equipment & supplies	1200	$ 20.00	$ 24,000.00	*Wound care, hygiene, harm reduction, meals, transportation vouchers,*	

				clothing, blankets, etc. *Based on SF SCRT data, assumes 100 contacts with clients per month, $20 per client contact; SF SCRT budgeted 10k and said they needed more*	
Office supplies and postage	12	$ 200.00	$ 2,400.00		
Communications	12	$ 600.00	$ 7,200.00		
Printing and copying	12	$ 100.00	$ 1,200.00		
Travel and transportation	12	$ 100.00	$ 1,200.00	*Local travel for care coordination & meetings*	
Training and meetings	12	$ 1,000.00	$ 12,000.00	*Equity, team dynamics, and other ongoing training*	
Licenses/fees/subscriptions	12	$ 50.00	$ 600.00		
Insurance			$ -		
Contract services			$ -		
Legal services			$ -		
Audit and consulting			$ -		
Utilities			$ -		
Facilities			$ -		
Subtotal			$ 337,600.00	*ongoing materials and services*	
Subtotal: Personnel and non-personnel recurring subtotal			$ 4,603,077.50		
Administrative overhead			$ 276,184.65	*6% for all recurring costs*	
Total recurring cost			**$ 4,879,262.15**		
One time cost			**Cost/Year**	**Notes**	
Vehicle	5	$ 60,000.00	$ 300,000.00	*Assume 60k per van with wheelchair capacity*	
Recruitment	27	$ 4,000.00	$ 108,000.00	*Median national average of recruiting new employee*	

Training (SCU staff and Dispatch)			$ 75,000.00	*Assume training for all Dispatch, BPD, Fire, MCT, & SCU staff; both program onboarding and emerging best practices related to crisis response*	
Technology (computers, phones, etc.)			$ 25,000.00	*Laptop/tablets, cell phones for all staff, MiFi, portable chargers*	
Rapid assessment			$ 40,000.00	*Evaluation planning meetings, data request development, community-input meetings*	
Community outreach and education (including materials development)			$ 25,000.00	*Curriculum development, materials, advertisement, outreach (SF SCRT hired consultant to do this work)*	
Subtotal			$ 573,000.00		
Administrative overhead			$ 34,380.00	*6% for all one-time costs*	
Total one-time cost			**$ 607,380.00**		
Recommendations			**Cost/Year**	**Notes**	
Signing bonus	7	$ 5,000.00	$ 35,000.00	*Signing bonus recommended for licensed clinical staff*	
Technical Assistance			$ 15,000.00	*Consultation from existing similar alternative models*	
Total additional recommendations			**$ 50,000.00**		
Total cost with recommendations			**$ 5,536,642.15**	*Estimated cost for program and recommendations*	

Appendix D: Anticipated Incident Volume

		Potential Daily Incidents for SCU (Average)	Potential Incidents per **shift** for SCU (Average)
Average daily BMH-Crisis incidents (FY15-19) *MCT, TOT, CAT*	10.73 incidents	19.82	6.61
Average daily BPD MH Incidents (FY14-20)	28.91 incidents		
Average time on task for transports BFD & Falck	101.48 minutes		

	Denver[31] 6 months, 1 team, not citywide, not 24/7	Portland[32] 6 months, 1 team, not citywide, not 24/7	CAHOOTS[33] Annual, 1-2 teams, 24/7
Average incidents per shift	5.75	3	(Per hour) 1.81
% incidents that resulted in a transport	14.30%	6.27%	23.38%
% transports that were to the hospital	16.82%	58.33%	
Average minutes on task	24.65	19.33	
Reduction of BPD calls	2.75%	4.60%	5-8%

[31] STAR Program Evaluation (2021, January 08). **https://wp-denverite.s3.amazonaws.com/wp-content/uploads/sites/4/2021/02/STAR_Pilot_6_Month_Evaluation_FINAL-REPORT.pdf**

[32] City of Portland
Bureau of Fire and Rescue (2021, October). Portland street response: Six-month evaluation. **https://www.portland.gov/sites/default/files/2021/psu-portland-street-response-six-month-evaluation-final.pdf**

[33] Eugene Police Department Crim Analysis Unit (2020, August 21). CAHOOTS program analysis. **https://www.eugene-or.gov/DocumentCenter/View/56717/CAHOOTS-Program-Analysis**