Office of the City Manager

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ACTION CALENDAR
March 10, 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: Presentation and Discussion of Reports Submitted by Reimaging Public Safety Task Force and National Institute for Criminal Justice Reform

SUMMARY

On July 14, 2020, in Resolution No. 69, 501-N.S. City Council passed a package of items providing direction for the development of a new paradigm of public safety in Berkeley. As part of the items that were adopted, City Council adopted Item 18c (Referral to City Manager to Re-imagine Policing Approaches to Public Safety Using a Process of Robust Community Engagement, to Develop a Path Forward to Transforming Public Safety and Policing in Berkeley) and Item 18d ("Transform Community Safety and Initiate a Robust Community Engagement") which directs the City Manager to engage a qualified firm(s) or individual (s) to lead a robust, inclusive, and transparent community engagement process with the goal of achieving a new and transformative model of positive equitable and community centered safety for Berkeley. Council will hear from both the National Institute for Criminal Justice Reform and from the Reimaging Public Safety Task Force with two reports with creative approaches to address the council direction. City Staff will receive community feedback and collect additional information from council with the goal of returning in April 2022 with a report and recommendations on a path forward to transforming public safety and policing in Berkeley. However since the Specialized Care Unit is an integral part of the future we have included this report which provides the Specialized Care Unit (SCU) Steering Committee's response to the recommendations from Research Development Associates (RDA) for the implementation of Berkeley's SCU. Considerations from this response will be incorporated into SCU implementation planning along with RDA's recommendations.

CURRENT SITUATION AND ITS EFFECTS

As part of its Re-Imagining Public Safety process, the City of Berkeley has been engaged in planning to implement a SCU. The City contracted with RDA to conduct best practice research and a community engagement process in order to make recommendations for the best SCU model for Berkeley. 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. RDA's twenty-five recommendations are below, followed by the Steering Committee's response to these recommendations.

RDA RECOMMENDATIONS FOR AN SCU FOR BERKELEY

RDA's recommendations are categorized into five sets as follows:

Recommendations 1-7: The SCU Mobile Team

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 the Mobile Crisis Team.

Recommendations 8-10: Assessing the SCU Crisis Response: Dispatch & Alternative Phone Number

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.

Recommendations 11-14: 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.

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.

Recommendations 15-23: Administration and Evaluation

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.

Recommendations 24-25: Promoting Public Awareness

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.

SCU STEERING COMMITTEE RESPONSE

Following completion of RDA's final report, the SCU Steering Committee (Committee) held detailed discussions and further analyzed each category of recommendations. The purpose of these discussions, which occurred over two 90-minute meetings in January 2022, was to establish where there was broad agreement among steering committee members and where individual members differed, and also to add additional considerations where needed. While there was strong agreement among steering committee members with most of RDA's recommendations, there were some nuances and additional considerations that should be considered as part of SCU implementation.

Recommendations 1-7: The SCU Mobile Team

The Committee supports these recommendations with a few points of added clarification. Related to the first recommendation (*respond to mental health crises and substance use emergencies without a police co-response*), the Committee agrees that the SCU should maintain its independence from the Berkeley Police Department (BPD), however acknowledges that there may be incidents that involve a threat of violence. In

these exception cases, the SCU should have protocols to activate BPD to provide support. Similarly, the Committee recommends that if BPD is called to respond to a mental health and/or substance use crisis, and there is no threat of violence present, they should be able to transfer the client to an SCU response.

Regarding the third recommendation (s*taff a three-person SCU mobile team to respond to mental health and substance use emergencies*), the Committee believes that the level of required medical expertise on the SCU should be flexible, given constraints in hiring and potential lack of qualified candidates. There was some disagreement among Committee members about the level of medical expertise necessary on the SCU team. While one member in particular noting that a "peer" with basic medical training may be sufficient and more relatable, most members agreed that SCU users could benefit from a higher level of medical expertise that could be applied on the spot. The Committee also identified that, while the type of medical expertise could vary, it would be ideal to have a SCU member who could identify a medical need due to drug use versus a preexisting condition, such as an infected wound from using needles.

Not providing adequate medical expertise, instead relying on the Fire Department to provide urgent medical attention as needed, may result in patients being transported to the hospital, where there may be a lack of continued care. Ensuring some amount of medical expertise on the SCU will help maintain the spirit of the Unit to provide holistic care to individuals in crisis. This will continue to evolve in the implementation of the pilot program.

<u>Recommendations 8-10: Assessing the SCU Crisis Response: Dispatch & Alternative Phone Number</u>

The Steering Committee agrees with recommendations 8 and 9, yet would like to recommend an alternative to recommendation 10 (*plan for embedding a mental health or behavioral health clinician into Dispatch to support triage and SCU deployment*). The Committee agrees that it is important for the SCU to be well-coordinated with the 911 Communications Center, which is currently under the Berkeley Police Department, but does not agree that the behavioral health clinician, with mental health and substance use expertise, needs to physically sit in the dispatch space. The Committee is concerned that co-locating this individual with 911 Dispatch could lead to a misconception, and resulting lack of trust, about whether or not the SCU includes a police response. The Committee was also concerned that it would be challenging for an embedded individual with a unique roll that is a stretch beyond the current dispatch culture. Currently, most dispatch communications protocols are general and not tailored to responding to behavioral health calls, which could lead to law enforcement being deployed, instead of the SCU. During the implementation phase, the Committee recommends that the individual who provides dispatch services for the SCU should receive training, build relationships with the 911 Communications Center to ensure coordinated deployment of the appropriate resource, and should be physically located near or at the location where the rest of the SCU staff is stationed. This training would

be in addition to training recommended for existing dispatch staff to help them assign calls and effectively utilize the SCU.

Recommendations 11-14: Implement a Comprehensive 24/7 Mental Health Crisis Response Model

The Steering Committee offered additional suggestions to recommendations 11, 13, and 14. For 11, the Committee acknowledges that despite difficulty hiring new staff, it will be good to plan for redundancy in hiring to be able to keep the SCU fully-staffed for all shifts to provide continued coverage when staff are on vacation, sick, etc. Additionally, the team should avoid creating silos based on technical expertise by hiring a supervisor who is cross-trained in each of the different fields to help with team cohesion. This cross-training will be especially useful for a supervisor who is familiar with mental health and substance use, including harm reduction techniques and medication-assisted treatment (MAT). It is the Committee's view that this will support individuals who use drugs and desire to engage in this service delivery.

As the SCU moves into the implementation phase, the Committee supports the recommendation for team members to travel to other cities to learn from similar teams, and emphasizes that the Peer Supervisor should also be included in these visits. These training opportunities should focus on teams with a variety of expertise including: behavioral health, mental health, substance use, harm reduction techniques, and MAT. This will support cross-training and provide additional context for the Peer Supervisor to help support a successful team. Additionally, the Steering Committee recognizes that there are a variety of trainings that will be applicable and necessary for the SCU before they begin responding in the community. It will be important to prioritize specific trainings in the initial rollout, and add more trainings as the SCU progresses. While training is important, it must be balanced with the urgent need to fill this crisis response gap in the Berkeley community.

Recommendations 15-23: Administration and Evaluation

The SCU Steering Committee supports these recommendations and wants to make sure that the City will maintain a coordinated and collaborative relationship with the contracted Community-Based Organization (CBO). The City of Berkeley, in partnership with the SCU Steering Committee, will continue to discuss the exact parameters of contracting the work of the SCU to a CBO. This contract will be different than a traditional contract, given the required integration with current City services, and partnership across City departments. In addition, the Steering Committee recognizes that providing a physical space for the SCU may be a hurdle given Berkeley's geography. The implementation group should think creatively to provide a useful space to serve the staff, even if it means looking just outside Berkeley borders (i.e. North Oakland, Albany).

Developing a finance strategy will be critical for the long-term sustainability of the SCU. Inherent in developing a contract with a CBO will be the identification of known funding

for a considerable period of time, as no CBO will agree to stand something up this big for a short period of time without a plan for continuity. Recommendations 15-23 do not speak explicitly to financing the SCU (this is in the latter part of the report under the section "Systems Recommendations") but should have been named here more explicitly since it is fundamental to Administration and Evaluation. The Committee anticipates that funding will be a combination of state and federal funding for crisis response services, as well as Medi-Cal reimbursement of crisis services. The Committee recommends pulling a finance team together early to start strategizing how the SCU will be funded long term through this variety of sources.

Recommendations 24-25: Promoting Public Awareness
The Steering Committee supports these recommendations and further recommends relying on multiple forms of direct outreach and broader communications, given the City of Berkeley's limited messaging capacity. The Committee believes that the City of Berkeley should leverage the work of trusted partners to provide education about the SCU, such as the Lifelong Medical Street Medicine team. As the SCU gets started, members of the Unit should also conduct field outreach to introduce themselves, explain their duties, and provide a way to contact if needed. This field outreach will help build trust in the early stages.

BACKGROUND

RDA's recommendations, along with considerations generated in this response by the Steering Committee, will inform implementation of the SCU.

In its third report, RDA also provided a set of "Systems Recommendations" that the Committee did not address for this report, but will address as part of implementation and sustainability planning. These are addressed thoroughly in the report and include:

- Addressing the needs of dispatch
- A sufficient investment of resources
- The role of trust

The report concludes with "Next Steps and Future Considerations" (also not addressed for this report) and include discussion of:

- Long-term sustainable funding
- The location of 911 dispatch within the Berkeley Police Department
- Preventing social monitoring: clarifying the SCU's guiding principles
- Address the full spectrum of mental health and substance use crisis needs

ENVIRONMENTAL SUSTAINABILITY AND CLIMATE IMPACTS

There are no identifiable environmental effects or opportunities associated with the subject of this report.

POSSIBLE FUTURE ACTION
The City of Berkeley, in partnership with the SCU Steering Committee, will move into the implementation phase of the Specialized Care Unit.

FISCAL IMPACTS OF POSSIBLE FUTURE ACTION
Implementing the SCU will require significant funding. In addition to funding the operations, it will require staff time across several City departments, which may have varying financial impacts depending on the staff member's department. Additionally, the City anticipates releasing a Request for Proposals to recruit a community-based organization to serve as lead agency for the Specialized Care Unit and hiring a consultant in healthcare finance to develop a fiscal strategy for sustainability. These contracts will be funded through previously allocated American Rescue Plan Act funding. Identifying sustainable long-term funding for the SCU is an important next step, as described above.

CONTACT PERSON
Lisa Warhuus, Director, Health, Housing, and Community Services, (510) 981-5404.

Attachments:
1: City of Berkeley Crisis Models Report (Research Development Associates)
2: City of Berkeley Mental Health Crisis Response Services and Stakeholder Perspectives Report (Research Development Associates)
3: City of Berkeley Specialized Care Unit Crisis Response Recommendations (Research Development Associates)
4: National Institute for Criminal Justice Reform Final Report and Implementation Plan

City of Berkeley

Crisis Response Models Report

RDA CONSULTING

CITY OF BERKELEY

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

Caroline de Bie

Sarah Ferrell

Sasha Gayle-Schneider

Jamie Dorsey

Nicole Gamache-Kocol

Kevin Wu

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

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[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

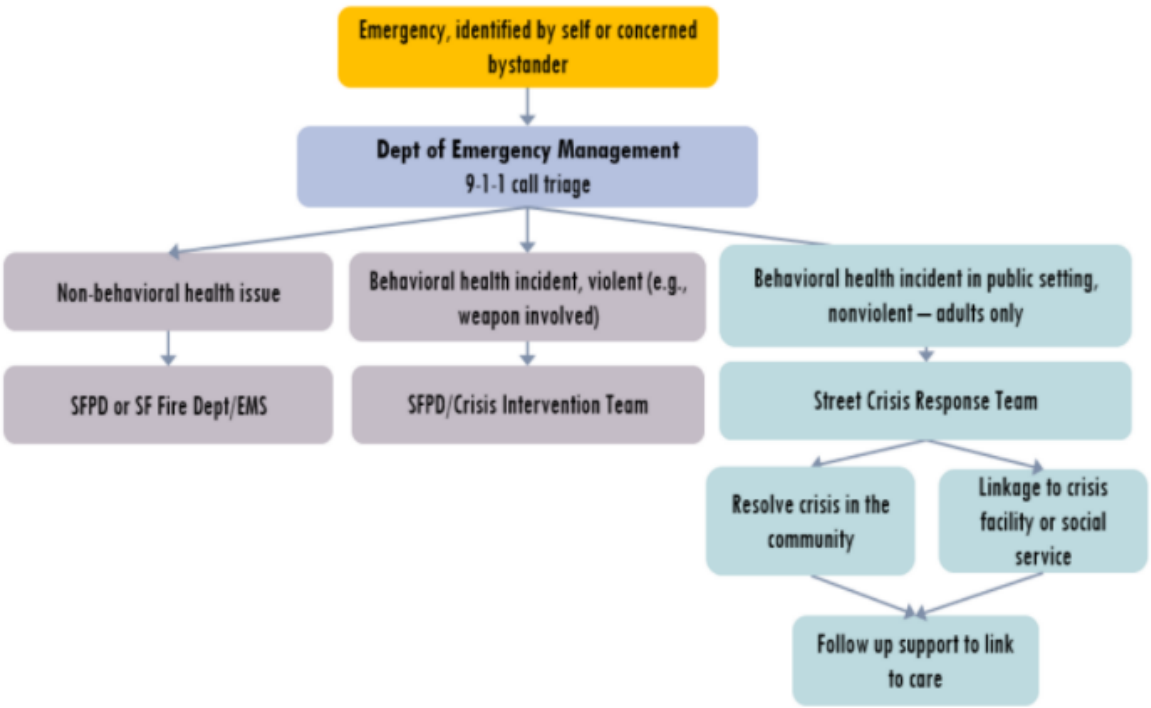
team; creating the need for additional training and supervision to ensure services are delivered in a manner that advances positive outcomes for those engaged in care. Verification of skills and knowledge of non-professional staff is essential to maintaining service delivery standards within a crisis 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

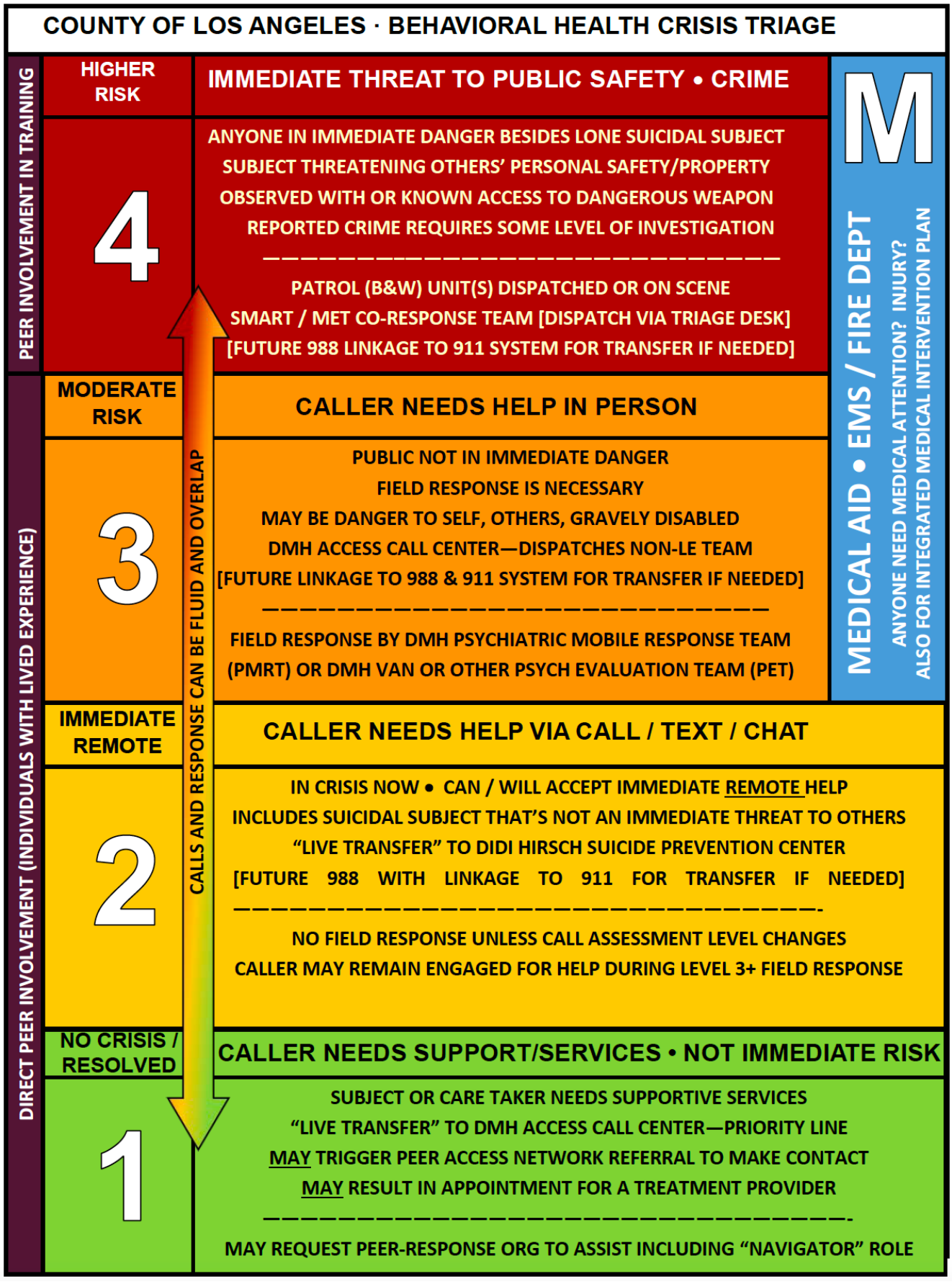
Crisis services must be designed to serve **anyone, anywhere and anytime**. Communities that commit to this approach and dedicate resources to address the community need decrease psychiatric boarding in emergency departments and reduce the demands on the justice system. These two benefits translate into 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

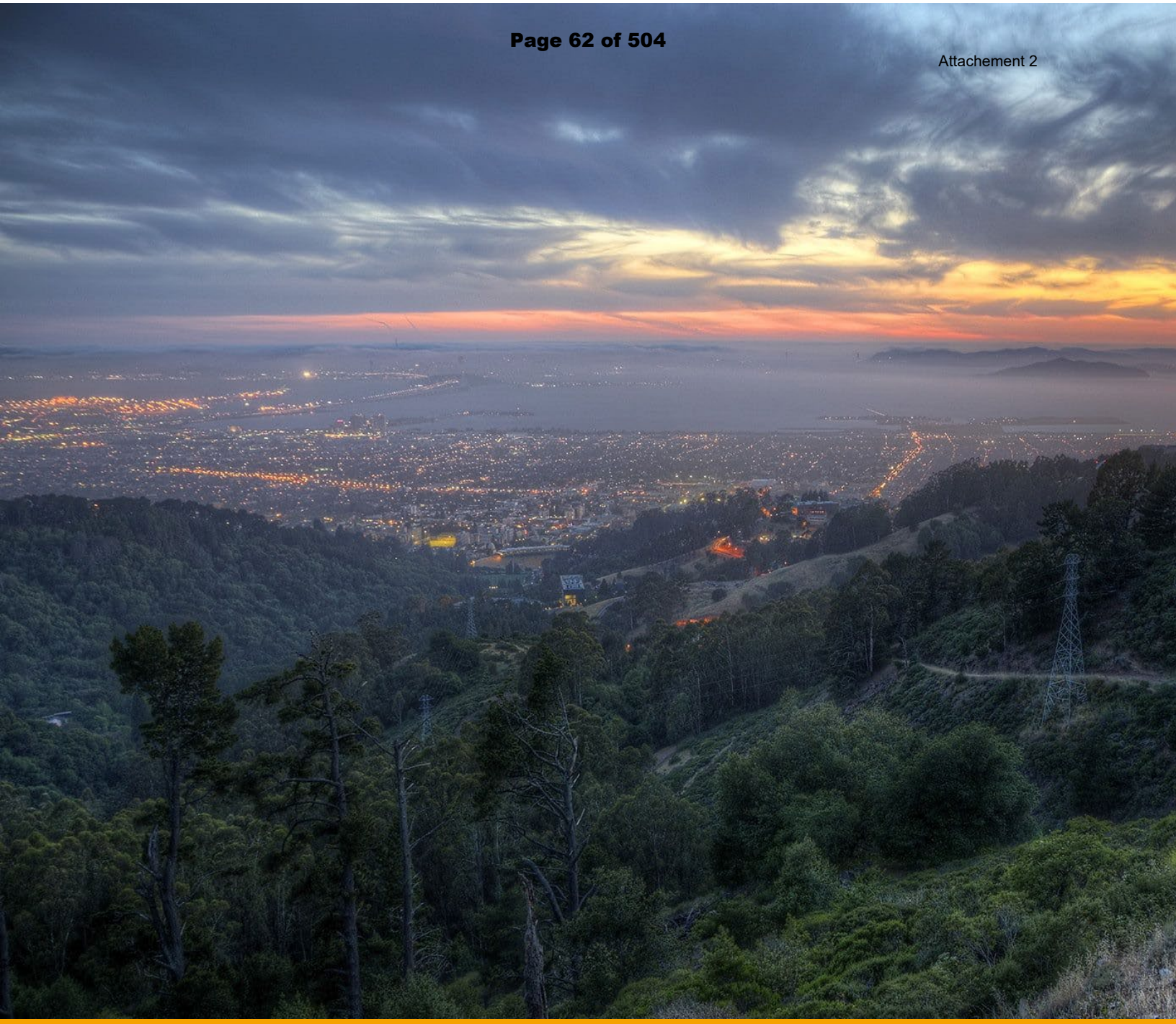
Program	Dispatch	Types of calls	Hours of operation	Crisis team staff	Vehicles	Follow-up process
Albuquerque Community Safety Department – *Albuquerque, NM*	911	Mental health, inebriation, homelessness, addiction	TBD	Clinicians or peers	TBD	TBD
B-HEARD (the Behavioral Health Emergency Assistance Response 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

Sarah Ferrell

Caroline de Bie

Sasha Gayle-Schneider

Jamie Dorsey

Nicole Gamache-Kocol

Kevin Wu

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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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)

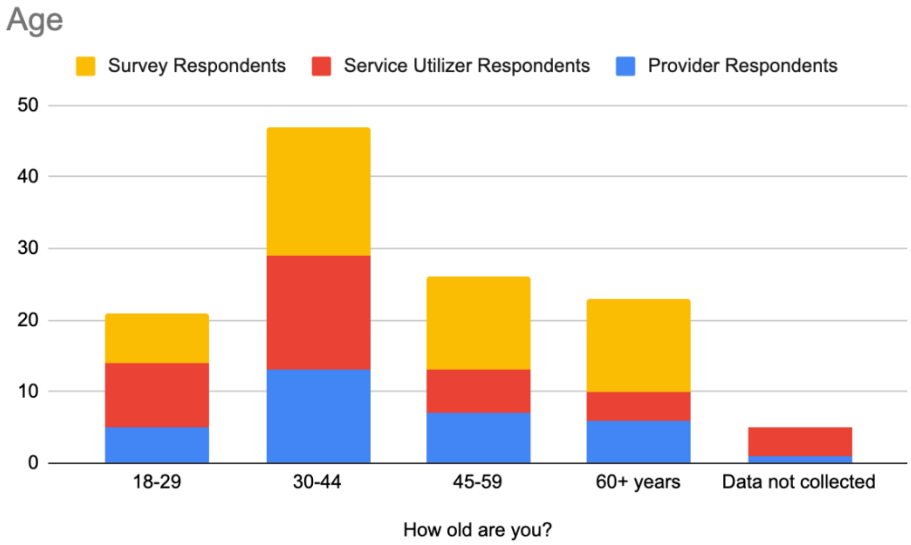


Figure 2 below shows the racial and ethnic distribution of participants in RDA's data collection.[30] Participants were asked to note all races/ethnicities that they identified with, so these are duplicated counts; for this reason, specific percentages should not be interpreted from this data. A large 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)

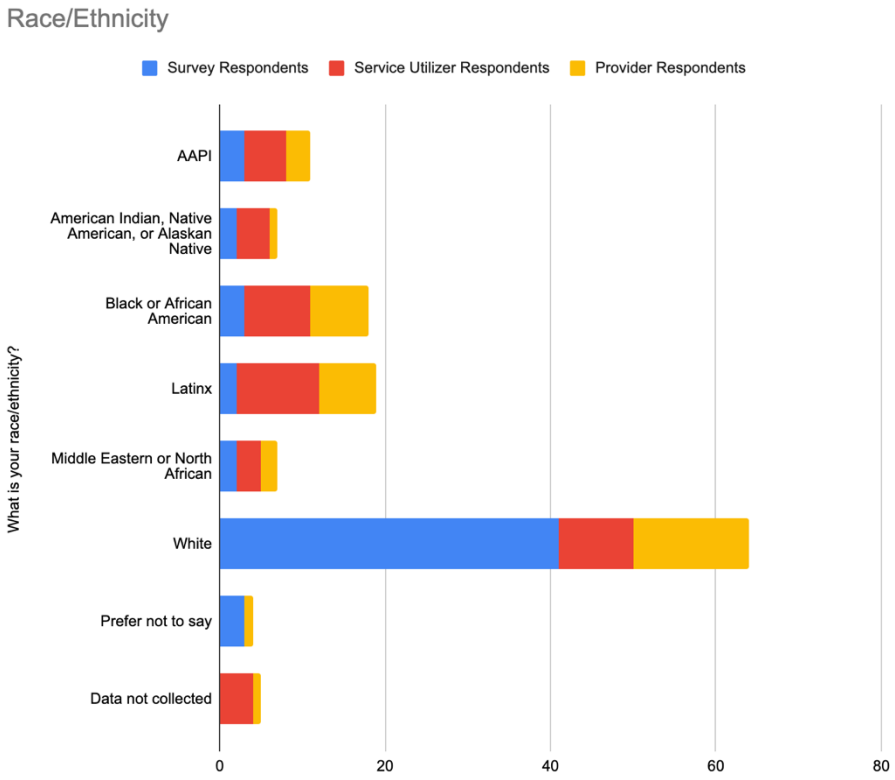


Figure 3 below shows the number of transgender and cisgender participants of RDA's data collection. Overall, there were far more cisgender participants than transgender participants. However, a higher proportion of service utilizer respondents (13%) were transgender, while less than 4% of survey respondents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

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

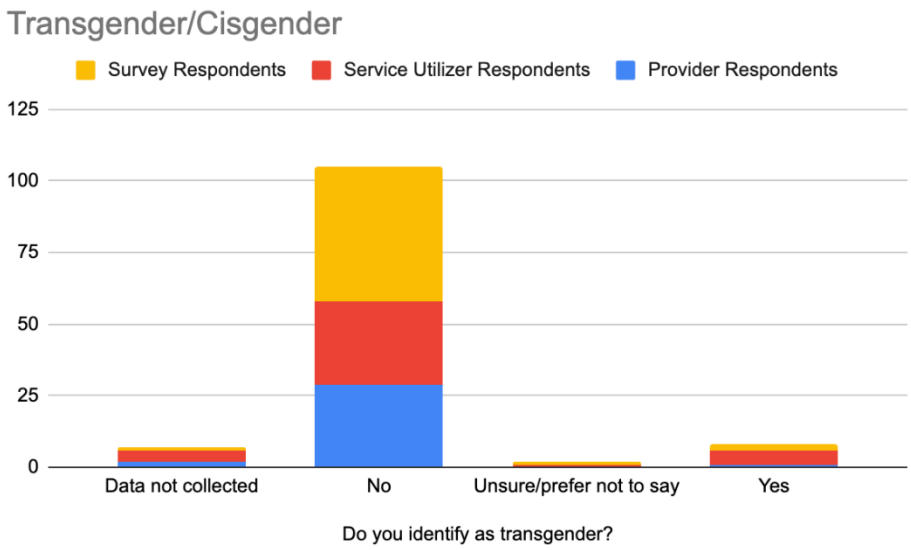


Figure 4 below shows the gender identity distribution of participants to RDA's data collection. RDA collected feedback from more than double the number of female-identifying participants (72) than male identifying participants (31). There was an even distribution among service utilizer respondents (41% 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)

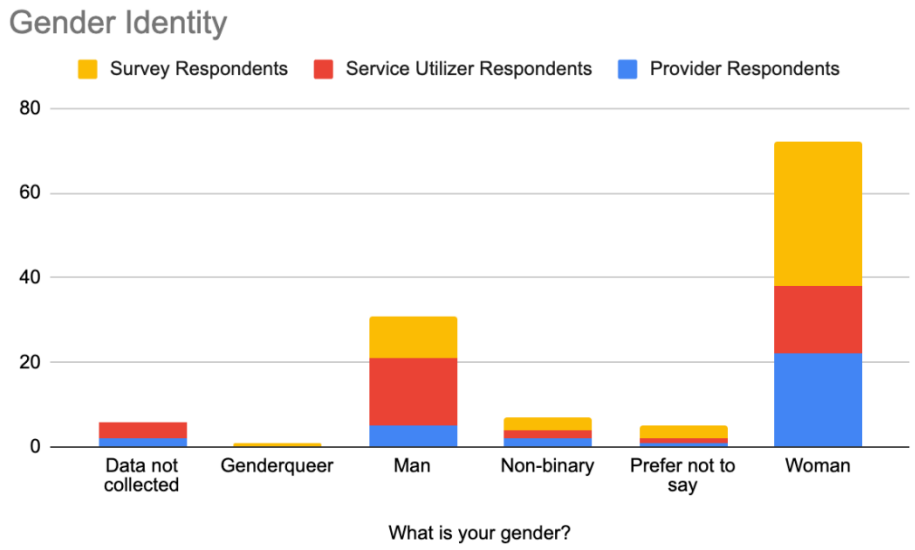


Figure 5 below shows the sexual orientation of participants of RDA's collection. Over one third (35%) of participants identified as heterosexual or straight, while over one fourth (28%) identified as LGBTQ+. The remaining participants did not share their sexual orientation or it was not asked of them. 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)

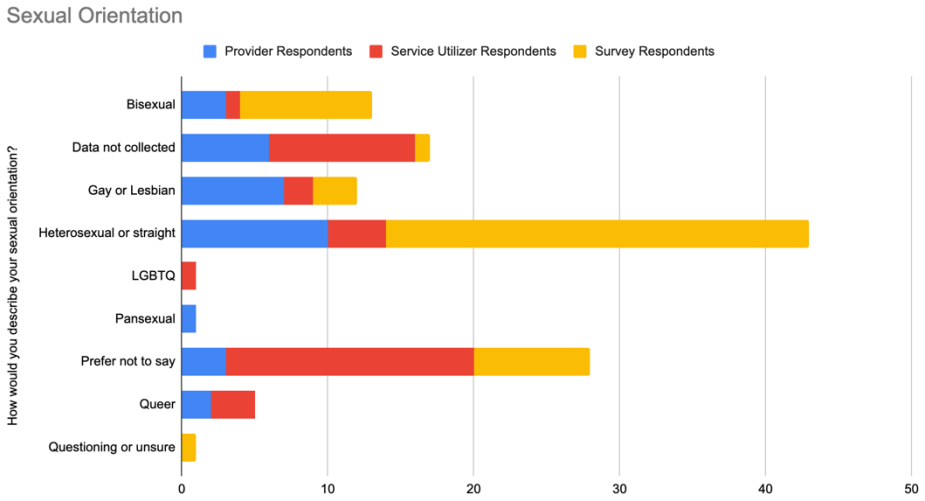
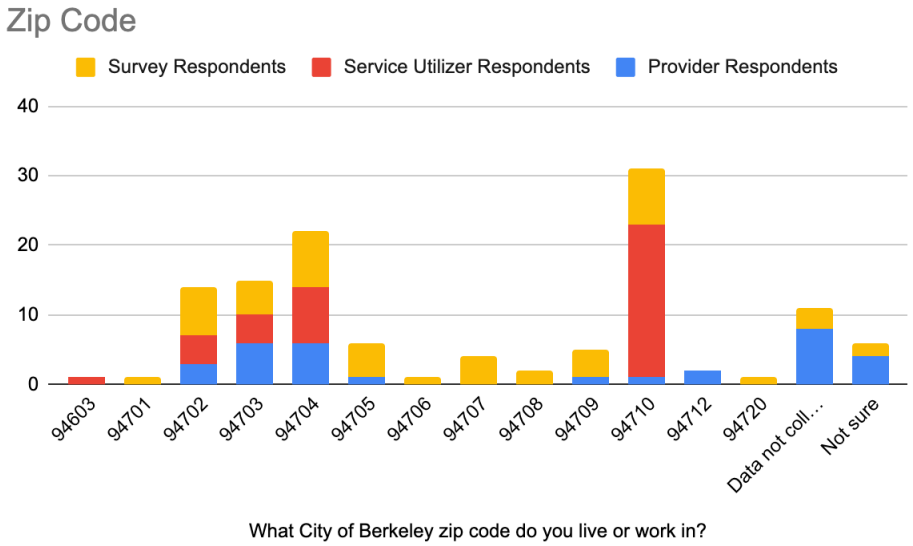
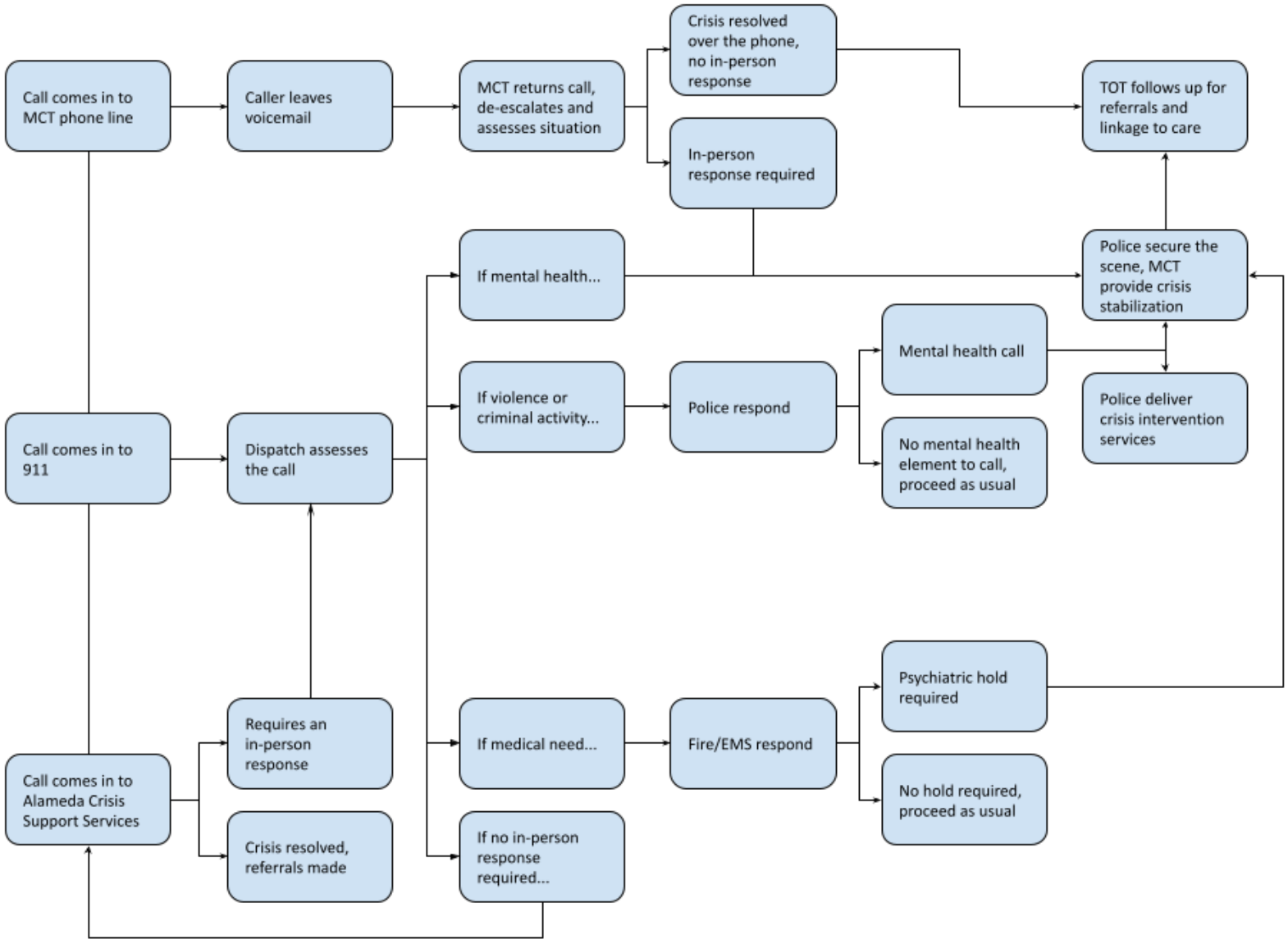


Figure 6 below shows the geographical distribution of participants of RDA's data collection. The most common zip code of participants was 94710 (25%), in large part due to the number of Seabreeze encampment residents that participated in this process. Closely following were the Berkeley ZIP codes of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

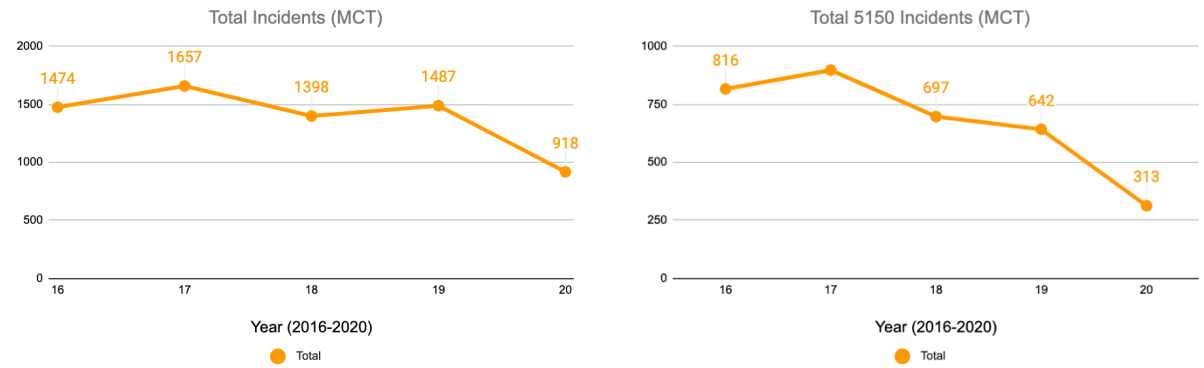
The data challenges that RDA encountered were very similar to those faced by the Berkeley City Auditor; please refer to the Berkeley City Auditor's report of its findings of Berkeley's Police Response for a thorough description of their data challenges.[32]

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**

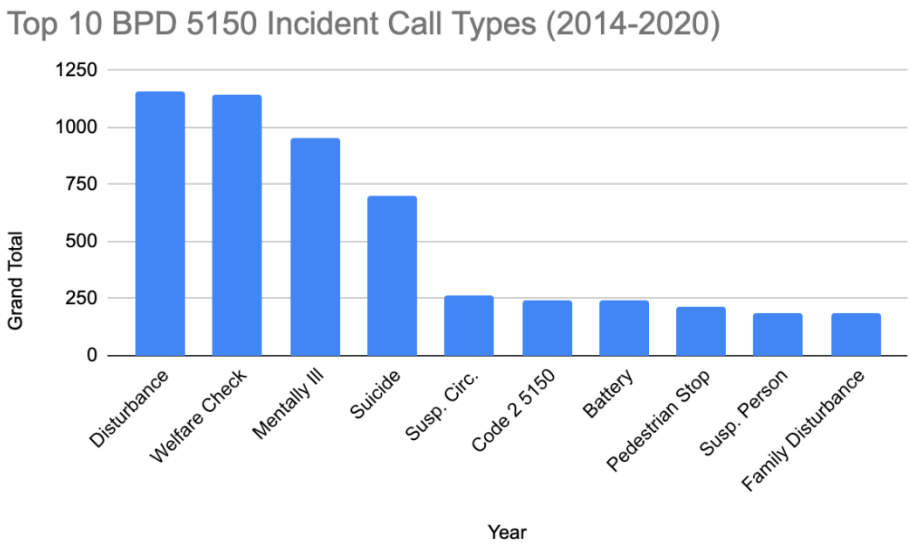


Since 2015, there has been a gradual decline in the number of total and 5150 incidents that MCT responded to in Berkeley due to staff vacancies as well as the COVID-19 pandemic.

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

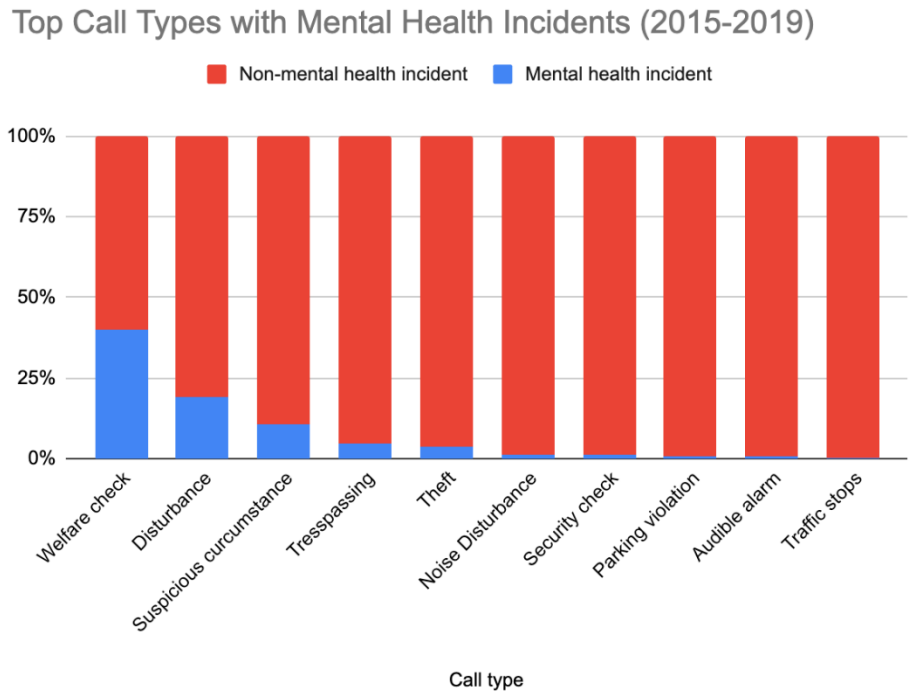
[32] Berkeley City Auditor. (2021, July 2). *Data Analysis of the City of Berkeley's Police Response*. https://www.cityofberkeley.info/uploadedFiles/Auditor/Level_3_-_General/Data%20Analysis%20of%20the%20City%20of%20Berkeley's%20Police%20Response.pdf



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.

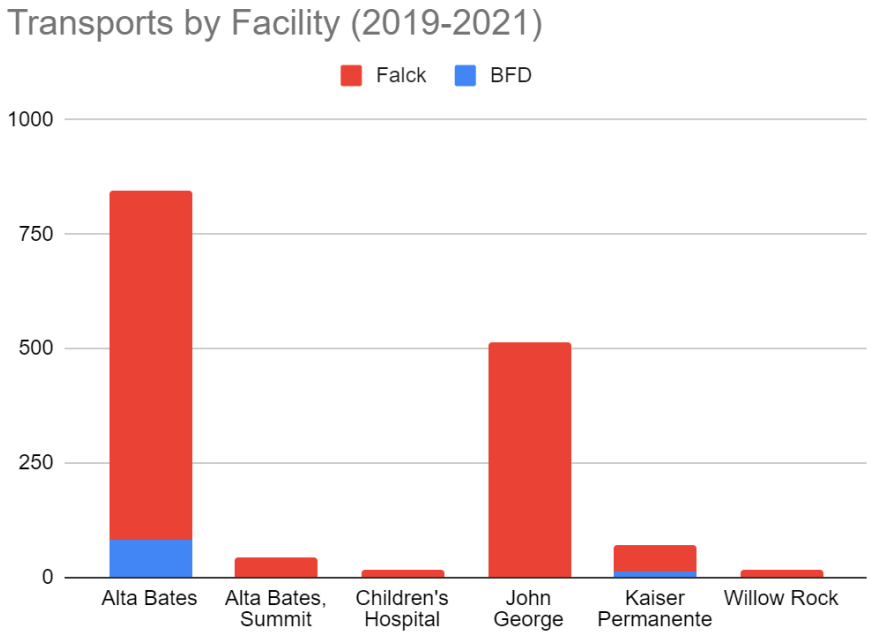
Figure 9. Berkeley Police Department (BPD) Call Types, 2015-2019



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.

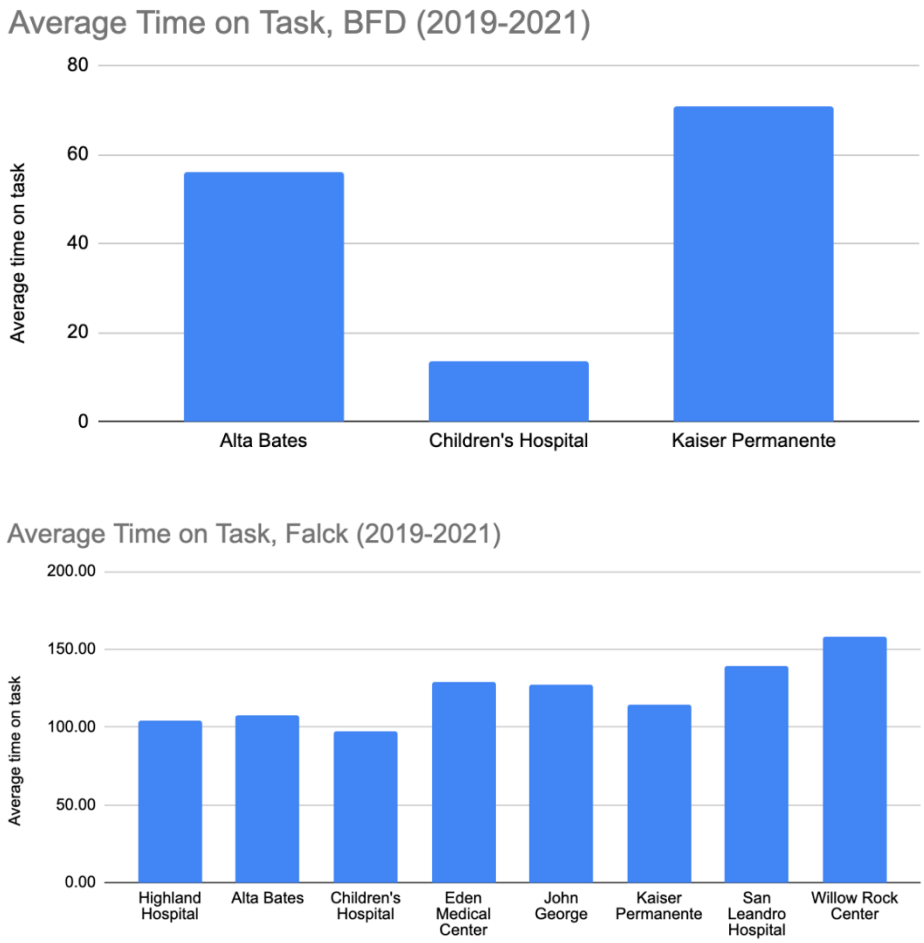
Berkeley Fire Department: The data that BFD shared with RDA (which included data from BFD and Falck) included information on the facilities that BFD and Falck transported 5150 cases to between 2019-2021. Falck conducted the large majority of 5150 transports in Berkeley. Most 5150 transports were to Alta 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



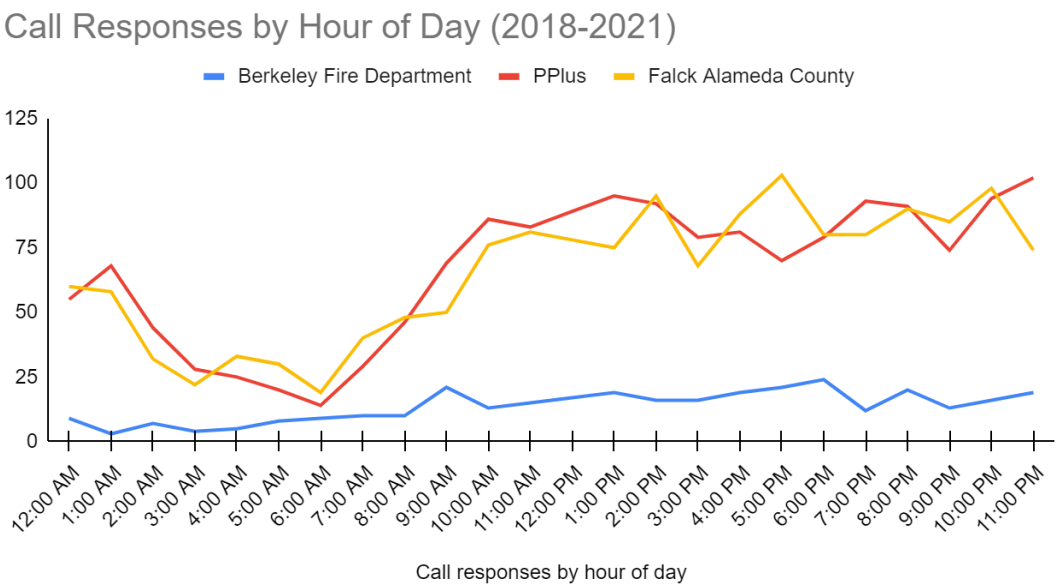
BFD also shared data regarding their and Falck's time on task for each 5150 response and transport. Time on task represents the time from which BFD or Falck arrive at the scene to the point in which they complete the transport of the patient to the destination. Of the 95 5150 transports that BFD conducted 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.

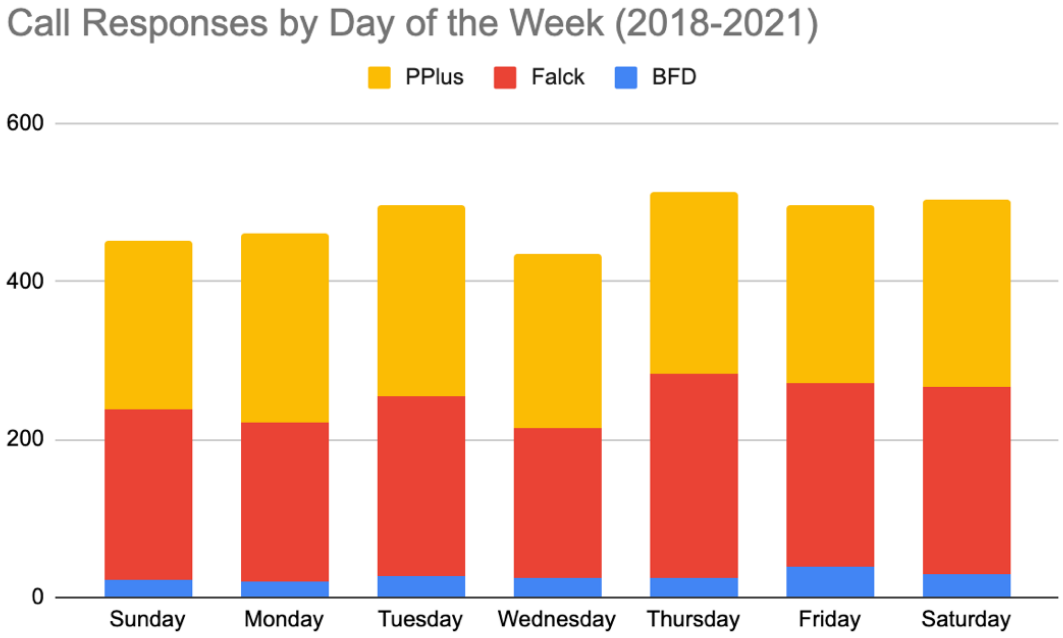
Figure 11. BFD and Falck Time on Task for 5150 Transports, 2019-2021



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



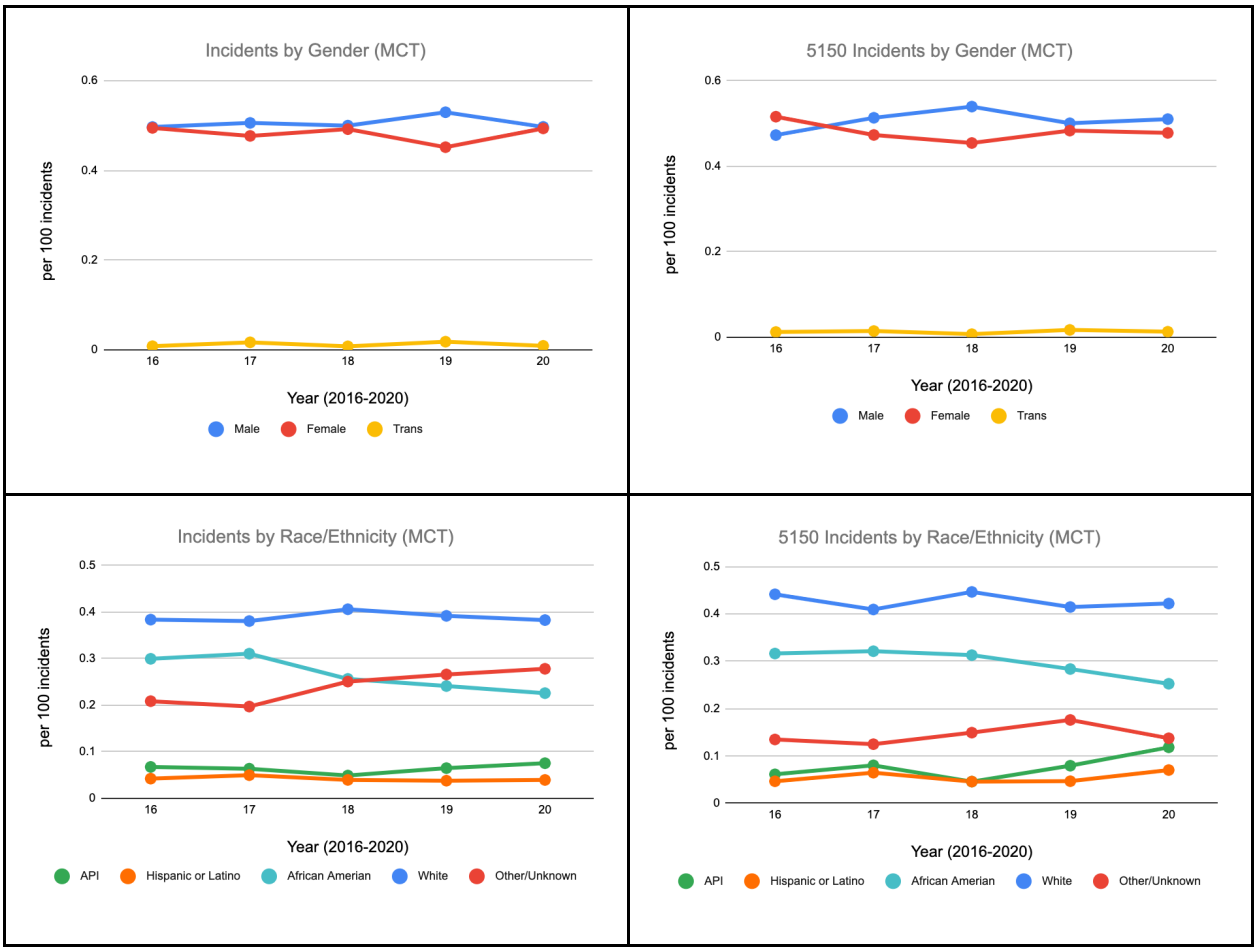


Demographics of Mental Health Call Responses

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



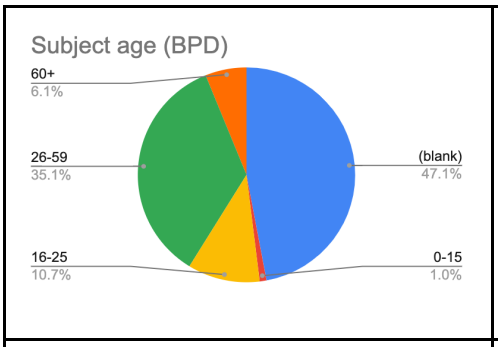
MCT incidents were with slightly more males than females, and very few trans individuals. And, regarding race/ethnicity, MCT cases were most often White, followed by African American, other/unknown, Asian Pacific Islander, and Hispanic or Latino. Given that African Americans comprise only 7.9% of Berkeley's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

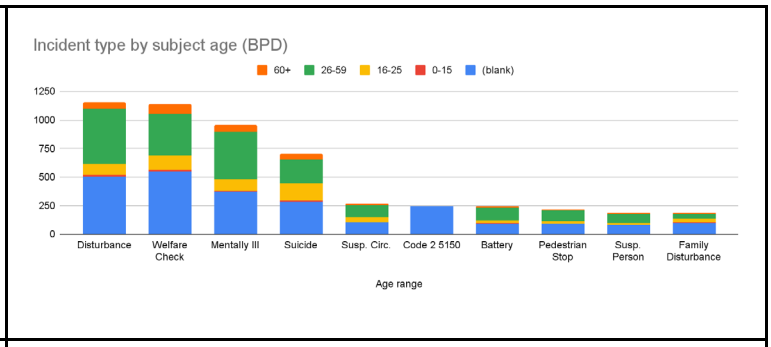
Berkeley Police Department: For the six-year period of CY 2014 through CY 2020, the Berkeley Police Department (BPD) shared data regarding demographics (age, race, and sex) for each of its calls that were originated as designated 5150 responses. Since 2019, the majority of 5150 responses were conducted 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.

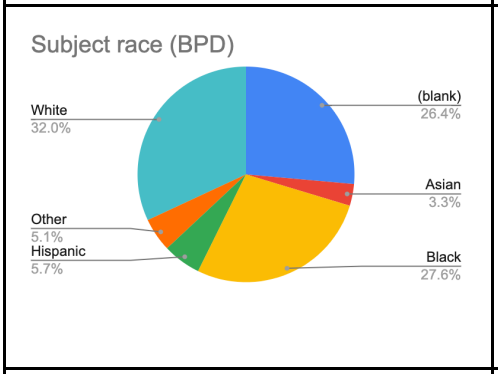
Figure 14. Berkeley Police Department (BPD) 5150 Subjects in 2014-2020 - Demographics and Incident Types[33]

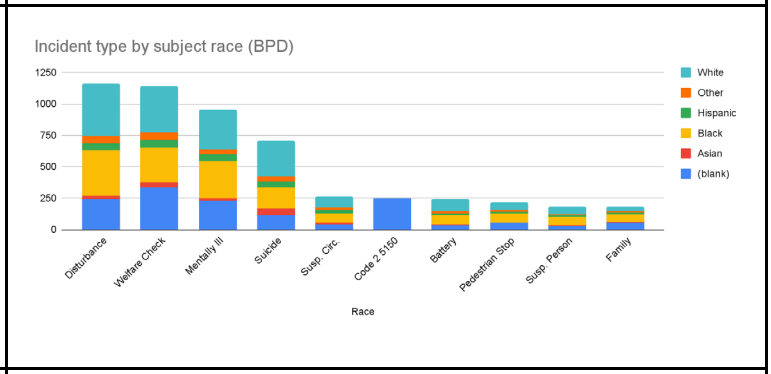
Subjects by Demographics	Incident Types by Demographics

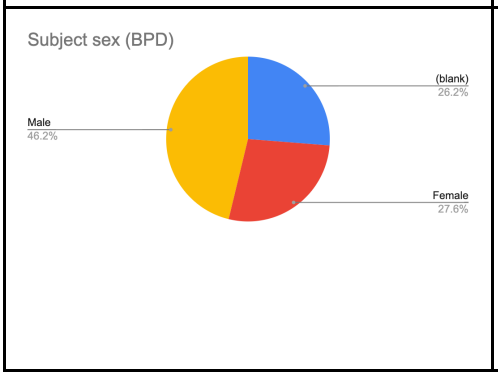
[33] Data noted as (blank) represent data points where data were missing.

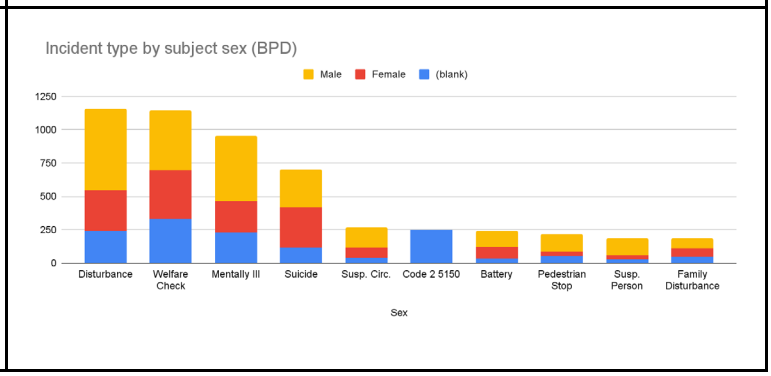










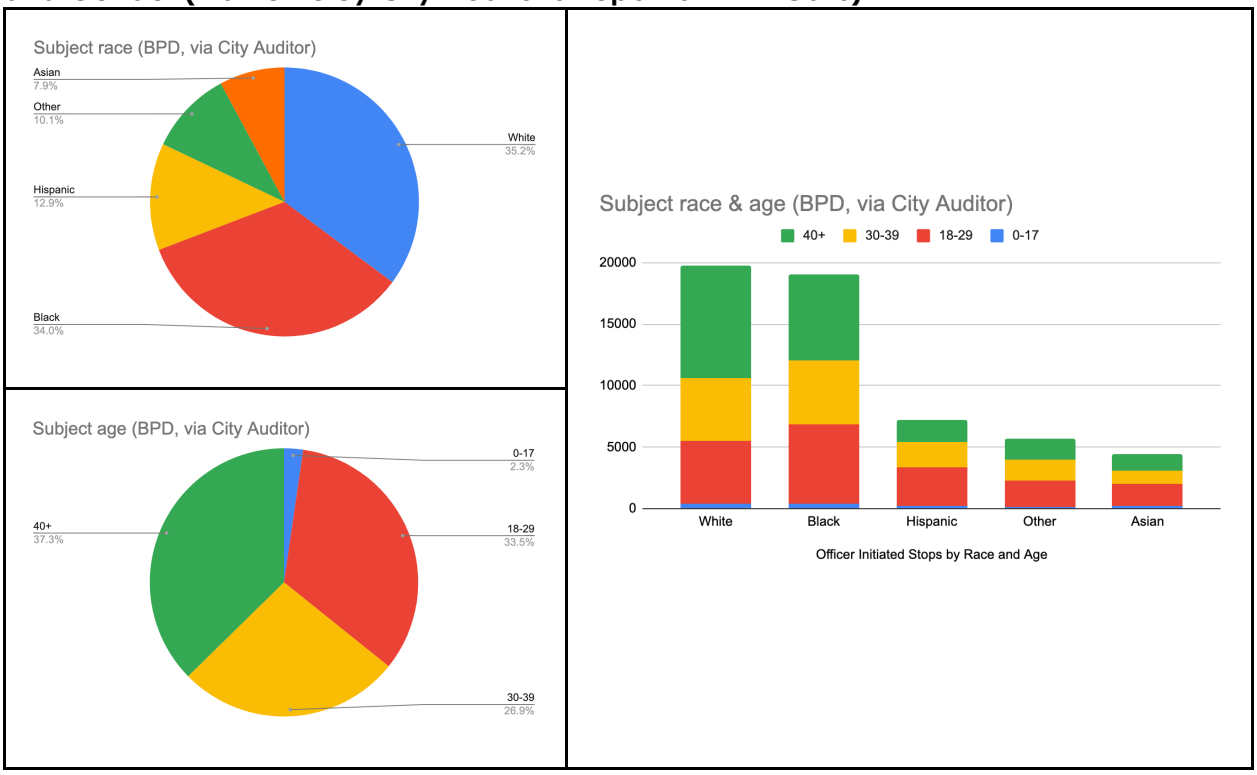


Of the BPD 5150 calls that had demographic variables coded, most responses were with individuals between ages 26-59, White, or male. Liked noted above with MCT's service utilizer population, given that African Americans comprise only 7.9% of Berkeley's population (see Table 1), they are also very overrepresented 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.

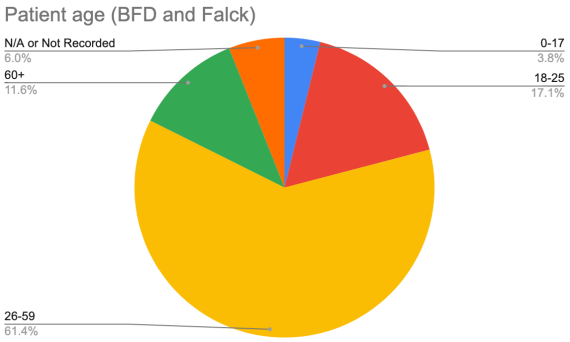
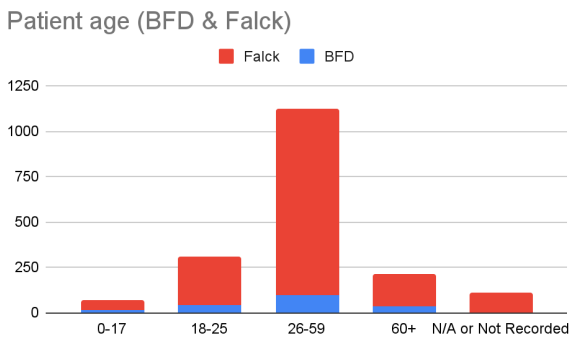
[34] Berkeley City Auditor. (2021, July 2). *Data Analysis of the City of Berkeley's Police Response*. https://www.cityofberkeley.info/uploadedFiles/Auditor/Level_3_-_General/Data%20Analysis%20of%20the%20City%20of%20Berkeley's%20Police%20Response.pdf

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**
	

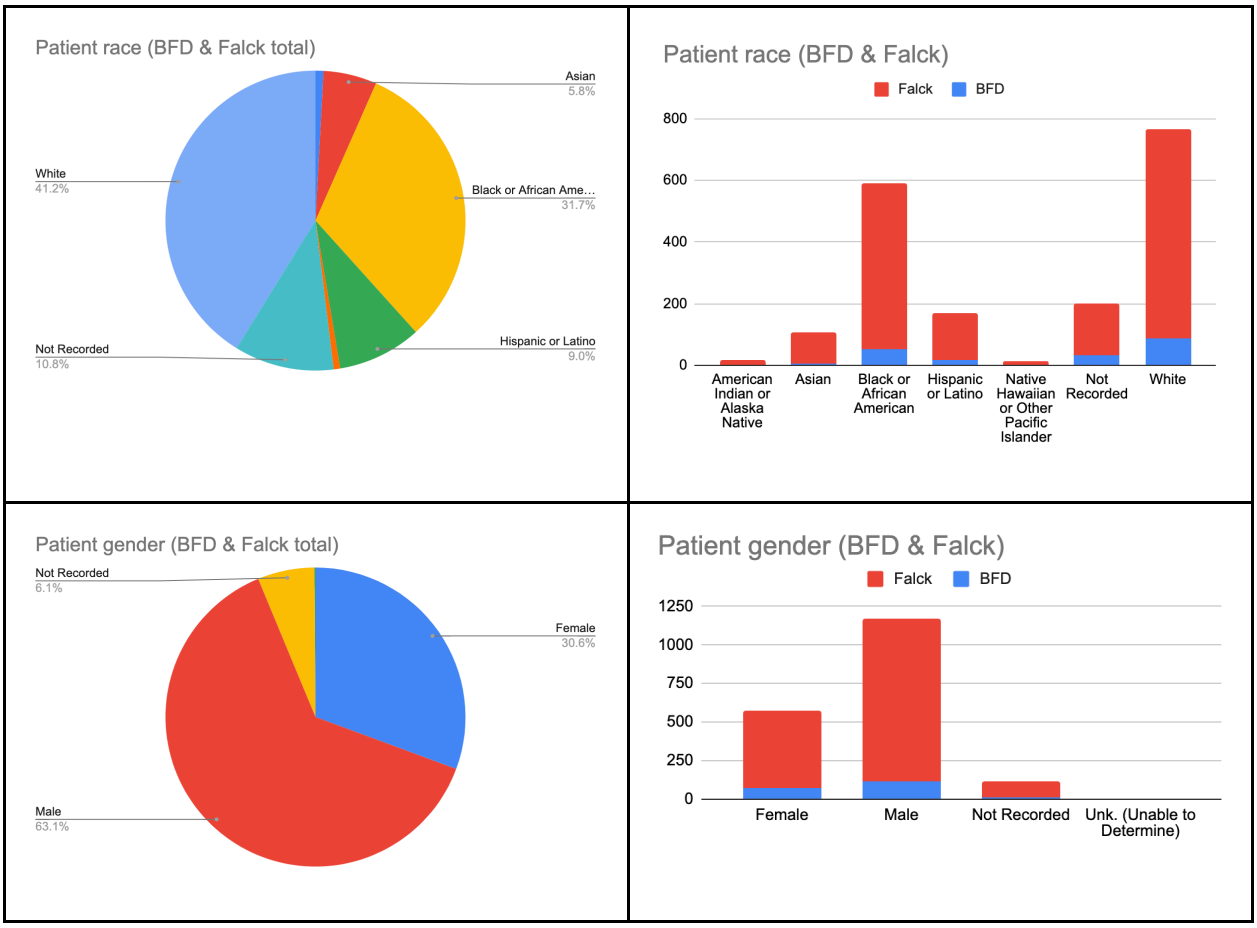
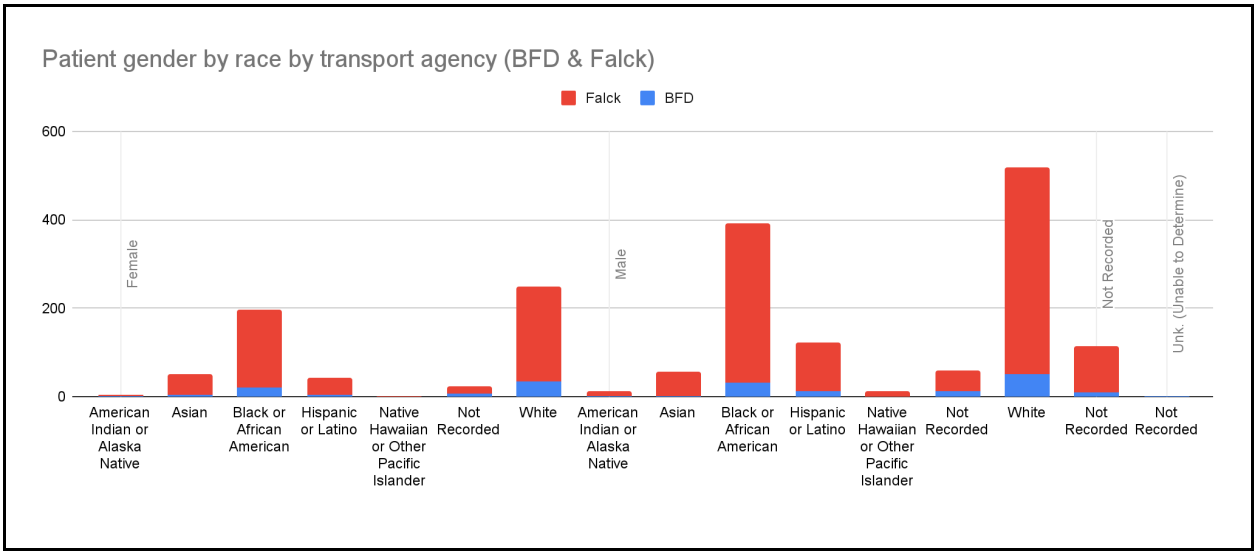
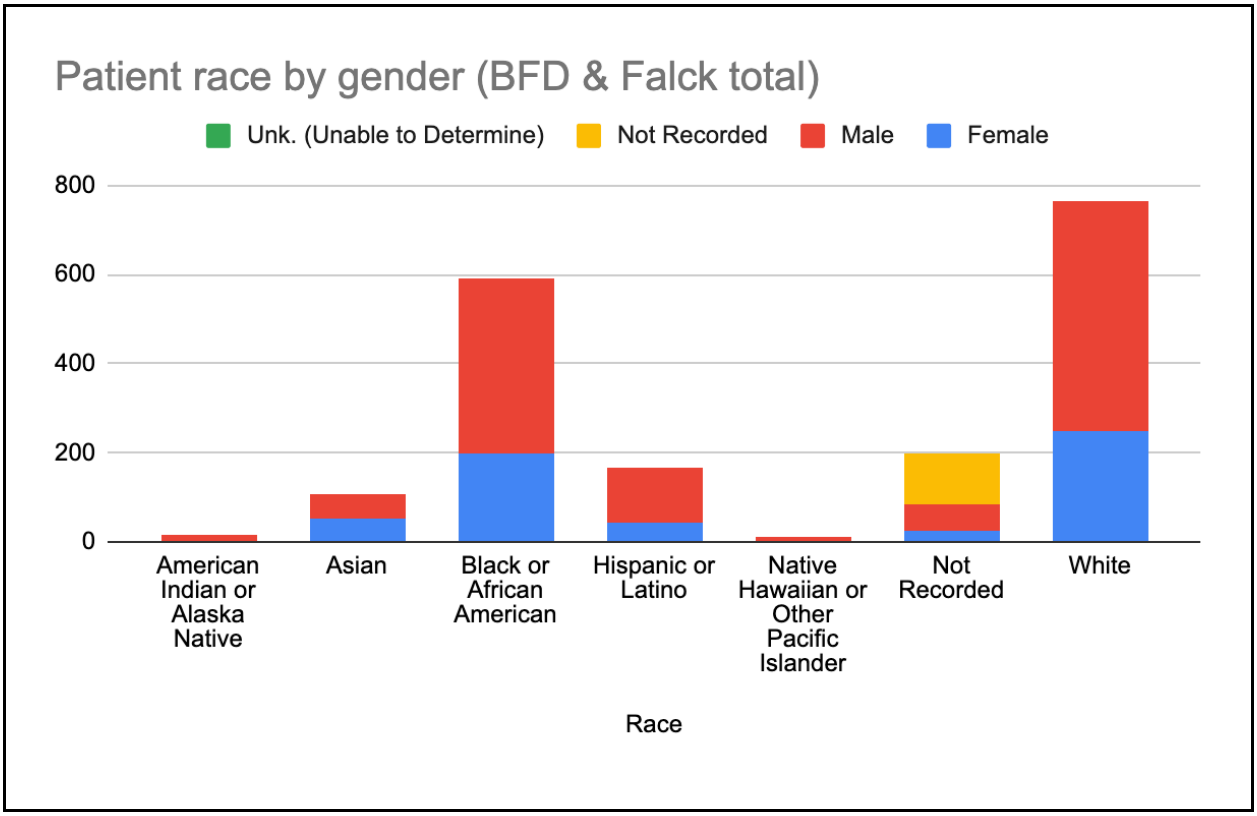


Figure 17. Berkeley Fire Department (BFD) and Falck 5150 Patients in 2019-2021 - By Gender and Race





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

Sarah Ferrell

Caroline de Bie

Sasha Gayle-Schneider

Amalia Egri Freedman

Nicole Gamache-Kocol

Jamie Dorsey

Kevin Wu

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**

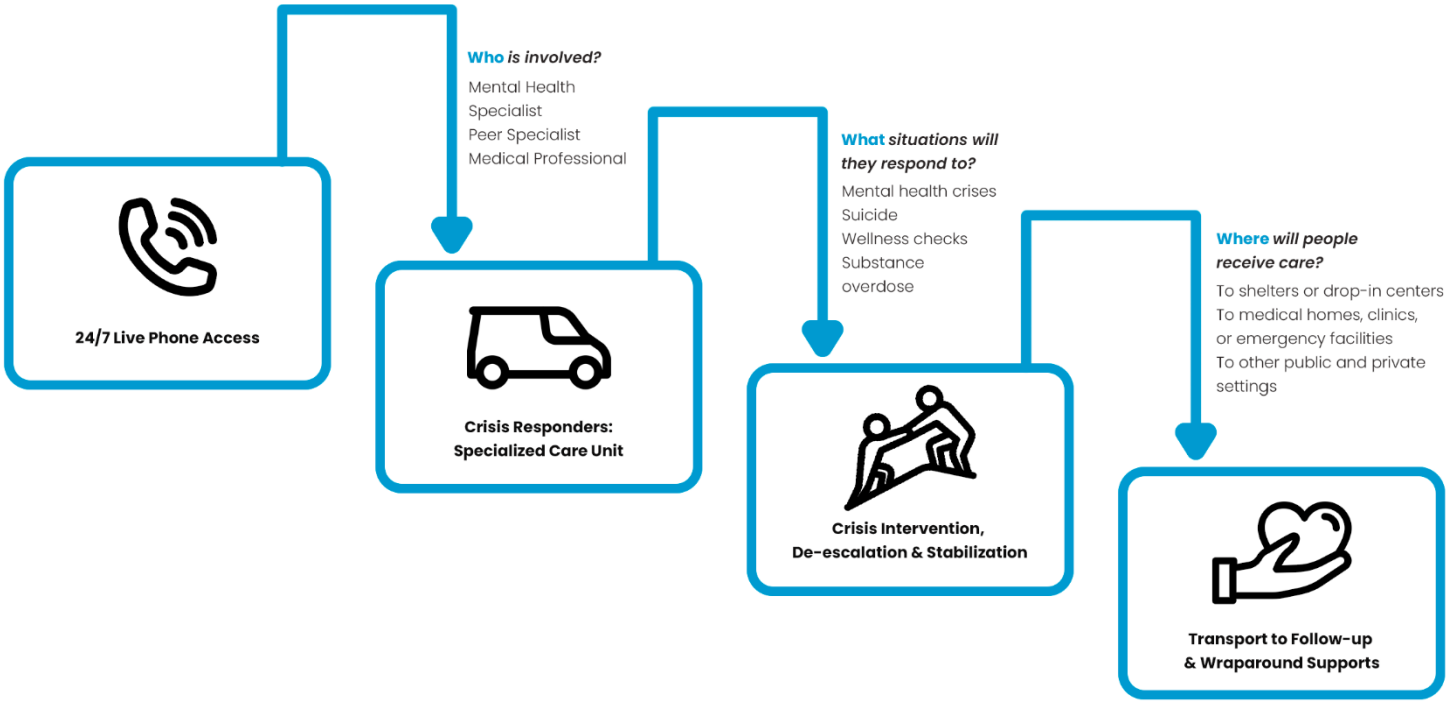
Recommendations

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

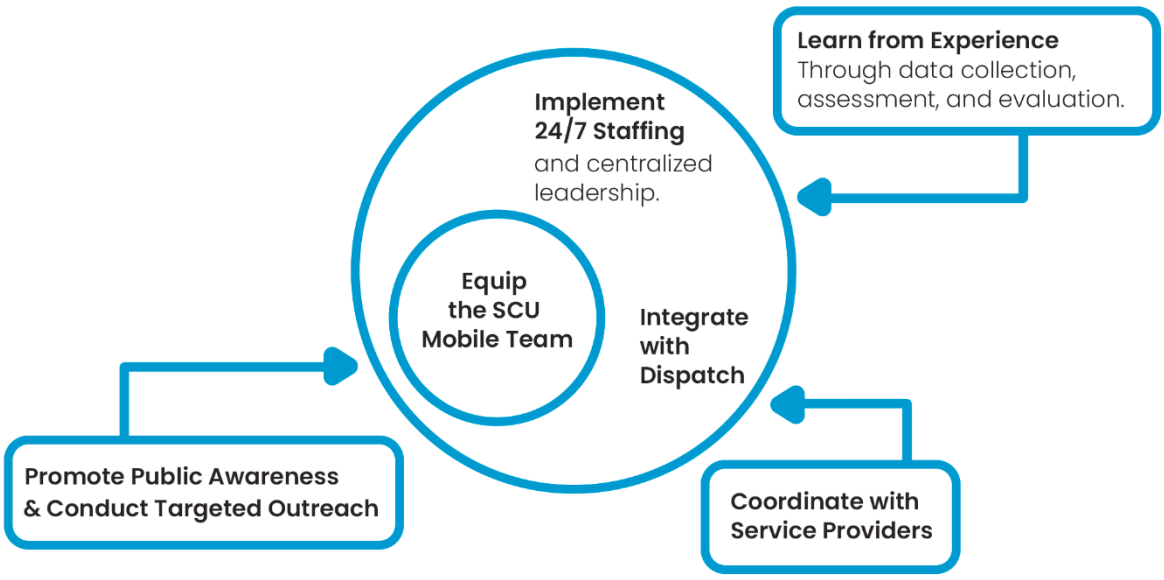
Figure 1: An overview of the SCU crisis response.



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:

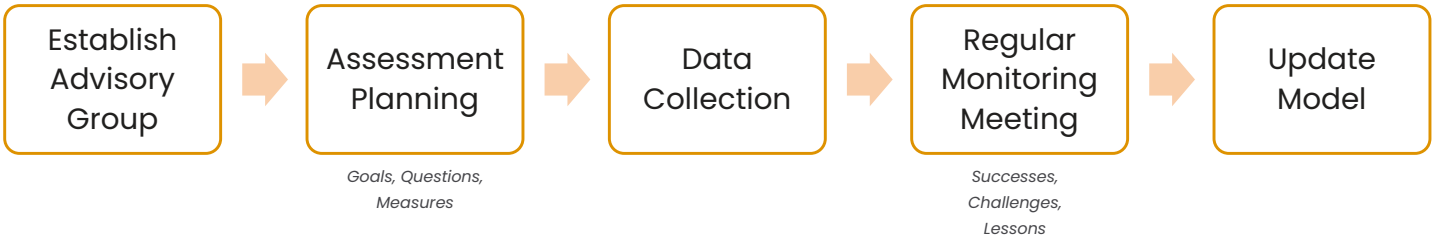
- Quantity of SCU services
- Quality of SCU services
- The impact or outcome of SCU services

*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	

Attachment 3

	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**

Reimagining Public Safety in Berkeley:

FINAL REPORT AND IMPLEMENTATION PLAN

TABLE OF CONTENTS

INTRODUCTION

On July 14, 2020, the Berkeley City Council (Council) made a historic commitment to reimagine the City's approach to public safety with the passage of an omnibus package of referrals, resolutions, and directives known as The George Floyd Community Safety Act. Central to the proposal was a commitment to achieve a "new and transformative model of positive, equitable, and community centered safety for Berkeley."[1]

Direction was given to the City Manager to collaborate with the Mayor and select Councilmembers to inform City of Berkeley (City) investments and reallocations to be incorporated into future Budget processes and to contract with independent subject matter experts to analyze the scope of work and community needs addressed by the Berkeley Police Department (BPD), to identify a more limited role for law enforcement, and to identify elements of police work that could be achieved through alternative programs, policies, systems, and community investments.

The National Institute for Criminal Justice Reform (NICJR) was selected through a Request for Proposal process to conduct this work in partnership with Bright Research Group, which led the community engagement; Renne Public Law Group, who has provided guidance on policy recommendations; Pastor Michael Smith, who supported the community engagement and outreach; and Jorge Camacho, the Policy Director of the Justice Collaboratory at Yale Law School.

This Final Report and Implementation Plan is the culmination of NICJR efforts over the past 10 months, a body of work reflected in the following deliverables:

1. New and Emerging Models of Community Safety and Policing report;
2. Berkeley Calls for Service Analysis;
3. Alternative Responses report;
4. Community Engagement report; and
5. A project website.

1 https://www.cityofberkeley.info/RIPST.aspx

REPORT INFOGRAPHIC SUMMARY

The City of Berkeley's George Floyd Act referenced NICJR's reform model of Reduce — Improve — Reinvest. This report is also primarily organized in those sections: Reduce the footprint of law enforcement; Improve the quality of law enforcement and public safety; and Reinvest into community and services. Some of the recommendations in this report are programs or policies that have been tried in other jurisdictions and have a track record of effectiveness or promise, other recommendations are new ideas, aligned with the goal of Reimagining!

The body of this report is already 40 pages for a total of 272 pages, including the appendices, therefore the below graphic provides a quick overview of the detailed recommendations included in this report instead of repeating the narrative.

Reduce

- Implement Tiered Dispatch & CERN model, thereby reducing BPD patrol duties
- End pre-text stops
- Eliminate BPD vacant positions through attrition
- Creation of BerkDOT

Improve

- Implement Highly Accountable Learning Organization (HALO)
- Launch new Progressive Police Academy
- New Police Accountability Board
- Implement BPD improvement measures

Reinvest

- Launch Guaranteed Income program
- Launch Community Beautification Employment Program
- Increase funding to CBOs for "fundamental cause" services:
  - Poverty
  - Homelessness
  - Education
  - Substance abuse
  - Unemployment and underemployment

BACKGROUND

Berkeley City Council George Floyd Act

In response to the national outcry for police reform, and in line with the City's long history of progressive policy making, the Berkeley City Council formally adopted the George Floyd Community Safety Act which included the following package of referrals, resolutions, and directions:

1. Have the City's elected Auditor perform an analysis of the City's emergency 9-1-1 calls-for-service and responses, as well as analysis of the Berkeley Police Department's (BPD) budget.
2. Create plans and protocols for calls for service to be routed and assigned to alternative preferred responding entities and consider placing dispatch in the Fire Department or elsewhere outside the Police Department.
3. Analyze and develop a pilot program to re-assign non-criminal police service calls to a Specialized Care Unit. This Specialized Care Unit (SCU) consists of trained crisis-response field workers who would respond to calls that the Public Safety Communications Center operator evaluated as non-criminal and that posed no imminent threat to the safety of community members and/or Police Department or Fire Department personnel.
4. Evaluate initiatives and reforms that reduce the footprint of the Berkeley Police Department and limit the Police Department's scope of work primarily to violent and criminal matters. This work should include an evaluation of programs and services currently provided by the Police Department that could be better served by trained non-sworn city staff or community partners.
5. Aspire to reduce the Police Department's budget by 50% to generate resources to fund the following priorities:
    - Youth programs;
    - Violence prevention and restorative justice programs;
    - Domestic violence prevention;
    - Housing and homeless services;
    - Food Security;
    - Public health and Mental Health services including a specialized care unit;
    - Healthcare;
    - New city jobs;
    - Expanded partnerships with community organizations, and
    - Establishing a new Department of Transportation to administer parking regulations and traffic laws
6. Engaging a qualified firm(s) or individual(s) to lead a robust, inclusive, and transparent community engagement process with the goal of achieving a new and transformative model of positive, equitable and community-centered safety for Berkeley.
7. Pursue the creation of a Berkeley Department of Transportation to ensure a racial justice lens in traffic enforcement and the development of transportation policy, programs and infrastructure, and identify and

implement approaches to reduce and/or eliminate the practice of pretextual stops based on minor traffic violations.

8. Analysis of litigation outcomes and exposure for city departments in order to guide the creation of city policy to reduce the impact of settlements on the General Fund.

Recent History of Problems with Policing in Berkeley

Although immediately inspired by the events of 2020, the Council's George Floyd Act came on the heels of a period of challenges with the BPD:

February 12, 2013: Death of Kayla Moore, Black transgender woman in mental health distress

Kayla Moore, a Black transgender woman with schizophrenia, died in her apartment on Allston Way while BPD officers were responding to a call for a "wellness check." During the incident, half a dozen police officers forcibly held her down. The family of Kayla Moore filed a lawsuit in 2014 against the City of Berkeley, however, the City contended that minimal and appropriate force was used and sought a dismissal of the lawsuit in federal court, which was ultimately granted.

December 6, 2015: Use of Force at Black Lives Matter protests

During a Black Lives Matter protest in Berkeley on December 6, BPD was accused of beating peaceful protesters and journalists, and using excessive amounts of teargas without justification.[2]

In 2017, the City of Berkeley reached a settlement with several plaintiffs who sued the City and BPD for the attack. Seven plaintiffs received $125,000 and BPD agreed to amend its use of force policy.[3]

March 26, 2018: Black child falsely accused, chased, and run over by car

On March 26, 2018, on Telegraph and Stuart, a Black child in the 7th grade was chased and grabbed by a white man, who mistook the Black child roughhousing with a white female classmate on the sidewalk as an assault. The boy was then struck with a car by another man as he ran in fear of his safety. The family was told by a white police sergeant that nothing unlawful actually happened, and determined that the man chasing the child did not commit any crime, rather he was lawfully attempting to make a citizen's arrest. In addition, the child's grandmother, who is his legal guardian, reported that she was told by BPD that she had no right to any written reports or documentation of the incident without a court order.[4]

2 https://www.kqed.org/news/10402266/berkeleys-police-chief-on-protests-tear-gas-use
3 https://www.dailycal.org/2017/02/05/city-berkeley-reaches-conditional-settlement-lawsuit-regarding-police-use-force/
4 https://www.berkeleyside.org/2018/05/18/opinion-the-willard-school-community-wants-answers-fromberkeley-police-about-a-troubling-incident

May 2018: Report Reveals Racial Disparities in BPD Stops and Searches

An analysis by the nationally renowned Center for Police Equity published in May 2018 found the stops and searches conducted by BPD were racially disproportionate. The report states:

> "Our analysis of BPD vehicle and pedestrian stops found that Black and Hispanic persons were more likely than White persons to be stopped by BPD. Black persons in Berkeley were about 6.5 times more likely per capita than White persons to be stopped while driving, and 4.5 times more likely to be stopped on foot. Hispanic persons were about twice as likely, per capita, as White persons to be stopped while driving, and slightly less likely to be stopped on foot. In addition to their much higher stop rates, Black and Hispanic drivers (and pedestrians) were also searched at much higher rates. Once stopped, Black drivers were searched at a rate four times higher than their White counterparts (20% compared to 5%), while Hispanic drivers were searched at three times the White rate (15%)."

March 14, 2020: Less-lethal shooting of unarmed Black man, Ashby & Sacramento St.,

A BPD officer used a less-lethal weapon to shoot William Dean Brown, a Black man kneeling on the ground with his empty hands in the air. He was shot within a distance of 12 feet and was hit in the torso, and quickly handcuffed and tackled by three officers as soon as he hit the ground.

June 9, 2020: BPD Chief mentions shooting protesters at City Council Meeting

Just after a march organized by The Way church protesting the killing of George Floyd, then BPD Chief Andrew Greenwood made a comment during a Council meeting to discuss whether to permanently ban the use of tear gas as a method of crowd control. City Councilmember Susan Wengraf asked Greenwood what kind of alternative tools would be best to use if a crowd turned violent and police could not use tear gas, to which Greenwood replied "Firearms. We can shoot people." His statement immediately prompted a call from the community for his resignation.[5]

June 30, 2020: Officer shooting at Black man and minors in vehicle, North Berkeley

BPD Officer Cheri Miller fired her gun at three teenagers accused of shoplifting at CVS. Miller got out of her vehicle with her gun drawn, and, within less than a minute of her arrival, she had ordered the driver, 19-year-old Brandon Owens of Concord, a young Black man, to get into his car and put his keys on the roof. When Brandon got back into his vehicle, he began to drive away from the officer who then shot at the moving vehicle three times. There were two minors in the car with Brandon. Miller was found not to have committed any crime, but was found in violation of BPD's deadly force policy and was fired.

December 17, 2020: Use of force Parker and Mathews St., Southwest Berkeley

55-year-old David Frazier and an unnamed passenger were pulled over for multiple vehicle code violations. The initial call was categorized as a routine traffic stop. When Frazier finally stopped after multiple attempts from BPD, two officers approached Frazier's vehicle and began to forcefully attempt to pull Frazier out of the front seat, punching and pulling on him. The three officers were unsuccessful in gaining control over Frazier and then stepped back and pulled out their batons and began to beat Frazier while he sat in the front seat. Two more officers then approached the passenger side of the vehicle with their guns drawn, broke the passenger window, pulled the passenger out, handcuffed him and dragged him away. Frazier was dragged out of the car and tackled by five or six officers, handcuffed, and forced to sit upright on the hood of a police vehicle.

5 https://www.berkeleyside.org/2020/06/13/marchers-in-berkeley-demand-resignation-of-police-chief

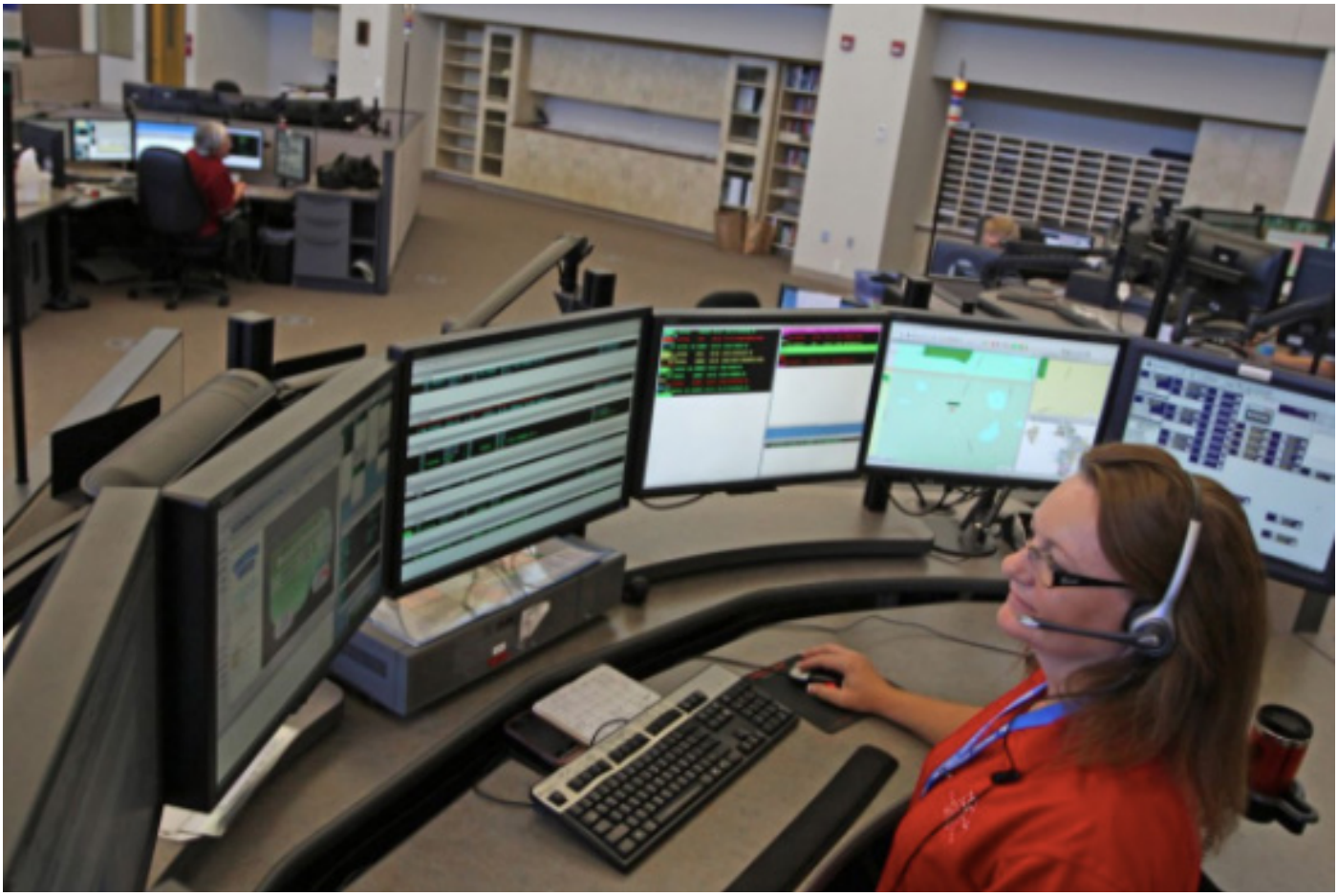
January 2, 2021: Use of force on unhoused Black man with mental illness, Shattuck Ave., Downtown Berkeley

Bryant, a 50-year-old unhoused Black man who suffers from mental illness, tried to purchase a sandwich, bag of chips, and a bag of candy from Walgreens with $1.00 in coins. He attempted to walk out of the store without paying for the remaining amount owed, but security locked the doors on him. Bryant then pulled out a bike chain from his backpack which prompted security to open the doors and let Bryant leave the store. Dispatch categorized the initial call as a possible 5150 (mental health hold) based on employees' description of the event. The arriving officer shot Bryant in the face, shattering his jaw, within 20 seconds of arriving on the scene.

Reimagining Public Safety Task Force

As part of the George Floyd Act, the City created the Reimagining Public Safety Task Force (RPSTF), which was charged with making recommendations to the consultant (NICJR) and city staff on structures and initiatives to outline a new, community-centered safety paradigm as a foundation for deep and lasting change, grounded in the principles of Reduce, Improve and Reinvest as proposed by the NICJR, considering, among other things:

- The social determinants of health and changes required to deliver a holistic approach to community-centered safety;
- Defining an appropriate response to calls-for-service including size, scope of operation and powers and duties of a well-trained police force;



- Limiting militarized weaponry and equipment; and
- Identifying alternatives to policing and enforcement to reduce conflict, harm, and institutionalization, introduce restorative and transformative justice models, and reduce or eliminate use of fines and incarceration. Options to reduce police contacts, stops, arrests, tickets, fines, and incarceration and replace these, to the greatest extent possible, with educational, community serving, restorative, and other positive programs, policies, and systems.

The Task Force is comprised of:

- One (1) representative appointed by each member of the City Council and Mayor,
- One (1) representative appointed from the Mental Health Commission, Youth Commission and Police Review Commission,
- One (1) representative appointed by the Associated Students of the University of California (ASUC) External Affairs Vice President,
- One (1) representative appointed by the Berkeley Community Safety Coalition (BCSC) Steering Committee, and
- Three (3) additional members appointed "At-Large" by the Task Force.

District 1 - Margaret Fine	Youth Commission - Nina Thompson
District 2 - Sarah Abigail Ejigu	Police Review Commission - Nathan Mizell
District 3 - boona cheema	Mental Health Commission - Edward Opton
District 4 - Jamie Crook	Berkeley Community Safety Coalition - Jamaica Moon
District 5 - Dan Lindheim	Associated Students of U. California - Alecia Harger
District 6 - La Dell Dangerfield	At-Large - Vacant
District 7 - Barnali Ghosh	At-Large - Liza Lutzker
District 8 - Pamela Hyde	At-Large - Frances Ho
Mayor - Hector Malvido	

NICJR REPORTS

NICJR produced drafts of the following series of reports then received feedback from the RPSTF and City staff and made necessary edits and additions then finalized:

1. New and Emerging Models of Community Safety and Policing Report
2. Berkeley Calls For Service Analysis Report
3. Alternative Responses Report
4. Community Engagement Report

Included below is a brief description and summary of each of those reports. Links to the full reports are included below and the reports are appendices G through J.

New and Emerging Models of Community Safety and Policing Report

The New and Emerging Models of Community Safety and Policing report includes detailed overviews of a variety of examples of Emerging Non-Enforcement Models of Community Response; Non-Law Enforcement Crime Reduction Strategies; Community Driven Violence Reduction Strategies; and Policing Strategies. Highlighted below are some of the programs included in that report that informed NICJR's final recommendations for the City's reimagining work:

Emerging Non-Enforcement Models of Community Response include the Crisis Response Unit (CRU) and Street Crisis Response Team (SCRT).

The City of Olympia, Washington implemented the CRU in April of 2019 to serve as an option to respond to behavioral health calls for service. CRU teams consist of mental health professionals that provide support such as mediation, housing assistance, and referrals to additional services to their clients.[6] Calls for service for the CRU originate from community-based service providers, the City's 911 hub, and law enforcement personnel. [7]

The SCRT is a pilot program launched in November 2020 and administered by the Fire Department in San Francisco, California. The program targets individuals experiencing behavioral health crises. SCRTs consist of a behavioral health specialist, a peer interventionist, and a first responder. 911 calls that are determined to be appropriate for a SCRT are routed accordingly by dispatch. A team responds to calls in an average of 15 minutes.[8]

Non-Law Enforcement Crime Reduction Strategies include the Mayor's Action Plan (MAP) in New York City, NY. Launched in 2014 in fifteen New York City Housing Authority properties, MAP was designed to foster productive dialogue between local residents and law enforcement agencies, address physical disorganization, and bolster pro-social community bonds. MAP's focal point is NeighborhoodStat, a process that allows residents to have a say in the way NYC allocates its public safety resources.[9] Early evaluations show a reduction in various crimes as well as increased perception of healthier neighborhoods.[10]

6 https://olympiawa.gov/city-services/police-department/Crisis-Response-Peer-Navigator.aspx
7 https://www.vera.org/behavioral-health-crisis-alternatives/cru-and-familiar-faces
8 https://sfmayor.org/article/san-franciscos-new-street-crisis-response-team-launches-today
9 https://www.americanprogress.org/issues/criminal-justice/reports/2019/10/02/475220/neighborhoodstat-strengthening-public-safety-community-empowerment/
10 https://johnjayrec.nyc/wp-content/uploads/2020/10/MAP_EvalUpdate06.pdf

Calls for Service Analysis

The Berkeley City Auditor conducted an extensive report on BPD Calls For Service (CFS or events) which was published in July of 2021. NICJR conducted a complementary Calls for Service Analysis as part of its work on the City's remaining effort.

The three primary objectives for the NICJR CFS report were to 1) provide an analysis of BPD CFS according to NICJR's crime categories; 2) map NICJR's crime categories to NICJR's proposed Tiered Dispatch model; and 3) identify which CFS should be responded to by a non-BPD alternative.

The proposed Tiered Dispatch model and Community Emergency Response Network (CERN) reduce the burden on police to respond to certain calls for service and improve outcomes through community response to lower level and non-criminal incidents. The CERN will use community safety and problem solving responders who have expertise in community engagement, crisis response, de-escalation, and conflict mediation and resolution skills. Implementing the Tiered Dispatch and CERN can serve to increase public safety by refocusing law enforcement officers on the most serious crimes, applying a more appropriate response to public health and quality of life CFS, and more effectively utilizing public dollars and resources.

A review of over 358,000 CFS over the 5-year study period (2015-2019) found that over 81 percent of BPD CFS were for non-criminal events. Only 7.4 percent of CFS were for felonies of any kind. NICJR's assessment of viable alternative responses indicated that 50 percent of CFS can be responded to with no BPD involvement, with another 18 percent of CFS requiring BPD to be present, but to serve in a support, rather than a lead role.

As a result of an assessment of the CFS and the narrative of the actual incidents, NICJR recommended that alternative response options be developed for the 50 percent of CFS that were determined to not require a law enforcement response.

Alternative Response Report

The Alternate Responses Report expands upon the Calls for Service analysis, providing a detailed overview of NICJR's Tiered Dispatch model, the CERN, and describes how specific call types are assigned to the four tiers:

- **Tier 1:** Non-Criminal: 911 calls and other CFS that are not crimes, like noise complaints or suspicious persons
- **Tier 2:** Misdemeanors
- **Tier 3:** Non-violent felonies
- **Tier 4:** Serious and violent felonies

Eventually, all Tier 1 and some Tier 2 CFS should be able to be responded to by the CERN or other non-police responders.

The report concludes with an overview of a framework for the City's alternative response model, drawing upon both existing and planned City resources.

A description and implementation plan utilizing Tiered Dispatch and the CERN model are outlined in detail in the Implementation Plan below.

Community Engagement Report

Berkeley's Reimagining Public Safety process has included comprehensive outreach and engagement of local community members in an effort to develop a community safety model that reflects the needs of the community and creates increased safety for all. In collaboration with the City of Berkeley's RPSTF and the City Manager's Office, Bright Research Group (BRG) developed and conducted a community survey to gather residents' experiences with and perceptions of BPD and crisis response; and their perspectives on and priorities for reimagining public safety. More than 2,700 people responded to the survey. NICJR and its partners, as well as RPSTF members, held 14 listening sessions to hear from community members, especially hard to reach community members and those not well represented in the survey, including: the unhoused residents, formerly incarcerated, youth, Black residents and Latinix residents. Details of the survey responses and listening session feedback are contained in the Community Engagement Report.

IMPLEMENTATION PLAN

Based on the extensive research that was conducted by NICJR and partners, input from the community engagement process, feedback from the Task Force and other stakeholders, NICJR provides the following detailed recommendations to the City of Berkeley categorized in the Reduce — Improve — Reinvest framework.

REDUCE

To achieve the goal of a smaller law enforcement footprint and to reallocate a portion of the BPD budget towards more community supports, NICJR recommends the following measures:

- Implementation of the Tiered Dispatch/CERN model
- End pretextual stops
- Implementation of BerkDOT, which should further reduce the size of BPD

Tiered Dispatch/Emergency Response Network

The graph below depicts the response to certain 911 and other calls for service based on the Tiered Dispatch model, which contemplates a tiered response to CFS based on the nature of the call as reflected below:

As reflected in the CFS Analysis, 81 percent of the 358,000 calls for service to BPD between 2015 -2019 were for non-criminal events. While some of these calls were determined not to be appropriate for non-police response based on an analysis of call narratives, NICJR recommends that 50 percent of these non-criminal calls be handled by a non-police response.

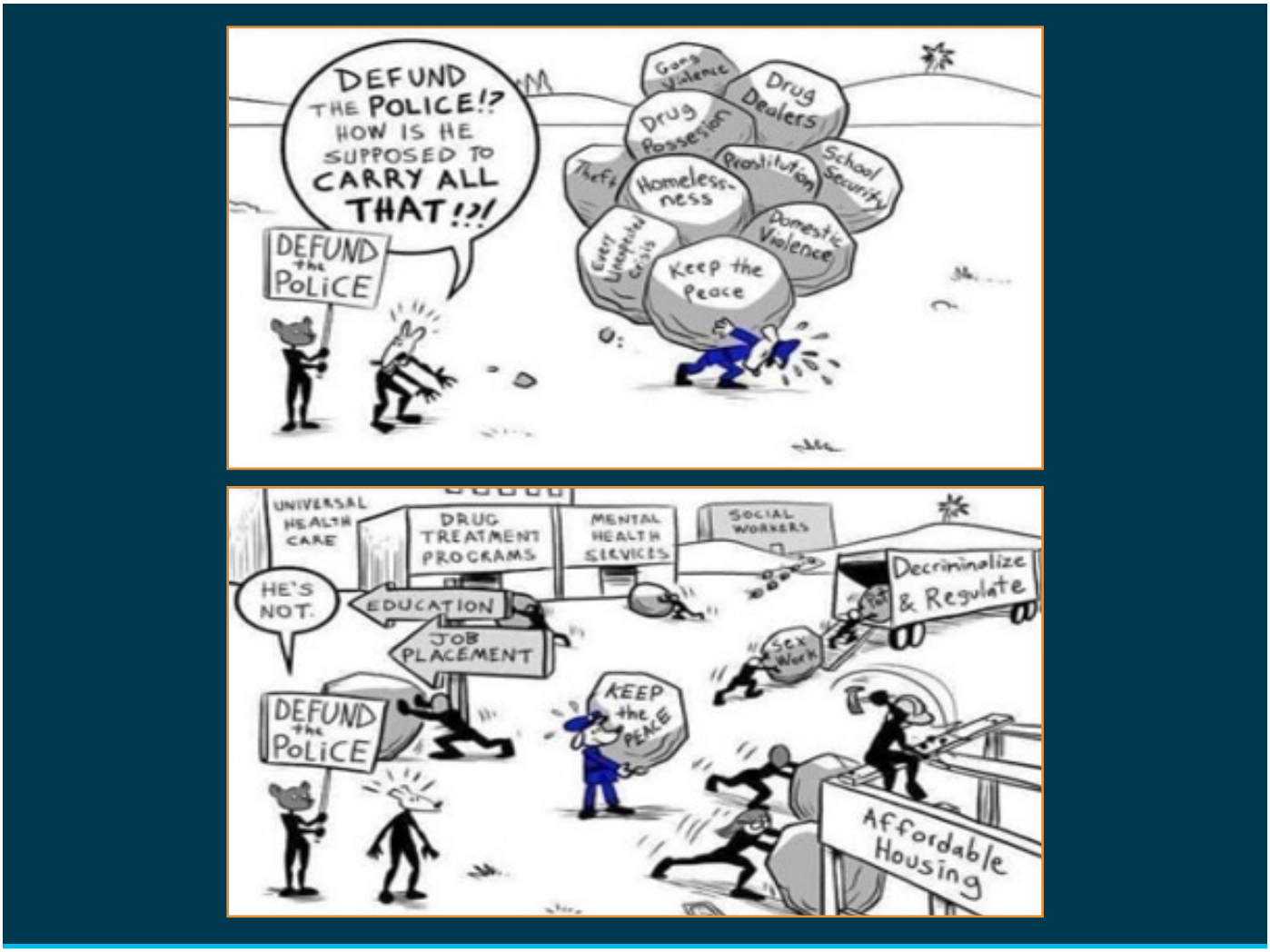
With BPD freed up to focus its efforts and attention on serious and violent crime, community-based responders can focus on the variety of needs that fall into the identified 50 percent of non-police calls. In addition to being available twenty-four hours a day, seven days a week, the CERN would be designed to build on the professional skills and expertise of non-sworn staff and to utilize collaborative community partnerships and the other necessary resources to appropriately and holistically respond to individuals in need. Some examples of this in practice include:

- The Albuquerque Community Safety Department provides a third option when individuals call 911, instead of only having the option of police or fire department services. Community Safety responders are dispatched with and without other first responders (Police and Fire). Community Safety responders may have backgrounds as social workers, peer to peer support, clinicians, counselors, or other similar fields.[11]
- The Durham Community Safety Department dispatches trained, unarmed responders that may include licensed clinical social workers and mental health clinicians paired with paramedics to calls involving mental or behavioral health needs, minor traffic accidents, quality of life issues (trespassing, loitering, panhandling, etc), and calls for general assistance.[12]
- New York City B-HEARD (Behavioral Health Emergency Assistance Response Division) Program focuses on using a mental-health centered response to 911 mental health calls. The B-HEARD teams have the expertise to respond to a range of behavioral health problems, such as suicide ideation, substance misuse, and mental illness, including serious mental illness, as well as physical health problems, which can be exacerbated by or mask mental health problems.[13]

A national poll conducted in June of 2021 found that 70 percent of likely voters support a non-police response for 911 calls about mental health crises, and 68 percent support the creation of non-police emergency response programs.[14] In many jurisdictions, police are the first to respond to 911 calls about people experiencing issues related to mental health, homelessness, and substance use. However, police officers report not having the proper training or expertise to appropriately respond to those situations and often resort to their training and treat non-criminal situations as crimes.

Chief Eric Hawkins of the Albany, NY police department said, “Fundamentally I don’t have a problem with the basic premise to defund the police, and that is police officers should be doing police work and not social work. Police officers shouldn’t be the point of contact for individuals with mental health issues, substance abuse issues, or unhealthy family structural issues.”

11 https://www.cabq.gov/acs
12 https://durhamnc.gov/4576/Community-Safety
13 https://www1.nyc.gov/assets/nypd/downloads/pdf/public_information/b-heard-public-faqs-5-27-2021.pdf
14 https://theappeal.org/the-lab/polling-memos/likely-voters-support-non-police-emergency-response/



Development and implementation of the Tiered Dispatch model advances the Berkeley City Council's July 14, 2020, direction "to evaluate initiatives and reforms that reduce the footprint of the Police Department and limit the Police's scope of work primarily to violent and criminal matters".[15]

Tiered Dispatch/CERN Pilot Program

Based on the information garnered from the preparation of its deliverable reports and an understanding of the approaches being taken by jurisdictions across the country, **NICJR recommends the establishment of a Tiered Dispatch/CERN Pilot Program, focused on a subset of the Tier 1 call types that can be used in the pilot phase in order to work out logistical and practical challenges prior to scaling up the program**. Upon implementation of the pilot phase of the Tiered Dispatch/CERN, BPD would no longer respond to the identified subset of Tier 1 (non-criminal) calls for service which would instead be handled by the CERN responders.

NICJR recommends contracting with local Community Based Organizations (CBOs) who are best prepared to successfully navigate and leverage local resources, services, and supports, to respond to the pilot Tier 1 calls.

The call types designated for the pilot phase are the 13 call types listed in the Table below. This subset of Tier 1 calls, selected due to the combination of high volume of calls and incidents that could be effectively handled by community respondes, accounts for 89,283 total calls or approximately 25 percent of all calls over the 5-year study period.

15 https://www.cityofberkeley.info/RIPST.aspx

Tier 1 Subset of CFS for Pilot	# of calls in 2015	# of calls in 2016	# of calls in 2017	# of calls in 2018	# of calls in 2019
Abandoned Vehicle	403	449	481	476	496
Disturbance	6741	6955	7447	7540	6709
Found Property	900	914	888	779	726
Inoperable Vehicle	–	–	–	1	6
Lost Property	16	16	17	15	14
Noise Disturbance	3359	3307	3239	3158	2709
Non-Injury Accident	561	617	571	564	492
Suspicious Circumstances	2586	2354	2254	2184	2041
Suspicious Person	1628	1698	1756	1653	1479
Suspicious Vehicle	1560	1687	1626	1385	1448
Vehicle Blocking Driveway	–	–	–	345	953
Vehicle Blocking Sidewalk	–	–	–	15	45
Vehicle Double Parking	–	–	–	6	14
Total	**17,754**	**17,997**	**18,279**	**18,121**	**17,132**

Tiered Dispatch/CERN Pilot Program Implementation Steps

NICJR recommends that the City develop and issue a request for proposals to contract with Community Based Organizations (CBOs) to become CERN responders.

NICJR's recommendation is to divide the City into two CERN districts and award contracts to two CBOs to cover each district. Each CERN district should have three teams (one team per shift) of two CERN responders or Community Intervention Specialists, plus two additional Community Intervention Specialists as floaters to cover staff who call out or are on vacation.

For the pilot program, each CERN district would include the following staff:

- 8 Community Intervention Specialists
  - 3 of the Community Intervention Specialists would be leads, to have a lead Community Intervention Specialist (CIS) on each shift
- 1 CERN Supervisor
- 3 CERN Dispatch/Administrative staff

A position overview for the Community Intervention Specialist is included as Appendix A.

Although as a part of the RFP process applicant CBOs would submit proposed budgets, a sample budget of one CERN team is included in Appendix B. According to BPD's June 10, 2021, budget presentation to the City

Council, the Department is currently holding $6.4 million in annual salary savings in vacant positions while the Reimagining Public Safety process plays out. These funds more than cover the costs of a CERN pilot. This budget does not include training and technical assistance for the CERN and BPD dispatch that NICJR suggest be provided by an organization that has implemented an alternative response program.

Dispatch

The following information was provided by BPD about dispatch:

> Dispatchers are trained to identify approximately 170 pre-established call types for CFS in the CAD system. Some call types may be administrative and specific to BPD or categorized by California penal or vehicle code, and others are categorized by the Berkeley municipal code. Dispatchers are also trained to identify about 40 pre-determined call types for fire and EMS CFS.
>
> The dispatcher identifies an applicable call type to assign the CFS based on what the caller is describing. The call type also determines the response level priority. The reliability of the call type assignment is dependent upon what the dispatcher is being told by the caller. Often the information the dispatcher obtains is unclear, fractured, or incomplete.
>
> If the information or circumstances of an incident do not clearly fit a call type, BPD uses a 'catch all' call type description that dispatchers apply to initiate a response to the CFS. Some examples of call types include:
>
> - 415 (Disturbance)
> - SUSCIR (Suspicious Circumstance)
> - 10-42 (Welfare Check)
> - UNK (Unknown Problem)
> - PCVIO (Miscellaneous Penal Code Violation)
> - ADVICE (Advice)
>
> Therefore, the outcome of the CFS can be very different from the original call type assignment. Call types may change based on receiving new information prior to an officer arriving on-scene. Once an officer arrives on-scene the call type remains the same, but the final disposition or outcome of the CFS can be different from the call type when dispatched.

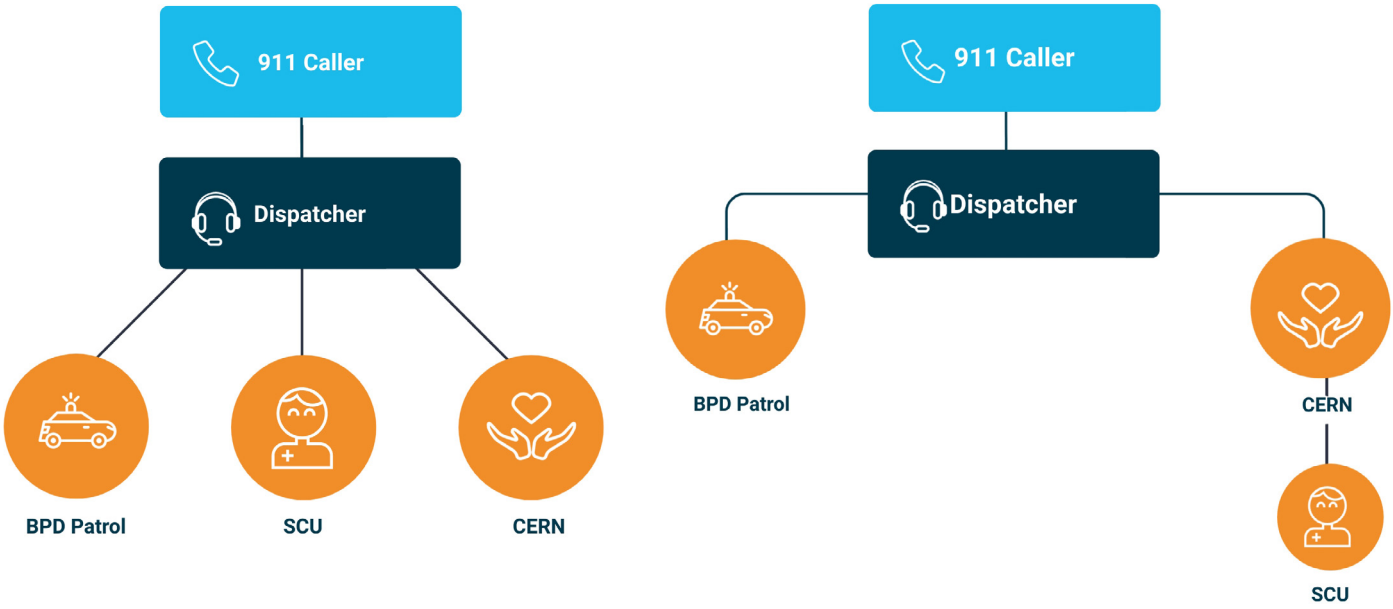
To implement the Tiered Dispatch/CERN model, training will be needed for dispatchers. But, per the process described above by BPD, there is not much of a change to how dispatchers will be asked to operate. When dispatchers identify a call as one of the 13 pilot program call types, they will send that call to the CERN Dispatch in the CERN district the call is coming from.

NICJR has suggested the 13 call types for the pilot initiative based on an examination of the call for service data including the call type at intake as well as final disposition. Appendix C includes a summary of and some actual Berkeley 911/CFS incidents among the 13 suggested call types to be in the pilot.

BPD currently receives many calls to its non-emergency phone line and often dispatches officers to those CFS. The CERN would also receive those CFS through BPD dispatch but the CERN should also have its own direct non-emergency line to receive CFS directly from the community that do not have to be routed through BPD.

Specialized Care Unit (SCU)

The City of Berkeley has initiated several police reform/public safety reimagining initiatives in the past 18 months, including the development of a SCU that was separate from this Reimagining Public Safety process. NICJR consultants worked with the Task Force and consultants on the SCU project to collaborate on community outreach addressing response to mental health calls. In the broad survey that received more than 2800 responses, a large majority of the respondents (80.8%) indicated a preference for trained mental health providers to respond to calls related to mental health and substance use, with most among those respondents indicating that police support should be available when needed.[16] NICJR has received occasional updates on the SCU development process. The final report on the SCU is due to be released on the same day as the submission of the draft of this Final Report to the City and Reimagining Public Safety Task Force. With the understanding that the SCU will respond to calls for service related to mental health and substance abuse, NICJR recommends that either the SCU becomes a division of the CERN and responds to the specified call types identified in the SCU development process or that the SCU becomes a separate, third dispatch option. Both options are depicted below:



16 Page 16 of the Community Engagement Report

Example Tiered Dispatch/CERN Response from Call to Completion

A Berkeley resident who lives in an apartment building calls 911 at 2:00 a.m. saying there has been ongoing loud music and noises coming from a nearby unit in the apartment building. The dispatcher determines that the call is a 415E - Noise Disturbance call in South Berkeley and routes the call information to the South Berkeley CERN. The CERN dispatcher calls or radios the Community Intervention Specialist team on duty and provides them information about the call, both verbally and in the CAD, and directs them to the call.

The CIS team arrives on scene and hears the loud music. They knock on the door that the music is emanating from and talk with the occupants. After some discussion using their mediation training, the CIS team convinces the occupants to turn down their music. The lead CIS enters notes into the CAD (or other data system if an alternative is decided upon)

In 2019, according to the BPD CAD data, there were at least 1,000 disturbance calls for service involving loud music. Nearly all of those calls were responded to by a sworn police officer.

Once the pilot has been initiated, NICJR recommends the following steps:

1. Assess the pilot program, including response times, resolution of emergency, how often officers are being requested to the scene by the CERN, and other measures;
2. Implement regular CERN debriefs to assess circumstances in which officers were asked to respond and the associated outcome, as well as when they were not called and the associated outcome -- this will assist in identifying potential expansion or reduction of specific types of CFS in each response tier and allow the City to better tailor the program to the community needs;
3. Evaluate administrative, budget, and staffing implications from the transfer of services, noting both successes and challenges that impact program implementation - i.e. vacant positions, staff turnover, access to data, additional or specific training needed etc.;
4. Gradually expand the pilot to have CERN respond to all Tier 1 CFS

Alternative responses should be piloted and scaled after proven effective. As the Tiered Dispatch system is built out, BPD patrol staffing can be reduced through attrition and the budget can be reduced, and more funds can continue to be made available to support alternative responses and investment in addressing root cause issues.

NICJR is not recommending officer layoffs, but reducing the BPD budget through attrition. According to data provided by BPD, in the five years between 2016-2020, an average of 17 officers per year left the Department.

As alternative response is implemented, BPD should concentrate its officers' efforts on serious, violent felonies, with a top priority on gun crimes. We also recommend shifting BPD resources and staff time (sworn and non-sworn) to investigations, with a focus on solving violent crimes and improving clearance rates.

Potential CERN CBO Providers

There are a small number of community based organizations in Berkeley that could operate a CERN. Three of these are briefly highlighted below:

Building Opportunities for Self-Sufficiency (BOSS)

Established in 1971, Building Opportunities for Self-Sufficiency (BOSS) oversees a variety of programs and services encompassing housing, reentry, violence prevention, employment, education, and criminal justice policies. A major initiative BOSS has created is Neighborhood Impact Hubs, which provide resources and services to neighborhoods in Alameda County that experience concentrated poverty and violence. Supports provided include job training, community outreach, peer support, mediation, and others.[17]

BOSS also operates many transitional and permanent housing sites for individuals experiencing homelessness. Specialists known as Housing Navigators work to provide housing to individuals and families in the BOSS Network as well as those referred to the organization by way of the 211 Coordinated Entry System and Alameda County Behavioral Health Care Services.[18] BOSS also manages Street Outreach teams in Oakland, working in neighborhoods with high rates of violence. BOSS has worked in Berkeley since its inception.

Bonita House, Inc.

Bonita House, Inc. is a non-profit organization that provides an array of services ranging from treatment for psychiatric and substance use disorders, intensive residential treatment, independent living programs, housing and employment assistance, and outpatient case management. The organization takes a social rehabilitative approach to assisting people recovering from mental health and substance use disorders.[19]

Currently, Bonita House, Inc.'s Creative Wellness Center (CWC) is funded by the City of Berkeley and serves as an entry point for recovery and supportive services for people with mental health needs and co-occurring conditions. Bonita House recently launched a Community Assessment and Transport Team (CATT) to serve as a crisis response system. This program is a joint effort among Alameda County Health Care Services Agency programs, 911 dispatch, the County Sheriff's Office, and others. Through CATT, a a mental health provider and an Emergency Medical Technician will be available in a mobile transport unit to assist clients with a medical assessment along with transport to further services.[20]

Bay Area Community Services (BACS)

Bay Area Community Services (BACS) was established in 1953 to elevate under-served individuals and families by supplying innovative behavioral health and housing assistance in northern California. BACS' philosophy centers on a trauma-informed, person-centric approach.[21] The organization's North County Housing Resource Center (HRC) connects adults across Alameda County with housing opportunities. Services include housing navigation, financial assistance, legal workshops, and connections to additional resources.[22] The HRC is a part of Berkeley's Coordinated Entry System (CES), an initiative which aims to more effectively tackle homelessness.[23]

Another major program BACS administers is the Berkeley Pathways STAIR Center. The Berkeley Pathways STAIR Center is a re-housing program that assists individuals experiencing homelessness with transitioning into permanent housing in West Berkeley.[24] Open twenty-four hours a day, seven days a week, individuals at the STAIR Center are connected to case managers, supplied with meals and storage, and provided mental health services.[25] A critical component of the program is street outreach, in that outreach workers sustain

17 https://www.self-sufficiency.org/supportsjcf
18 https://www.self-sufficiency.org/housingnavigation
19 https://bonitahouse.org/about-us/
20 https://bonitahouse.org/catt/
21 http://bayareacs.org/who-we-are/
22 http://www.bayareacs.org/wp-content/uploads/2019/07/HS-Flyer-HRC-North-County.pdf
23 https://www.cityofberkeley.info/homeless-entry/
24 https://alamedakids.org/resource-directory/view-program.php?id=1223
25 https://chancellor.berkeley.edu/sites/default/files/berkeleypathwaysinformation.pdf

a presence in Berkeley's encampments and build relationships with their residents. During the first year of the STAIR Center, 170 individuals acquired a STAIR bed, with 101 clients exiting the shelter to permanent housing.[26]

Berkeley Police Department Staffing & Budget Implications with Implementation of Tiered Dispatch & CERN

Implementation of the Community Emergency Response Network (CERN) Pilot:

According to BPD's June 10, 2021 budget presentation to the City Council, the Department is currently holding $6.4 million in annual salary savings in 30 vacant positions (23 sworn/7 un-sworn) while the Reimagining Public Safety process plays out. These funds more than cover the costs of implementing a CERN pilot, which is estimated to cost $2.5 million.

Full Implementation of Tiered Dispatch and CERN:

BPD has 164 total sworn officers.[27]

According to a BPD presentation to the RPSTF, as of March 2021, there were 97 officers assigned to the Patrol Division, not including 16 reserve officers.[28]

Based on NICJR's assessment of Calls for Service (CFS), it was determined that 50% of CFS could be responsibly responded to by an alternative response program, like CERN. If fully implemented well, in stages to ensure safety and quality, Tiered Dispatch and CERN could result in a 50% reduction in the BPD's Patrol Division.

Reduce BPD Patrol Division by 50%:

- Reducing the Patrol Division by 50% would equate to 49 officer positions.
- We suggest transferring 5 officers to the recommended Quality Assurance and Training Bureau under the new HALO initiative.
- We suggest transferring another 5 officers to investigations to increase the solve rates of serious and violent crime.
- This would leave 39 officer FTEs to eliminate.
- Cost per officer: $245,656 annually
  - Step 3 Median salary: $56.24 per hour x 2080 hrs (year of work) + 110% for benefits and other compensation (this fringe rate verified by City Administrator)
  - Does not include equipment costs (car, gun, computer, phone, protective equipment etc.)

Savings:

- Eliminating 39 FTEs in the patrol division would generate an annual savings of $9,580,584.
- These dollars can be used to fund the CERN as well as increased investment in fundamental cause issues (education, housing, employment, drug treatment, mental health, etc).

26 https://www.cityofberkeley.info/Clerk/City_Council/2019/09_Sep/Documents/2019-09-24_Item_41_Pathways_STAIR_Center__First_Year_Data_Evaluation.aspx
27 Quick Facts - City of Berkeley, CA
28 Berkeley Patrol Operations (cityofberkeley.info)

Time Frame:

- Reallocate funds from current vacant BPD positions to fund the CERN pilot and investment in community based services as identified in the Reinvest section of this report.
  - 23 current sworn vacancies x $245,656 = $5,650,088[29]
- Three CERN teams (which would serve one CERN district for 24 hours) have an estimated annual cost of $1.26 million (see Example CERN Budget in Appendix B)
  - The proposed pilot includes 6 CERN teams (two districts, one team per shift for three shifts a day) for an estimated annual cost of $2.52 million
- BPD Annual attrition rate: 17 officers per year at annual savings of $4,176,152.
- With the annual attrition savings: Expand CERN each year by 6 CERN teams (doubling each district's staff or dividing the city into three districts) at an estimated cost of $2.52 million and invest the remaining $1.65 million in community-based services.
- Though the final decision will have to be determined by the outcomes of the pilot, NICJR estimates a fully implemented CERN in Berkeley would have:
  - 3 CERN Districts: 2 teams per shift, per district for a total of 6 teams per shift across the 3 districts, for a total of 18 teams.
  - 18 CERN teams = estimated cost of $7.59 million.
  - Full implementation can be achieved two years after the pilot is initiated.
  - Two years of attrition equals 34 eliminated positions, 5 positions short of the full 39 identified as able to safely reduce from the Patrol Division. Revaluation after two years can determine the need for those 5 positions or move forward with elimination to increase investment in community-based services.

A Note about Violent Crime: (Update by BPD on 10/19/21)

- In 2020, total Part One crime in Berkeley decreased by 11% overall.
- Part One Violent Crime decreased by 13% (81 crimes), and Part One Property Crimes decreased by 11% (738 crimes).
- In the first six months of 2021, total Part One crime in Berkeley decreased by 12% overall compared to the same timeframe in the prior year. Part One Violent Crime decreased by 10% (29 crimes), and Part One Property Crimes decreased by 12% (362 crimes).
- Homicides increased from zero in 2019, to five murders in 2020. There were no homicides in the first six months of 2021.
- Robberies decreased by 26% with 274 incidents as compared to 369 in 2019.
- In the first half of 2021, robberies decreased by 1% with 148 incidents as compared to 150 in the same timeframe in 2020.
- Shootings: There were 40 confirmed shooting incidents in 2020 versus 28 in 2019. There were 38 confirmed shooting incidents in the first nine months of 2021 versus 26 incidents in the same timeframe in 2020.
  - Confirmed shooting incidents include loud report calls where shell casings or other evidence of gunfire is found. In 2019 and 2020, arrests were made in at least a third of these incidents.

29 Budget (cityofberkeley.info)

End Pretextual Stops

Pretextual or "pretext" traffic stops occur when police officers stop a driver for a minor violation, like vehicle equipment failure, and then try to leverage that opportunity to find evidence of a more significant crime, or when officers have made the stop on a low level violation assuming the driver or vehicle occupants are guilty of more serious offenses the officer is trying to find. A recent evaluation of 100 million traffic encounters demonstrated that Black and Latino drivers experience higher rates of pretextual stops and searches.[30] However, most of these stops do not actually yield any contraband or weapons.[31] Because the nature of pretextual stops relies heavily on officer discretion, there is a high likelihood that implicit racial biases come into play. Such stops that end in violence or death disproportionately affect Black and Latino drivers.[32]

Despite public concern, elimination of pretextual stops does not increase crime rates. An analysis by the police department in Fayetteville, North Carolina showed that violent crime was not affected after the police department reformed its use of pretextual stops.[33]

Pretextual stops are in the process of being regulated in many states across the country. Oregon's Supreme Court ruled in November 2019 that it was unconstitutional for police to stop a driver and proceed to ask unrelated questions, thereby effectively banning pretextual stops.[34] Virginia policymakers recently passed a bill restricting pretextual stops.[35] Other legislation has been introduced across the country that prevents police officers from conducting certain types of pretextual stops including, for example, broken tail or brake lights, objects obstructing the rearview mirror, and tinted windows.[36] Advocates of these bills state the proposed limitations would decrease racial incongruities in traffic stops.[37] The Berkeley City Council has already approved the formation of BerkDOT in order to address and decrease the frequency of pretextual traffic stops.[38] The City Council also approved the recommendations of the Mayor's Workgroup on Fair and Impartial Policing, which included the elimination of pretext stops.

BerkDOT

Another element of the George Floyd Act passed by the Berkeley City Council was to create the Berkeley Department of Transportation (BerkDOT), the purpose of which would be to enhance safety and mobility in Berkeley. Although California law does not currently allow for an alternative response to traffic stops, the vision for the new civilian-staffed BerkDOT combines the current Public Works Department's above-ground street and sidewalk planning, maintenance, and engineering responsibilities and the current transportation-related BPD functions of parking enforcement, traffic law enforcement, school crossing guard management, and collision response, investigation, data collection, analysis, and reporting.

30 https://www.vera.org/blog/ending-pretextual-stops-is-an-important-step-toward-racial-justice
31 https://www.law.upenn.edu/live/files/7898-rudovskyoslj
32 https://www.berkeleyside.org/2021/03/02/opinion-for-berkeley-to-reimagine-public-safety-we-must-grapple-with-traffic-enforcement
33 https://injepijournal.biomedcentral.com/articles/10.1186/s40621-019-0227-6
34 https://www.opb.org/news/article/oregon-supreme-court-bans-police-officers-random-questions/
35 https://lis.virginia.gov/cgi-bin/legp604.exe?202+sum+HB5058
36 https://theappeal.org/traffic-enforcement-without-police/
37 https://www.dailypress.com/news/crime/dp-nw-northam-legislation-traffic-20201021-3f2tmucyl5csdmbhhv2zh3atya-story.html
38 https://www.berkeleyside.com/2021/03/02/opinion-for-berkeley-to-reimagine-public-safety-we-must-grapple-with-traffic-enforcement

IMPROVE

This section focuses on how BPD and the public safety system in Berkeley can improve its quality, increase its accountability, and become more transparent. NICJR recommends the following improvement strategies:

- Implementation of HALO
- Creation of Bay Area Progressive Police Academy
- Implement additional police reform measures: Increase diversity of BPD leadership; Increase standards for Field Training Officers; and further amend the BPD Use of Force policy

Highly Accountable Learning Organization

During community listening sessions with Black, LatinX, system-impacted, and unstably housed / food-insecure residents there was a common perception amongst participants that the BPD is racist and classist. They expressed feeling targeted and unsafe with a militarized, aggressive approach to policing by BPD.[39] A Highly Accountable Learning Organization (HALO) is one that holds staff accountable and continues to learn and grow. A HALO police department is one where staff hold each other accountable, where management trains, coaches, and encourages staff and admonishes and disciplines when necessary. A HALO police department continually learns and improves its performance. It immediately responds to poor performance, critical incidents, and problematic staff with accountability, learning, training, and correction. A HALO police department provides significantly more training than the minimum required by the California Peace Officer Standards and Training (POST).

NICJR recommends that the Berkeley Police Department become a Highly Accountable Learning Organization. BPD's HALO initiative would include the following:

- Implementation of a peer intervention program like EPIC and ABLE which train officers to intervene when they observe fellow officers engaged in inappropriate behavior.
- In line with recommendations from the Mayor's Task Force on Fair and Impartial Policing which were adopted by the Council, BPD should implement or improve on the Early Intervention System (EIS). The EIS should be designed to catch problematic officers early and provide appropriate training and correction or discipline and dismissal.
- Creation of Quality Assurance and Training Division: Significantly expand the current Training Unit and develop a Quality Assurance and Training Division that provides additional training, reviews body worn camera footage, and reviews critical incidents and complaints to develop officer and squad specific trainings.
- Increase Transparency: Provide regular reports to the public and increase the open data portal.

Ethical Policing Is Courageous (EPIC)

The EPIC program is a peer-to-peer intervention strategy that was created by the police department in New Orleans, Louisiana in 2016. EPIC involves training officers to be accountable to each other and to intervene before an unlawful act takes place, irrespective of hierarchy. This initiative aims to alter the culture surrounding policing in order to limit police misbehavior and promote a collaborative environment.[40]

39 Page 38 of the Community engagement report
40 http://epic.nola.gov/home/

The EPIC program is founded on active bystandership psychology, which explains that active bystanders intercede when they are made aware of problematic behavior. EPIC training allows officers to overcome factors that may prevent them from intervening. These factors include a lack of confidence in their ability to deescalate a situation, uneasiness about potential retribution, and worry about breaking an unwritten code of silence.[41]

Leadership in police departments who participate in the EPIC program must be committed to changing their organizational culture. Police departments implementing EPIC must provide education, training, and on-going learning and support to officers for the initiative to be successful. EPIC can also integrate with other initiatives to boost officer well-being, including counseling and trauma assistance as well as stress reduction education. [42]

Data has shown that police departments where EPIC programs have been implemented have better community relations, lower rates of misconduct, and lower rates of public grievances. The majority of the feedback from New Orleans police officers has also been positive.[43] Moreover, there is strong research that peer intervention is effective when successful strategies for interceding are provided.[44]

Project Active Bystandership for Law Enforcement (ABLE)

Project ABLE is a joint effort between the Georgetown Innovative Policing Program and the Sheppard Mullin law firm to train officers to be able to properly intervene in a crisis situation and promote a policing atmosphere that reinforces peer intervention. Project ABLE is based on the principles of the New Orleans EPIC Peer Intervention Program and curriculum created by Dr. Ervin Staub for California law enforcement. Through Georgetown, law enforcement agencies are able to receive training in Project ABLE along with a host of other resources to assist them in advancing their own bystandership strategies.[45] [46] The training consists of a minimum of a one-time, eight hour ABLE-specific training along with a minimum of two hours of annual refresher training.[47] All of these resources are provided to law enforcement agencies free of charge.

Project ABLE's aim is to reduce police misconduct and errors and assist in improving officer health and well-being. In order to prevent any retaliation from occurring to those officers who intervene, police departments must implement stringent anti-retaliation guidelines. Since its inception, over 70 police departments have enlisted in Project ABLE.[48]

Research has shown that there are many advantages to the implementation of significant bystander training. This is critical because most police departments have a culture that dissuades officers from intervening when they see problematic behaviors.[49] Identified benefits include a decrease in violence to civilians, a decrease in violence to police officers, enhanced relationships between community residents and the police officers, and growth in officer well-being.[50] Evidence also suggests a strong correlation between departments that maintain robust duty to intervene protocols and decreased rates of police deaths per capita.

BPD should join the ABLE program to receive training and technical assistance and use the new Quality Assurance and Training Bureau discussed below to ensure the department adheres to the training, principles, and practices of the program.

41 http://epic.nola.gov/epic/media/Assets/EPIC-Overview.pdf
42 Id.
43 https://www.apa.org/monitor/2017/10/police-misconduct
44 https://epic.nola.gov/epic/media/Assets/Aronie-Lopez,-Keeping-Each-Other-Safe.pdf
45 https://www.law.georgetown.edu/cics/able/
46 https://www.law.georgetown.edu/innovative-policing-program/active-bystandership-for-law-enforcement/our-mission/
47 https://www.law.georgetown.edu/innovative-policing-program/active-bystandership-for-law-enforcement/able-program-standards/
48 https://www.wsj.com/articles/nypd-officers-to-get-training-on-speaking-up-against-bad-policing-11611838809
49 https://assets.foleon.com/eu-west-2/uploads-7e3kk3/41697/pdf_-_duty_to_intervene.6e39a04b07b6.pdf
50 https://www.law.georgetown.edu/innovative-policing-program/active-bystandership-for-law-enforcement/able-program-standards/

Early Intervention System

Early intervention systems (EIS) — also known as Early Warning System (EWS) or Early Warning and Intervention System (EWIS) — can be thought of as a personnel management or risk management tool designed to identify potential problematic behavior that puts the individual, organization, and/or community at risk. These systems consolidate a variety of data as well as indicators to analyze for potentially problematic behavior as early as possible. Indicators include but are not limited to: use of force incidents; citizen complaints; and disciplinary history. Identification of habitual misconduct by officers is often accomplished through a "peer officer comparison system" where officers assigned to the same beat are juxtaposed.[51] Once an officer is identified by the EIS for habitual misconduct, training, supports, and services to aid the officer are provided to encourage officer wellbeing and aid in behavioral change that is consistent with organizational and community goals. Continued monitoring of officer progress, as well as frequent reviews of EIS data, is necessary for successful implementation.[52] The collection and analysis of aggregate data within EIS is also recommended to be utilized to identify problem areas within teams, units, departments, or entire organizations.

Examples of areas that EIS commonly tracks are:

Performance category	Possible considerations
Arrests, especially excessive 'discretionary' arrests	May signify underlying bias of officer or over-zealousness; or could be due to agency reinforcement of arrests as a "good statistic" (therefore an agency-level problem)
Traffic Stops	May highlight concern over bias if indicative of profiling, may be due to agency reinforcement of arrests as a "good statistic" (therefore an agency-level problem)
Use of force by type (e.g., baton, pepper spray, gun, etc.	Limited use of less lethal may indicate underlying fear or lack of confidence in ability to resolve encounters with a minimal amount of force. May uncover bias, overly aggressive tendencies, lack of verbal ability, lack of skill or training in de-escalation.

In February 2021, the Mayor's Task Force on Fair and Impartial Policing recommended the implementation of an EIS and outlined the following seven areas in which the EIS should focus:

1. Evaluate and assess stop incidents for legality and enforcement yield.
2. Analyze data to determine whether racial disparities are generalized across the force or are concentrated in a smaller subset of outlier officers or squads/groups of officers. To the extent that the problem is generalized across the department, supervisors as well as line officers should be re-trained and monitored, and department recruitment, training, and structure should be reviewed. In addition, department policy should be examined for their impacts.
3. Where disparities are concentrated in an individual or a group of officers, with no race-neutral legitimate evidence for this behavior in specific cases, initiate an investigation to determine the cause for the disparity. Evaluate whether there are identifiable causes contributing to racially disparate stop rates and high or low rates of resulting enforcement actions exhibited by outlying officers. Determine and address any trends and patterns among officers with disparate stop rates In the risk management process, the responsible

51 https://samuelwalker.net/issues/early-intervention-systems/
52 https://www.policefoundation.org/publication/best-practices-in-early-intervention-system-implementation-and-use-in-law-enforcement-agencies/

personnel in the chain of command reviews and discusses the available information about the subject officer and the officer's current behavior.

4. Absent a satisfactory explanation for racially disparate behavior, monitor the officer. Options for the supervisor in these cases include reviewing additional body-worn camera footage, supervisor ride-alongs, and other forms of monitoring. Further escalation to intervention, if necessary, may include a higher form of supervision, with even closer oversight. If performance fails to improve, command should consider other options including breaking up departmental units, transfer of officers to other responsibilities, etc. The goal of this process is to achieve trust and better community relations between the department as a whole and all the people in Berkeley. Formal discipline is always a last resort unless there are violations of Department General Orders, in which case this becomes an IAB matter.
5. Identify officers who may have problems affecting their ability to make appropriate judgments, and monitor and reduce time pressures, stress and fatigue on officers.
6. An outside observer from the PRC shall sit in on the risk management and/or EIS program. Reports from these meetings, or other accurate statistical summary, can be given to the commission without identifying any officers' names.
7. Report the results of this data analysis quarterly.

In response to the Fair and Impartial Policing recommendations, BPD has indicated it is implementing an EIS for traffic, bike, and pedestrian stops, which is a very good start. NICJR recommends that the EIS should also be expanded to assess all Use of Force incidents, complaints, and information gleaned from the Body Worn Camera (BWC) footage reviewed by the Quality Assurance and Training Bureau described below.

Quality Assurance and Training Bureau

In order for BPD to become and maintain a Highly Accountable Learning Organization, it must have an internal accountability and continual improvement process and structure. To this end, as a part of the HALO initiative, **NICJR recommends that BPD either expand its current Personnel and Training Bureau or create a new Quality Assurance and Training (QAT) Bureau**. The QAT Bureau would be responsible for supporting officers and personnel throughout the Department to maintain and increase high standards and professionalism, as well as quickly detect and correct any patterns of misconduct.

The QAT Bureau should examine every complaint filed, every Use of Force, and regularly examine BWC footage to assess where individual officers, squads, and the entire Department need additional training, specialized training, and coaching, to address the specific deficiency discovered through the complaint, incident, or pattern observed.

Unlike current operations, if the QAT Bureau observed discourteous treatment by an officer, they would be authorized and required to pull that officer into a special training and/or coaching session. The QAT Bureau would then review the BWC footage of officers in that squad to determine if there was an issue with the entire squad and sergeant.

The QAT Bureau would also increase the number and quality of trainings currently offered in the Department. POST, which oversees mandated training of officers in California, only requires 40 hours of training per year, but local departments can go beyond that minimum. Under the HALO initiative, BPD officers should receive far more training than the minimum POST requirements. In addition to *more* training, the QAT unit would provide not just one-size fits all training to a group of officers, but specifically tailored training to individual officers and squads based on their needed improvements or after critical incidents.

BPD has conducted a number of good trainings for its officers and non-sworn staff, including: Fair and Impartial Policing; Principled Policing; Bias Based; Communication-Keeping Your Edge; and Implicit Bias (a full listing of the trainings BPD provided to NICJR is in Appendix D). Based on the information BPD provided, there has not been a single Fair and Impartial Policing training in five and a half years, and not one held for all officers for the past seven.

Increased training and education programs are frequently promoted to police departments to help improve the quality of policing and support officers in gaining new skills. As noted by two Columbia Law School professors in an article on police reform, "... training does not take root unless officers are held accountable for obeying the rules and practicing the skills they are taught."[53] **Training alone is not adequate to transform a police department or change the behavior of an officer. But combined with culture change, new policies and accountability, training can be an effective tool to improve and reform the police.**[54]

One of the trainings BPD should add for all officers is a full day Procedural Justice course. According to the Department of Justice's Community Oriented Policing Services, "Procedural justice refers to the idea of fairness in the processes that resolve disputes and allocate resources. It is a concept that, when embraced, promotes positive organizational change and bolsters better relationships."[55]

A comprehensive evaluation of procedural justice trainings found that "training increased officer support for all of the procedural justice dimensions. Post-training, officers were more likely to endorse the importance of giving citizens a voice, granting them dignity and respect, demonstrating neutrality, and (with the least enthusiasm) trusting them to do the right thing."[56] Several evaluations of procedural justice have found the education has been correlated with an improvement in relations between a community and a police department. In Oakland, CA, the police department trained all officers in procedural justice and provided specialized procedural justice training to the department's gun violence reduction unit. Oakland's police department was also the first department in the country to have members of the community teach a portion of the procedural justice training. BPD should increase its use of local community members providing training to officers.

To implement the QAT Bureau, **NICJR recommends that BPD transfer five officers from the patrol division and two civilian staff into what is now the Personnel and Training Bureau and rename it the Quality Assurance**

53 https://www.themarshallproject.org/2014/12/19/the-new-new-policing
54 https://nicjr.org/wp-content/uploads/2021/08/GeneralNewAndEmergingReport.pdf
55 https://cops.usdoj.gov/prodceduraljustice
56 https://www.scholars.northwestern.edu/en/publications/training-police-for-procedural-justice

and Training Bureau and amend the duties of those officers to achieve the above goals. With the implementation of the Tiered Dispatch model, the patrol division will have significantly less work load and officers can be reassigned to other duties, like the QAT Bureau.

Increased training hours will require negotiation with the union and the City Manager's Office will have to engage with the Meet and Confer process to implement these changes.

Greater Transparency

The issues of accountability and transparency in policing are intertwined and efforts to address each often include both. There are, however, specific efforts that work to daylight information about departmental activities as well as individual officers' behaviors for the purposes of identifying patterns and problems.

BPD should provide semi-annual reports to the public on stops, arrests, complaints, and uses of force, including totals, by race and gender, by area of the city, and other aggregate outcomes.

The Oakland Police Department (OPD) recently implemented a series of Microsoft Power BI (Business Intelligence) dashboards that allow for a precise review of police behavior. Working with Slalom, a data consulting firm, OPD has increased transparency and accountability through data analysis. Patterns of enforcement, historical activity, and performance over time are all monitored in close to real-time.[57]

The dashboards were created with input from OPD staff and leadership, community based organizations, other law enforcement agencies, and Stanford University's SPARQ (Social Psychological Answers to Real-world Questions). Each dashboard can be accessed by OPD leadership, depending on security clearance. The dashboards have a simple interface, allowing supervisors to access and understand the data easily. Police supervisors can access a variety of data, from long-term information to arrests made within the last twenty-four hours.[58] Dashboards allow for an easy breakdown of incidents by factors including race, gender, ethnicity, and officer. This permits police departments to monitor problematic patterns and address them quickly.[59] One necessary improvement with these systems is allowing the public access to the information.

Bay Area Progressive Police Academy

The following section of this report provides detailed research, components, and recommendations to support the development of a Bay Area Progressive Police Academy (BAPPA) to address what has been identified as a significant and stark mismatch between the primary reasons for calls for service and the training that officers receive to appropriately respond to those calls.

A progressive training program like BAPPA understands, values, and reinforces through the appropriate proportion of skill building and practice that first and foremost an officer must create a positive relationship with the community and that relationships are built on communication and personal interaction. BAPPA instructors would teach using guidance, coaching, and feedback, rather than humiliation or demands for

57 https://www.slalom.com/case-studies/city-oakland-creating-police-transparency-and-trust-data
58 https://medium.com/slalom-data-analytics/data-is-the-new-sheriff-in-town-but-is-it-biased-4aa140904dd7
59 https://cao-94612.s3.amazonaws.com/documents/Police-Commission-7.23.20-Agenda-Packet.pdf

compliance. The approach emphasizes critical thinking, active and engaged learning, and thoughtful, informed, and quick analysis. It also prioritizes a strong understanding of human behavior including behaviors exhibited by individuals experiencing high degrees of stress, shock, trauma, or in more extreme circumstances, a mental health crisis, and integrates real-life scenarios and debriefs that teach which responses are likely to escalate or de-escalate a situation.

The BAPPA structure would be centered on adult learning models and focus on the demonstrated acquisition and application of well-practiced skill as opposed to rote memorization. The content of the curriculum will include honest discussions about civil rights, the Constitution, what it means to connect to, uphold, and exhibit the values inherent in a community guardian, and to serve a community in which you are responding to highly vulnerable, rather than just potentially threatening people. The program's focus is to hold both officer safety and public trust in equal proportions -- not in competition or as mutually exclusive.

Although activists' concerns and complaints dominate the headlines, when asked to reflect on the relevance and utility of their academy experience, much of the criticism has come from officers themselves.[60] [61] Police administrators have also expressed that they do not believe that police academy training is sufficient in preparing officers for the reality of the work they are asked to do.[62]

The general disconnect between academy training and job preparation tends to revolve around two interrelated topics concerning the content and delivery of academy curriculum: 1) the typical paramilitary format fails to prepare recruits to work in a manner consistent with the community-oriented police services model; and 2) it is delivered in a manner that is inconsistent with basic principles of adult-learning theory and styles. Essentially, in order to produce officers who are able to successfully perform community-oriented policing techniques (e.g., proactive collaboration with community members), **police academies must train recruits to be independent, creative problem solvers who are connected to the human impact of their decisions and see their role as a guardian, not a warrior.**[63]

According to a resolution authored by Berkeley City Councilmember Ben Bartlett and co-sponsored by Mayor Jesse Arreguin in June 2020:

"Berkeley Police Department recruits currently train at the Contra Costa County Sheriff's Office Academy Training Center, Sacramento Police Academy, Santa Clara County Sheriff's Office Justice Training Center, and Alameda County Sheriff's Office Academy Training Center. Unfortunately, these facilities are paramilitary in structure, potentially instilling the warrior mentality that forces a divide between law enforcement and the public and promotes fear. Additionally, the Alameda County Sheriff's Office's history of using military technology, deploying armored vehicles, equipping deputies with automatic rifles, and support for Urban Shield casts doubt on the ability of the Alameda County Sheriff's Office Regional Training Center in Dublin to train cadets in a progressive, non-paramilitary manner." The resolution goes on to say:

"Rooting out the paramilitary aspect of policing begins with transforming police training. It necessitates equipping officers with practical and effective decision-making methods that prioritize de-escalation and reserve use of force as a last resort. It necessitates teaching police officers that they have the power and the choice to perpetuate or defeat injustice. It necessitates engaging officers with the history of their profession and challenging their socioeconomic and racial biases."[64]

60 https://www.emerald.com/insight/content/doi/10.1108/13639519810206600/full/html
61 https://psycnet.apa.org/record/1987-29889-001
62 https://heinonline.org/HOL/LandingPage?handle=hein.journals/injposcim4&div=25&id=&page=
63 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6950698/#B2-ijerph-16-04941
64 https://www.cityofberkeley.info/uploadedFiles/Clerk/Progressive%20Police%20Academy%20June%202020.pdf

Unfortunately, the approach in which most police academies continue to be conducted is in a paramilitary fashion. This means that recruits are held to a high standard of discipline and regimentation seemingly for discipline and regimentation sake. They utilize the mentality of a warrior going to battle and view the police force as being an occupying army. This approach has been referred to as the "warrior mentality" for many years. Instilled or reinforced in police officers at the academy, the warrior concept is saturated throughout police culture. Another, more insidious problem in a military-style academy is the behavior modeled by academy staff. Those without power (recruits) submit without question to the authority of those who have power (academy staff). In this way, academy training staff are often indistinguishable from military drill sergeants, who verbally harass and even demean recruits who are not measuring up.[65] Pushups, extra running, and writing reports are used as punishment for failure to demonstrate skills and/or properly follow directions. Although this type of approach can sometimes build camaraderie, it has not been shown to effectively build recruits' skill. There are, however, many other ways to build camaraderie while achieving the primary goal of improving the recruit's skill and ability to do their job. What the paramilitary model has been shown to do is contribute to a fairly high dropout rate. This is especially true in organizations that have implemented newer hiring practices that recruit more mature individuals, with advanced degrees and whose education, training, and life experience has taught them to ask questions, critically analyze, debate, and discuss rather than just follow orders. Which means that the paramilitary training model results in high drop-out or failure rates amongst the very recruits departments are attempting to attract and retain.

The contrast to the warrior mentality is the guardian mentality, which promotes community engagement, the establishment of meaningful relationships, and providing support to residents. The notion of being a guardian or protector of the public is a noble one, one in which trust and respect can replace fear and intimidation. If police agencies are committed to hiring officers who will do things differently and exemplify the guardian qualities, they must create agencies that exhibit those same qualities and train recruits in a manner that reinforces them.

NICJR recommends that the preceding information be used to develop a Bay Area Progressive Police Academy built on adult learning concepts and focused on helping recruits develop the psychological skills and values necessary to perform their complex and stressful jobs in a manner that reflects the guardian mentality. In order to leverage resources as well as build a regional approach, BAPPA is proposed as a partnership between area cities that may have similar goals to transform their police departments, which may include: Berkeley, Albany, and potentially Oakland.

65 Couper, D.C., Arrested Development: A Veteran Police Chief Sounds Off About Protest, Racism, Corruption and the Seven Steps Necessary to Improve Our Nation's Police, Indianapolis, Indiana: Dog Ear Publishing, 2011.

Other Police Reform Measures:

Increase Diversity of BPD Leadership

Overall, BPD has a relatively diverse sworn staff as it relates to Berkeley's demographics in terms of race and ethnicity. But there is a significant disparity in gender, with males making up 86 percent of sworn staff. BPD also only tracks gender as male or female; this should be changed. Another concern is that, of the 13 executive staff in the Department (Lieutenants/Captains/Chief), nine are white, three are Asian, one is Black, and none are Latinx (a chart of BPD personnel by race and rank is in Appendix E). Intentional focus on increasing the racial and gender diversity of BPD line staff and leadership will be important in the near term.

Increase Standards for Field Training Officers

The Minneapolis police officer who murdered George Floyd was a Field Training Officer (FTO) despite having 13 previous complaints leveled against him and he was involved in three previous shootings.

BPD should amend its policy to disallow any officer from becoming a Field Training Officer who has either more than two complaints or any one sustained complaint in any 12 month period.

Further Amend the BPD Use of Force Policy

NICJR recommends that BPD's Use of Force policies be revised to limit any use of deadly force as a last resort to situations where a suspect is clearly armed with a deadly weapon and is using or threatening to use the deadly weapon against another person. All other force must be absolutely necessary and proportional.

REINVEST

Berkeley is an affluent city with resources, one of the most well regarded academic institutions in the country, and a progressive electorate that supports social programs. Unfortunately, this combination of assets has not resulted in appropriate and sustained investment in the most vulnerable populations in the city.

The City of Berkeley must increase its investment in communities, families, and individuals who: live in poverty, are unhoused, are unemployed, are underemployed, have mental health challenges, and/or have substance abuse challenges. Particular attention to racial and ethnic intersectionality with respect to these socio-economic demographic characteristics is critically important (especially in relation to Black and Latinx communities). The Community Engagement Report, Appendix J, includes a wealth of input and ideas for investment from many of Berkeley's most vulnerable populations. The information contained in this report can serve an ongoing benefit in addressing the needs of the community and its unique diversity.

When the Tiered Dispatch/CERN model is fully implemented, up to 50 percent of calls for service in the City can be diverted to a non-police response, allowing for BPD staffing to be responsibly and safely reduced and the Department's budget to be significantly reallocated.

Even before the BPD budget can be reduced and reallocated, the City should use General Fund dollars and other revenue sources to increase investment in "fundamental cause" drivers of trauma, crime, and violence. These fundamental causes include, but are not limited to:

- Poverty
- Homelessness
- Education
- Substance Abuse
- Unemployment and underemployment

NICJR recommends that the City take the following measures to increase investment in vulnerable communities and fundamental cause issues:

- Launch a Guaranteed Income program to provide monthly stipends to individuals and families living under the poverty level
- Launch a Community Beautification Employment Program
- Increase Funding for Community Based Organizations

Guaranteed Income

The poverty rates from the national to the local level show deepening poverty levels as we get closer to home. In 2019, the national poverty rate was 10.5 percent and in California it was 11.8 percent.[66] Drilling down, we find that Alameda County's poverty rate was 14.1 percent and that Berkeley's was 19.2 percent.[67] The 2019 American Community Survey conducted by the U.S. Census Bureau reveals that nearly 36 percent of Black and 24 percent of Latino residents live below the poverty line, compared to only 12 percent of white residents.[68] Consistent with those findings, immigrant Californians experienced a poverty rate of 21.6 percent, compared to 14.4 percent for non-immigrants, and poverty among undocumented immigrants was 35.7 percent. More

66 https://www.statista.com/statistics/205434/poverty-rate-in-california/
67 https://www.census.gov/quickfacts/berkeleycitycalifornia
68 https://www.census.gov/programs-surveys/acs

than one in five (21.4 percent) Latinos lived in poverty, compared to 17.4 percent of African Americans, 14.5 percent of Asian Americans/Pacific Islanders, and 12.1 percent of whites.[69]

While Guaranteed Income or Universal Basic Income (UBI) programs have recently become popular in the United States, the state of Alaska has a program that provides regular unconditional payments to residents. The Eastern Band of Cherokee Indians Casino Dividend in North Carolina has given every tribal member between $4,000 and $6,000 per year since 1997. Studies of both efforts have shown a reduction in crime associated with the unconditional cash payments. These findings have been replicated in international studies, including one in Namibia which showed a direct correlation between UBI and crime reduction. There are smaller pilot efforts currently underway in the United States. Oakland recently launched a Guaranteed Income program and San Francisco is starting in 2022. In Jackson, Mississippi, Springboard to Opportunities and the Magnolia Mothers Trust are giving $1,000 per month to Black mothers.

In Stockton, California, 125 residents have been receiving $500 per month, since February 2019. Former Stockton mayor Michael Tubbs launched the initiative in the city and championed several Mayors from across the country in coming together to pledge to launch UBI initiatives in their cities through Mayors for a Guaranteed Income. A preliminary study of the Guaranteed Income program in Stockton found several positive outcomes, including that recipients were "healthier, showing less depression and anxiety and enhanced well-being."[70]

Berkeley should launch a Guaranteed Income pilot program similar to other cities in the region. The pilot program should select a subpopulation of 200 Black and Latinx families that have children under 10 years of age and have household incomes below $50,000. These families should be provided a monthly stipend of $750 at an annual cost to the City of $1.8 million, a sum that can be taken from: the General Fund; federal funding already received or forthcoming, or the soon to be passed Infrastructure Bill; or raised through philanthropy akin to the approach in other cities.

Community Beautification Employment Program

NICJR recommends that the City launch a crew-based employment program, or expand an existing program that employs formerly incarcerated and unhoused people to help beautify their own neighborhood. Hire and train no less than 100 formerly incarcerated and unhoused Berkeley residents to conduct Community Beautification services, including: blight abatement, tree planting, plant and maintain community gardens, make and track 311 service requests, and other community beautification projects." has been changed to

69 https://www.census.gov/programs-surveys/acs
70 SEED_Preliminary+Analysis-SEEDs+First+Year_Final+Report_Individual+Pages+.pdf (squarespace.com)

"blight abatement, tree planting, planting and maintenance of community gardens, making and tracking 311 service requests, and other community beautification projects.

There are many Berkeley and Bay Area CBOs that are capable of implementing this program, including the Center for Employment Opportunity (CEO) that operates a crew-based employment program for people on probation in Alameda County or BOSS, which has also provided similar services. However, this program would be focused on beautifying Berkeley neighborhoods and employing Berkeley residents.

A recent study showed that community beautification efforts in Philadelphia had a direct impact in reducing violence in those neighborhoods.[71]

Under AB 109 Criminal Justice Realignment, each year Alameda County receives an allotment of funds from the state to serve adults in the community who are under probation supervision and for other related operations. The Alameda County Board of Supervisors has mandated that half of those funds be allocated to community based services. In fiscal year 2019-2020, Alameda County received more than $50 million in Realignment funds from the state, with $25 million of it dispersed to community services.[72]

According to Alameda County Probation Department data, five percent of probation caseloads are from Berkeley. Of the annual $25 million in Realignment funds allocated to community services each year, 5%, or $1.25 million, should be spent on Berkeley residents. CEO also provides a crew based employment program in Oakland, which serves 80 people at an annual cost of $345,000. If Berkeley receives its fair share of Realignment funding, it would more than cover the cost of the Community Beautification Employment program.

Increase Funding to Community Based Organizations

CBOs that provide services to those who are unhoused, live in poverty, have mental health challenges, have substance abuse challenges, are system-involved, and/or are LGBTQ should receive an increase in funding using Reinvest dollars. A list of Berkeley CBOs that provide such services are included as Appendix F.

For FY 2022, the City of Berkeley plans to spend $20,484,394 to support CBOs; this allocation level represents a 22 percent decrease from the $26,311,113 amount allocated to these organizations in FY 2021.[73] At the same time, BPD's FY 2022 budget saw an increase, from $65,460,524 (adopted FY21) to $73,228,172 (proposed FY22), an 11.9 percent increase.[74]

Increased funding can come from Measure W funds (described below); when the BPD's budget is gradually reduced; the soon to be passed Infrastructure Bill; and concerted efforts to increase philanthropic dollars. Many Foundations, locally and nationally, are interested and have funded Reimagine Public Safety efforts. If the City of Berkeley adopts the innovative measures in this report and through other efforts being developed from the George Floyd Act, it will attract greater investment from philanthropy.

The City of Berkeley should increase funding to CBOs in one of two ways:

- An across the board 25% increase of grant amounts to currently funded CBOs
- Create a local government agency to be the centralized point of coordination, such as a Department of Community Development to develop a detailed plan to increase the investment in local CBOs that provide services to address fundamental cause issues.

71 Citywide cluster randomized trial to restore blighted vacant land and its effects on violence, crime, and fear | PNAS
72 http://www.acgov.org/board/bos_calendar/documents/DocsAgendaReg_12_12_19/PUBLIC%20PROTECTION/Regular%20Calendar/item_3_AB_109_rpt_12_12_19.pdf
73 https://www.cityofberkeley.info/uploadedFiles/Manager/Budget/cob-proposed-budget-fy2022.pdf
74 https://www.cityofberkeley.info/uploadedFiles/Manager/Budget/cob-proposed-budget-fy2022.pdf

In Oakland, the Reimagining Public Safety Task Force recommended a $20 million increase in funding to CBOs to be distributed through the Department of Violence Prevention. In response, the City Council allocated $17 million to DVP and required the Department to develop a plan on how to disperse the funds to local CBOs. Berkeley could do something similar through the creation of the Department of Community Development.

Measure W

In November of 2020 Alameda County voters passed Measure W, a sales tax measure that is anticipated to generate $150 million per year to provide housing and services for the unhoused. The funds are to be distributed geographically based on the number and percentage of unhoused individuals in each jurisdiction. The measure will establish a half percent (0.5%) sales tax increase for 10 years to provide essential County services such as housing, mental health services, job training, and other social safety services. Funded housing programs will include rapid rehousing, ongoing rental subsidies, expanded emergency shelters, and permanent supportive housing in certain cases.

As of 2019, there were approximately 1,108 unhoused people living in Berkeley, constituting 13.8 percent of Alameda County's unhoused population.[75] Berkeley should therefore expect to receive 13.8 percent of the $150 million annually, which amounts to $20.7 million for housing and other social services. The measure contemplates annual audits and citizen oversight, program components that Berkeley residents can leverage to ensure adequate spending and care is provided to unhoused people and people experiencing mental health crises in Berkeley in addition to ensuring safe, secure housing.

75 Berkeley+Homeless+Count+2019.pdf (squarespace.com)

Implement Advance Peace Program

Berkeley has a relatively low rate of gun violence, but has experienced an increase in the past year. As of December 9, 2021, Berkeley has had 48 confirmed calls regarding gunfire compared to the same time last year when 39 calls were recorded[76]. This represents an increase of approximately 23 percent. When compared with the numbers from 2019 (28 incidents of confirmed gun violence), the increase is further magnified resulting in a 71 percent increase. NICJR recommends the City implement the renowned Advance Peace program.

Advance Peace is a nonprofit organization that focuses on achieving tangible reductions in cyclical and retaliatory firearm-related assaults and deaths. The organization was formed in response to an analysis done by the City Council in Richmond, CA that found gun violence disproportionately affected Black men aged 18-24, with that population constituting 73 percent of homicide fatalities.[77] This goal is achieved through the implementation of strategic partnerships and interventions that strengthen neighborhood ties and promote community welfare. Advance Peace works to provide resources including life skills training and mentoring to individuals who are at greatest risk of being involved in gun violence.

Leveraging their relationships in the community, Advance Peace staff known as Neighborhood Change Agents (NCAs) conduct daily sweeps of their communities, an effort that provides a continuous flow of critical information that informs staff response. Advance Peace's main program is the Peacemaker Fellowship, which provides transformational opportunities to young men involved in lethal firearm offenses by placing them in a high-touch, personalized fellowship. The Fellowship provides life coaching, mentoring, connection to needed services, and cultural and educational excursions to those deemed to be the very most dangerous individuals in the city. Fellows can also receive significant financial incentives for participation and positive behavior as a gateway to developing intrinsic motivation. Since the establishment of the ONS, firearm-related homicides have declined in Richmond by more than 70 percent. For individuals enrolled in the Peacemaker Fellowship, 77 percent have not been involved in any gun violence activity.[78] The Peacemaker Fellowship has been replicated in the cities of Stockton and Sacramento, CA, with promising outcomes.[79]

Implementation of the Advance Peace program will cost the City approximately $500,000 per year.

76 https://www.berkeleyside.org/2021/05/22/2021-berkeley-gunfire-map
77 https://www.evidentchange.org/sites/default/files/publication_pdf/ons-process-evaluation.pdf
78 https://www.advancepeace.org/about/the-solution/
79 https://www.advancepeace.org/about/learning-evaluation-impact/

CONCLUSION

NICJR is proud to present this Final Report and Implementation Plan to the Mayor, City Council, City Manager and the Reimagining Public Safety Task Force.

The research and experience of NICJR and its partners; the feedback and input from the Task Force and City staff; and the engagement with and input from the community all culminated in the innovative ideas presented in this Final Report. This report and our recommendations provide a blueprint to move toward a public safety model that is community centered. As police reform efforts move forward, the City will have greater resources and additional information on continuing the process of mental health specialists and CBOs taking leadership of responding to the needs of the communities most impacted by the inequities in the current system and provide the necessary supportive resources for those in greatest need.

Through implementing the recommendations in this report and the other parallel processes (SCU, BerkDOT, etc), the City of Berkeley is poised to transform its public safety system, improve the outcomes of Berkeley residents, and become a national model for other cities to emulate.

By safely and responsibly reducing the footprint of law enforcement in Berkeley, vastly improving the quality of policing, and significantly increasing investment into community based services, Berkeley will have truly reimagined public safety.

NICJR would like to thank its partners: Bright Research Group, Pastor Michael Smith, Renne Public Law Group, and Jorge Camacho of the Justice Collaboratory at Yale Law School. NICJR would also like to thank the Task Force, a group of passionate and committed volunteers who spent many hours working to make Berkeley a better city for all its residents. Lastly, NICJR thanks and appreciates all the members of the community who participated in a listening session, completed the survey, attended a community meeting, or in any way participated in this process.

IMPLEMENTATION PLAN			
REDUCE			
Recommendation	**Estimated Cost**	**Funding Source**	**Timeline**
Establishment of a Tiered Dispatch/CERN Pilot Program.	$2,532,000, plus some costs associated with training for Dispatch.	Current BPD vacant positions.	Issue RFP 30 days after City Council approval, select vendors 90-120 days afterward, and begin pilot six months after City Council approval.
Contracting with local Community-Based Organizations (CBOs).			
Full Implementation of Tiered Dispatch/ CERN Pilot Program and reduction of BPD patrol division of 50%.	$7,596,000	Reduction of BPD Patrol Division by 50%.	Two years after implementation of the pilot initiative.
IMPROVE			
Recommendation	**Cost**	**Funding Source**	**Timeline**
Berkeley Police Department should become a Highly Accountable Learning Organization (HALO).			
BPD should join the ABLE program to receive training and technical assistance and use the new Quality Assurance and Training Bureau discussed below to ensure the department adheres to the training, principles, and practices of the program.	Joining ABLE is free of cost.	N/A	Within six months of approval from City Council.
Expand the Early Intervention System to assess all Use of Force incidents, complaints, and information gleaned from the Body Worn Camera (BWC) footage reviewed by the Quality Assurance and Training Bureau.	No additional costs.	N/A	Within six months of approval from City Council.
Transfer five officers from the patrol division and two civilian staff into what is now the Personnel and Training Bureau. Rename it the Quality Assurance and Training Bureau and amend the duties of those officers to achieve the above goals.	No additional costs.	N/A	Within six months of approval from City Council.
BPD should provide semi-annual reports to the public on stops, arrests, complaints, and uses of force, including totals, by race and gender, by area of the city, and other aggregate outcomes.	Internal re-organization can achieve this goal without additional costs.	N/A	First report should be issued July 1, 2022.

Develop a Bay Area Progressive Police Academy (BAPPA).	An analysis of police academies throughout the Bay Area found that the cost per student range is roughly $4,300 - $4,600 per student, with a significant proportion of costs eligible for reimbursement through the Commission on Peace Officers Standards and Training (POST.) The development of the BAPPA would include certification through POST in order to satisfy State requirements. NICJR recommends that collaboration with Albany and potentially Oakland be explored.	Reduced BPD budget through eliminating patrol positions through attrition, revenue from partner law enforcement agencies.	Launch two years after City Council approval.
Revise BPD's Use of Force policies to limit any use of deadly force as a last resort to situations where a suspect is clearly armed with a deadly weapon and is using or threatening to use the deadly weapon against another person.	Training costs.	Savings from eliminating patrol positions through attrition.	Within six months of approval from City Council.
REINVEST			
Recommendation	**Cost**	**Funding Source**	**Timeline**
Launch a Guaranteed Income pilot program.	$1,800,000	General Fund; federal funding already received or forthcoming, from the Infrastructure Bill; or raised through philanthropy akin to the approach in other cities.	Launch within six months of approval from City Council.
Launch a Community Beautification Employment Program.	$1,250,000	5% of County Criminal Justice Realignment funds allocated to community services for Berkeley residents.	Launch one year after approval from City Council.
Increase Funding for Community-Based Organizations.	$25,605,492.50	Measure W funds, when the BPD's budget is gradually reduced; the Infrastructure Bill; and concerted efforts to increase philanthropic dollars.	FY 22-23.
Launch the Advance Peace Program	$500,000	General fund	Launch in first quarter of FY 2023, on going for at least three years.

APPENDICES

APPENDIX A

Community Intervention Specialist Position Overview

A Community Intervention Specialist (CIS) responds to non-criminal and low level 911 and other Calls for Service (CFS) in Berkeley as a part of the Community Emergency Response Network (CERN). CISs help to address, mediate, and resolve challenges, emergencies, conflicts, and other causes for CFS.

CISs will respond to a wide array of calls and situations and must engage the community in a thoughtful, patient, serious and compassionate manner.

Although the work of a CIS will evolve as the CERN develops and will always be dynamic and fluid, the following are the general duties of a CIS:

- Respond to emergency and non-emergency calls for services in Berkeley and attempt to resolve the problem, like noise complaints and neighbor disputes.
- Use mediation and de-escalation skills and tactics to ease tensions and mediate conflict
- Help those in need of support, including providing water, food, and encouragement.
- Communicate well with your team and with the CERN dispatcher
- Use compassion and empathy when engaging with the community and those in crisis
- If a situation escalates and proves dangerous and/or a deadly weapon is involved, call for an officer to respond
- Write notes and reports and perform other administrative tasks

Necessary Qualifications

- Experience working in diverse communities
- Experience working in crisis and/or high stressful situations
- Experience with mediation
- Lived experience in the justice system and/or neighborhood groups is welcome and encouraged
- Works in a professional manner
- Is energetic and passionate about serving the community
- Proficient in writing and use of a computer
- Bachelor's degree, preferably in social work or public health field, or no less than five years of experience relevant to this position

APPENDIX B

Example Annual CERN Team Budget

Personnel	FTE %	
ED or other Org Manager	25%	$50,000.00
CERN Supervisor	100%	$90,000.00
CERN Dispatcher (3)	100%	$75,000.00
Lead CIS (3)	100%	$75,000.00
CIS (5)	100%	$70,000.00
Subtotal		$ 360,000.00
Fringe (25%)		$90,000.00
Total Personnel		**$360,010.00**
Operations		
Office Rent		$36,000.00
Supplies		$6,000.00
Vehicles (3)		$105,000.00
Fleet gas and maintenance		$32,400.00
Insurance		$10,000.00
Radios (6)		$1,500.00
Cell Phones (10)		$2,000.00
Cell Phone lines		$12,000.00
Water & Snacks		$3,000.00
Uniforms		$1,000.00
Total Operations		**$208,900.00**
Subtotal		$568,910.00
In-Direct (10%)		$56,891.00
TOTAL		**$625,801.00**

APPENDIX C

Tiered Dispatch/ CERN Pilot Calls for Service Summaries

Vehicle Double Parking, Blocking Driveway or Sidewalk, Inoperable or Abandoned

Calls for service (CFS) BPD receives related to vehicles blocking driveways, sidewalks, being double parked, inoperable or abandoned are call types that lend themselves to having an alternate response. Of the 3,690 CFS in the tier 1 subset of call types that were for the previously mentioned, only 56 percent were handled by BPD Parking Enforcement Division.

Any reason for parking enforcement not handling closer to 100 percent of call types falls short because the aforementioned call types are non-criminal and not likely to necessitate a sworn police response. Examples of CFS related to vehicles blocking driveways, sidewalks, being double parked, inoperable or abandoned, include an array of narratives that summarily and accurately capture the call type.

General Disturbance and Noise Disturbance

CFS BPD receives related to general disturbances or noise disturbances are also call types that may be better served with an alternate response. CERN community responders who are better equipped to mediate conflicts or de-escalate situations through a community centered approach may serve as a better option than dispatching sworn officers. BPD would not be precluded from responding to the call types, but rather a second option if needed.

Disturbance and Noise Disturbance CFS are generally non-violent and non-criminal in nature. In some cases, an argument or heated debates are categorized as disturbances and in other cases petty theft from retail stores are categorized as disturbances. In other cases, by the time an officer arrives to the scene the responsible parties are either unable to locate or gone on arrival. In many of the Noise Disturbance call types, officers were able to make contact with the responsible parties and ask them to cease what they were doing or move along. These types of calls are prime examples of how an alternate response would work in Berkeley.

Found and Lost Property

Found and lost property call types include calls where an individual has either found or lost money, credit cards, their wallets, and other personal property.

Non-Injury Accident

Calls for service (CFS) BPD receives related to certain non-injury collision may be better served with an alternate response. Civilian personnel should be the primary handlers of these types of CFS. Unless there are barriers that legally preclude civilian personnel from handling certain types of property, civilian personnel or telephone reporting can serve to address these call types.

Although there may be some cases where major injury collisions occur, most collisions that occur in Berkeley are relatively minor and can be handled by civilian personnel within a traffic unit or the Berkeley Department of Transportation (BerkDOT) that is being developed. In cases where there are no injuries to be reported, civilian personnel or BerkDOT can handle these calls to take reports. Individuals may also call in to a telephone reporting unit to make a report.

Suspicious Person, Vehicle, Circumstances

Calls for service (CFS) BPD receives related to suspicious person, vehicle, or circumstances may be better served with an alternate response. Civilian personnel should be the primary handlers of these types of CFS. CERN allows for community responders to request officer assistance if needed. In some cases, an officer is needed, but in many other cases, the suspicious person or vehicle is gone on arrival or unable to be located. Suspicious circumstances call types are usually a suspicious person or vehicle driving around or someone doing something seemingly out of the ordinary leading someone to call 911. Most of the time, the call types do not necessitate the need for a sworn response, even for welfare checks.

911 Call Narratives from Computer Aided Dispatch (CAD) Data

Disturbance Call Narratives:

"2 MALES HEARD IN A 415, CLOSE TO THE CLUBHOUSE, TOO DARK TO GET ANY FURTHER, Dispatch received by unit 4A9, 1194 on 2, 4 people admonished and moved along." (Sworn Officer)

"Refusing to leave for 3 hours .. Smell of marijuana .., nature of call: refuse to leave, rp is front office manager, guest, guest, resp / guest in room 3128; wm mid 50's 507 wild hair grey north face jacket and blue jeans guest has two boxer dogs brown in color aggressive with guest, dispatch received by unit 5a16, dispatch received by unit 5a18, dispatch received by unit 5a16, subject gone on arrival unable to locate from room, no further service requested." (Sworn Officer)

Noise Disturbance Call Narratives:

"4 or 5 people on the sidewalk talking loudly, dispatch received by unit 6a7, quiet on arrival and departure 1008 no paper." (Sworn Officer)

"Very loud music, walls are shaking, dispatch received by unit 4a7, code 4, dispatch received by unit 4a7, secured apt blding, u/r rp, unable to gain access to complex, no answer on intercom, quite from street." (Sworn Officer)

"Nature of call: loud music, loud music coming from van ifo rp wants quieted, dispatch received by unit 2a7, music was coming from an rv. The driver was a dj and was practicing. Driver agreed to stop." (Sworn Officer)

Found and Lost Property Call Narratives:

"rp at 1630 berkeley way, found credit card, Dispatch received by unit 7A4, The credit card was not active. I destroyed the credit card." (Sworn Officer)

"Found wallet, has dl, rp will leave the wallet on her front steps if she leaves her house, found in front of her garage, dispatch received by unit 1a16, dispatch received by unit 1a16, dispatch received by unit 1a16." (Sworn Officer)

Non-Injury Accident Report Call Narratives:

"UCPD was flagged down, req bpd response, blk toyota highlander vs silver buick sentry, dispatch received by unit 3a6, silver buick, reg valid from: 05/02/14 to 05/02/15 yrmd:05 make:buick btm :4d vin : 1040 jackson st apt 423 city:albany c.c.:01 zip#:94706, 11-82 only. Parties exchanged info." (Sworn Officer)

"Rp driving a "bauer's" company bus, hit a parked a vehicle on the street, victim vehicle is silver volvo rp req'ing pd due to it being a company vehicle - and so the victim doesn't think he is a victim of 20002, dispatch received by unit 7a6, contacted the rp pannell who advised that he hit a parked vehicle causing minor damage. Pannell's vehicle also had minor damage. I stood by while pannell left a company print out with the victim vehicle that contained the insurance information and contact information. No further service was requested." (Sworn Officer)

Suspicious Circumstances Call Narratives:

"On ca between delaware and francisco, 2 males poss working on a car, rp thinks looks sus, 1 of the males shined a green led light on the rp, veh is a red sportscar, poss corvette, hood was up on car, occ: 5 min ago, rp is passerby, walking dog, rp unable to give desc on subjects, dispatch received by unit 6a5, dispatch received by unit 7a2, reg valid from: 09/24/14 to 09/24/15 yrmd:76 make:chev btm: 9405 bass rd city:kelseyville c.c.:17 zip#:95451, proves ok" (Sworn Officer)

"Someone left a bag outside rp's house yesterday, rp is concerned because it has a gang mark on it, bldg is not secure, bag is outside apt #3, dispatch received by unit 5a6, black faux purse with no id and a meth pipe and two baggies of crystalized substance." (Sworn Officer)

"Ladder leaned up against the fence and a bag of potato chips in the backyard, occ: 0830 - 1830 hours, nature of call: 1021, dispatch received by unit 7a12, i contacted rp via telephone. He advised that he did not think that a crime occurred, but rather

someone may have used his backyard as an escape route during a police pursuit. Ladder granted access to the eastern neighbors yard. That neighbor advised nothing was taken. I thanked him for the information and advised that i would pass it on to my supervisors. He did not have cameras in his backyard that would assist pd tho. No further pd service requested. Nfi msc only." (Sworn Officer)

Suspicious Person Call Narratives:

"2 males out in the area on bikes with flashlights 10 prior both poss bma's 20's both tall-- 600 thin build both in dark heavy coats or parkas unknown description pants no bags seen, nature of call: poss casing, nature of call: poss casing -10 prior, reg mens style bikes no further desc last wb stuart then nb college, broadcast, rp at 2745 stuart st in #2 will be leaving in 20 mins for work, dispatch received by unit 5a8, dispatch received by unit 5a10, unable to locate." (Sworn Officer)

"On grant between parker st and blake, male living in a camper, house is under construction, bma, 50-60 5'8 med build with dark color sweat shirt, occ 2 mins prior tor, camper dark green is parked ifo the vacant house , rp thinks subj is casing the house under construction, dispatch received by unit 4a17, dispatch received by unit 4a5, dispatch received by unit 4a11, vehicle is gone on arrival c4 doing area check, unable to locate, susper is gone on arrival, attempted to contact rp with negative results" (Sworn Officer)

"2 bm's with ties and clip boards, unknown what they wanted., ls eb on woolsey on ft, no further desc, dispatch received by unit 7a6, dispatch received by unit 6a7, 2nd caller from woolsey, 2 bm's, 20's.... #1 whi shirt, a tie and clipboard. #2 red and black jacket, no further desc., gone on arrival unable to locate." (Sworn Officer)

Suspicious Vehicle Call Narratives:

"White van light off running and creeping around neighborhood for past 30 mins, 2 males in vehicle, wm's or hm's, flat bcst, vehicle still in the area, now ifo 2808 garber, gmc van, plate, now headed towards college, 2nd rp, dispatch received by unit 4a15, dispatch received by unit s11, dispatch received by unit 3a6, dispatch received by unit s11, gone on arrival unable to locate." (Sworn Officer)

"Ongoing issues with same vehicle driving around the elmwood area at night, rp thinks vehicle is casing, vehicle is now parked at elmwood laundry in parking lot, white gmc, washington plate, unknown if occupied, usually occupied by 2 hm's aprox late 20's - 30's, dispatch received by unit 2a7, unoccupied." (Sworn Officer)

"Blk chrysler with red rims, 4 yr old child in the car all by herself, rp is a witness just driving by, unknown plate on the chrysler, dispatch received by unit 2a3, rp now says there is an adult asleep in the car
still thinks we should check it out, nature of call: 1042, dispatch received by unit 2a5, proves ok mother and daughter waiting for their father, who is a mechanic across the street, to get off work." (Sworn Officer)

Vehicle Double Parking Call Narratives:

"Vehicle blocking roadway, construction vehicle, near Malcolm x school, double parked, large white work truck. Vehicle moved." (Parking Enforcement)

"Vehicle double parked / blocking reporting parties vehicle from getting out, blk Audi sedan, hazards are on, reporting party in beige Nissan alt, gone on arrival." (Parking Enforcement)

Vehicle Blocking Sidewalk Call Narratives:

"Blk Honda accord 8jdt371, no record, neighbor is in wheelchair has not been able to pass by, waiting for lock smith." (Sworn Officer)

Vehicle Blocking Driveway Call Narratives:

Vehicle: white Honda, information given to parking, vehicle is a Honda clarity, the vehicle is in compliance and is not blocking the driveway homeowner can get into and out of the driveway, i will call and advise the reporting party of this." (Parking Enforcement)

Abandoned Vehicle Call Narratives:

"Car has been at location for 2 1/2 weeks, vehicle: blk Dodge min van, nothing suspicious about vehicle per reporting party." (Sworn Officer)

"Nature of call: 1 week, parked on sidewalk, windows down, back full of garbage, white ford pickup (late 80s) Husteads Towing en route." (Sworn Officer)

Inoperable Vehicle Call Narratives:

"Across from, need flat bed, silver ford titanium sedan (TN), whole front end is smashed, tire is pushed in backwards with rim down to the ground, SVR Notes: BERRY BROS TOW, SILV FORD TITANIUM DWIGHT WY, #821, 19-1967, berry bros tow advised eta 20-30 min." (Sworn Officer)

"Gold Toyota camry no rear lic plate, nb adeline from stanford seen just prior, rear tire look as if it's about to fly off, rear right, unable to locate, gone on arrival." (Sworn Officer)

APPENDIX D

FIP and Related Course Training History

Professional Standards Division Personnel and Training Bureau

Fair and Impartial Policing:

Description: The science of human bias indicates that even the best officers might manifest bias and therefore even the best agencies must be proactive to achieve Fair and Impartial Policing. This training presents what is known about human biases and provides guidance to promoting Fair and Impartial Policing in the areas of policy, training, supervision/accountability, leadership, recruitment/hiring, institutional practices/priorities, outreach and measurement.

Keynote Speaker is Dr. Lori Fridell, former Director of PERF and a nationally recognized expert on Racially Biased Policing. BPD Instructors certified by Dr. Fridell.

DATE	PROVIDER	HOURS	PERSONNEL TRAINED
8/17/10	Dr. Lori Fridell	12	8 and Community Members
11/5/12	Dr. Lori Fridell	12	10
11/16/13	Dr. Lori Fridell	12	4***Train-the Trainer Course***
4/22/14 to 10/31/14	BPD	8	267
11/18/14	Dr. Lori Fridell	12	11 and Community Members
4/9/16	Dr. Lori Fridell	12	17 and Community Members

Fair and Impartial Policing Policy Training:

Description: The Berkeley Police Department will hold trainings on General Order B-4, Fair and Impartial Policing. The training will cover the purpose, definition, and policy related to Fair and Impartial Policing as well as the responsibility to report misconduct. Statistical dispositions and common questions related to this new policy will also be addressed. Presented by BPD Instructors certified by Dr. Fridell.

DATE	PROVIDER	HOURS	PERSONNEL TRAINED
11/23/14 to 11/25/14	BPD	1	167

Biased Based Policing:

Description: California State Commission on Peace Officers Standards and Training has developed a DVD course, "Bias Based Policing: Remaining Fair and Impartial" (formerly known as racial profiling) to satisfy the Continuing Professional Training requirement. This course is mandated by POST. This course was administered by supervisors and requires group discussion on topic.

DATE	PROVIDER	HOURS	PERSONNEL TRAINED
11/1/14 to 2/27/15	BPD	2	177

Principled Policing:

Description: This course provides a "how to" on teaching policy approaches that emphasize respect, listening, neutrality, and trust, while also addressing the common implicit biases that can be barriers to these approaches (implicit bias). Instructors were certified and trained by the California Department of Justice.

DATE	PROVIDER	HOURS	PERSONNEL TRAINED
9/21/16	DOJ	16	3***Train-the-Trainer Course***
5/15/17	CA POST	16	3***Train-the-Trainer Course***
12/28/17 to 1/25/18	BPD	8	64
12/17/20 & 1/14/21	BPD	4	88

Crisis Intervention Training:
36 to 40-hour Crisis Intervention Course:

Description: Law enforcement personnel will receive information about mental illnesses, crisis and suicide intervention techniques, common psychiatric medications, crisis intervention training for adolescents, cultural competency in the community, post-traumatic stress disorder and officer resiliency, assessing the risk for violence in a mentally ill individual, Welfare & Institution Code 5150 "(mental health hold) procedures, Mobile Crisis information and community resource contacts. CIT trained officers develop an increased understanding of mental illness which enables them to effectively coordinate appropriate interventions for individuals with mental illness.

DATE	PROVIDER	HOURS	PERSONNEL TRAINED
7/28/11 to 10/26/18	Various	36-40	75 and counting

8-hour Crisis Intervention Course:

DATE	PROVIDER	HOURS	PERSONNEL TRAINED
1/31/13 to 5/13/13	BPD	8	106

2-hour Crisis Intervention Update:

DATE	PROVIDER	HOURS	PERSONNEL TRAINED
12/28/15 to 4/21/16	BPD	2	181
12/27/18	Berkeley Mental Health	2	17

Crisis Intervention for Dispatchers:

Description: This course is designed to provide Public Safety Dispatchers with an overview of mental illness, tools to assess suicidal callers, and crisis intervention techniques. Mental health issues unique to the youth, veterans, and senior citizens are discussed. Excited delirium and agitated chaotic events are explained.

DATE	PROVIDER	HOURS	PERSONNEL TRAINED
5/21/14 to 8/30/17	Alameda County Behavioral Health	16	17

Crisis Negotiations for Dispatchers:

Description: This course will provide the student with an understanding of hostage negotiations principles, knowledge of the various roles, responsibilities and challenges a Dispatcher may face in such a situation. Students will also learn techniques used by negotiators; field unit response to negotiations incidents; and techniques for dealing with the aftermath and stress management. It will also provide the student with the necessary information to practically apply these principles during critical incidents such as: Hostage situations Barricaded subjects Suicidal subjects when the student may be the call taker. This course also addresses "Swatting".

DATE	PROVIDER	HOURS	PERSONNEL TRAINED
11/30/16 and 9/21/17	IXII Group	8	2

Communication- Keeping Your Edge:

Description: California State Commission on Peace Officers Standards and Training has developed a web based course, "Communications-Keeping Your Edge" to satisfy the Perishable Skills Continuing Professional Training requirement. This course is available to POST regulated employees at the POST Learning Portal online and its completion is mandated every two years.

The training will include verbal and non-verbal communication techniques, including responding to rude and abusive individuals, active listening, deflection, re-direction, and other communication techniques.

DATE	PROVIDER	HOURS	PERSONNEL TRAINED
Ongoing	POST	2	All Sworn

Tactical De-escalation:

Description: ***First POST approved Tactical De-escalation training***

The student will receive instruction designed to educate law enforcement officers in the theory, methodology, and application of tactical de-escalation skills. Course instruction is intended to provide the student with an in-depth understanding of tactics used to handle unarmed non- compliant subjects, subjects armed with weapons other than firearms, and subjects who may attempt suicide by cop. The course consists of lecture, video review and hands-on/practical tactical de-escalation training for in-service officers.

DATE	PROVIDER	HOURS	PERSONNEL TRAINED
6/14/16 to 10/27/16	BPD	8	135
8/13/18 to 3/12/20	BPD/Various	8	76

Harassment Prevention Training:

Description: Gov. Code 12950.1 (Amended by **SB 1343)** and the City of Berkeley prohibit harassment on the basis of sex, race, age, religion, color, national origin, ancestry, physical disability, mental disability, medical condition (associated with cancer, a history of cancer, or genetic characteristics), HIV/AIDS status, genetic information, marital status, pregnancy, sexual orientation, gender, gender identity, gender expression, military and veteran status, and any other classifications protected by state or federal law.

DATE	PROVIDER	HOURS	PERSONNEL TRAINED
Ongoing	COB/BPD	1 to 2 depending on rank.	All Personnel

LGBT Awareness for Law Enforcement:

Description: This interactive course includes five modules that are designed to address the following learning outcomes:

1. The student will explain the difference between sexual orientation and gender identity and how these two aspects of identity relate to each other and to race, culture and religion.
2. The student will define terminology used to describe sexual orientation and gender identity.
3. The student will identify ways to create an inclusive workplace and to support LGBTQ+ co-workers.
4. The student will identify key moments in the LGBTQ+ civil rights movement.
5. The student will understand how hate crimes and domestic violence impact LGBTQ+ people.

DATE	PROVIDER	HOURS	PERSONNEL TRAINED
June – July 2021	Out to Protect	4	All Personnel

Upcoming Trainings:

Personnel and Training are currently in the process of scheduling additional 8 hour Implicit Bias training for the Fall 2021

APPENDIX E

FY 2020 Year End Workforce Report

ATTACHMENT 16: POLICE DEPARTMENT WORKFORCE BY OCCUPATIONAL CATEGORIES, RACE & GENDER

POLICE DEPARTMENT	TOTAL	M	F	WHITE		BLACK OR AFRICAN AMERICAN		HISPANIC OR LATINO		ASIAN		NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER		AMERICAN INDIAN AND ALASKA NATIVE		TWO OR MORE RACES		MINORITIES
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	
DEPARTMENT * REPRESENTATION	**160**	**134** 83.8%	**26** 16.3%	**76** 47.5%	**15** 9.4%	**19** 11.9%	**4** 2.5%	**20** 12.5%	**3** 1.9%	**16** 10.0%	**2** 1.3%	**0** 0.0%	**0** 0.0%	**0** 0.0%	**0** 0.0%	**3** 1.9%	**2** 1.3%	**69** 43.1%
ALAMEDA ACS		85.7%	14.3%	47.7%	7.4%	11.7%	3.8%	9.6%	0.4%	11.8%	2.5%	2.9%	0.0%	0.3%	0.0%	1.8%	0.3%	45.0%
POLICE CHIEF REPRESENTATION	**1**	1 100.0%	0 0.0%	1 100.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%
ALAMEDA ACS		80.2%	18.7%	49.5%	13.2%	20.9%	0.0%	8.7%	0.0%	0.0%	6.6%	0.0%	0.0%	2.2%	0.0%	0.0%	0.0%	38.4%
CAPTAINS REPRESENTATION	**3**	2 66.7%	1 33.3%	1 33.3%	1 33.3%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	1 33.3%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	1 33.3%
ALAMEDA ACS		80.2%	18.7%	49.5%	13.2%	20.9%	0.0%	8.7%	0.0%	0.0%	6.6%	0.0%	0.0%	2.2%	0.0%	0.0%	0.0%	38.4%
LIEUTENANTS REPRESENTATION	**9**	8 88.9%	1 11.1%	5 55.6%	1 11.1%	1 11.1%	0 0.0%	0 0.0%	0 0.0%	2 22.2%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	3 33.3%
ALAMEDA ACS		80.2%	18.7%	49.5%	13.2%	20.9%	0.0%	8.7%	0.0%	0.0%	6.6%	0.0%	0.0%	2.2%	0.0%	0.0%	0.0%	38.4%
SERGEANTS REPRESENTATION	**31**	23 74.2%	8 25.8%	16 51.6%	5 16.1%	3 9.7%	0 0.0%	2 6.5%	1 3.2%	2 6.5%	1 3.2%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	1 3.2%	10 32.3%
ALAMEDA ACS		80.2%	18.7%	49.5%	13.2%	20.9%	0.0%	8.7%	0.0%	0.0%	6.6%	0.0%	0.0%	2.2%	0.0%	0.0%	0.0%	38.4%
POLICE OFFICERS REPRESENTATION	**117**	101 86.3%	16 13.7%	54 46.2%	8 6.8%	15 12.8%	4 3.4%	18 15.4%	2 1.7%	11 9.4%	1 0.9%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	3 2.6%	1 0.9%	55 47.0%
ALAMEDA ACS		86.4%	13.6%	47.3%	6.6%	10.4%	4.3%	9.8%	0.4%	13.3%	2.0%	3.3%	0.0%	0.0%	0.0%	2.0%	0.3%	45.8%
NON - SWORN REPRESENTATION	**91**	30 33.0%	61 67.0%	10 11.0%	13 14.3%	12 13.2%	27 29.7%	3 3.3%	10 11.0%	5 5.5%	6 6.6%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	5 5.5%	68 75%
ALAMEDA ACS		57.9%	42.1%	19.7%	19.7%	2.0%	10.2%	11.4%	11.0%	19.7%	0.8%	0.0%	0.0%	0.8%	0.0%	2.4%	0.8%	59.1%

APPENDIX F

Community Based Organizations and Nonprofits Providing Services in Berkeley

Youth after-school and recreational programs

Youth Spirit Artworks

Youth Spirit Artworks works to empower homeless and low-income young people in Berkeley by teaching youth-specific vocational skills related to commercial arts and entrepreneurship, providing youth with an income from jobs training and sales of art and teaching budgeting and money management skills, helping youth modeling experiences of healthy family and community relationships, and promoting youth commitment to personal health and wholeness, including a commitment to nonviolence.[1]

Currently the City of Berkeley only funds the Youth Spirit Artworks' (YSA) Youths TAY Tiny Homes Management program, which is discussed below, but funding could be expanded to their Fine Arts program that uses art jobs and jobs training to empower and transform the lives of youth, giving young people the skills, experience, and self- confidence needed to meet their full potential, and the Community Arts programs, that centers around public artmaking for community revitalization.[2]

Berkeley Youth Alternatives

Berkeley Youth Alternatives (BYA) uses a strength-based, holistic, continuum of care approach that emphasizes education, health and well-being, and economic self- sufficiency in order to help children, youth, and their families build capacity to reach their innate potential. BYA uses preventative measures by reaching youth before their problems become crises and uses intervention measures by providing support services to youth engaged in the youth justice system.

The City of Berkeley's fiscal year 2022 budget reflects an allocation of $30,000 to the BYA After School Program[3] and $30,000 to BYA's Counseling program for children.[4]

Other programs at the BYA that would benefit from City funding are the Environmental Training Center, a youth internship program for youth ages 16-24 that teaches basic work ethic, professionalism and skills necessary for future employment,[5] the youth and Family Opportunity Hub that focuses on increasing access to health and wellness services for low-income and uninsured children and their families[6], Career Development Center which administers multiple employment readiness strategies for youth and young adults ages 16-24[7], and lastly; Sports and Fitness which provides a structured and disciplined environment for participants to learn quality values such as teamwork, confidence building and self-discipline.[8]

Violence Prevention and Restorative Justice Programs

SEEDS Community Resolution Center will expect to see a $22,553 allocation of City funding to provide facilitation, training, and coaching in restorative justice, community building, conflict resolution, restorative inquiry, verbal de-escalation, harm repair, and positive school culture and climate development. SEEDS School Services help to foster positive relationships among and between educators and students, thereby increasing students' engagement in school, and maximizing the effectiveness of the adults who serve them. SEEDS School Services can serve to strengthen the essential links between students, their peers, their families, and their educators.[9]

SEEDS also offers community mediation services that offer a supportive place where people can talk through their conflict in a productive manner,[10] and conflict coaching to help people process and problem solve specific issues.[11]

1 https://youthspiritartworks.org/
2 https://youthspiritartworks.org/programs/community-art-program/
3 https://www.cityofberkeley.info/uploadedFiles/Manager/Budget/cob-proposed-budget-fy2022.pdf
4 https://www.byaonline.org/programs/afterschool-center
5 https://www.byaonline.org/programs/health-and-environment/environmental-training-center
6 https://www.byaonline.org/programs/teen-center/youth-and-family-opportunity-hub
7 https://www.byaonline.org/programs/career-development-and-prevent-center
8 https://www.byaonline.org/programs/sports-and-fitness/sports-and-fitness
9 https://www.seedscrc.org/school-services
10 https://www.seedscrc.org/community-mediation
11 https://www.seedscrc.org/community-conflict-coaching

Intimate Partner Violence, Sexual Violence and Sexual Exploitation Prevention and Intervention

The City of Berkeley does not currently fund any CBOs that work explicitly with survivors of intimate partner violence, sexual violence, or sexual exploitation; however, the City does fund two women's specific shelters. The Women's Daytime Drop-In Center's[12] Bridget Transitional House Case Management component will receive $118,728, the Daytime Drop-In Services will receive $48,153, and the Homeless Case Management – Housing Retention will receive $100,190.[13] Berkeley Food & Housing Project's Women's Shelter receives $230,644 in City funding.

Organizations identified by members of the Task Force that support these population specifically, but who do not receive City funding include Motivating, Inspiring, Supporting and Serving Sexually Exploited Youth (MISSSEY)[14], Bay Area Women Against Rape (BAWAR)[15], and the Family Violence Law Center[16]. The City could also be innovative and develop RFPs for CBOs that work directly to support these populations of people. It should be noted that, while a large proportion of women experience these types of issues, men and LGBTQ populations experience them as well, which should be taken into consideration in the creation of RFPs.

Housing and Homeless Services

Building Opportunities for Self-Sufficiency (BOSS)

BOSS, which was summarized previously, currently receives $932,975 which is the most funding of all the CBOs contracted in the City and centered on homelessness. BOSS current receives funding for their BOSS House Navigation Team that provides needs assessments, housing education, access to listings, advocacy with landlords, help filling out housing applications, connection to subsidies as available, and case management to facilitate a successful transition to housing along with critical time intervention to ensure stabilization, Representative Payee Services to individuals who have been designated by Social Security as needing a payee to manage their income, or who have been referred for this assistance, Ursula Sherman Village Families Program and Village Singles Shelter a shelter for homeless disabled adults.

Youth Spirit Artworks (YSA); Tiny House Village

Youth Spirit Artworks' Tiny House Village[17] was built in early 2021 for homeless Transitional Age Youth; age 18-23 in crisis. YSA partnered with a non-profit developer to create a multi-faceted, community-led Village with 26 tiny homes that was designed by the young people it will benefit. The completed Village features on-site communal bathrooms and showers, a kitchen yurt for residents to cook weekly communal meals and securely store their own food, community gathering space for meetings, and on-site Resident Assistants who live in the community. Residents in the Village, are engaged in building a strong and connected community, have opportunities for personal and professional growth, including access to training and mentorship in the following areas: artmaking, art entrepreneurship and sales, nonprofit management, gardening, sewing, medicine, music, biking and exercise, cooking, construction, and more. Residents are supported in developing a responsibility to the community at large, achieved through connections to local faith organizations and active involvement with local social justice projects. Additionally, all residents at the Village take part in YSA's core jobs training program, where they will receive wrap-around case management services and engage in youth-led workshops around healthy interpersonal relationships, restorative practices, and more.[18]

YSA is expected to receive an $117,000 allocation from the City for the case management component[19] of the initiative, however expanding funding to build up the community would be incredibly impactful.

Rebuilding Together

Rebuilding Together works to bring warmth, safety, and independence to Berkeley residents by

12 https://www.womensdropin.org/
13 https://www.cityofberkeley.info/uploadedFiles/Manager/Budget/cob-proposed-budget-fy2022.pdf
14 https://misssey.org/
15 https://bawar.org/
16 http://fvlc.org/get-help/resources/

17 https://youthspiritartworks.org/programs/tiny-house-village/
18 https://youthspiritartworks.org/programs/tiny-house-village
19 https://www.cityofberkeley.info/uploadedFiles/Manager/Budget/cob-proposed-budget-fy2022.pdf

revitalizing homes and neighborhood facilities.[20] The City is expected to allocate $98,275, to the Our Safe at Home program, which provides safety assessments and hazard elimination for qualified applicants. By implementing safety modifications such as grab bars in the bathroom, handheld shower heads, elevated toilet seats, exterior handrails, or wheelchair ramps, the Safe at Home program helps prevent accidents or exposure that can cause injury, illness, or even death. The Safe at Home program improves quality of life for its clients by performing upgrades including painting, lead abatement, repairing/installing heating systems, replacing electrical panels, smoke alarm installation, fire extinguishers, and carbon monoxide detectors to address environmental hazards in the home.[21]

City funding could be expanded to the Community Facility Improvement program which provides local nonprofits and community centers with much-needed repairs and upgrades, which will contribute to an organizations' ability to effectively serve the Berkeley community. Rebuilding Together also provides emergency repairs services and energy and efficiency upgrades, reducing the number of residents living in uninhabitable conditions.[22]

Food security, increased access to nutritious food

Healthy Black Families Inc.

Healthy Black Families Inc, educates, engages, and advocates for the holistic growth and development of diverse Black individuals and families. They will receive funding for their Sisters Together Empowering Peers (STEP) program; a peer-led support and empowerment group that addresses health and social inequities for African American parenting women in our community, but funding could be expanded to their program; Thirsty for Change (T4C), a healthy eating and nutrition education and advocacy program that engages Black families in South and West Berkeley through a wide array of activities to improve the health of the community.[23]

20 https://rtebn.org/
21 https://rtebn.org/our-work/#our-programs
22 https://rtebn.org/our-work/#our-programs
23 https://www.healthyblackfamiliesinc.org/t4c

Mental Health and Co-Occurring Conditions

Bonita House

As previously explained, Bonita House provides mental health and addiction treatment, intensive residential treatment, independent living programs, housing and employment assistance, and outpatient case management. The City currently allocated $24,480 to its case management services, which could be increased substantially to build capacity and efficacy of its services.

Bay Area Community Resources; School Based Behavioral Health Services (BACR)

BARC provides school-linked mental health and prevention services for middle and high school children and their families, in high-need. BACRs prevention and early intervention approach draws from evidence-based practices and proven resiliency models utilizing experienced licensed and pre-licensed clinicians.[24] BACR offers restorative, culturally humble, and trauma-informed mental health services to help youth cope with challenging life circumstances and develop positive strategies to be successful and healthy in and out of school.

Substance Use and Addiction

New Bridge Foundation

The New Bridge Foundation (NBF) is a residential and outpatient addiction treatment center that provides comprehensive services and has a community outreach component to their program. It does not currently receive City funding but is a well- known and respected CBO in the community, and could benefit from expanded funding.

Healthcare Management

Lifelong Medical Care (LMC)

The City will allocate a total of $304,398 for some treatment services such as geriatric and hypertension care, however LMC also has initiatives such East Bay Community Recovery Project, which supports the self-sufficiency and wellness of individuals and

24 https://www.bacr.org/behavioral-and-mental-health

families by providing comprehensive and integrated services for mental health, substance use and related health conditions while addressing housing and employment.[25] They also have a program called Heart to Heart which fosters the idea that community connectedness and cohesion through community engagement, building relationships, and trust are critical for improving community health.

Heart 2 Heart works to prevent high blood pressure and heart disease while connecting community members to resources and services they need. The Heart 2 Heart program serves as a bridge between community members and health centers throughout the Heart 2 Heart community.[26] Funding can also be increased for their Case Management Tied to Permanent Housing program ($163,644), Supporting Housing Program ($55,164), and Street Medicine/ Trust Clinic ($50,000).[27]

Berkeley Free Clinic

The Berkeley Free Clinic is a health collective that provides free medication, supplies, dental and medical care, peer counseling, and community referrals. The Clinic relies solely on individual or organizational donations and government support and is one of the only clinics in California offering primary health care free of charge. The clinic maintains that health care should be available at a level and quality sufficient to meet the basic needs of everyone regardless of race, gender, age, immigration status, income level, or any other characteristic, and believes health care is a right, not a privilege. The clinic is expected to receive only $15,858 for the Free Women and Transgender Health Care Service. Funding for this program could be significantly increased. Funding could additionally be expanded to services such as the Outreach Team which uses volunteers to hand out hot meals, hygiene supplies, and more to people in need, TB Tests, Local, Resource Navigation & Referrals, Health Insurance & Food Benefits, Peer Counseling, STI, Screenings & Treatment, UTI Testing & Treatment, Hepatitis, HIV, and TB Counseling +, Screenings, and Dental Services.[28]

Economic development and new city jobs

Inner-City Services (ICS)

ICS will receive just $101,351 of City funding to provide comprehensive employment training and job placement services to thousands of Bay Area residents. ICS combines traditional content-based education with hands-on classroom training and cutting-edge computer technology. ICS's main objective is to instill workplace character values: a sense of pride and professionalism, dignity, respect, integrity, and excellence throughout our diverse student body, in order to help people thrive in society and the business world.[29]

Multicultural Institute

Multicultural Institute (MI) helps increase access to opportunities for immigrant families to reach economic stability, and their programming uses strategies to enhance economic, educational, and skill opportunities, cultivate leadership development, provide direct services, and stimulate positive transformation of individuals, families, and communities. These programs ultimately, assist individuals in contributing and participating in the civic life and well-being of their community. MI will receive $68,136 for their Lifeskills Program[30] that provides economic development, vocational skill development, learning opportunities, and immigration and health services to people living in Berkeley.[31] In addition to their Lifeskills program MI will receive $33,603 in City funding for their Youth Mentoring program.[32]

25 https://lifelongmedical.org/ebcrp/
26 https://lifelongmedical.org/heart-2-heart/
27 https://www.cityofberkeley.info/uploadedFiles/Manager/Budget/cob-proposed-budget-fy2022.pdf
28 https://www.berkeleyfreeclinic.org/servicesupdate
29 https://www.icsworks.com/about.php
30 https://www.cityofberkeley.info/uploadedFiles/Manager/Budget/cob-proposed-budget-fy2022.pdf
31 https://mionline.org/what-we-do/
32 https://www.cityofberkeley.info/uploadedFiles/Manager/Budget/cob-proposed-budget-fy2022.pdf

Parks and open spaces including activities for young people and families

Berkeley Community Gardening Collaborative (BCGC)

Berkeley Community Gardening Collaborative is a diverse group of community garden members who share a commitment to organic, urban agriculture and access to healthy food for all residents of Berkeley. They protect existing gardens, facilitate the formation of new gardens, and advocate for food security initiatives in local schools and within the city. BCGC actively seeks to create a more sustainable society by engaging in urban agriculture, the preservation of open space, habitat restoration, and cultivating community. To broaden its impact and build alliances, BCGC partners with other organizations that share its goals. BCGC will receive $11,895 in City funding, which could be expanded to strengthen their impact on communities in Berkeley.[33]

Moving South Berkeley Forward (MSBF)

Moving South Berkeley Forward is a youth-driven environmental, social justice project focused on community health and educational equity in South Berkeley and is spearheaded by youth of color and the South Berkeley community. This project is a joint effort between the Berkeley Community Gardening Collaborative, UC Berkeley's Environmental Science, Policy & Management Department, Berkeley High School, and the community of South Berkeley. MSBF wants the community to have accessible health resources and a better future.[34] MSBF does not currently receive any City funding.

Childcare

BANANA

BANANAS works in partnership with early education providers in order to provide support for families in their parenting journey. BANANAs programs and services include assisting families find and pay for quality childcare, parenting workshops, playgroups, and professional development for all types of early care and education providers. Their services and support allow working families to thrive and be confident their children are in quality and nurturing learning environments.[35] BANANA Currently receives funding for childcare subsidies ($283,110), playgroups ($10,527), and Quality Rating and Improvement System services ($95,000).

The City could additionally, expand funding subsidies to early childcare providers such as Nia House Learning Center in West Berkeley, and Bay Area Hispano Institute for Advancement, Inc. (BAHIA Inc.). Nia House Learning Center's mission is to bring together children from different socio-economic backgrounds to grow and work in harmony and cooperation, and to actively work toward all of Dr. Maria Montessori's concepts, especially that of peace through education.[36] BAHIA Inc. is a nonprofit organization that provides high quality, bilingual learning environments where children grow to become successful lifelong bilingual learners. BAHIA is the only full-time; Latino nonprofit in Berkeley providing bilingual (Spanish-English) childcare and education to children ages 2-10 years of age. BAHIA is a respected leader in the community that strives to improve the quality of life of children and their families in the community.[37]

Bay Area Hispano Institute for Advancement

Bay Area Hispano Institute for Advancement, Inc. (BAHIA Inc.) is a nonprofit organization that provides high quality, bilingual learning environments where children grow to become successful lifelong bilingual learners. BAHIA is the only full-time; Latino nonprofit in Berkeley providing bilingual (Spanish-English) childcare and education to children ages 2-10 years of age. BAHIA is a respected leader in the community that strives to improve the quality of life of children and their families in the community.[38]

LGBTQ Services and Support

Pacific Center for Human Growth (PCHG)

Pacific Center for Human Growth is the oldest LGBTQIA+ center in the Bay Area, the third oldest

33 https://ecologycenter.org/bcgc/
34 https://movingsouthberkeleyforward.weebly.com/
35 https://bananasbunch.org/about/
36 http://www.niahouse.org/
37 https://www.bahiainc.com/about-us
38 https://www.bahiainc.com/about-us

in the nation, and operates the only sliding scale mental health clinic for LGBTQIA+ and QTBIPOC people and their families in Berkeley.[39] PCGH helps enhance the mental health and overall well-being of LGBTQIA+ and QTBIPOC communities by providing culturally responsive therapy, peer to peer support groups, community outreach services, and facilitated workshops. The City will allocate $23,245 to their Safer Schools Project, but funding could be expanded to their Youth Program that supports young people in feeling connected, supported, and uplifted.[40]

Community Alternative Placement Hub (CAPH)

In order to complement the CERN as it relates to a response to a CFS, certain CBOs should be designated as "community alternative placement hubs" (CAPH) which can serve as an alternative to jail or mental institutions for people in need or immediate shelter or services who have not committed any crime.

BOSS, Bonita House New Bridge Foundation and Bay Area Community Services (BACS) have already been identified above in and previous section and could additionally be well positioned CBOS to build out the CERN and serve as CAPHs. BOSS, which was summarized in an above section, currently receives the most funding of all the homeless CBOs contracted in the City could be best positioned to serve as a general CAPH for people in crisis or experiencing a high need of services or intervention. Bonita House could serve as a hub that specifically handles people with mental health crises and co-occurring conditions cases, and the Newbridge Foundation could be utilized specifically for people experiencing substance abuse crises. BACS can also serve as a candidate for a CAPH for people experiencing crises related to homelessness and behavioral health needs.

Additionally, and specific for youth in need of immediate shelter and services, the Youth Spirit Artworks; TAY Tiny Homes could also be utilized. Lastly, the New Bridge Foundation, which does not currently receive City funding could also be utilized as a CAPH, for people with mental health challenges.

39 https://www.pacificcenter.org/about-us
40 https://www.pacificcenter.org/youth-programs

APPENDIX G

Berkeley Calls for Service Analysis

EXECUTIVE SUMMARY

The Berkeley City Auditor conducted an extensive report on Berkeley Police Department (BPD) calls for service (CFS or events) which was published in July of 2021. This report has been prepared to illustrate the application of NICJR's CFS classification methodology to BPD CFS data. To the extent possible, the City Auditor's analyses have not been replicated.

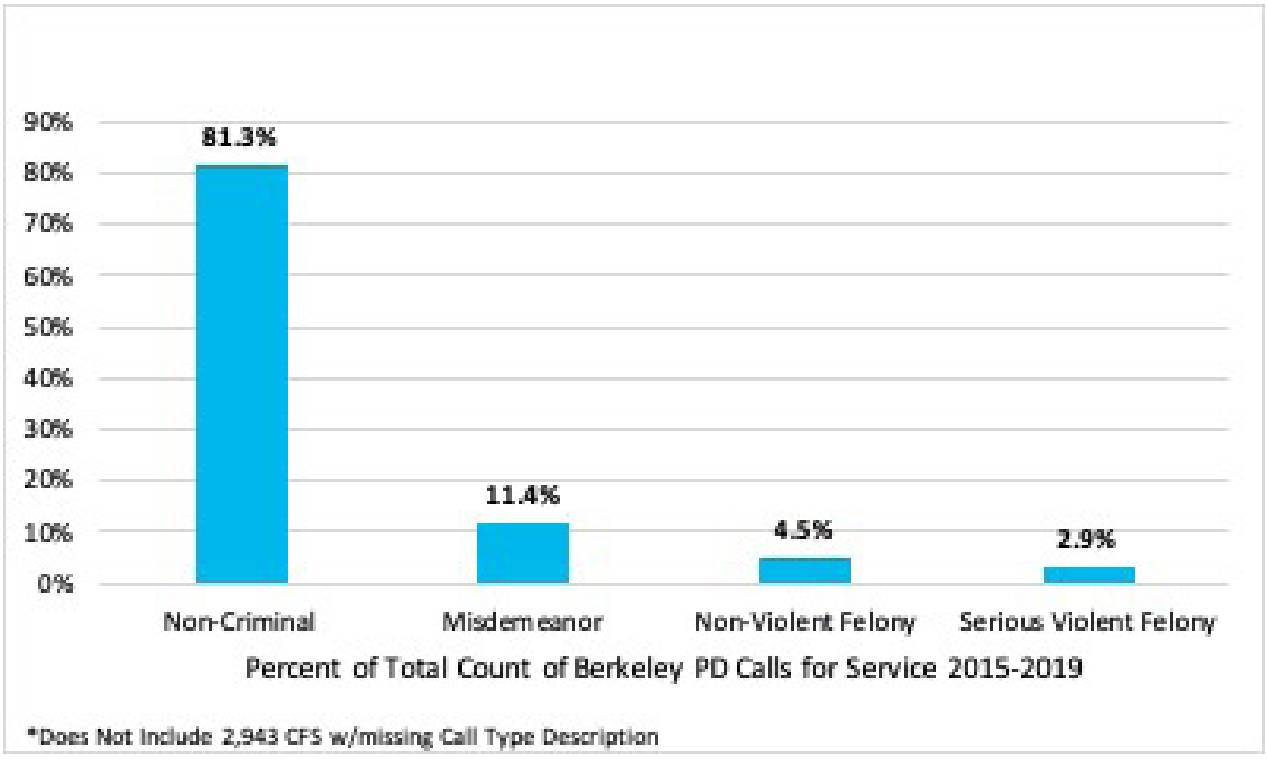
Specific Analysis Objectives

1. Provide an analysis of BPD calls for service according to NICJR's Crime Categories
2. Map NICJR's Crime Categories to NICJR's proposed Community Emergency Response Network (CERN)
3. Identify which calls for service should be responded to by a non-BPD alternative

Findings

A review of over 358,000 calls for service covering the period 2015-2019 found that over 81 percent of BPD calls were for Non-Criminal events. Only 7.4 percent of calls were associated with felonies of any kind.

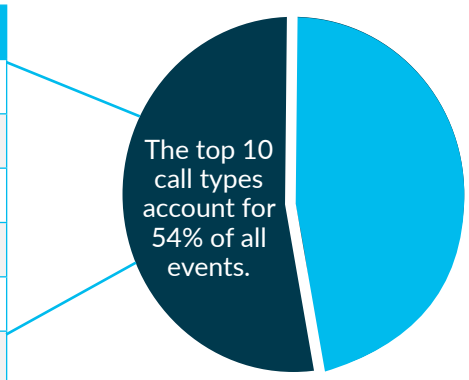
Figure 1. Calls for Service by Crime Category



Although the BPD utilized nearly 200 call types during the study period, just ten comprised over half of all events.

Table 1. Top 10 Call Types, Auditor Report

Call Types	Total Events
Traffic Stop	44,795
Disturbance	35,696
Audible Alarm	19,920
Noise Disturbance	15,773
Security Check	15,262
Welfare Check	15,030
Suspicious Circumstance	11,547
Trespassing	11,058
Theft	10,556
Wireless 911	9,899



NICJR has developed a tiered dispatch model for CFS, one that includes a robust, structured, and well-trained team of community responders – a Community Emergency Response Network. Pursuant to the NICJR methodology, CFS are initially allocated to CERN Tiers based on a standardized approach outlined below:

Tier 1: CERN dispatched only

- Event type: Non-Criminal

Tier 2: CERN lead, with officers present

- Event type: Misdemeanor with low potential of violence
- If CERN arrives on scene and determines there is low potential for violence and an arrest is unnecessary or unlikely, officers leave.

Tier 3: Officers lead, with CERN present

- Event type: Non-Violent Felony or an arrest is likely
- If officers arrive on scene and determine there is no need for an arrest or an arrest is unlikely and violence is unlikely, officers step back and CERN takes the lead.

Type 4: Officers only

- Event type: Serious Violent Felony or high likelihood of arrest

Default Tier assignments are adjusted based on factors including call type arrest rates and a qualitative assessment of whether specific call types would benefit from an alternate response; the arrest analysis typically results in CFS "moving up" a Tier, whereas the alternate response benefit analysis generally results in CFS moving down a level. In Berkeley, application of the default Tier assignment, adjusted to take into account arrest rates and alternate response benefit, results in 50 percent of BPD events being categorized as Tier 1; CERN would play a lead role in responding to over 64 percent of all CFS.

Table 2. Recommended Tiered Dispatch Model

Crime Category	CERN	BPD	% of Call Types	# of Call Types in Each Tier
Tier 1	Only		50%	92
Tier 2	Lead	Present	10%	19
Tier 3	Present	Lead	18%	33
Tier 4		Only	21%	39

Of the top ten call types by call initiation source, 100 percent of On-View, and 80 percent of 911 and Non-Emergency event types are assigned to CERN Tier 1.

Table 3. Top Ten Call Types by Initiation Source and Tier

Officer Initiated	CERN Tier	911 Emergency	CERN Tier	Non-Emergency Line	CERN Tier
Traffic	1	Disturbance	1	Disturbance	1
Security Check	1	Wireless 911	1	Audible Alarm	1
Pedestrian Stop	1	Ascertain 911	1	Noise Disturbance	1
Officer Flagged Down	1	Welfare Check	1	Welfare Check	1
Suspicious Vehicle	1	Suspicious Circumstances	1	Trespassing	1
Parking Violation	1	Battery	3	Petty Theft	2
Bike Stop	1	Suspicious Person	1	Advice	1
Abandoned Vehicle	1	Family Disturbance	1	Suspicious Circumstances	1
Found Property	1	Petty Theft	2	Parking Violation	1
Disturbance	1	Mental Illness	1	Suspicious Person	1

An average of slightly more than 2 officers responds to each CFS, spending an average of .61 hours event, as measured by arrival on-scene to call clearance.

Table 4. Time Spent Responding to Events

Crime Category	Total Hours Arrival to Close	Average Hours Per Event	Proportion of Total Officer Time
Non-Criminal	98,119	.38	52.3%
Misdemeanor	20,414	.53	10.9%
Non-Violent Felony	33,836	.79	18.0%
Serious Violent Felony	35,275	.74	6.9%
Total	187,644	.61	18.8%

KEY RECOMMENDATIONS

Analysis of BPD CFS data for the period 2015-2019 indicates that over 81 percent of CFS were for Non-Criminal events, and that the non-emergency line was the single largest event generating source. Although the vast majority of CFS during the analysis period were Non-Criminal, an average of 2.4 officers was dispatched per event response. NICJR's assessment of viable alternate responses indicates that 50 percent of CFS can be responded to with no BPD involvement, with another 18 percent requiring BPD to be present, but to serve in a support, rather than a lead, role.

With these results in mind, NICJR recommends that alternative response options be developed for the 50 percent of CFS that do not require a law enforcement response. This process should involve an assessment of both relevant municipal and community-based resources that can serve as the basis for the Berkeley CERN.

OBJECTIVES, SCOPE, AND METHODOLOGY

This report is designed to:

1. Provide an analysis of BPD CFS according to NICJR's Crime Categories
2. Map NICJR's Crime Categories to NICJR's proposed Community Emergency Response Network (CERN)
3. Identify which calls for service should be responded to by a non-BPD alternative

NICJR has developed a tailored approach to the analysis of CAD (Computer Aided Dispatch) calls for service data based on hands-on experience in multiple cities nationwide. NICJR CFS analyses use the following categorization of *final disposition* CAD events: Non-Criminal (NC), Misdemeanor (MISD), Non-Violent Felony (NV FEL), and Serious Violent Felony (SV FEL). NICJR categories are aligned with state specific penal codes and their associated penalties. If a call type is not found in the penal code, it is placed into the Non-Criminal Category.

NICJR uses this method of categorizing events because it affords the most linear correlation between the event and its associated criminal penalty. By categorizing events in this manner, NICJR can clearly identify the portion of CFS that are either non-criminal or are for low-level and non-violent offenses. Categorizing call data into a simple criminal vs. non-criminal, violent, vs. non-violent, structure also supports conversations with the community about alternatives to policing for specific call types grounded in easily understandable data.

NICJR's methodology was informed by an assessment of the limitations of other approaches to categorizing CAD data. Alternative approaches include matching CFS to Federal Bureau of Investigation (FBI) Uniform Crime Report (UCR) categories or to the newer National Incident Based Reporting System (NIBRS) categories. Both options have serious limitations. The UCR data set only includes violent and property crimes, while the more expansive NIBRS platform has not been widely adopted by policing agencies. In 2018, for example, UCR data was submitted for 16,659 (out of 18,000) law enforcement agencies across the country, while only 7,283 reported crime data via NIBRS.[1]

With respect to the present analysis, the BPD provided NICJR with a comprehensive CFS data set for calendar years 2015-2019, representing 358,269 unique calls for service.

Each year's worth of data included the call type descriptions for the respective reporting period. There were 183 available call type descriptions for each year. The data set included 18 non-traffic related disposition codes by which calls were cleared or disposed. There were also numerous Racial Identity and Profiling Advisory (RIPA) Board disposition codes as required by Assembly Bill 953, which requires law enforcement agencies to collect "perceived demographic and other detailed data regarding pedestrian and traffic stops."

NICJR consolidated these call types into four descriptive Crime Categories for reporting purposes: Non-Criminal, Misdemeanor, Non-Violent Felony, and Serious Violent Felony. Call types were assigned to Crime Categories based on mapping to the California Penal Code Part 1, Title 1-15. A crosswalk of BPD call types used during the 2015-2019 period, and Crime Categories, is provided in Appendix A.

1 dd_number_of_leas_enrolled_part_status_and_method_of_data_sub_by_pop_group-2018_final.pdf (fbi.gov)

Table 5. NICJR Crime Categories

Crime Category	Description
Non-Criminal (NC)	Any event not identified in the California State Penal Code
Misdemeanor (MISD)	Any event identified in the California State Penal Code as a Misdemeanor
Non-Violent Felony (NV FEL)	Any event identified in the California State Penal Code as a Non-Violent Felony
Serious Violent Felony (SV FEL)	Any event identified in the California State Penal Code as a Serious Violent Felony

Call type description variables also allowed NICJR to determine CFS initiation source – BPD Public Safety Communications Center, officer-initiated activity or On-View, CHP transfer, telephone, VOIP, or other source.

In addition, CFS response time data was used to determine how long it takes BPD officers to respond to CFS and how much time officers spend on CFS by incident type once they arrive on-scene. There were five-time variables provided in the data. To determine how long it took officers to respond to CFS, NICJR assessed the length of time between call dispatch and an officer arriving on-scene. To determine how long officers spent responding to events, NICJR analyzed the length of time between an officer arriving on-scene and clearing the call. NICJR was also able to use CAD data to determine the mean number of officers responding to each type of call by Crime Category.

Table 6. Berkeley CAD Data Time Variable Descriptions

CAD Data Variable Label	CAD Translation
CreateDateTime	Time call first came into the Communications Center
DispatchTime	Time call was first dispatched to an officer
EnRouteTime	Time officer is enroute to the scene of a call
OnSceneTime	Time officer arrived on-scene
ClearTime	Time officer is back in service to take new calls

CHARACTERISTICS OF CALLS

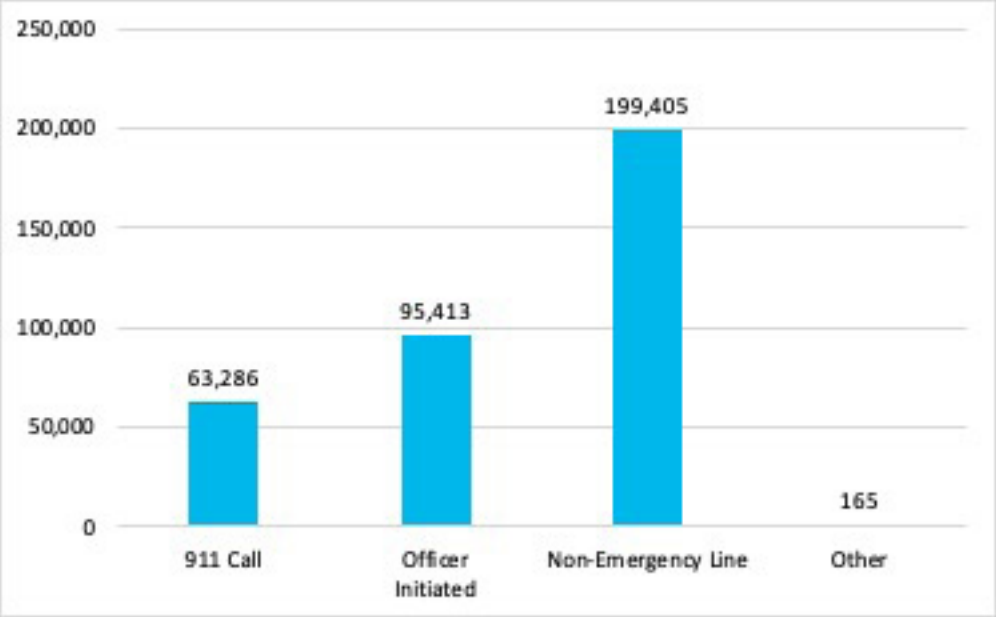
Analysis of 358,269 events from 2015-2019

NICJR analyzed the CFS data set across a number of metrics including overall call type frequency, call initiation source, and call Crime Category. Figures and tables in this section draw from a sample of 358,269 unique calls for service covering the period 2015-2019 within the CAD files NICJR obtained from BPD. As noted in the Objectives, Scope, and Methodology, section above, BPD used 183 unique call types during the reviewed period. This section provides various analyses of this data.

Event Initiation

Calls for service may be initiated in three primary ways: by calling 911, by calling the BPD non-emergency line, or by officer-initiated call. The other ways in which a CFS may be initiated are through a CHP transfer, telephone, VOIP, alarm, cell phone, on view, traffic stop, or other means. Figure 1 shows the proportion of events by initiation source. Over 55 percent of all calls during the 2015-2019 period were initiated through the non-emergency line.

Figure 2. Events by Initiation Source



* Does not include calls with missing values

Top Ten Events

Table 7 provides the top ten events by Initiation Source. Together, these call types comprised 68 percent of all BPD events over the study period.

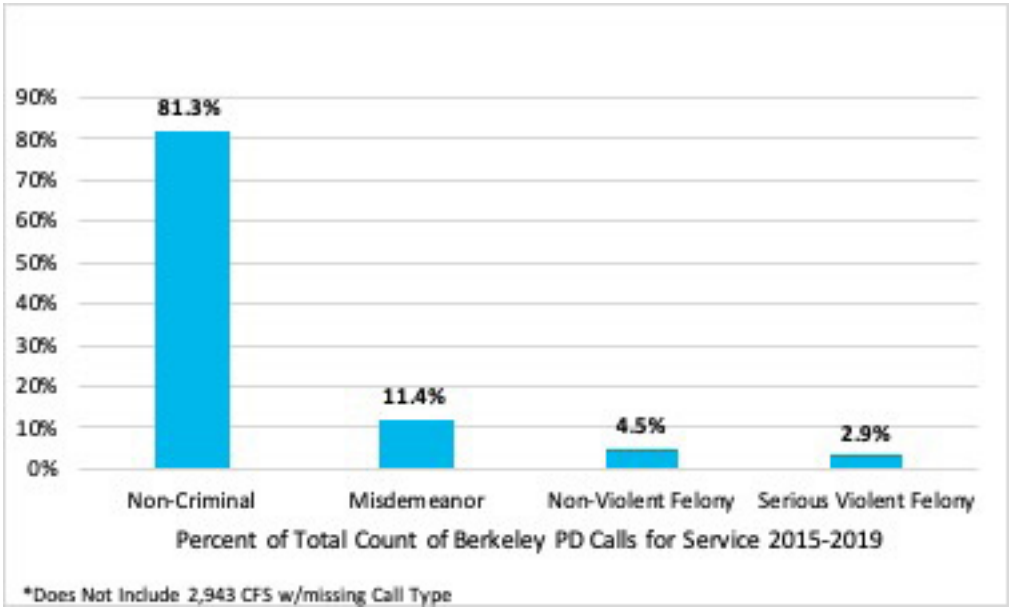
Table 7. Top 10 Calls by Initiation Source

Officer Initiated	911 Emergency	Non-Emergency Line
Traffic	Disturbance	Disturbance
Security Check	Wireless 911	Audible Alarm
Pedestrian Stop	Ascertain 911	Noise Disturbance
Officer Flagged Down	Welfare Check	Welfare Check
Suspicious Vehicle	Suspicious Circumstances	Trespassing
Parking Violation	Battery	Petty Theft
Bike Stop	Suspicious Person	Advice
Abandoned Vehicle	Family Disturbance	Suspicious Circumstances
Found Property	Petty Theft	Parking Violation
Disturbance	Mental Illness	Suspicious Person

Events by Crime Category

Figure 2 shows the frequency of call types by Crime Category. BPD averaged 71,654 events per year during the analysis period. The vast majority of these CFS, 81.3 percent, are classified as Non-Criminal; as reflected in Appendix B, Non-Criminal CFS consistently comprised a majority of events during the 2015 to 2019 period.

Figure 3. Percent of Events by Crime Category



*Does Not Include 2,943 CFS w/missing Call Type Description

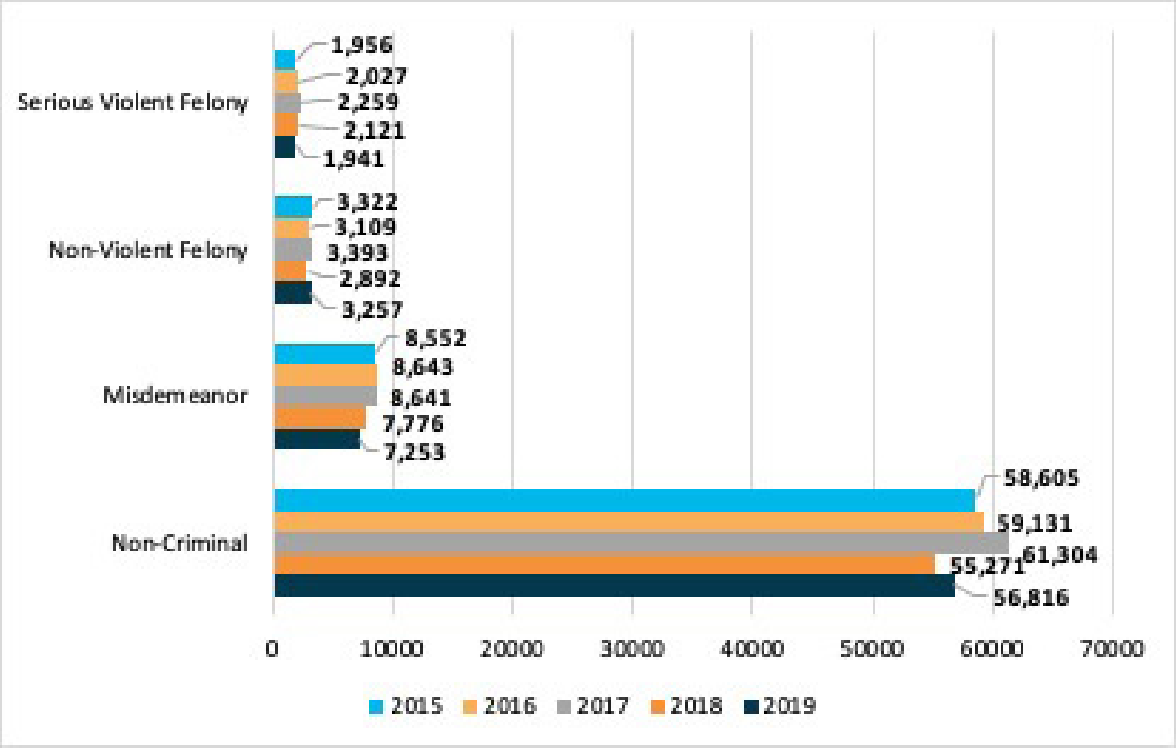
During the five-year period reviewed, at least 96.7 percent of On-View events were Non-Criminal and over 76 percent of 911 calls comprised Non-Criminal events. Interestingly, Officer-Initiated calls were the most likely to be Non-Criminal.

Table 8. Percent of Non-Criminal Events by Initiation Source

Event Initiation Source	Year				
	2015	2016	2017	2018	2019
911 Calls	77.5%	76.6%	76.6%	76.7%	72.7%
Non-Emergency Calls	72.3%	72.7%	72.8%	73.5%	71.1%
Officer-Initiated	98%	98.3%	98.1%	96.7%	96.9%

Figure 3 identifies the number of events by Crime Category over the review period. The total number of events across all categories declined between 2015 and 2019.

Figure 4. Number of Events by Crime Category



NUMBER OF RESPONDING PERSONNEL

The number of personnel who responded to CFS varied depending on the event type. Table 9 shows the average number of personnel who responded to a CFS by Crime Category. As expected, when dealing with a call that is more serious in nature, the average number of responding officers was higher than for a less serious event. The average number of responding personnel across all event types was 2.4.

Table 9. Responding Personnel by Crime Category

	Non-Criminal	Misdemeanor	Non-Violent Felony	Serious Violent Felony
2015	1.8	1.7	1.9	4.2
2016	1.8	1.7	1.7	4.5
2017	1.8	1.7	1.9	4.4
2018	1.7	1.7	1.8	3.7
2019	1.7	1.7	1.9	3.8

Time Spent Responding to Calls

Tables 10 and 11 outline the total amount of time spent on CFS by Crime Category. In determining the time spent on event response, NICJR analyzed two time periods. First, the time period beginning when an officer arrived on-scene to when the officer closed or "cleared" the call and was back "in-service" and able to take other calls. Using this methodology, NICJR was able to identify how much time officers actually spent handling a specific call. An alternate and more comprehensive view of officer response time accounts for the time from event initiation to close.

Table 10. Time Spent Responding to Events, On-Scene to Close

Crime Category	Total Hours Arrival to Close	Average Hours Per Event	Proportion of Total Officer Time
Non-Criminal	98,119	.38	52.3%
Misdemeanor	20,414	.53	10.9%
Non-Violent Felony	33,836	.79	18.0%
Serious Violent Felony	35,275	.74	6.9%
Grand Total	187,644	.61	100.0%

Note* Excludes calls with missing on-scene or clear times.

Table 11. Time Spent Responding to Events, Initiation to Close

Crime Category	Total Hours Initiation to Close	Average Hours Per Event	Proportion of Total Officer Time
Non-Criminal	266,832	1.0	42.1%
Misdemeanor	120,063	2.9	18.9%
Non-Violent Felony	161,656	4.8	25.5%
Serious Violent Felony	85,703	2.5	13.5%
Grand Total	634,254	3.4	100.0%

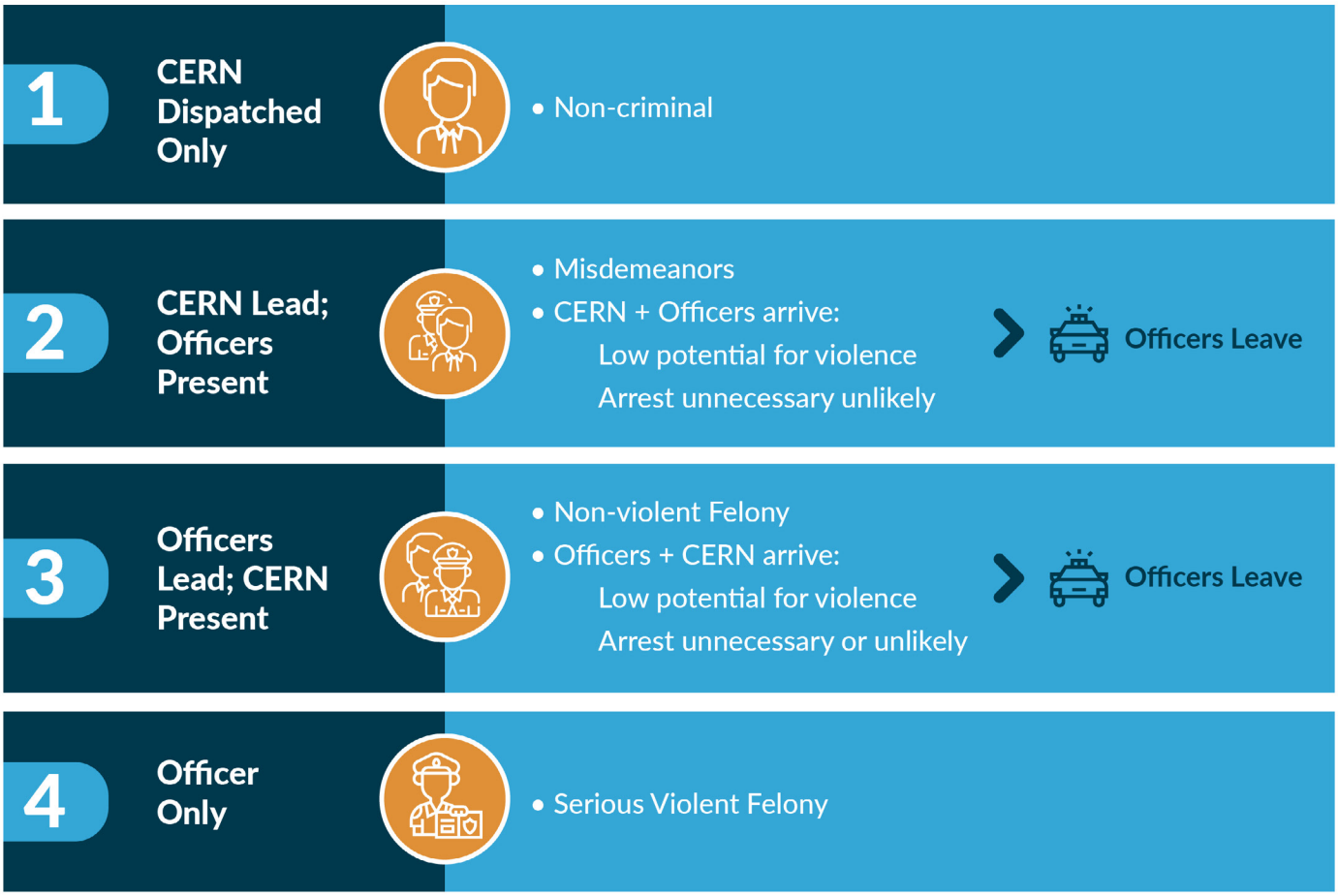
Note* Excludes calls with missing on-scene or clear times.

NICJR CERN CATEGORIZATION

In our work to Reimagine Public Safety and transform policing, NICJR has developed a tiered dispatch system to provide alternatives to police response to CFS, increase public safety, and improve the quality of emergency response. This model, the Community Emergency Response Network (CERN), builds upon NICJR's CFS classification structure.

Once each call type is associated with one of NICJR's four CFS Categories, an additional step is taken to do a default assignment of CFS to CERN Tiers as follows:

Figure 5. Tiered Dispatch



CERN default Tier assignments for the 2015-2019 BPD CFS analyzed are outlined below.

Table 12. CERN Tier Default Assignment Table

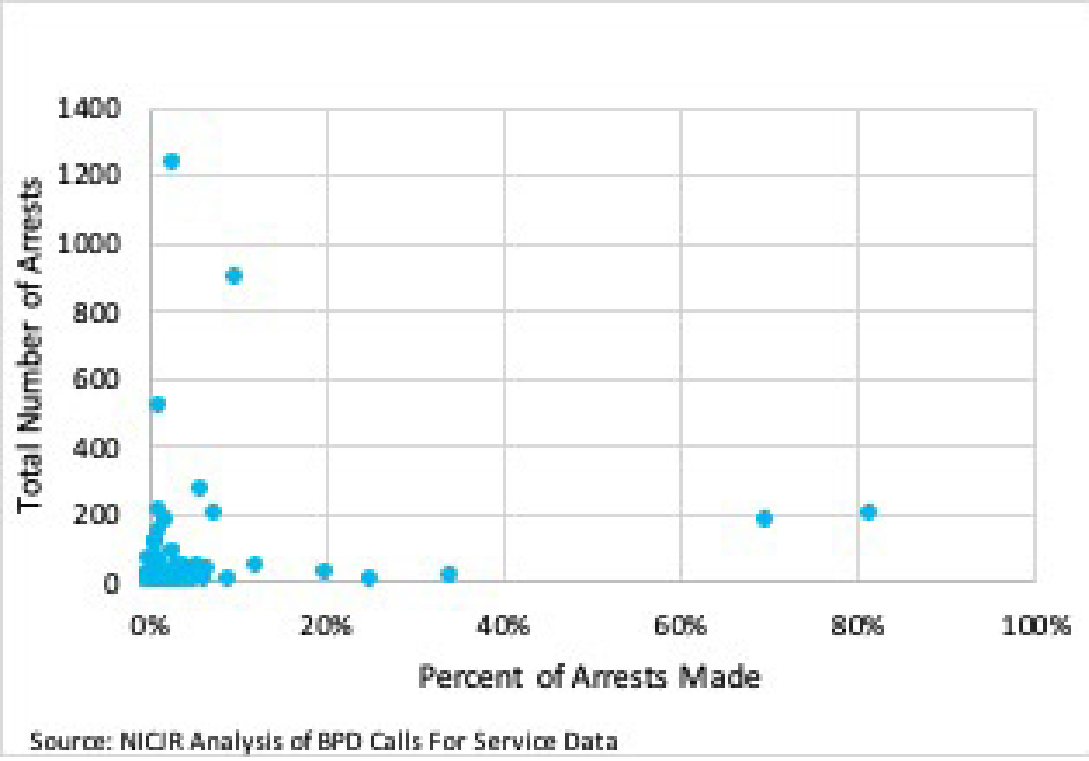
Crime Category	CERN	BPD	% of Call Types	# of Call Types in Each Tier
Tier 1	Only		50%	92
Tier 2	Lead	Present	14%	25
Tier 3	Present	Lead	9%	16
Tier 4		Only	27%	50

Default Tier Assignment Modified Based on Arrest Data and Other Factors

A. Arrest Rates

Subsequent to the default classification, NICJR examines arrest data to determine if adjustments to default Tier assignments are warranted. Most typically, this results in CFS "moving up" a Tier based on the likelihood of arrest. The arrest analysis includes the identification of the overall jurisdiction arrest rate, as well as the high-end of that rate, below which the vast majority of CFS arrest rates fall. For Berkeley, 10 percent was set as the arrest rate triggering Tier assignment review; only 6 of 91 CFS that resulted in an arrest had an arrest rate in excess of 10 percent in the years 2015 to 2019. Call types with arrest rates that significantly exceed the triggering arrest rate generally moved to higher Tiers. For example, the Non-Criminal CFS *warrant service* was moved from Tier 1 to Tier 4 based on arrest rate data.

Figure 6. Total Arrest Rate Count Dispersion Scatterplot



Source: NICJR Analysis of BPD Calls For Service Data

Table 13. CFS CERN Tier Assignments After Arrest Review

Crime Category	CERN	BPD	% of Call Types	# of Call Types in Each Tier
Tier 1	Only		50%	91
Tier 2	Lead	Present	13%	24
Tier 3	Present	Lead	9%	16
Tier 4		Only	28%	52

B. Alternate Response Warranted

Beyond arrest data, CERN Tier assignment is modified based on NICJR's assessment of call types that would benefit from an alternate response. Some Serious Violent Felony call types typically move from Tier 4 to Tier 3 pursuant to this aspect of the analysis, in order to allow for a CERN response with an officer leading. For example, the call type *assault, gang related* has been downgraded from a Tier 4 to a Tier 3 in order to allow the CERN to assist officers involved. Warrants have similarly been downgraded from a Tier 4 to a Tier 3 with this rationale in mind. Conversely, some call types moved from lower to higher Tiers as a result of this aspect of the default Tier assignment modification methodology. Various events that fall under the assist call type, for example, are allocated to Tier 4 even though these CFS are Non-Criminal in nature. The rationale here is that if the BPD is being asked to assist another law enforcement agency, for example, a BPD response is required.

Table 14. CFS CERN Tier Assignments After Alternate Response Review

Crime Category	CERN	BPD	% of Call Types	# of Call Types in Each Tier
Tier 1	Only		50%	92
Tier 2	Lead	Present	10%	19
Tier 3	Present	Lead	18%	33
Tier 4		Only	21%	39

Based on NICJR's analysis, and as reflected in Table 14, 50 percent of BPD CFS could be handled solely by a community-response, reflecting 76 percent of BPD calls for service.

NICJR appreciates that there may be questions about the assignment of certain call types to Tier 1. Selected Tier 1 event types have been tagged for additional explanation of Tier assignment in that vein; the explanations can be found following in Appendix C.

As a final cut of the data, Table 15 depicts the top ten call types by initiation source and CERN Tier. One hundred percent of the top ten On-View event types, and 80 percent of top ten 911 and Non-Emergency event types, are assigned to CERN Tier 1.

Table 15. Top Ten Call Types by Initiation Source and Tier

Officer Initiated	CERN Tier	911 Emergency	CERN Tier	Non-Emergency Line	CERN Tier
Traffic	1	Disturbance	1	Disturbance	1
Security Check	1	Wireless 911	1	Audible Alarm	1
Pedestrian Stop	1	Ascertain 911	1	Noise Disturbance	1
Officer Flagged Down	1	Welfare Check	1	Welfare Check	1
Suspicious Vehicle	1	Suspicious Circumstances	1	Trespassing	1
Parking Violation	1	Battery	3	Petty Theft	2
Bike Stop	1	Suspicious Person	1	Advice	1
Abandoned Vehicle	1	Family Disturbance	1	Suspicious Circumstances	1
Found Property	1	Petty Theft	2	Parking Violation	1
Disturbance	1	Mental Illness	1	Suspicious Person	1

RECOMMENDATIONS AND CONCLUSION

Analysis of BPD CFS data for the period 2015-2019 indicates that over 81 percent of CFS were for Non-Criminal events, and that the non-emergency line was the single largest event generating source. Although the vast majority of CFS during the analysis period were Non-Criminal, an average of 2.4 officers was dispatched for event response. NICJR's assessment of viable alternate responses indicates that 50 percent of CFS types, representing 76 percent of all calls for service, can be responded to with no BPD involvement, with another 18 percent requiring BPD to be present, but to serve in a support, rather than a lead, role.

With these results in mind, NICJR offers the following recommendations:

Key Recommendations

1. Alternative response options should be developed for the 50 percent of CFS that do not require a law enforcement response or are appropriate for a dual response by law enforcement and a community-based/ non law enforcement service provider.

Data-Specific Recommendations

2. Develop a mechanism for clear identification of mental health related calls within the data including ones that overlap with homelessness.
3. Provide a coding element in the data that allows a researcher or analyst to identify those types of calls that result in a use of force including the type of use of force.
4. Create a publicly accessible data key for all of the variable code types in BPD data.

APPENDIX H

Berkeley Calls for Service Analysis

Table of Contents

INTRODUCTION

As a part of the City of Berkeley's Reimagining Public Safety process, the National Institute for Criminal Justice Reform (NICJR) was commissioned to conduct an assessment of programs and models that increase safety, properly respond to emergencies, reduce crime and violence, and improve policing. The New and Emerging Models of Community Safety and Policing report has been prepared in response to that charge. NICJR submits this report to the Reimagining Public Safety Taskforce (RPSTF) to inform the RPSTF's development of recommendations for submission to the Berkeley City Council (Council) on alternative responses and police reforms.

The report comprises a brief overview of several examples of Emerging Non-Enforcement Models of Community Response; Non-Law Enforcement Crime Reduction Strategies; Community Driven Violence Reduction Strategies; and Policing Strategies. As hundreds of cities across the country engage in reimagining public safety processes and launching new programs or altering existing models, this report could not possibly be universally comprehensive; it does however provide the RPSTF and the Council with illustrative examples of key options to consider as the City of Berkeley (City) reimagines its public safety system. The programs and strategies featured in this report were selected based on a number of factors including relationship to the core pillars of NICJR's reimagining framework: **Reduce, Improve, Reinvest**; level of institutionalization and track record; City of Berkeley staff and RPSTF request; and relevance to particular reform efforts underway or likely to be underway in Berkeley.

Note that one aspect of police reform, relating specifically to police oversight, is not directly addressed in this report. Review of these bodies was not included due to the City's new Police Accountability Board, approved overwhelmingly by the voters in November 2020. The Berkeley Police Accountability Board will be one of the most expansive and progressive of its kind in the country when launched in the summer of 2021.

NICJR's second commissioned report for the City, *Alternative Responses to Law Enforcement*, will draw from and build upon several of the new and emerging models outlined herein.

This report last updated October 2021. Due to the evolving nature of these models, information may be outdated.

EMERGING NON-ENFORCEMENT MODELS OF COMMUNITY RESPONSE

Police departments receive a large volume of 911 calls or other Calls for Service (CFS) requesting emergency response. In the past several decades policing has evolved from officers walking beats to departments primarily responding to CFS with patrol officers in squad cars. A number of new assessments of these CFS have revealed that a majority are low-level or even non-criminal in nature, like noise complaints, abandoned cars, and petty theft. Multiple analyses have estimated that less than 2 percent of CFS are for violent incidents.[1,2] Retired Chicago police officer David Franco explains "We spend entire shifts dealing with noncriminal matters from disturbance and suspicious person calls…With so many low-level issues put on our shoulders, police cannot prioritize the serious crimes."[3]

In addition to responding to a high volume of low-level and non-criminal 911 CFS, police have also been increasingly asked to respond to people experiencing mental health crises. Many of these encounters have resulted in uses of force by police, including deadly officer involved shootings. A number of the emerging examples of effective community driven crime reduction and emergency response models focus specifically on mental health incidents.

Eugene Crisis Assistance Helping Out on the Streets (CAHOOTS)

Crisis Assistance Helping Out on The Streets, or CAHOOTS, is a mobile emergency intervention service established in 1989 in Eugene, Oregon.[4] This program is free and readily available twenty-four hours a day for mental health and other non-violent related calls.[5] CAHOOTS is directed by the White Bird Clinic, a regional health center in partnership with the City of Eugene. Each CAHOOTS unit is comprised of an emergency medical technician (EMT) and a mental health service provider.[6]

CAHOOTS staff are required to go through 40 hours of classroom education and over 500 hours of field work that is supervised by a qualified guide. Their education consists of de-escalation methods and emergency response services. CAHOOTS personnel are able to perform wellness checks, offer mental health services and substance use resources, administer medical aid, and provide mediation assistance.[7]

More than 60 percent of CAHOOTS clients are experiencing homelessness and nearly 30 percent have serious mental illness. CAHOOTS had some level of involvement in nearly 21,000 public-initiated CFS in 2019, with the number of calls having steadily increased since the program's inception. Among all adults involved with CAHOOTS, the average age was 45.5 years.

Numerous evaluations have shown consistent, robust results for the CAHOOTS program. Approximately 5-8 percent of calls are diverted from the police to CAHOOTS, comprising nearly 14,000 calls annually that CAHOOTS alone responds to annually, according

1 https://www.vera.org/downloads/publications/understanding-police-enforcement-911-analysis.pdf#page=134
2 https://www.nytimes.com/2020/06/19/upshot/unrest-police-time-violent-crime.html
3 https://chicago.suntimes.com/2020/12/9/22166229/chicago-police-department-911-calls-civilian-community-responders-cpd

4 Id.
5 https://www.americanprogress.org/issues/criminal-justice/reports/2019/10/02/475220/neighborhoodstat-strengthening-public-safety-community-empowerment/
6 https://www.mentalhealthportland.org/wp-content/uploads/2019/05/2018CAHOOTSBROCHURE.pdf
7 https://www.mentalhealthportland.org/wp-content/uploads/2019/05/2018CAHOOTSBROCHURE.pdf

to an analysis of 2019 CFS. Of these, only 2.2 percent necessitated backup or police involvement.[8] The program costs approximately $2 million annually and generates an estimated $8.5 million in savings for the Eugene Police Department along with an additional $2.9 million in savings for other city government agencies.[9,10]

Several cities have explored or are currently implementing replications of CAHOOTS. In Oakland, the city is preparing to launch the Mobile Assistance Community Responders of Oakland (MACRO) initiative.[11] The pilot program will be managed by the Oakland Fire Department and will be available twenty-four hours per day, seven days per week in two-person teams.[12] The City of Oakland has allocated $4.5 million for the year 2022-2023 along with $10 million in other funding. The program is projected to pilot in East Oakland neighborhoods anywhere from November 2021 to February 2022.[13]

Denver Support Team Assisted Response (STAR)

Based on the CAHOOTS program in Eugene, Oregon, STAR is a community responder model created in 2020. STAR is a joint effort between many stakeholders, including the Denver Police Department (DPD), Denver's Paramedic Division, Mental Health Center of Denver, and community-based organizations. STAR provides direct, emergency response to residents of the community who are experiencing difficulties connected to mental health, poverty, homelessness, or substance use. The STAR transport vehicle operates seven days a week from 6 AM to 10 PM.[14] The time frame of operation was chosen based on an analysis of CFS data.[15] STAR unit staff are made up of unarmed personnel, with each team including a mental health service provider and a paramedic.[16]

Before the implementation of STAR, calls to 911 were either transmitted to the DPD or the hospital system. The majority of calls (68 percent) routed to STAR concerned individuals that were experiencing homelessness. Around 41 percent of individuals who STAR had been involved with were referred to additional services by the STAR unit staff.[17]

In just half a year after the program was established, the STAR unit had addressed 748 calls. The DPD was never called to support the unit in responding to these CFS. Moreover, there were no arrests made in any of the calls evaluated during the initial six months of program operation. To expand the program, the City of Denver has approved $1 million from the City's supplemental fund to go along with the already allocated $1.4 million in the original 2021 budget.[18]

Olympia Crisis Response Unit (CRU)

Incorporating both CAHOOTS principles and crisis intervention teams, the Crisis Response Unit (CRU) was implemented in Olympia, Washington in April 2019, as a result of a 2017 citywide safety measure that allocated an initial half million dollars for an improved crisis response model. The Olympia Police Department (OPD) contracted with a community-based organization to serve as a new option for behavioral health calls for service. The CRU team consists of six mental health professionals that operate in pairs. Along with a state certification in behavioral health, CRU staff must undergo training that includes police patrol exposure, community engagement, and education about available community support.[19]

8 https://www.eugene-or.gov/DocumentCenter/View/56717/CAHOOTS-Program-Analysis
9 https://www.vera.org/behavioral-health-crisis-alternatives/cahoots
10 https://www.mentalhealthportland.org/wp-content/uploads/2019/05/2018CAHOOTSBROCHURE.pdf
11 https://urbanstrategies.org/wp-content/uploads/2020/06/USC-MACRO-REPORT-6_10_20.pdf
12 https://abc7news.com/macro-oakland-civilian-crisis-response-team-mental-health-police-dept/10430680/
13 https://www.ktvu.com/news/oakland-leaders-push-to-start-urgently-needed-macro-program-create-oversight
14 https://denver.cbslocal.com/2021/08/31/star-program-mental-health-denver-police/
15 https://wp-denverite.s3.amazonaws.com/wp-content/uploads/sites/4/2021/02/STAR_Pilot_6_Month_Evaluation_FINAL-REPORT.pdf
16 https://www.9news.com/article/news/denver-star-program-results-police/73-90e50e08-94c5-474d-8e94-926d42f8f41d
17 Id.
18 https://denver.cbslocal.com/2021/08/31/star-program-mental-health-denver-police/
19 https://www.vera.org/behavioral-health-crisis-alternatives/cru-and-familiar-faces

CRU operates from 7 AM to 8:40 PM Monday through Thursday and 10 AM to 8:40 PM Friday through Sunday, supplying clients with supports such as mediation, housing assistance, and referrals to additional services.[20] Police lines of communication are utilized by CRU staff to identify situations that necessitate CRU response. The City's 911 operations hub and law enforcement personnel can also refer callers directly to CRU. Often, 911 callers request CRU assistance specifically, as the team has fostered strong community ties. Moreover, a significant portion of calls for service referred to CRU originate from community-based service providers, as opposed to the 911 system itself. When CRU staff encounter an individual the team has been called on to support multiple times, they refer the individual to Familiar Faces, a peer navigation program.[21]

Most individuals who were assisted by CRU were experiencing homelessness or mental health issues at the time of service. Out of the 511 calls CRU engaged with from April to June of 2020, OPD was only needed 86 times. Establishing and maintaining trust between CRU and residents is an essential part of the initiative.[22] Post-implementation surveys show that many police officers became advocates of the model after seeing the program in action for six months.

San Francisco Street Crisis Response Team (SCRT)

The City and County of San Francisco has implemented a pilot alternative response program for individuals experiencing a behavioral health crisis. The San Francisco Fire Department, in conjunction with the Department of Public Health and the Department of Emergency Management, responds to 911 calls related to these issues via Street Crisis Response Teams (SCRT). Street Crisis Response Teams include a community paramedic, behavioral clinician, and peer specialist.[23] Currently, there are six teams that provide an around-the-clock response.[24]

20 https://www.olympiawa.gov/services/police_department/crisis_response___peer_navigators.php
21 https://www.vera.org/behavioral-health-crisis-alternatives/cru-and-familiar-faces

22 https://www.americanprogress.org/issues/criminal-justice/reports/2020/10/28/492492/community-responder-model/
23 https://sf.gov/street-crisis-response-team
24 https://sf.gov/sites/default/files/2021-10/SCRT%20September%20Update%20%281%29.pdf

SCRT collaborated with community-based organizations including RAMS, Inc. (Richmond Area Multi-Services) and HealthRIGHT360 to ensure that community providers and local residents would be able to provide feedback and input about the new program.[25] The proposed SCRT budget for fiscal year 2021-2022 is approximately $13.5 million, which includes staff training and team expansion. An evaluation of the pilot program place is currently underway.[26]

When 911 calls come into the dispatch center that are determined to be appropriate for SCRT, SCRT is dispatched; a team responds on average in fifteen minutes. No calls for service routed to SCRT required police action or backup in the first two months of the pilot. Approximately 74 percent of individuals assisted by SCRT had their issues resolved, whether it be through transfers to additional supports or de-escalation techniques.[27] Initial analyses show that SCRT could respond to up to 17,000 behavioral health calls each year. Because of the small scope of the initial pilot, only 20 percent of behavioral health calls received during the first two months of implementation were able to be responded to by the SCRT.

Austin Expanded Mobile Crisis Outreach Team (EMCOT)

In order to reduce the burden on the Austin Police Department (APD) associated with mental health calls, the City of Austin, Texas established the Expanded Mobile Crisis Outreach Team (EMCOT) in conjunction with Integral Care, the City's community-based mental health service provider. EMCOT assists individuals undergoing a behavioral or mental health crisis. Agencies such as APD or the Sheriff's Office are able to call for EMCOT services by way of the 911 dispatch hub. EMCOT provides its clients with supports in the form of therapy, life coaching, rehabilitation, and other services.[28]

Since its establishment in 2013, EMCOT has assisted 6,859 clients. The most recently available data is from FY2017, which shows that EMCOT responded to 3,244 CFS, at a rate of approximately 9 times per day. Each client was served for an average of 21 days and provided three different types of supports. In general, post-crisis services are available for up to 3 months after initial contact.[29] Integral Care reported that 86 percent of calls routed to a mental health response did not require police backup.[30]

EMCOT is currently available from 8AM to 12AM Monday through Friday and 10AM to 8PM on Saturday and Sunday.[31] With the additional funding, EMCOT is now projected to provide around-the-clock availability for calls for service. Expansion of telehealth services for the program is also included in the new funding.[32] For all CFS involving EMCOT, 85.4 percent were handled without police officers.[33]

In 2020, a new dispatch system was established in Austin and a mental health paraprofessional was permanently stationed in the 911 dispatch center. Callers to 911 now have the option to request mental health services instead of police.[34] If the operator determines the caller would benefit from these supports, the call is handed over to a mental health professional. If a clinician is unavailable at the time, an EMCOT staff member is deployed. Currently, the clinicians are present all week for a set number of hours each day. This initiative was funded by the reallocation of $11 million from the Austin Police Department's budget. The EMCOT budget itself was also recently increased to $3.15 million, a 75 percent increase in funding for the program.[35]+

25 https://sf.gov/street-crisis-response-team
26 https://www.sfdph.org/dph/files/IWG/SCRT_IWG_Issue_Brief_FINAL.pdf
27 Id.
28 https://www.austintexas.gov/edims/document.cfm?id=302634
29 Id.
30 https://www.kxan.com/news/local/austin/new-911-call-option-offers-direct-mental-health-help-that-one-attorney-says-may-have-saved-one-familys-son/
31 https://www.fox7austin.com/news/crisis-counselors-responding-to-more-mental-health-calls-in-austin
32 http://www.austintexas.gov/edims/pio/document.cfm?id=320044
33 https://www.austinmonitor.com/stories/2020/08/integral-care-set-to-address-most-mental-health-emergency-calls-without-involving-apd/
34 https://www.kvue.com/article/news/health/apd-adds-mental-health-services-to-911-answering-script/269-e7dde2e6-4a65-4d5c-a2a7-a26e57110a81
35 https://www.austinmonitor.com/stories/2020/08/integral-care-set-to-address-most-mental-health-emergency-calls-without-involving-apd/

Houston Crisis Call Diversion (CCD)

The Crisis Call Diversion (CCD) program in Houston, Texas is a joint effort between the fire department, police department, emergency center, and mental health service providers in the area. In 2017, the Houston Police Department (HPD) received 37,032 calls for service that involved behavior or mental health problems. When calls for service come in, dispatchers flag any that would necessitate CCD response-- non-emergency behavioral and mental health calls. Once flagged, these callers are connected to CCD counselors. The CCD counselor evaluates the situation and the mental health of the caller and attempts to provide assistance over the phone.[36]

If additional community response or police presence is needed, the dispatcher can request that as well. The call is taken off the police dispatch line when the CCD dispatcher verifies that the CCD team is on the way to the scene. CCD teams can contact the caller while traveling to the specified location in order to collect as much relevant information as possible. Upon examination of the data, each rerouted call generates savings of nearly $4,500. The CCD costs approximately $460,000 annually and is estimated to generate over $860,000 in annual savings.[37]

City of Albuquerque Community Safety Department (ACS)

The City of Albuquerque's recently created Community Safety Department (ACS) serves as the third branch of Albuquerque's first responder system. The ACS responds to non-violent and non-medical Calls for Service (CFS) related to mental health, substance use, and homelessness as well as non-behavioral issues such as abandoned vehicles and needle pickups.[38] Once a call is received through 911, it is routed to the Albuquerque Police Department (APD) Dispatch Center, who will then facilitate the deployment of ACS responders.

ACS' Field Response Unit is made up of four types of responders: Behavioral Health Responders, Community Responders, Street Outreach and Resource Coordinators, and Mobile Crisis Team (MCT) Licensed Clinicians.

Each responder's role is as follows[39]:

- Community Responders: provide support to community members related to inebriation, homelessness, addiction, mental health as well as minor injuries, incapacitation, abandoned vehicles, non-injury accidents, and needle pickups
- Behavioral Health Responders: respond in pairs to requests for assistance regarding mental and behavioral health, inebriation, homelessness, addiction, chronic mental illness, etc.
- Street Outreach and Resource Coordinators: provide street outreach to individuals experiencing homelessness in encampments
- Mobile Crisis Team (MCT) Licensed Clinicians: co-respond to high acuity mental and behavioral health emergencies

In its first operational month (August 30- October 1, 2021), ACS responders addressed an average of nine calls daily, for a total of 212 CFS. 50% of those CFS were provided with either resources, direct services, or transportation. The average response time for ACS responders is slightly over 14 minutes.[40] Once ACS is fully scaled, as many as 3,000 calls could be diverted per month.[41]

Los Angeles County Alternative Crisis Response (ACR)

The LA County Alternative Crisis Response is a collaboration between the Department of Mental Health (DMH) and the Chief Executive Office's (CEO) Alternatives to Incarceration Initiative to address gaps within LA County's current crisis response system.[42] Set to rollout in July of 2022, preliminary recommendations put forth to the Los Angeles County Board of Supervisors include designing and implementing a Regional Crisis Call Network,

36 https://www.americanprogress.org/issues/criminal-justice/reports/2020/10/28/492492/community-responder-model/
37 https://www.houstoncit.org/ccd/
38 https://www.cabq.gov/acs/our-role
39 https://www.cabq.gov/acs/our-response
40 https://www.cabq.gov/mayor/news/albuquerque-community-safety-responders-hit-the-streets
41 https://www.abqjournal.com/2428380/abqs-community-safety-department-launches-patrols.html
42 https://ceo.lacounty.gov/ati/alternative-crisis-response/

instituting a crisis mobile response team, and increasing behavioral health bed capacity.[43]

In accordance with recent ACR recommendations, the Los Angeles Police Department (LAPD) expanded its Didi Hirsch Pilot, which diverts 911 behavioral health CFS to the Didi Hirsch Suicide Prevention Center. The ACR will utilize a 988 number for behavioral health emergency needs also overseen by the Didi Hirsch Suicide Prevention Center.[44]

Seattle Department of Community Safety & Violence Prevention

The Seattle City Council passed Resolution 31962 in August of 2020, which lays the foundation for a civilian led Department of Community Safety & Violence Prevention. This Department, which is expected to be up and running by the fourth quarter of 2021, will assume responsibility for manning 911 call lines, replacing police operators with "civilian-controlled systems."[45]

Ithaca Department of Community Solutions and Public Safety

In February 2021, the Mayor of Ithaca, New York, proposed the creation of a new Department of Community Solutions and Public Safety that would replace the Ithaca Police Department.[46] This new department would include both armed officers and unarmed workers who focus on crime and neighborhood service. The department would work with a new alternative service provider that provides non-law enforcement crisis intervention and support. All current police officers would have to reapply to be employed by the new department.

The proposal is a part of the Ithaca Reimagining Public Safety Collaborative and a response to the New York State Governor's Executive Order mandating every police department in the state to submit a reform plan by April 1, 2021.[47]

The new Department of Community Solutions and Public Safety would be charged with implementing an alternative to the police response system and establishing a pilot program for non-emergency calls, implementing a culturally responsive training program that includes de-escalation techniques, and developing a comprehensive community healing plan.

Other initiatives proposed under this strategy include standardizing a data review process on traffic stops as well as consistent reviews of officers' body camera footage. Minor grievances would be outsourced to neighborhood mediation centers. Adolescent engagement support programs would be broadened in order to reach those at high risk of violence. The new personnel of the Department would be recruited from a more varied body of applicants as well to reflect the residents of the city in which they operate.[48]

In order to oversee the recommendations made by the Mayor and Ithaca Reimagining Public Safety Collaborative, the City of Ithaca has arranged for the creation of an operations hub known as the Community Justice Center (CJC). The CJC will have its own full-time staff including but not limited to a project manager and a data analyst. The CJC is set to give progress updates to the Tompkins County Legislature and the City of Ithaca Mayor to ensure each recommendation is properly addressed.[49]

Tiered Dispatch & Community Emergency Response Network

NICJR has developed a tiered dispatch model for CFS, one that includes a robust, structured, and well-trained team of community responders – a Community Emergency Response Network (CERN). Pursuant to the NICJR methodology, CFS are initially allocated to CERN Tiers based on a standardized approach outlined below:

43 https://file.lacounty.gov/SDSInter/bos/supdocs/149254.pdf
44 https://file.lacounty.gov/SDSInter/bos/supdocs/149282.pdf
45 https://www.washingtonpolicy.org/publications/detail/seattle-city-council-passes-cuts-to-police-budget-and-resolution-to-establish-civilian-led-department-of-community-safety-violence-prevention
46 https://www.gq.com/story/ithaca-mayor-svante-myrick-police-reform
47 https://www.governor.ny.gov/news/governor-cuomo-announces-new-guidance-police-reform-collaborative-reinvent-and-modernize
48 https://drive.google.com/drive/u/0/folders/1NTZ6j6WRze75m5fTuf-wC4BgC-1ddJnO
49 Id.

Tier 1:
CERN dispatched only

- Event type: Non-Criminal

Tier 2:
CERN lead, with officers present

- Event type: Misdemeanor with low potential of violence
- If CERN arrives on scene and determines there is low potential for violence and an arrest is unnecessary or unlikely, officers leave.

Tier 3:
Officers lead, with CERN present

- Event type: Non-Violent Felony or an arrest is likely
- If officers arrive on scene and determine there is no need for an arrest or an arrest is unlikely and violence is unlikely, officers step back and CERN takes the lead.

Type 4:
Officers only

- Event type: Serious Violent Felony or high likelihood of arrest

NON-LAW ENFORCEMENT CRIME REDUCTION STRATEGIES

New York City Mayor's Action Plan (MAP) for Neighborhood Safety

The Mayor's Action Plan for Neighborhood Safety (MAP) was launched in 2014 in fifteen New York City Housing Authority (NYCHA) properties. MAP was designed to foster productive dialogue between local residents and law enforcement agencies, address physical disorganization, and bolster pro-social community bonds. Disorganized neighborhoods are characterized by dense poverty, a lack of social mobility, and underdeveloped community connections. These factors contribute to circumstances that make a given neighborhood more vulnerable to crime and violence.[50] The 15 housing developments chosen for the program account for approximately 20 percent of violence in NYCHA housing.[51]

MAP's focal point is NeighborhoodStat, a process that allows local officials and residents to communicate directly with each other. Issues in each particular housing development are addressed in local meetings which involve multiple stakeholders, including residents, community-based organizations, law enforcement, and government officials. NeighborhoodStat allows residents to have a say in the way New York City (NYC) allocates its public safety resources. The process is facilitated by a team of 15 community members who conduct polls and interviews to determine what the residents feel are the biggest issues in their neighborhoods. NeighborhoodStat also utilizes data analyses regarding employment, physical structure, access to resources, and other metrics in developing its recommendations for key areas of focus. At community meetings, this data and other benchmarks for performance are presented by community-based partners, allowing for full transparency. Residents and law enforcement also put forward their concerns and ideas. Once problems are pinpointed through meaningful dialogue, residents and NYC officials come together to generate solutions, which are then implemented by the Mayor's Office and assessed over time.[52]

Other initiatives MAP has undertaken include providing employment and life coaching services to youth who are at most risk for violence. MAP also focuses on addressing major chronic disease determinants, including low physical activity levels and nutrient-poor diets. Programs such as NYPD Anti-Violence basketball games and pop-up healthy food stands have been established. In addition, public infrastructure has been improved through enhanced lighting, green spaces, and park improvements.[53]

Early evaluations of MAP show promising results for a reduction in various crimes as well as increased perception of healthier neighborhoods. Significantly, misdemeanor offenses against individuals decreased in developments where residents expressed a positive change in their neighborhood's condition.[54] Furthermore, shootings in MAP sites decreased by 17.1 percent in 2015 and 2016 when compared with non-MAP sites.[55]

50 http://www.children.gov.on.ca/htdocs/English/professionals/oyap/roots/volume5/chapter04_social_disorganization.aspx
51 https://criminaljustice.cityofnewyork.us/programs/map/
52 https://www.americanprogress.org/issues/criminal-justice/reports/2019/10/02/475220/neighborhoodstat-strengthening-public-safety-community-empowerment/
53 https://criminaljustice.cityofnewyork.us/programs/map/
54 https://johnjayrec.nyc/wp-content/uploads/2020/10/MAP_EvalUpdate06.pdf
55 https://www1.nyc.gov/assets/operations/downloads/pdf/mmr2016/mayors_action_plan_for_neighborhood_ safety.pdf

Domestic Violence

Every year, an estimated 10 million people in the US experience domestic and family violence. Often a cycle of abuse is perpetuated in these situations, as experience with previous violence is a strong predictor for future abuse.[56] The financial expense of domestic and family violence is projected to be $12 billion each year. In Berkeley, approximately 2,000 reports related to domestic violence are registered annually; the actual number of incidents is probably much higher.[57]

Domestic violence is a difficult and complex problem. Laws have been established that mandate arrests even for minor incidents; these same laws have generated a growing movement of survivors calling for non-enforcement responses. The challenges here are significant, as a lack of intervention can lead to serious injury and death, primarily of women and transgender women.

An additional complication in domestic violence work is the retraumatization of survivors that occurs in the judicial system. When survivors of domestic violence endeavor to obtain recourse through the courts, they are often blamed for the abuse and undergo a disparagement of their character. Moreover, testimony is often given in an open court setting, which requires that a survivor recount the abuse they have undergone while simultaneously appearing composed in order to credibly convey their trauma, often in the presence of their abuser.[58] Reliving one's trauma and facing an abuser can cause feelings of helplessness, anxiety, and PTSD to surface in the survivor. Unfortunately, retraumatization often results in a major roadblock for survivors to pursue justice in domestic violence cases.[59]

There is a significant overlap in addressing domestic violence incidence and anti-poverty work, as intimate partner violence is correlated with devastating monetary effects on survivors who seek to leave their abusive situations. Interventions such as economic education and employment training can both reduce violence and provide critically necessary financial support.

Major domestic violence support programs implemented by the Centers for Disease Control (CDC) include STOP Sexual Violence (SV) and the Preventing Intimate Partner Violence (IPV).[60] According to the CDC, these strategies focus on promoting social norms that protect against violence; teaching skills to prevent SV; providing opportunities, both economic and social, to empower and support girls and women; creating protective environments; and supporting victims/survivors to reduce harms. Research indicates that IPV is most prevalent in adolescence and young adulthood and then begins to decline with age, demonstrating the critical importance of early prevention efforts.[61] Analyses of these financial support programs have demonstrated results including increased confidence for survivors as well as decreases in domestic assault incidences.[62]

Another area of focus has been to revisit the mandatory arrest policies for domestic violence calls in place in many jurisdictions.[63] Alternatives to this approach emphasize coordinated community response teams that maximize the role of community. An effective model integrates other providers, including faith leaders and the courts.[64]

Commercial Sexual Exploitation

Sexual exploitation of minors has historically been difficult to adequately address. This is due to a plethora of factors, ranging from difficulty in identifying adolescents who experience sexual exploitation to a limited understanding of the various methods used to traffic children and the best approaches to engage the victims.[65] Too often, sexually exploited minors have faced arrest and incarceration instead of

56 https://www.ncbi.nlm.nih.gov/books/NBK499891/
57 https://www.cityofberkeley.info/uploadedFiles/Health_Human_Services/Level_3_-_General/dvfactsheet.pdf
58 https://www.seattletimes.com/opinion/a-justice-system-that-re-traumatizes-assault-survivors/
59 https://arizonalawreview.org/pdf/62-1/62arizlrev81.pdf
60 http://www.preventconnect.org/2019/08/addressing-poverty-to-prevent-violence/
61 https://www.cdc.gov/violenceprevention/pdf/ipv-technicalpackages.pdf
62 https://vawnet.org/material/economic-empowerment-domestic-violence-survivors
63 https://opdv.ny.gov/help/fss/part22.html
64 https://www.bwjp.org/our-work/topics/ccr-models.html
65 https://ojjdp.ojp.gov/mpg/literature-review/csec-sex-trafficking.pdf

intervention and support.[66] More than 1,000 children are arrested for "prostitution" annually. However, anywhere from 57,000 to 63,000 individuals are estimated to be involved in commercial sexual exploitation in the United States, a disproportionate number being youth of color.[67]

The Vera Institute has produced a screening procedure for service providers to follow when encountering an individual who could potentially be a survivor of sexual exploitation. Consisting of a thirty-subject questionnaire, the Trafficking Victim Identification Tool (TVIT), serves to aid in trafficking victim identification. Evaluations have proven that the tool has high accuracy and validity rates.[68] Health care providers, social workers, legal aid personnel, and others can use the screening tool to better identify those who have experienced commercial sexual exploitation.[69]

Jurisdictions have also begun to halt prosecution of prostitution. In April of 2021, the District Attorney's Office of Manhattan, New York, announced it would dismiss all open cases with a prostitution charge. Prostitution adjacent crimes such as sex trafficking and soliciting sex workers would still be charged. The cities of Baltimore, Maryland, and Philadelphia, Pennsylvania, have stopped any prosecution of sex workers as well.[70]

Many community-based organizations have established programs that outreach, support, and provide services to minors who have been sexually exploited. It is critical that community-based service providers have the requisite training and education to provide appropriate services and interventions to this population who have experienced abuse, trauma, and exploitation. The training should be trauma-informed, and screeners should be focused on

establishing trust with their clients.[71] Organizations like FAIR Girls (Washington, D.C.) and MISSEY (Oakland, CA) have initiatives that intervene directly with girls who have been exploited. At MISSEY, case workers engage at-risk youth in the Alameda County foster system and offer them support and services in the form of financial resources, life coaching, and housing.[72] In Washington DC, young girls that stayed at the FAIR Girls group home had a 58 percent higher likelihood of permanently withdrawing from commercial sexual exploitation when compared with those who were not provided housing.[73]

Traffic Enforcement

Data from The Stanford Open Policing Project shows that Black men and women are stopped at a higher rate than white drivers and are more likely to be

66 https://www.washingtonpost.com/posteverything/wp/2014/12/05/child-prostitutes-arent-criminals-so-why-do-we-keep-putting-them-in-jail/
67 https://www.vera.org/publications/out-of-the-shadows-identification-of-victims-of-human-trafficking
68 https://www.vera.org/downloads/publications/human-trafficking-identification-tool-summary-v2.pdf
69 https://www.vera.org/publications/out-of-the-shadows-identification-of-victims-of-human-trafficking
70 https://www.nytimes.com/2021/04/21/nyregion/manhattan-to-stop-prosecuting-prostitution.html

71 https://www.nytimes.com/2021/04/21/nyregion/manhattan-to-stop-prosecuting-prostitution.html
72 https://misssey.org/foster-youth-program/
73 https://fairgirls.org/vida-home/

fatally shot during the course of that traffic stop.[74] To significantly lessen the exposure of the general public to the police and instead address transportation violations without law enforcement involvement, a number of strategies have been employed including: reallocation of certain traffic services to non-law enforcement organizations; the implementation of automation; and decriminalization.

In the City of Berkeley, the Berkeley Police Department (BPD) performed approximately 11,000 traffic stops in 2019. Black people were stopped by BPD at a rate 4.3 times than their representative population in the City.[75] This disproportionate traffic enforcement highlights the need to change policies and practices regarding traffic stops.

Reducing the use of police officers in traffic enforcement is one potential solution; this approach can be greatly enabled by technology. Speeding and red-light violations are two areas that constitute a large portion of traffic enforcement. There are 19 states that allow speed cameras, and 21 states that allow red-light camera usage.[76] Implementing automatic speed citations along with red-light cameras could allow for a reduction of up to 20 percent of police interactions. It is important to note that although this technology is successful at reducing the need for police, it can generate other issues such as enforcement problems and privacy concerns.[77]

As Berkeley is considering through the Berkeley Department of Transportation (BerkDOT) initiative, transferring traffic enforcement duties to an agency of unarmed staff can limit problematic police contact with motorists. Analogous programs have been proposed in Cambridge, Massachusetts; St. Louis Park, Minnesota; and Montgomery County, Maryland.[78] In 2019, automation-based traffic enforcement capabilities were transferred to the Department of Transportation in Washington, D.C.[79] New York's Attorney General proposed the end of the NYPD's involvement with traffic enforcement in September of 2020.[80]

Another potential strategy can be illustrated by a pilot program in Staten Island, New York, aimed at reducing the number of calls for service related to minor collision.[81] When a call comes in regarding a collision, dispatch will determine if the collision is minor or serious enough to merit police response. If a collision is deemed to be minor, all individuals involved in the crash simply complete a collision report and then exchange contact and identification information.[82]

Lastly, ending pre-textual stops for minor traffic infractions, as proposed by the Berkeley Mayor's Fair and Impartial Policing Workgroup and approved by the City Council in March 2021, could significantly reduce traffic stops. This issue is addressed in more detail in the Policing section of this report.

Neighbor Disputes

Police officers are frequently the first personnel called in when there is a dispute, even a minor one, between neighbors. These events can encompass a broad array of issues, from property damage, blocking a driveway, to noise complaints. Even if police do intervene, the solution is often only temporarily, rather than resolving the root problems that caused the conflict. Police response wastes time and resources and can lead to escalation and violence. Furthermore, neighbor conflicts in low-income and communities of color have a higher likelihood of resulting in an arrest.[83]

74 https://openpolicing.stanford.edu/findings/
75 https://sites.google.com/view/saferstreetsberkeley/home
76 https://www.ghsa.org/state-laws/issues/speed%20and%20red%20light%20cameras
77 https://www.governing.com/archive/gov-cities-hit-brakes-red-light-cameras.html
78 https://theappeal.org/traffic-enforcement-without-police/
79 https://www.washingtonpost.com/transportation/2019/10/01/bowser-does-an-end-run-around-dc-council-transfers-speed-red-light-camera-program-ddot/https://www.washingtonpost.com/transportation/2019/10/01/bowser-does-an-end-run-around-dc-council-transfers-speed-red-light-camera-program-ddot/
80 https://apnews.com/article/bronx-arrests-traffic-archive-new-york-c93fa5fc03f25c2b625d36e4c75d1691
81 https://www.silive.com/news/2019/03/nypd-dont-call-911-for-crashes-without-injuries.html
82 https://abc7ny.com/traffic/nypd-rolls-out-pilot-program-wont-respond-to-every-accident/5205383/
83 https://mdmediation.org/wp-content/uploads/2019/10/Giving_Police_and_Courts_a_Break.pdf

Community mediation is a strategy that has proven to reduce police calls for service and decrease the burden on police for nuisance complaints. Several cities have implemented community mediation programs to utilize non-enforcement options to resolve neighbor disputes. In areas where community mediation is prioritized, neighborhood social ties are strengthened, and communities are more harmonious. Moreover, residents who participate in community mediation use less court and police resources. In a study analyzing mediation's effect in Baltimore, Maryland, for example, researchers found that community mediation for neighbor disputes decreased calls for service to the Baltimore Police Department. For a single mediation session, the Baltimore Police Department produced cost savings between $208 and $1,649. Among individuals who went through a mediation, the likelihood of arrest and prosecution was lower when compared to those who did not participate.[84]

Neighbor disputes can also be triaged through a 311 system. Priority is given to complaints based on frequency and the potential to escalate into violence. Outsourcing responses to neighborhood organizations and associations that can operate in conjunction with police officers can be valuable in order to promote a peaceful resolution to violent disputes. These organizations can also conduct sweeps through neighborhoods in order to gain valuable information regarding any disputes.[85]

Substance Use

In 2016, 25 percent of lethal law enforcement shootings in the US affected individuals undergoing behavioral health or substance use crises.[86] Data regarding drug-related charges demonstrates that Black and LGBTQIA+ individuals are disproportionately charged and experience lower rates of treatment.[87,88] In addition, calls for service stemming from substance use place an undue strain on emergency departments as well as jails, both of which are often ill-equipped to handle substance use crises. Amid the COVID-19 pandemic, increases in drug and opioid related overdoses have been observed across California, underscoring the need for adequate substance use response.[89]

It is important to note that this "adequate response" must reflect the reality that successfully addressing substance use is about management, not halting usage.

The establishment of safe injection facilities (SIF) is a potential avenue for reduction of drug-related deaths. These facilities are supervised areas that allow the uptake of drugs in a safe and hygienic setting.

There are a plethora of positive impacts that stem from SIF implementation. SIF have prevented thousands of overdoses with most reporting zero overdose fatalities.[90] Studies have noted a significant decrease in transference of blood-borne diseases such as HIV and Hepatitis B/C at SIFs due to their clinical standards.[91] An increase in uptake of treatment for substance use disorder was also observed after SIF involvement. An evaluation done by the Vancouver Mental Health and Addiction Services demonstrated a significant curtailment of drug injection in public areas as well as a reduction in associated litter post-SIF implementation.[92] SIFs have also been shown to reduce emergency ambulatory calls for service while open.[93]

San Francisco recently approved a bill that would implement safe injection facilities in the City.[94] The Department of Public Health would oversee the establishment of two pilot SIFs. The City estimates that cost savings generated by reducing HIV and Hepatitis C caseload would be approximately $3.5 million annually.[95]

84 Id.
85 https://popcenter.asu.edu/sites/default/files/2020-spi_spotlight_series-retailiatoryviolentdisputes_final.pdf
86 https://www.washingtonpost.com/graphics/national/police-shootings-2016/
87 https://www.americanprogress.org/press/release/2016/02/23/131547/release-broken-criminal-justice-system-disproportionately-targets-and-harms-lgbt-people/
88 https://www.marylandaddictionrecovery.com/impact-of-addiction-african-american-community/
89 https://www.ama-assn.org/system/files/2020-12/issue-brief-increases-in-opioid-related-overdose.pdf
90 https://www.ohtn.on.ca/rapid-response-83-supervised-injection/
91 Id.
92 http://www.healthyalamedacounty.org/promisepractice/index/view?pid=3840c
93 https://kingcounty.gov/~/media/depts/community-human-services/behavioral-health-recovery/documents/herointf/Safe_Consumption_Facilities_Evidence_Models.ashx?la=en
94 https://www.ktvu.com/news/san-francisco-supervisors-unanimously-approve-legislation-for-safe-injection-sites
95 https://www.glide.org/safe-injection-sites-are-coming-to-san-francisco/

Syringe services programs (SSPs), also known as Needle Exchange Programs (NEPs), are a harm reduction mechanism that offer individuals with hygienic and safe needles and syringes along with referrals to other services. These services can include further medical care, treatment programs, and therapy access. SSPs also provide testing for diseases, vaccinations, and naloxone dispensation. A critical component of SSPs is the communication of education regarding overdose signs and proper injection technique. They are typically overseen by local public health departments that work in conjunction with community-based organizations.[96]

Numerous benefits have been linked to proper SSP implementation including decreases in the rate of drug use frequency when compared with individuals who have never utilized an SSP.[97] Sterile equipment provided by SSPs is also associated with a reduction in bloodborne infections, sexually transmitted diseases, and other health issues. When an SSP is instituted in a community, there is no corresponding increase in drug usage or crime in the area.[98]

The Needle Exchange Program in Baltimore, Maryland provides clean needles to intravenous drug users in order to reduce related health issues. There are currently 16 locations across Baltimore, with plans for expansion.[99] An evaluation of the intervention program found that participation in the program was correlated with a 33 percent increase in the likelihood of entering treatment.[100]

Berkeley's Needle Exchange Emergency Distribution (NEED) is an SSP operating out of a mobile van created in 1990. Naloxone training, fentanyl testing strips, and screening for HIV/ AIDS are all offered via one of NEED's three sites.[101] Berkeley's NEED program is currently funded by grants from the City of Berkeley and Alameda County.[102]

Street outreach programs that connect intravenous drug users and individuals suffering from substance use disorder to services are also beneficial.

The City of San Francisco is launching a sobering site for individuals using methamphetamines. In non-emergent cases, clients will be transported to the sobering site and offered medication such as antipsychotics or sedatives. This site will reduce the burden on emergency departments and free up psychiatric services in hospitals.[103] HealthRIGHT 360, a community-based organization, will oversee the sobering site after it is opened.[104] In order to recruit clients to the sobering center, the site will collaborate with San Francisco's Street Crisis Response Team (SCRT), referenced in detail in the Emerging Non-Enforcement Models of Community Response section of this report.

The Arlington Opiate Outreach Initiative was created in 2015 in Arlington, Massachusetts. The partnership brings together social workers, community-based organizations, health workers, and public health clinicians housed in the Arlington Police Department in order to foster relationships with residents of the community and then connect them to treatment and supports. Individuals in the community are identified for possible treatment after frequent police encounters, prior history of drug usage, or previous hospitalization related to overdoses.[105] Public health clinicians will then attempt to engage the identified community member through home visits, contact with family/ friends, and provision of naloxone kits.

Conversations for Change, a program based in Dayton, Ohio, is marked by its emphasis on meetings that serve to engage the community and offer residents education regarding potential treatment choices and services. The program is a partnership between the Dayton Police Department and East End Community Services, a non-profit, community-based organization. Individuals are recruited through an array of avenues, from parole officers to community-based organizations that are involved

96 https://www.cdc.gov/ssp/syringe-services-programs-faq.html
97 https://pubmed.ncbi.nlm.nih.gov/11027894/
98 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446444/
99 https://health.baltimorecity.gov/hiv-std-services/community-risk-reduction
100 https://pubmed.ncbi.nlm.nih.gov/16364566/
101 https://www.berkeleyneed.org/sp/index.php
102 https://pha.berkeley.edu/2019/12/01/the-needle-exchange-program-crisis/
103 https://www.sfdph.org/dph/files/MethTaskForce/Meth%20Task%20Force%20Final%20Report_FULL.pdf
104 https://www.sfexaminer.com/news-columnists/new-search-launched-for-meth-sobering-center-site/
105 https://icjia.illinois.gov/researchhub/articles/rethinking-law-enforcement-s-role-on-drugs-community-drug-intervention-and-diversion-efforts#fnref52#fn44

with substance use disorders. Monetary benefits in the form of grocery store gift cards are used to incentivize individuals to attend meetings. Meetings first involve a direct, one-on-one conversation with a motivational mediator from the Dayton Mediation Center about a client's current status and goals. After this initial conversation, presentations from health officials and residents with similar lived experiences are given. Providers finally offer naloxone training to the clients at the meetings.[106] The Conversations for Change program also includes an SSP.[107]

A more direct approach to curbing the impact of substance use disorders on the demand for policing is decriminalization.

Oregon became the first state in the United States to decriminalize the possession of all drugs effective February 2021. Possessing heroin, cocaine, methamphetamine and other drugs for personal use is no longer a criminal offense in Oregon.[108]

Those drugs are still against the law, as is selling them. But possession is now a civil – not criminal – violation that may result in a fine or court-ordered therapy, not jail.

There are three main arguments for decriminalization:

1 Criminalization has failed

The reason for punishing drug users is to deter drug use. But decades of research have found the deterrent effect of strict criminal punishment to be small, if it exists at all. This is especially true among young people.

Because criminalizing drugs does not really prevent drug use, decriminalizing has not been found to increase it. Portugal, which decriminalized the personal possession of all drugs in 2001 in response to high illicit drug use, has much lower rates of drug use than the European average. Use of cocaine among young adults age 15 to 34, for example, is 0.3 percent in Portugal, compared to 2.1 percent across the EU.

2 Decriminalization allows reinvestment in treatment

Arresting, prosecuting and imprisoning people for drug-related crimes is expensive.

The Harvard economist Jeffrey Miron estimates that all government drug prohibition-related expenditures were $47.8 billion in 2016. Money spent arresting, prosecuting and incarcerating individuals for drug-related offenses can be more effectively, from both outcomes and cost perspectives, reinvested in treatment services.

3 The drug war disproportionately impacts people of color

Another aim of decriminalization is to mitigate the significant racial and ethnic disparities associated with drug enforcement.

Illegal drug use is roughly comparable across races in the U.S. But people of color are significantly more likely to be searched, arrested and imprisoned for a drug-related offense.

106 Id.
107 https://icjia.illinois.gov/researchhub/articles/rethinking-law-enforcement-s-role-on-drugs-community-drug-intervention-and-diversion-efforts#fnref52#fn46
108 Oregon discussion draws heavily from: https://www.usnews.com/news/best-states/articles/2020-12-10/oregon-just-decriminalized-all-drugs-heres-why-voters-passed-this-groundbreaking-reform

COMMUNITY DRIVEN VIOLENCE REDUCTION STRATEGIES

Crime is often concentrated low-income neighborhoods, with Black and Latinx individuals disproportionately experiencing higher rates of violence. These 'hot spots' of violent crime experience a complex array of challenges, ranging from high rates of poverty and incarceration to poor quality education and a lack of trust in government institutions. Unfortunately, the effects of exposure to violence are widespread, affecting the health and development of not only those directly involved but also that of their families and communities. Neighborhoods with these characteristics necessitate immediate intervention to disrupt the cycle of interpersonal violence and its devastating consequences.[109]

There has however been consistent success in a small number of effective strategies summarized briefly below and described more comprehensively in a 2021 NICJR publication, Four Proven Violence Reduction Strategies. When implemented with fidelity, these interventions have been successful at reducing violence, with many initiatives showing improvements in the first six to twelve months of implementation.

The four highlighted strategies, Gun Violence Reduction Strategy, Hospital-Based Violence Intervention, Office of Neighborhood Safety/ Advance Peace, and Street Outreach – all incorporate similar best practices:

- Identifying and focusing on individuals, groups, and communities at the highest risk of being involved in violence;
- Employing Credible Messengers/community outreach workers to engage those individuals/ groups in a positive and trusting manner; and
- Providing ongoing services, supports, and opportunities to high-risk individuals.

These core elements are essential to the success of any violence intervention strategy.

Gun Violence Reduction Strategy

Gun Violence Reduction Strategy (GVRS) is known by many other names: Ceasefire, Focused Deterrence, and Group Violence Intervention. GVRS is a comprehensive strategy that utilizes a data-driven process to identify the individuals and groups at the highest risk of committing or being involved in gun violence and deploying effective interventions with these individuals. Initially developed in Boston, where it was referred to as the "Boston Miracle", GVRS has evolved as it has been implemented in cities including Oakland and Stockton, California, to include more in-depth and intensive services and supports.[110]

Identification of Program Participants

GVRS employs a data-driven process to identify the individual and groups who are at the very highest risk of being involved in a shooting. This involves an initial Gun Violence Problem Analysis, which provides a thorough examination of the shootings and homicides in a given city over the past two to three years in order to produce information about victim and suspect demographics, group conflicts in the area, prior history of violence, and general trends.

109 https://www.huduser.gov/portal/periodicals/em/summer16/highlight2.html

110 https://www.theguardian.com/cities/2018/dec/06/bostons-miracle-how-free-nappies-and-a-little-mentoring-are-curbing

Engagement: Direct and Respectful Communication

Once high-risk individuals and groups are identified, the GVRS strategy requires immediate engagement. This engagement involves direct and respectful communication to inform identified individuals of their risk and offering them services. There are two primary formats for these discussions: Group meetings, referred to as "Call-Ins" and individual meetings, sometimes referred to as "Customized Notifications". At Call-Ins, the recently identified very high-risk individuals are invited to attend a meeting with community leaders, law enforcement officials, formerly incarcerated individuals, survivors of violence, and service providers. Custom Notifications convey similar messages about the risk of violence and the availability of services. However, Custom Notifications are individual meetings where a high-ranking police officer and a community leader directly make contact with an individual at their home or community.

Provision of Services

Subsequent to a Call-In or a Custom Notification, individuals identified as being at very high risk of gun violence are directly connected to available services, supports, and opportunities. The first and primary service is a positive and trusting relationship with a Life Coach or Violence Intervention worker, someone with similar lived experiences as the people they are serving. These individuals are often known as Credible Messengers. The Life Coach or Intervention Worker is an intensive and personal relationship – which is the most important aspect of the services. Unlike service brokering based case management, contact between the Life Coach and the client must be frequent, flexible, consistent, and on-going for a long period of time.

In Oakland's GVRS, clients are also eligible to receive monthly, modest financial incentive stipends for achieving certain milestones.

Focused Enforcement

One of the overt goals of GVRS is to reduce the footprint of police by focusing enforcement on serious and violent crime. For those individuals and groups who do not respond to the GVRS message and continue to engage in violence, this means that there is follow-up supervision and focused enforcement by police, probation, parole, and prosecutors; enforcement action is not taken simply for failure to participate in GVRS programming.

Hospital-Based Violence Intervention Programs (HVIPs)

Hospital-Based Violence Intervention Programs (HVIP), view violence through a public health-centered lens. Analogous to the spread of an illness, violence has been shown to proliferate with increased proximity and exposure to others.[111] That is, contact with violence itself increases the probability that those exposed will be directly involved in violence.[112]

Identification of Program Participants

Under the HVIP model, the physical location of a trauma center or emergency room is seen as valuable in the fight against violence. One of the major risk factors for future violence is a history of previous violence. With this in mind, the HVIP model places the responsibility for identifying clients with hospital workers who pinpoint patients that are at highest likelihood for future victimization.

Engagement Strategy

HVIPs make use of the distinct cross-section of time—known as a "teachable moment"— in which after an injury an individual is open to making changes in their behavior and circumstances. During this time period, specialized hospital staff and community-based partners come together in support of the patient in order to diminish the chance of retaliation and further violence. HVIPs are especially important right now in the fight against violence, as injury recidivism rates have been shown to be as high as 60 percent in certain areas.[113]

Provision of Services

Once this initial bond is created, Intervention Specialists construct a comprehensive plan with their clients to spur on meaningful change. These plans typically include non-violent crisis management methods, counseling for both the client and their family, information on risks and outcomes associated with violence, as well as access to community services including employment assistance, mentoring, education, and court assistance. Consultation with family and health providers is necessary to develop a plan that is feasible and trauma-informed.

Office of Neighborhood Safety/ Advance Peace

In 2007, the City of Richmond, CA launched the Office of Neighborhood Safety (ONS), amid escalating homicide rates and increasing numbers of firearm cases. Prior to the establishment of the ONS, the Richmond City Council analyzed violence in Richmond and found that gun violence disproportionately affected Black men aged 18-24, with that population constituting 73 percent of homicide fatalities.[114] This finding served as the basis for the creation of the Office of Neighborhood Safety.

Identification of Program Participants

The ONS employs a data-driven approach in identification of individuals at highest risk. Leveraging their relationships in the community, ONS Neighborhood Change Agents (NCA) conduct daily sweeps of their communities, an effort that provides a continuous flow of critical information that informs staff response. NCAs are able to gather information regarding those individuals that are most prone to violence, current conflicts or family issues that may result in violence, and other information that is used to directly inform subsequent intervention activity.

111 https://www.cdc.gov/injury/wisqars/fatal.html
112 https://www.ncbi.nlm.nih.gov/books/NBK207245/
113 https://journals.lww.com/jtrauma/Abstract/2020/08000/Recidivism_rates_following_firearm_injury_as.17.aspx
114 https://www.evidentchange.org/sites/default/files/publication_pdf/ons-process-evaluation.pdf

In addition, ONS obtains data from the Richmond Police Department (RPD) to support identification of those individuals at highest risk based on the data from law enforcement.

Provision of Services

ONS's main program is the Peacemaker Fellowship. ® The Peacemaker Fellowship interrupts gun violence by providing transformational opportunities to young men involved in lethal firearm offenses and placing them in a high-touch, personalized fellowship.

The Fellowship provides life coaching, mentoring, connection to needed services and cultural and educational excursions, known as Transformative Travel, to those deemed to be the most dangerous individuals in the city. Fellows travel across the country and to several international destinations. Fellows can also receive significant financial incentives for participation and positive behavior as a gateway to developing intrinsic motivation that arises from internal and not external rewards.

Street Outreach

Referred to by a variety of names and long seen as the primary entry point for violence reduction programs, Street Outreach can be an effective intervention when implemented correctly. A number of organizations and programs throughout the country have successfully operated Street Outreach initiatives, including Urban Peace Initiative in Los Angeles, who also provide a Street Outreach training academy; the Newark Community Street Team; and the Professional Community Intervention Training Institute.

Identification of Program Participants

Street Outreach programs are designed to address the manner in which violence spreads from person to person. Studies show that those who have been continually in contact with violence can be thirty times more likely to commit a violent act in the

SEVEN TOUCHPOINTS:

future.[115] Moreover, violence often has ripple effects in the community, whether it be in the form of retaliation or further escalation of conflict.[116]

Because of this pattern in violence, Street Outreach programs recognize potentially lethal conflicts in the community by utilizing trained Violence Interrupters. These Violence Interrupters identify ongoing conflicts by speaking to key members of the community about ongoing disputes. Information regarding arrests, prison releases, and prior criminal history are also utilized to pinpoint violent outbreaks.[117]

Engagement and Services Strategy

Engagement is primarily facilitated by the work of trained Violence Interrupters. Following a shooting, these individuals immediately operate in the community and at hospitals to pacify heightened emotions and prevent retaliations. This involves coordination with local groups and business owners to hold constructive dialogue around community violence and the appropriate actions to take in response. Events are then organized by Violence Interrupters to promote a change in overall neighborhood attitudes towards violence.

115 https://1vp6u534z5kr2qmr0w11t7ub-wpengine.netdna-ssl.com/wp-content/uploads/2019/09/Infographic-Top-10-v1.pdf
116 https://www.lagryd.org/mission-comprehensive-strategy
117 https://cvg.org/what-we-do/

POLICE TRAINING

The following strategies have shown to be effective in reducing crime, resolving incidents, and improving the quality of policing without a focus on heavy-handed enforcement.

SARA Problem Solving Model

The Scanning, Analysis, Response, and Assessment (SARA) model was created in Virginia in 1987 to facilitate the problem-oriented policing procedure.[118] The cornerstone of this model is a priority on outcomes; the model outlines four steps that are necessary for a proper police response to problems within their jurisdictions. To ensure proper implementation, a significant facet of this method is that officers must be ready to build trust between the community and the police department through the establishment of interpersonal relationships.[119]

Scanning. This step consists of pinpointing and then triaging repeated issues that necessitate a response from the police department.[120] Frequent problems that occur in the community are given priority. Relevant outcomes of the problem are matched to their corresponding cause. For example, examining which properties in a given area have the highest number of calls for service in a year or given time period is an important initial step in the SARA model.

Analysis. Here, law enforcement officers examine the root causes of the issue, community sentiment regarding the problem, and gather needed contextual data.48 This step also involves assessing the status quo response to the problem and identifying the shortcomings of that strategy. Ultimately, the cause of the problem and potential solutions are determined during this phase.

Response. Officers utilize collected data to ascertain potential intervention strategies. When determining strategies, a thorough review of implemented interventions in different areas with comparable issues is critical. Once a strategy is selected, clear goals must also be established. Execution of the chosen plan is the last part of this step.

Assess. After a plan is implemented and officers have attempted to address a problem, the police department must analyze the efficacy of their strategy. Continued evaluation of the intervention is necessary to guarantee lasting success. Alternatives or additions to the strategy are considered as well.[121]

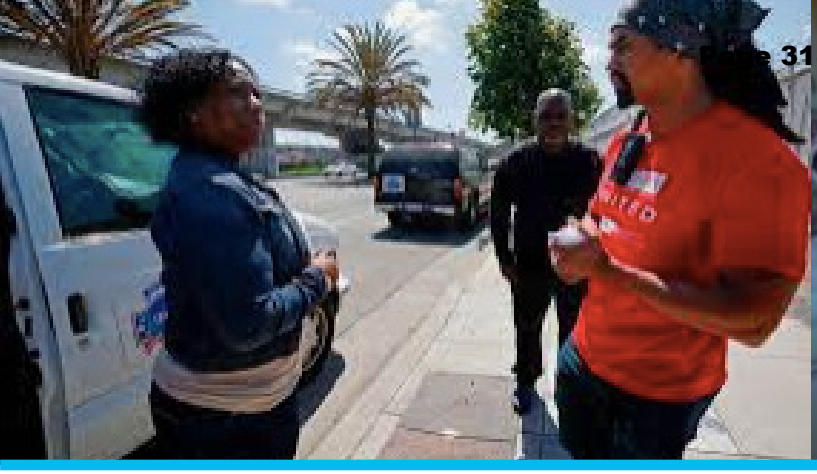
Many police departments have incorporated the SARA model into their interventions. In San Diego, the police department reported that a trolley station was the location of gang fights, violent crimes, and narcotic activity. A squad of officers collected information to show the local transit board that the design of the station contributed to crime. Based on the information provided by the officers, the transit board agreed to provide funds to redesign the station.[122]

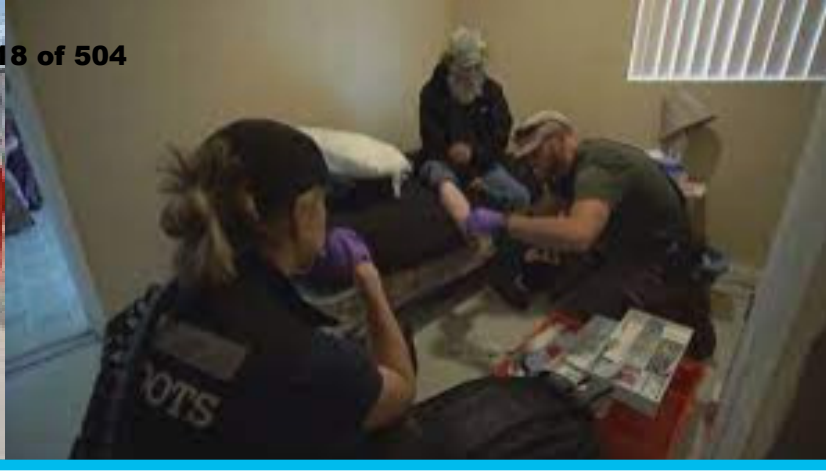
Ethical Policing Is Courageous (EPIC)

The EPIC program is a peer-to-peer intervention strategy that was created by the police department in New Orleans, Louisiana in 2016. EPIC involves training officers to be accountable to each other and intervene before an unlawful act takes place, irrespective of hierarchy. This initiative aims to alter the culture surrounding policing in order to limit police misbehavior and promote a collaborative environment.[123]

The EPIC program is founded on active bystandership psychology, which explains that active bystanders intercede when they are made aware of problematic behavior. EPIC training allows officers to overcome factors that may prevent them from intervening.

118 https://www.researchgate.net/publication/297556988_Police_innovation_Contrasting_perspectives
119 https://movementforward.org/a-look-inside-strategies-contributing-towards-community-policing-sara-model/
120 https://www.evidence-basedpolicing.org/refresher-sara-model-and-problem-oriented-policing/
121 https://movementforward.org/a-look-inside-strategies-contributing-towards-community-policing-sara-model/
122 https://www.sandiego.gov/department/problem-oriented-policing
123 http://epic.nola.gov/home/





These factors include a lack of confidence in their skills to deescalate a situation, uneasiness about potential retribution, and worry about breaking an unwritten code of silence.[124]

Leadership in police departments who participate in the EPIC program must be committed to changing their organizational culture. Police departments implementing EPIC must provide education, training, and on-going learning and support to officers for the initiative to be successful. EPIC can also integrate with other initiatives to boost officer well-being, including counseling and trauma assistance as well as stress reduction education.[125]

Areas where EPIC programs have been implemented have better community relations, lower rates of misconduct, and lower rates of public grievances. The majority of the feedback from New Orleans police officers has also been positive.[126] Moreover, there is strong research that peer intervention is effective when successful strategies for interceding are provided.[127]

Project Active Bystandership for Law Enforcement (ABLE)

Project ABLE is a joint effort between the Georgetown Innovative Policing Program and the Sheppard Mullin law firm to train officers to be able to properly intervene in a crisis situation and promote a policing atmosphere that reinforces peer intervention. Project ABLE is based on the principles of the New Orleans EPIC Peer Intervention Program and curriculum created by Dr. Ervin Staub for California law enforcement. Through Georgetown, law enforcement agencies are able to receive training in Project ABLE along with a host of other resources to assist them in advancing their own bystandership strategies.[128,129] The training consists of a minimum of a one-time eight hour ABLE-specific training along with a minimum of two hours of annual refresher training.[130] All of these resources are provided to law enforcement agencies free of charge.

Project ABLE's aim is to reduce police misconduct and errors and assist in improving officer health and well-being. In order to prevent any retaliation from occurring to those officers who intervene, police departments must implement stringent anti-retaliation guidelines. Since its inception, over 70 police departments have enlisted in Project ABLE.[131]

Research has shown that there are many advantages to the implementation of significant bystander training. This is critical because most police departments have a culture that dissuades officers from intervening when they see problematic behaviors.[132] Identified benefits include a decrease in violence to civilians, a decrease in violence to police officers, enhanced relationships between community residents and the police officers,

124 http://epic.nola.gov/epic/media/Assets/EPIC-Overview.pdf
125 Id.
126 https://www.apa.org/monitor/2017/10/police-misconduct
127 https://epic.nola.gov/epic/media/Assets/Aronie-Lopez,-Keeping-Each-Other-Safe.pdf

128 https://www.law.georgetown.edu/innovative-policing-program/active-bystandership-for-law-enforcement/
129 https://www.law.georgetown.edu/innovative-policing-program/active-bystandership-for-law-enforcement/our-mission/
130 https://www.law.georgetown.edu/innovative-policing-program/active-bystandership-for-law-enforcement/able-program-standards/
131 https://www.wsj.com/articles/nypd-officers-to-get-training-on-speaking-up-against-bad-policing-11611838809
132 https://assets.foleon.com/eu-west-2/uploads-7e3kk3/41697/pdf_-_duty_to_intervene.6e39a04b07b6.pdf

and growth in officer well-being.[133] Evidence also suggests a strong correlation between departments that maintain robust duty to intervene protocols and decreased rates of police deaths per capita.

Community Safety Partnership (Watts)

Established in November 2011, the Community Safety Partnership (CSP) is a joint effort between the Los Angeles Police Department (LAPD), the Housing Authority of the City of LA (HACLA), and local residents.[134] The program was created in order to address the high violence levels in housing developments in the Watts area and offer residents there supports and services. The broader goal of the CSP is to implement "relationship-based policing." This process involves police officers creating legitimate relationships with residents of their precinct in order to meaningfully benefit community wellness for the long-term.[135] One of the major stakeholders in the project is the Watts Gang Task Force, a team of neighborhood residents, local faith leaders, and other community-based organizations.

Along with high violence rates, the community was also grappling with concentrated poverty, low education quality, and deteriorating physical infrastructure. Community engagement initiatives the CSP implemented in response include a football team coached by police officers, Fun Runs, health fairs, and organized walks for residents to interact with officers in a non-confrontational setting.[136,137]

In 2020, the CSP Bureau was formed within LAPD to expand the work that was achieved in Watts citywide. The LAPD also consolidated CSP programs creating a centralized point of contact and engagement for the community. The main objectives of the CSP Bureau were to serve as a resource for officer--community interaction and promotion of neighborhood safety.[138]

The CSP Bureau is also responsible for certifying and training officers for 5-year terms. CSP officers undergo over 100 hours of education from the nonprofit Urban Peace Institute. The training centers on cultural competency, de-escalation skills, and understanding community data.[139]

Originally formed for one housing site, CSP has spread to ten additional developments. In 2017, the program was broadened to the Harvard Park area due to its efficacy. During the initial three years after the CSP's formation, both violent offenses and arrest rates decreased by over 50 percent in the Watts housing developments. One Watts location even had three consecutive years without a homicide. Residents of these Watts developments have even reported increased perceptions of safety along with greater trust in the police.[140] An evaluation of CSP by UCLA found that this effort reduced crime, arrest rates, and use of force grievances from residents.[141]

Focused Deterrence

Focused Deterrence strategies involve the communication of risks, ramifications, and avenues of support to individuals involved in gun violence. This strategy is based on the fact that a very small number of people are responsible for a large portion of gun violence.

One of the most prominent implementations of focused deterrence is Boston, Massachusetts's Operation Ceasefire. Experiencing an increase in violence, Boston police identified and communicated with individuals and groups that were pinpointed as most at risk of engaging in violence.[142] Boston police also partnered with the Boston Ten Point Coalition, a group of faith and community leaders,

133 https://www.law.georgetown.edu/innovative-policing-program/active-bystandership-for-law-enforcement/able-program-standards/
134 https://www.lamayor.org/mayor-garcetti-announces-new-expansion-community-safety-partnership
135 https://static1.squarespace.com/static/55b673c0e4b0cf84699bdffb/t/5a1890acec212d9bd3b8f52d/ 1511559341778/President%27s+Task+Force+CSP+Policy+Brief+FINAL+02-27-15updated.pdf
136 https://lasentinel.net/hundreds-of-south-la-residents-attend-launch-of-community-safety-partnership-in-harvard-park.html
137 https://empowerla.org/lapds-community-relationship-division/
138 https://www.lamayor.org/mayor-garcetti-announces-creation-lapd-community-safety-partnership-bureau
139 https://static1.squarespace.com/static/55b673c0e4b0cf84699bdffb/t/5a1890acec212d9bd3b8f52d/ 1511559341778/President%27s+Task+Force+CSP+Policy+Brief+FINAL+02-27-15updated.pdf
140 Id.
141 https://www.lamayor.org/mayor-garcetti-announces-creation-lapd-community-safety-partnership-bureau
142 https://cebcp.org/evidence-based-policing/what-works-in-policing/research-evidence-review/focused-deterrence/

in order to provide support and services to these targeted individuals and groups. Oakland has also implemented a version of Focused Deterrence that is profiled in the Gun Violence Reduction section of this report.

Focused Deterrence strategies are often tailored to the location in which they are being implemented. Project Safe Neighborhoods in Lowell, Massachusetts, instituted this strategy in areas of high crime. Lowell dealt with a significant Asian gang presence largely comprising youth involved in illicit gambling operations. In order to address the youth violence, the City of Lowell worked with older Asian males in charge of the gambling. The older Asians intervened in youth violence in order to prevent their gambling enterprise from being destroyed. Lowell experienced a major decline in adolescent violence following the implementation of this Focused Deterrence strategy.[143]

After Ceasefire was implemented in Boston, evaluations found a 63 percent drop in youth homicides and a 32 percent decline in calls for service related to gun violence.[144] A meta-analysis of several Focused Deterrence strategies found steady reductions in violent crime of up to 60 percent, particularly for group and gang related violence.[145]

Elimination of Pretextual Stops

Pretextual or pretext traffic stops occur when police officers stop a driver for a minor violation, like vehicle equipment failure, and then try to leverage that opportunity to find evidence of a more significant crime. A recent evaluation of 100 million traffic encounters demonstrated that Black and Latino drivers experience higher rates of pretextual stops and searches.[146] However, most of these stops do not actually yield any contraband or weapons.[147] Because the nature of pretextual stops relies heavily on officer discretion, there is high likelihood that implicit racial biases come into play. Such stops that end in violence or death disproportionately affect Black and Latino drivers.[148]

Elimination of pretextual stops does not negatively affect crime. An analysis by the police department in Fayetteville, North Carolina showed that violent crime was not affected after the police department reformed its use of pretextual stops.[149]

Pretextual stops are in the process of being regulated in many states across the country. Oregon's Supreme Court ruled in November 2019 that it was unconstitutional for police to stop a driver and proceed to ask unrelated questions, thereby effectively banning pretextual stops.[150] Virginia policy makers are also considering restricting pretextual stops.[151] Other legislation has been introduced across the country that prevents police officers from conducting certain types of pretextual stops including, for example, broken tail or brake lights, objects obstructing the rearview mirror, and tinted windows.[152] Advocates of these bills state the proposed limitations would decrease racial incongruities in traffic stops.[153] The Berkeley City Council has already approved the formation of BerkDOT in order to address and decrease the frequency of pretextual traffic stops.[154] The City Council also approved the Mayor's Fair and Impartial Policing Workgroup's recommendations, which includes elimination of pretextual stops.

Ethical Society of Police (ESOP)

Instituted in 1972 by Black St. Louis Metropolitan Police Department officers, the Ethical Society of Police (ESOP) is a police union that was created in order to combat systemic racism within the

143 https://cebcp.org/evidence-based-policing/what-works-in-policing/research-evidence-review/focused-deterrence/
144 https://www.ojp.gov/pdffiles1/nij/188741.pdf
145 https://prohic.nl/wp-content/uploads/2020/11/2020-03-31-FocussedDeterrenceBraga.September2019.pdf
146 https://www.vera.org/blog/ending-pretextual-stops-is-an-important-step-toward-racial-justice
147 https://www.law.upenn.edu/live/files/7898-rudovskyoslj
148 https://www.berkeleyside.com/2021/03/02/opinion-for-berkeley-to-reimagine-public-safety-we-must-grapple-with-traffic-enforcement
149 https://injepijournal.biomedcentral.com/articles/10.1186/s40621-019-0227-6
150 https://www.opb.org/news/article/oregon-supreme-court-bans-police-officers-random-questions/
151 https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2020/09/03/police-pretext-traffic-stops-need-to-end-some-lawmakers-say
152 https://theappeal.org/traffic-enforcement-without-police/
153 https://www.dailypress.com/news/crime/dp-nw-northam-legislation-traffic-20201021-3f2tmucyl5csdmbhhv2zh3atya-story.html
154 https://www.berkeleyside.com/2021/03/02/opinion-for-berkeley-to-reimagine-public-safety-we-must-grapple-with-traffic-enforcement

department and greater community. The group is comprised of 220 members, who are either police officers or civilian contractors.[155] The organization recently scaled up to include the St. Louis County Police Department. ESOP has been particularly outspoken in cases of police wrongdoing. The group places a higher premium on ethical decision making, even though openly criticizing actions of their fellow police officers can be difficult.

Most recently, ESOP condemned the actions of a police officer in Brooklyn Center, Minnesota that resulted in the death of Daunte Wright, expressing that the officer was irresponsible in upholding her duties.[156] ESOP has also sponsored many events in order to improve relationships between police officers and their community including Pizza with a Cop, community clean-up days, and basketball games. In August of 2020, ESOP also released a groundbreaking report that details systemic racism throughout the St. Louis Metropolitan Police Department.

Chicago PD Black Public Safety Alliance (BPSA)

A group of Black Chicago Police Department (CPD) officers created the Black Public Safety Alliance (BPSA) in 2021.[157] The organization serves to give Black police officers a voice amidst the deep-rooted issues between communities of color and the CPD. The BPSA was created in response to concerns with the broader Fraternal Order of Police (FOP).[158] Officers in the BPSA have explained they "...do not feel supported or comfortable at the FOP," especially after the local police union refused to undergo mandated precinct reform to promote trust in the community.[159]

The formation of the alliance is a reflection of the national conversation that was ignited by George Floyd's death. The members of BPSA have expressed that advocating for the Black community is one of their main goals, even if that involves challenging the status quo. Currently operating as a nonprofit, the BPSA has established working groups on diversity policies, adolescent coaching, and police reform.[160]

Police Diversity

With the recent demands for law enforcement to address racial injustice and the disparate impact of policing on communities of color, diversity in the ranks of officers has emerged as a potential area of reform. In a New York Times analysis of federal Bureau of Justice Statistics data on nearly 500 police departments across the country, more than 66 percent of the departments experienced a reduction in diversity and became more white from 2007 to 2016. Although the share of police officers of color has risen in that time period as well, the demographics of police departments do not reflect the demographics of communities they serve.[161] Black officers are twice as likely than their white counterparts to espouse the belief that the deaths of people of color at the hands of police officers are a legitimate problem.[162]

Diversity in law enforcement is correlated with stronger bonds between a department and the community they serve, particularly communities of color. Use of force grievances have also been shown to decrease when there are more non-white officers in leadership positions.[163] A new comprehensive study of police diversity in Chicago, Illinois was conducted by a group of academics from Princeton University, Columbia University, the Wharton School of Business, and the University of California at Irvine. Their research concluded that, "Relative to white officers, Black and Hispanic officers make far fewer stops and arrests, and they use force less often, especially against Black civilians. These effects are

155 https://img1.wsimg.com/blobby/go/64ce42b7-f768-43ed-9590-dbd611afb7b6/downloads/1c6lj3b8j_482336.pdf?ver=1618276018416
156 https://www.nytimes.com/2021/04/14/opinion/police-officer-unions.html?action=click&module=Opinion&pgtype=Homepage
157 https://www.wbez.org/stories/black-chicago-police-officers-form-new-group/abb12a96-1103-4ced-a068-0ffbfb158da9
158 https://movementforward.org/a-look-inside-strategies-contributing-towards-community-policing-sara-model/
159 https://www.chicagotribune.com/news/criminal-justice/ct-black-chicago-police-organization-20210225-dvbzcs4z3feqvix4sumhcbbgru-story.html
160 Id.
161 https://www.nytimes.com/interactive/2020/09/23/us/bureau-justice-statistics-race.html
162 https://www.pewresearch.org/fact-tank/2017/01/12/black-and-white-officers-see-many-key-aspects-of-policing-differently/
163 https://www.nytimes.com/interactive/2020/09/23/us/bureau-justice-statistics-race.html

largest in majority-Black areas of Chicago and stem from reduced focus on enforcing low-level offenses, with greatest impact on Black civilians. Female officers also use less force than males, a result that holds within all racial groups."[164]

Warrior vs. Guardian Mentality

The mentality of a warrior going to battle and the police force being an occupying army has been referred to as the "warrior mentality" for many years. Instilled, or reinforced, in police officers at the academy, the warrior concept is saturated throughout police culture. The guardian mentality is a newer idea that promotes community engagement, the establishment of meaningful relationships, and providing support to residents.[165]

"From Warriors to Guardians: Recommitting American Police Culture to Democratic Ideals," a report by the Harvard University Kennedy School of Government and the National Institute of Justice, directly addresses the problems of the warrior culture in policing. The report states: "In some communities, the friendly neighborhood beat cop — community guardian — has been replaced with the urban warrior, trained for battle and equipped with the accouterments and weaponry of modern warfare."[166]

The report goes on to highlight problems with police academies and the aggressive, warrior type manner in which new recruits are trained: "Another, more insidious problem in a military-style academy is the behavior modeled by academy staff. Those without power (recruits) submit without question to the authority of those who have power (academy staff). Rule violations are addressed by verbal abuse or physical punishment in the form of pushups and extra laps."[167]

A novel initiative has been implemented at the Washington State Criminal Justice Training Commission (WSCJTC) to try to instill the guardian culture in police departments in the state. The WSCJTC conducts and implements training of over 10,000 police officers annually. Curricular and approach changes include the removal of salute requirements for recruits, motivating instead of criticizing recruits during training, and the incorporation of behavioral education into the curriculum. Early longitudinal evaluations of the WSCJTC program show that the officers that participated in the training felt more comfortable responding to behavioral and mental health crises when compared with officers that did not receive the training.[168] Gains in emotional intelligence and peer support were observed as well.

Accountability

Current police accountability mechanisms are largely perceived to be ineffective. While the challenges in this area are myriad, there are two particularly critical areas of focus in the police accountability conversation, the Law Enforcement Officers' Bill of Rights and Qualified Immunity.

Law Enforcement Officers' Bill of Rights

Sixteen states currently employ some sort of police officer bill of rights, including California. These bills provide workplace safeguards for police officers, including but not limited to erasing misconduct complaints after a time period, a bar against civilian investigation, and a waiting period before any investigation can begin.[169] They have been consistently cited as a central barrier to police accountability in jurisdictions across the country.

Maryland, the state which enacted the first police officer bill of rights and had what many consider the most draconian, recently repealed its Law Enforcement Officers' Bill of Rights in April 2021 in order to increase police accountability drastically.[170] Maryland's replacement legislation involves a stringent use-of-force measure, incorporation of

164 https://scholar.princeton.edu/sites/default/files/bkmr.pdf
165 https://www.sciencedaily.com/releases/2019/02/190226155011.htm
166 https://www.ojp.gov/pdffiles1/nij/248654.pdf
167 https://www.ojp.gov/pdffiles1/nij/248654.pdf
168 https://www.seattleu.edu/media/college-of-arts-and-sciences/departments/criminaljustice/crimeandjusticeresearchcenter/documents/Helfgott-and-Hickman-2021_Longitudinal-Study-of-the-Effect-of-Guardian-Training-for-LE.pdf
169 http://www.cato.org/blog/police-misconduct-law-enforcement-officers-bill-rights
170 https://www.washingtonpost.com/history/2020/08/29/police-bill-of-rights-officers-discipline-maryland/

civilian panels for discipline, and an emphasis on de-escalation tactics.[171]

Qualified Immunity

Qualified immunity, established by the Supreme Court in 1967, effectively protects state and local officials, including police officers, from personal liability unless they are determined to have violated what the court defines as an individual's "clearly established statutory or constitutional rights." The doctrine can be used only in civil cases, not criminal, and allows victims to sue officials for damages only under those circumstances.

Critics and reform advocates say that the doctrine gives officers free rein to use excessive force with impunity and argue that what it defines as "clearly established" law remains largely elusive and difficult to prove, as it requires the victim to present a previous case with nearly identical circumstances that a court ruled as unconstitutional. They also assert the law helps officers escape accountability and prevents victims from achieving justice.

Elimination of qualified immunity is thus another component of increasing police accountability. Colorado and New Mexico[172] have recently passed legislation modifying their respective qualified immunity provisions; similar legislation in California is pending.

The George Floyd Justice in Policing Act of 2020 calls for the national elimination of qualified immunity.[173]

Additional Accountability Measures of Note

A routine check of officers' social media can also be a powerful tool to address potentially racist or other problematic posts. After a 2019 analysis of approximately 4 million stops by police in California, the Racial and Identity Profiling Advisory Board has recommended that police departments perform checks on assigned department software as well as social media accounts in order to identify and hold accountable officers who are actively biased and reflect that bias on the job.[174]

Early intervention systems (EIS) are an additional mechanism by which police accountability can be fostered. These systems analyze a variety of indicators for potentially problematic behavior including use of force incidents, citizen grievances, and disciplinary history. Identification of habitual misconduct by officers is often accomplished through a 'peer officer comparison system,' where officers assigned to the same beat are juxtaposed.[175] Once an officer is identified by the EIS for habitual misconduct, supports, and services to aid the officer are provided in order to encourage officer well-being and aid in

behavioral change. Continued monitoring of officer progress as well as frequent reviews of EIS data are necessary for successful implementation.[176]

171 Id.
172 https://custom.statenet.com/public/resources.cgi?id=ID:bill:NM2021000H4&ciq=ncsl&client_md=562236734bdbcb53a3148c2e8d11ebbd&mode=current_text
173 https://www.congress.gov/bill/116th-congress/house-bill/7120/text
174 https://www.policemag.com/589521/advisory-board-recommends-ca-agencies-check-officers-social-media-activity-for-r
175 https://samuelwalker.net/issues/early-intervention-systems/
176 https://www.policefoundation.org/publication/best-practices-in-early-intervention-system-implementation-and-use-in-law-enforcement-agencies/

POLICE TRAINING

Increased training and education programs are frequently promoted to police departments to help improve the quality of policing and support officers in gaining new skills. As noted by two Columbia Law School professors in an article on police reform, "... training does not take root unless officers are held accountable for obeying the rules and practicing the skills they are taught."[177] Training alone is not adequate to transform a police department or change the behavior of an officer. But combined with culture change, new policies and accountability, training can be an effective tool to improve and reform the police.

Procedural Justice

Procedural Justice in policing improves police-community relations and emphasizes police departments and officers being transparent in their actions, fair in their processes, allowing community voice, and using impartiality in decision making.

According to the Department of Justice's Community Oriented Policing Services, "Procedural justice refers to the idea of fairness in the processes that resolve disputes and allocate resources. It is a concept that, when embraced, promotes positive organizational change and bolsters better relationships."[178]

A comprehensive evaluation of procedural justice training found that "training increased officer support for all of the procedural justice dimensions. . . Post-training, officers were more likely to endorse the importance of giving citizens a voice, granting them dignity and respect, demonstrating neutrality, and (with the least enthusiasm) trusting them to do the right thing."[179]

Several evaluations of procedural justice have found the education has been correlated with an improvement in relations between a community and a police department.[180] In Oakland, the police department trained all officers in procedural justice and provided specialized procedural justice training to the department's gun violence reduction unit. Oakland's police department was also the first department in the country to have members of the

177 https://www.themarshallproject.org/2014/12/19/the-new-new-policing

178 https://cops.usdoj.gov/prodceduraljustice

179 https://www.researchgate.net/publication/269723704_Training_police_for_procedural_justice

180 https://www.cityofberkeley.info/uploadedFiles/Police/Level_3_-_General/Principled%20Policing_outline.pdf

community teach a portion of the procedural justice training.

To aid in procedural justice incorporation into police departments, the Justice Collaboratory at Yale Law School has created a compilation of procedural justice training guides, departments who have implemented procedural justice training, and other pertinent resources.[181]

While also suggesting procedural justice training as a way to combat the "warrior mentality" in police departments, a Harvard University Kennedy School of Government report advises that "Police leaders dedicated to establishing practices in their agencies based on procedural justice principles must ensure that their organizational culture is not in conflict with these same principles."[182]

Implicit Bias

Implicit bias, as the name denotes, is an unconscious belief, attitude or bias against another race, ethnicity, or group. When Stanford University psychologist Jennifer Eberhardt conducted a large-scale study of policing, she discovered that the unconscious link between Black individuals and criminality is so high that even contemplating lawlessness can cause someone to fixate on Black people.[183] These societal biases end up affecting the judgment of police officers whether they are aware of it or not.

In Oakland, Professor Eberhardt and her team reviewed body camera footage from 1,000 traffic stops to elucidate the difference in officer language in encounters with Black versus white drivers. The research found that Oakland Police Department (OPD) officers consistently communicated with Black drivers in a less civil manner when compared with white drivers they addressed.[184] Various programs to address implicit bias were then recommended for implementation in OPD in response to these findings. Short, repeated education sessions were found to be associated with higher levels of officer comprehension and knowledge.[185] The training was accompanied by more community engagement and data transparency in order to allow officers to start the process of unlearning implicit biases.

A novel approach to implicit bias training is the Counter Bias Training Simulation (CBTSim). This strategy utilizes shooting automation and video sequences to demonstrate the risks of implicit bias in a realistic setting.[186] In the curriculum, officers are forced to deal with potentially explosive situations without reacting in a way that reflects preconceived notions.[187]

De-escalation

With an increase in the number of deadly interactions between police and unarmed civilians going viral, there has been an on-going call for officers to be required to utilize effective verbal de-escalation strategies. Law enforcement officers in the United States kill nearly 1,000 civilians annually, many of whom are unarmed.[188] However, many law enforcement agencies provide little to no de-escalation training to officers, and 34 states have no mandate for de-escalation training.

Successful de-escalation programs operate to assist law enforcement personnel in relaxing the situation in order to gain valuable time in a crisis. Ideal guidance for officers suggests that 40 hours of de-escalation instruction is needed. The Police Executive Research Forum (PERF) de-escalation training is a program that has seen substantial reductions in use of force complaints and civilian injury. The training includes active listening, forming physical space between the individual and officer, and education regarding mental illness and well-being.[189]

When the Dallas Police Department implemented a training curriculum involving de-escalation tactics,

181 https://law.yale.edu/justice-collaboratory/procedural-justice/guides-practitioners
182 https://www.ojp.gov/pdffiles1/nij/248654.pdf
183 https://psychology.stanford.edu/news/we-understand-implicit-bias-now-what-conversation-stanford-psychologist-jennifer-eberhardt
184 Id.
185 https://news.stanford.edu/2016/06/15/stanford-big-data-study-finds-racial-disparities-oakland-calif-police-behavior-offers-solutions/
186 https://www.npr.org/2020/09/10/909380525/nypd-study-implicit-bias-training-changes-minds-not-necessarily-behavior
187 https://www.faac.com/milo/cognitive/cbtsim/
188 https://www.washingtonpost.com/local/deescalation-training-police/2020/10/27/3a345830-14a8-11eb-ad6f-36c93e6e94fb_story.html
189 Id.

use of force grievances declined by 18 percent the following year. After the San Francisco Police Department incorporated de-escalation training into their curriculum, use of force incidents dropped by 24 percent annually.[190]

Community Engagement

A tense relationship between police and the community, especially communities of color, has been a long, intractable problem. Mistrust of law enforcement is not just theoretically problematic; it has also been proven to be linked to an increase in crime and violence.[191] Police officers should work to develop meaningful and positive relationships with members of the community by taking measures including regularly and actively attending community meetings, special events, neighborhood gatherings, positively communicating with area youth, and participating or hosting local sporting events. By doing saw law enforcement conveys the message that residents have a voice and that their input matters. Police should also connect with individuals in the community who advocate for greater social cohesion, such as faith leaders, in order to successfully engage a broad swath of the community.[192]

Crime Prevention Through Community Engagement (CPTCE), an extensive training guide for improving relations between police departments and the community, was recently developed by The American Crime Prevention Institute (ACPI). The training consists of strategies to engage communities of color, employ social media to interact with residents, coordinate with faith-based leaders, and partner with community-based organizations.[193]

In New Haven, Connecticut, the police department implemented 40-hours of community engagement education for its recruits, including education about the area's history as well as continuous outreach activities. Officers overwhelmingly supported the initiative and reported having positive interactions. After the pilot, the police department expanded the program to partner with the local community-based organization, Leadership, Education, & Athletics in Partnership (LEAP).[194] Community engagement training for law enforcement in general is correlated with increased trust and stronger social ties in neighborhoods.

Open Policing is a research-based strategy that incorporates elements of procedural justice to improve police-community relations. Residents of communities are able to offer their comments and observations regarding their exchanges with police officers anonymously. All comments are collated into Agency Pages, which can be explored by residents and officers.[195] In addition to the Open Policing policy, some departments have initiated CFS reviews. After any call for service, community members are able to give details about their interaction in a three-minute review without any fear of consequence.[196]

The four main components of procedural justice have been assimilated into Open Policing, including promotion of vocalization from the community, serving individuals with respect, objectivity in decision-making, and credibility with the community. The main goals of the strategy are to improve officer-civilian relations and responses to incidents as well as promoting accountability within the department. All comments are collated into Agency Pages, which can be explored by residents and officers.[197] Open Policing has been correlated with a 35 percent decrease in resident grievances and increased trust in police departments.[198]

Data Driven Risk Management

The Oakland Police Department (OPD) recently implemented a series of 15 Microsoft Power BI (Business Intelligence) dashboards that allow for a precise review of police behavior. Working with Slalom, a data consulting firm, OPD has increased transparency and accountability through data

190 https://www.washingtonpost.com/local/deescalation-training-police/2020/10/27/3a345830-14a8-11eb-ad6f-36c93e6e94fb_story.html
191 https://giffords.org/wp-content/uploads/2020/01/Giffords-Law-Center-In-Pursuit-of-Peace.pdf
192 https://courses.acpionline.com/community-engagement/
193 http://acpionline.com/seminars/cptcelou/
194 https://www.policefoundation.org/wp-content/uploads/2017/08/IAP_Outside-the-Academy-Learning-Community-Policing-through-Community-Engagement.pdf
195 https://www.policylink.org/sites/default/files/pl_police_commun%20engage_121714_c.pdf
196 https://www.openpolicing.org/how-open-policing-works/
197 Id.
198 https://www.openpolicing.org/try-open-policing/

analysis. Patterns of enforcement, historical activity, and performance over time are all monitored in close to real-time.[199]

The dashboards were created with input from OPD staff and leadership, community-based organizations, other law enforcement agencies, and Stanford University's SPARQ (Social Psychological Answers to Real-world Questions). Each dashboard can be accessed by OPD leadership, depending on security clearance. The dashboards have a simple interface, allowing supervisors to access and understand the data easily. Police supervisors can access a variety of data, from long-term information to arrests made within the last 24 hours.[200] Dashboards allow for an easy breakdown of incidents by factors including race, gender, ethnicity, and officer. This permits police departments to monitor problematic patterns and address them quickly.[201] Early Intervention Systems (EIS) such as these dashboards have been correlated with increased personnel safety, improved officer welfare, and an increase in police accountability.[202] One necessary improvement to these systems and their deployment is to universally allow the public to have access to the information they capture.

199 https://www.slalom.com/case-studies/city-oakland-creating-police-transparency-and-trust-data
200 https://medium.com/slalom-data-analytics/data-is-the-new-sheriff-in-town-but-is-it-biased-4aa140904dd7
201 https://cao-94612.s3.amazonaws.com/documents/Police-Commission-7.23.20-Agenda-Packet.pdf
202 https://www.emerald.com/insight/content/doi/10.1108/PIJPSM-02-2020-0027/full/html

APPENDIX I

Alternative Responses Report

INTRODUCTION AND REPORT OVERVIEW

In the effort to provide meaningful information and recommendations to the Berkeley Reimagining Public Safety process, the National Institute for Criminal Justice Reform (NICJR) was tasked by the City Manager's Office to conduct research and analysis to produce a series of reports for the Taskforce, City of Berkeley (City) leadership, and the public. NICJR reviewed the City Auditor's Calls for Services assessment, conducted further analysis of Berkeley Police Department Calls for Service (CFS), used the previously submitted New and Emerging Models of Public Safety report, and drew upon our team's experience and expertise, to develop this Alternatives Responses report.

This report provides an actionable roadmap for providing community and other non-law enforcement alternatives to a police response for 50 percent of CFS types to which the Berkeley Police Department (BPD) currently responds.

The initial section of this report presents the NICJR analysis of BPD's CFS and compares that analysis to the Berkeley City Auditor's report. The next section provides an overview of NICJR's alternative response model – Tiered Dispatch, which includes the Community Emergency Response Network (CERN) – and describes how specific call types are assigned to CERN tiers.

The report concludes with an overview of a framework for the City's alternative response model, drawing upon both existing and planned City resources. The specific parameters and scope of the Specialized Care Unit (SCU) have not yet been defined. The present analysis assumes that the SCU's role will be focused on mental-health and substance abuse related call responses.

CALLS FOR SERVICE ANALYSIS

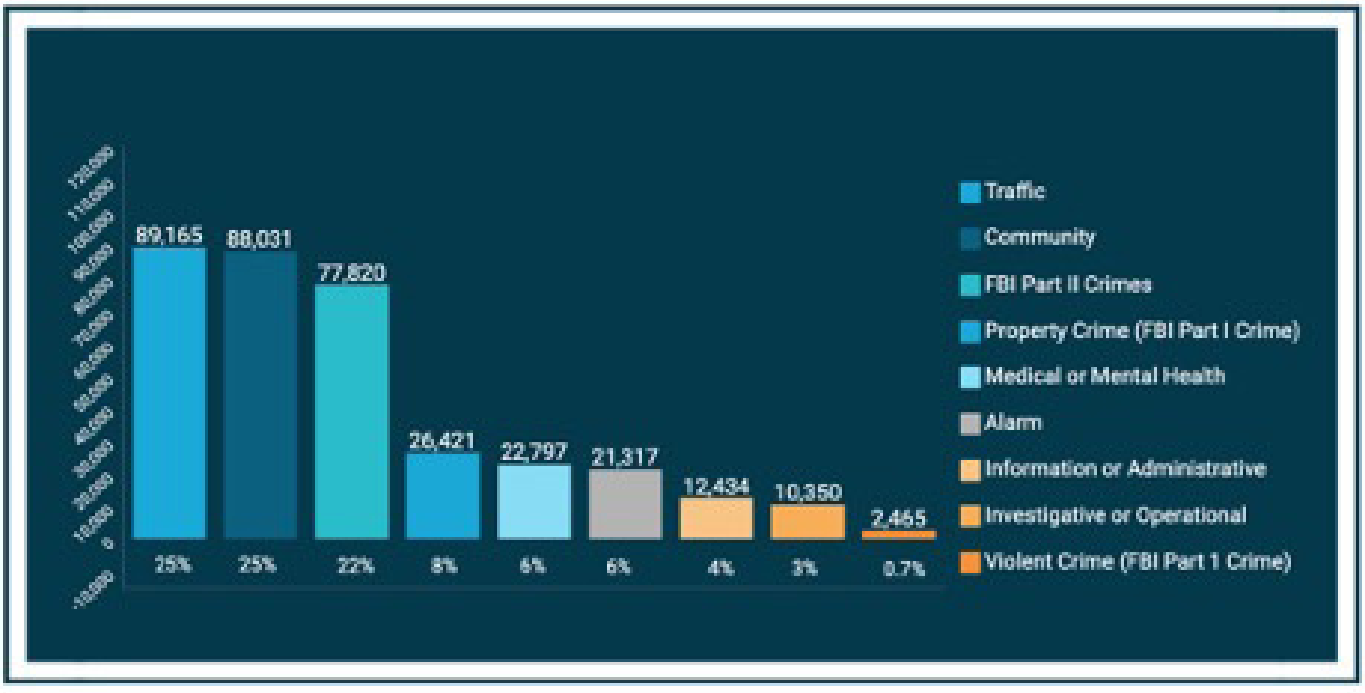
Summary of City Auditor Findings, NICJR Category Assignment and Crosswalk

The Berkeley City Auditor (Auditor) recently conducted an analysis of over 350,000 BPD calls for service covering calendar years 2015-2019. The BPD CFS audit, which can be found here, focused on the following questions:

1. What are the characteristics of calls for service to which Berkeley Police respond?
2. What are the characteristics of officer-initiated stops by Berkeley Police?
3. How much time do officers spend responding to calls for service?
4. How many calls for service are related to mental health and homelessness?
5. Can the City improve the transparency of Police Department calls through the City of Berkeley's Open Data Portal?

The Auditor categorized over 130+ call types into 9 categories in an effort to answer these questions: Violent Crime (FBI Part 1), Property Crime (FBI Part I), FBI Part II Crimes, Investigative or Operational, Medical or Mental Health, Information or Administrative, Community, Traffic, and Alarm.

Figure 1. BPD Calls by Auditor Call Categories



Between 2015 and 2019 the Auditor found that BPD responded to an average of 70,160 CFS annually, and that ten call types accounted for 54 percent of all CFS.

Table 1. Top Ten Call Types, Auditor Report

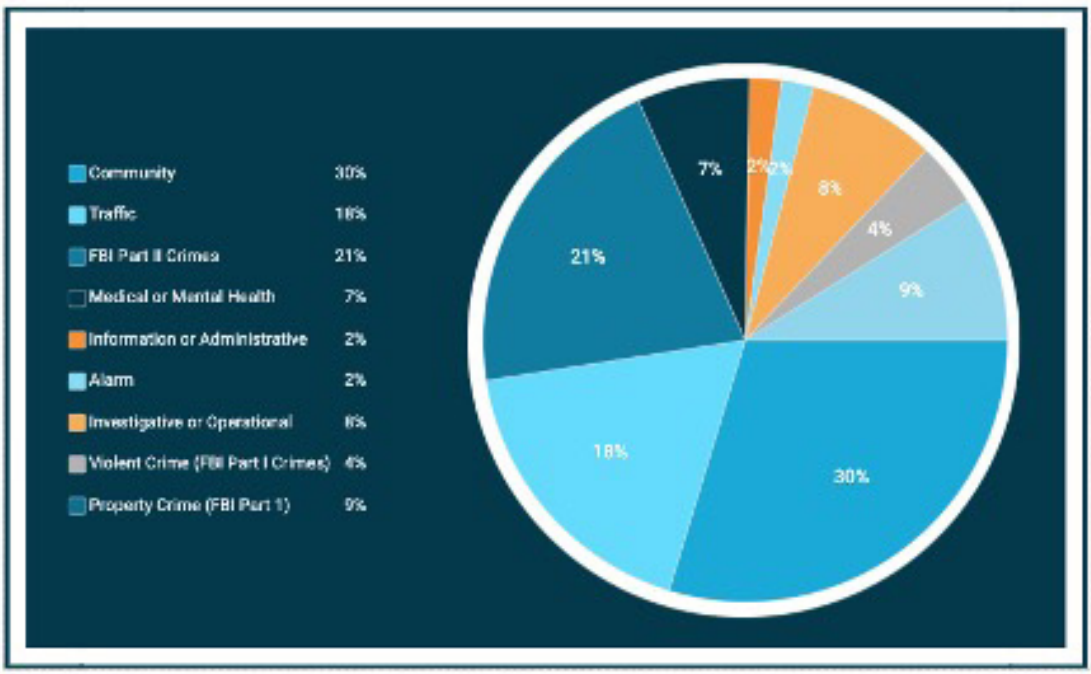
Call Types	Total Count
Traffic Stop	44,795
Disturbance	35,696
Audible Alarm	19,920
Noise Disturbance	15,773
Security Check	15,262
Welfare Check	15,030
Suspicious Circumstance	11,547
Trespassing	11,058
Theft	10,556
Wireless 911	9,899

Top 10 call types account for 54% of all events

The top ten call types fell into four categories: Traffic, Community, Alarm, and Property Crime. Mental health related CFS accounted for approximately 12 percent of all call types, while homelessness CFS accounted for 6.2 percent of all events. These types of CFS were identified by looking at keywords in narrative reports, disposition codes, call types, and/or Mobile Crisis Team response.

During the period reviewed, BPD officers spent most of their time (69 percent) responding to CFS that were categorized as Traffic (18 percent), Community (30 percent), or FBI Part II crimes (21 percent). Seven percent of BPD officers' time was spent handling Medical Mental Health CFS, another 9 percent on Property Crime CFS, and 2 percent on Alarms. The remainder of BPD officer time (14 percent) was spent on Information or Administrative, Investigative or Operational, and Violent Crime CFS.

Figure 2. BPD Officer Time Allocation, Auditor Report



NICJR EXPANDS UPON AUDITOR'S ANALYSIS

As a first step in developing this Alternative Response Report, NICJR reviewed the CFS analysis completed by the Auditor and compared the results of that analysis to its own CFS classification results.

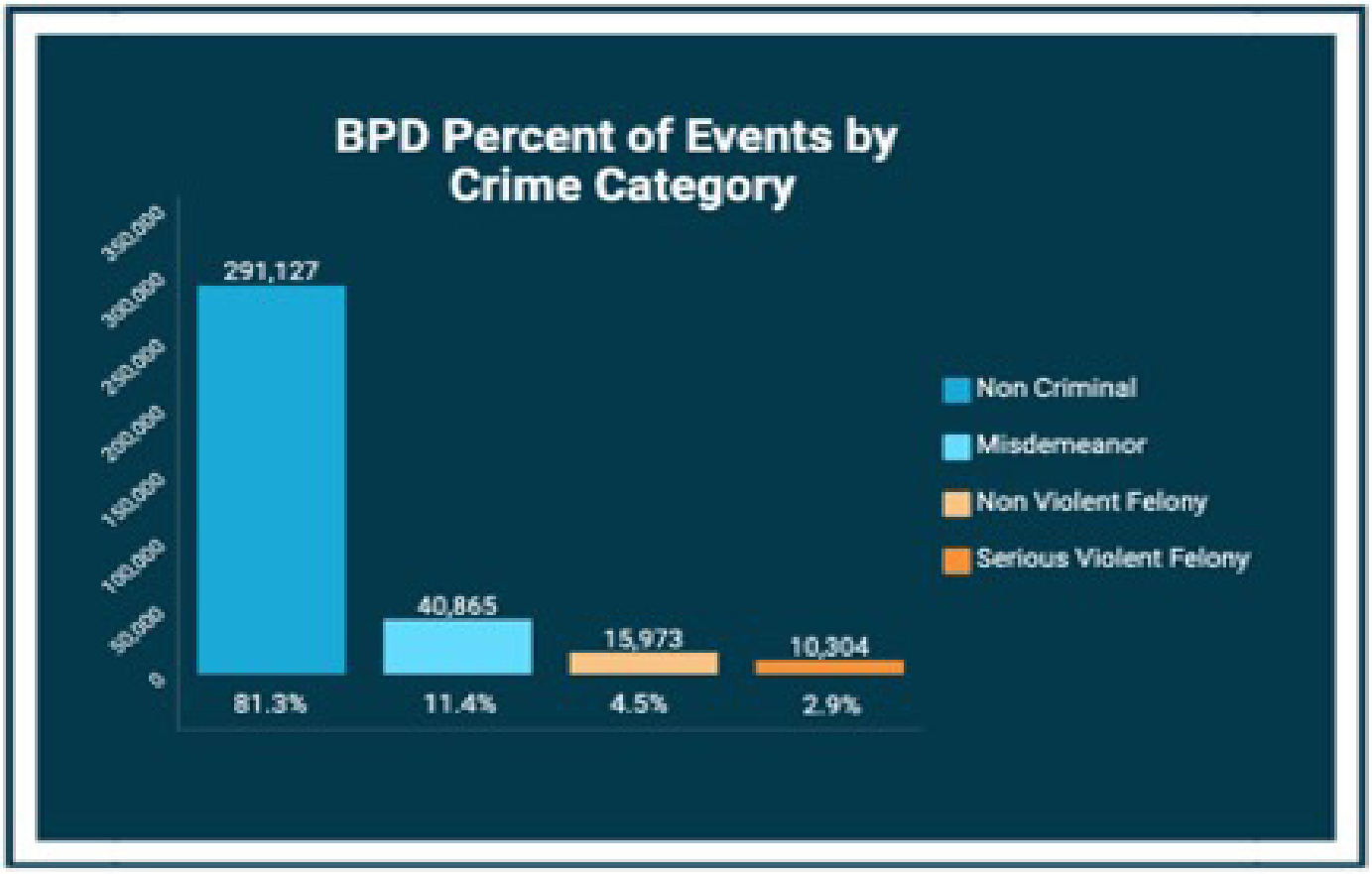
As outlined above, the Berkeley City Auditor aggregated all BPD call types into 9 categories, while NICJR uses 4 Categories to organize the same events. A crosswalk between the Auditor's 9 and NICJR's 4 CFS Categories is outlined in Table 2. NICJR categories are aligned with state specific penal codes and their associated penalties. If a call type is not found in the penal code, it is placed into the Non-Criminal Category.

Table 2. Crosswalk, Berkeley City Auditor and NICJR Call Type Categories

Berkeley Auditor Categories	NICJR Categories
Violent Crimes (FBI Part I)	Serious Violent Felony: Any event identified in the California Penal Code as a Serious Violent Felony
Property Crimes (FBI Part I)	Non-Violent Felony: Any event identified in the California Penal Code as a Non-Violent Felony
FBI Part II Crimes	Misdemeanor: Any event identified in the California Penal Code as a Misdemeanor
Community	Non-Criminal: Any event not identified in the Penal Code
Medical or Mental Health	
Traffic	
Informational or Administrative	
Investigative or Operational	
Alarm Calls	

NICJR uses this method of categorizing events because it affords the most linear association between the event and its associated criminal penalty. By categorizing events in this manner, NICJR can clearly identify the portion of CFS that are either non-criminal or are for low-level and non-violent offenses. Categorizing call data into a simple criminal vs. non-criminal, violent, vs. non-violent, structure also supports conversations with the community about alternatives to policing for specific call types grounded in easily understandable data.

Figure 3. BPD Events by NICJR Crime Category[1]



There were 22 call types[2] (11 percent) that differed in assignment when comparing the Auditor's report to NICJR results. A summary of these variances is outlined in Table 3 and described below.

Table 3. Key Variances, NICJR vs. Auditor Call Type Categorization

NICJR Classification	Auditor Classification	# of Impacted Call Types
Non-Criminal	FBI Part II Crimes	7
Serious Violent Felony	Traffic, Property Crimes (FBI Part I, FBI Part II Crimes	10
Non-Violent Felony	Investigative/Operational	1
Misdemeanor	Traffic, Informational or Administrative	4

Of the 22 call types, 7 (31.8 percent) were assigned to NICJR's Non-Criminal Category whereas the Auditor classified the same 7 as FBI Part II Crimes. For example, *family disturbance* is classified by the Auditor as an FBI Part II Crime while NICJR places it in the Non-Criminal Category. The largest source of variance between

1 Figure excludes null or missing values in the dataset.
2 There is a discrepancy in the number of call types evaluated by the Auditor versus NICJR. The Auditor evaluated approximately 130 CFS types; NICJR, 183. Part of this discrepancy is due to the fact that the Auditor and NICJR reviewed slightly different data sets. Additionally, NICJR reviewed all CAD data while the Auditor only reviewed those CFS resulting in a sworn response.

NICJR's Non-Criminal Category and the Auditor's classifications relates to the call type disturbance, which the Auditor classifies as an FBI Part II Crime while NICJR categorizes it as Non-Criminal. The *disturbance* call type accounted for nearly 10 percent of the 360,242 CFS reviewed in the Auditor's analysis.

Four out of the 22 (18.1 percent) differing call types were assigned to NICJR's Misdemeanor Category while the Auditor assigned them as Traffic and Informational or Administrative. These call types include *reckless driver*, *hit and run with injuries*, and *exhibition of speed*. Both *reckless driver* and *hit and run with injuries* were assigned as Traffic by the Auditor while NICJR assigns them as Misdemeanors. *Property Damage* was classified by the City Auditor as Informational or Administrative. NICJR classifies this call type as a Misdemeanor.

One out of the 22 (4.5 percent) differing call types, lo jack stolen vehicle, was assigned to NICJR's Non-Violent Felony Category while the Auditor assigned it as Investigative or Operational.

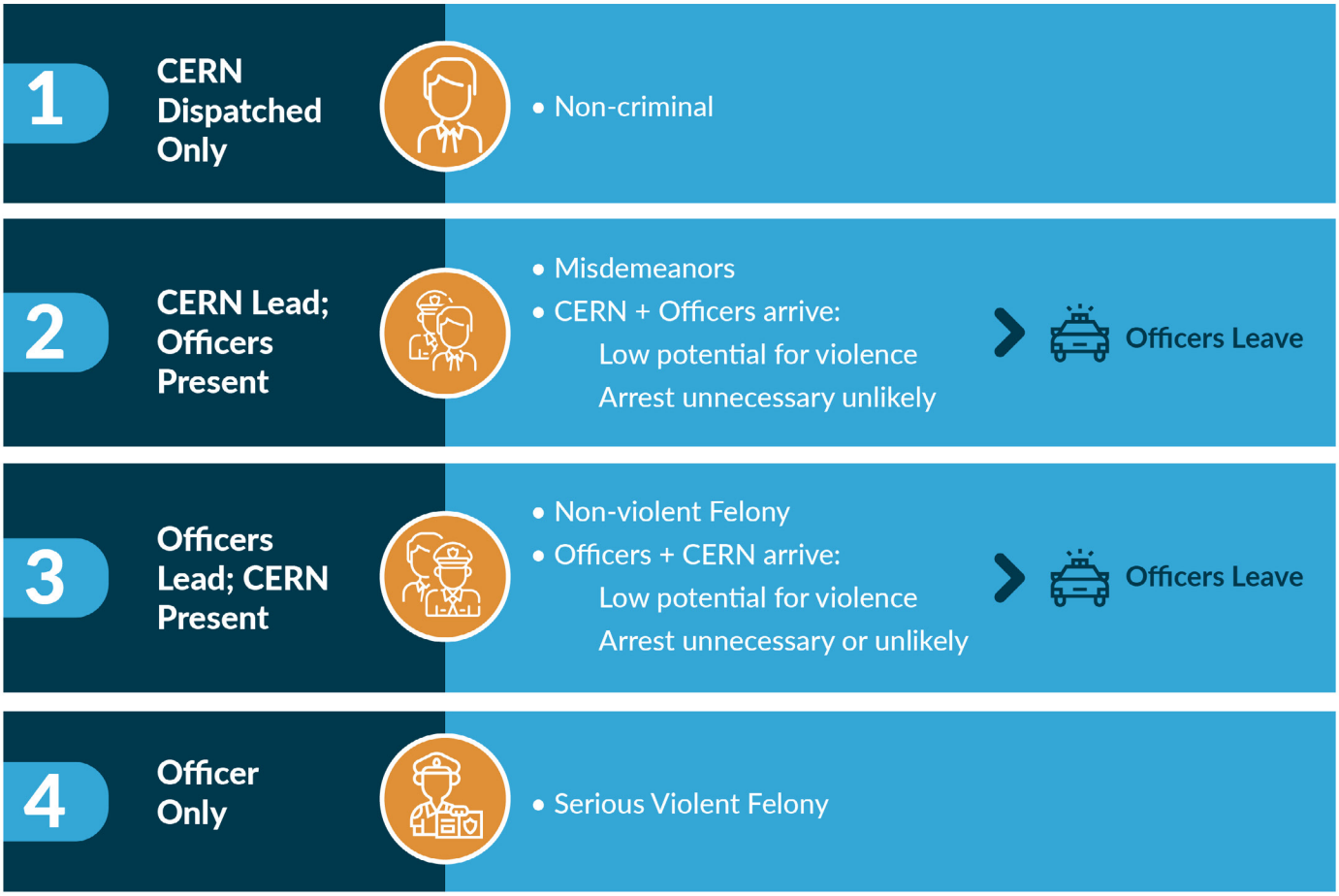
A final source of the variation in call type categorization between the Auditor and NICJR stems from NICJR's Serious Violent Felony assignment. The auditor used FBI UCR categories while NICJR used the California Penal Code to determine the penalty associated with the qualifying offense. Ten out of the 22 (45.4 percent) differing call types were assigned to NICJR's Serious Violent Felony Category. Out of the total 360,242 calls for service analyzed, NICJR classified 2.9 percent in the Serious Violent Felony Category. The Auditor only classified 0.7 percent of CFS in its Violent Felony Category. The variance is due to the fact that 9 call types classified by the Auditor as Traffic, Property Crime (FBI Part I), and FBI Part II Crimes fall into NICJR's Serious Violent Felony Category. This scenario is illustrated by the call types *hit and run with injuries* and *vehicle pursuit*. Both are classified by the Auditor as Traffic. NICJR classifies both calls in its Serious Violent Felony Category. Another example is arson, which is classified by the Auditor as Property Crime (Part I) while NICJR classifies arson as a Serious Violent Felony. Other call types generating this variance include battery, bomb threats, kidnapping, spousal or domestic abuse, child abuse, and sexual molestation.

The complete crosswalk is provided as Appendix A.

NICJR CERN CATEGORIZATION

In our work to Reimagine Public Safety and transform policing, NICJR has developed a tiered dispatch system to provide alternatives to police response to CFS, increase public safety, and improve the quality of emergency response.[3] This model includes the CERN, which builds upon NICJR's CFS classification structure.

Once each call type is associated with one of NICJR's four CFS Categories, they are given a default assignment on the Tiered Dispatch depicted in Figure 4:



The Tiered Dispatch assignments for the 2015-2019 BPD CFS analyzed are outlined below.

Table 4. Tiered Dispatch Default Assignment Table

Crime Category	CERN	BPD	% of Call Types	# of Call Types in Each Tier
Tier 1	Only		50%	92
Tier 2	Lead	Present	14%	25
Tier 3	Present	Lead	9%	16
Tier 4		Only	27%	50

Default Tier Assignment Modified Based on Arrest Data and Other Factors

A. Arrest Rates

Subsequent to the default classification, NICJR examines arrest data to determine if adjustments to default Tier assignments are warranted. Most typically, this results in CFS "moving up" a Tier based on the likelihood of arrest. The arrest analysis includes the identification of the overall jurisdiction arrest rate, as well as the high-end of that rate, below which the vast majority of CFS arrest rates fall. For Berkeley, 10 percent was set as the arrest rate triggering Tier assignment review; only 6 of 91 CFS that resulted in an arrest had an arrest rate in excess of 10 percent in the years 2015 to 2019. Call types with arrest rates that significantly exceed the triggering arrest rate generally moved to higher Tiers. For example, the Non-Criminal CFS *warrant service* was moved from Tier 1 to Tier 4 based on arrest rate data.

Table 5. CFS CERN Tier Assignments After Arrest Review

Crime Category	CERN	BPD	% of Call Types	# of Call Types in Each Tier
Tier 1	Only		50%	91
Tier 2	Lead	Present	13%	24
Tier 3	Present	Lead	9%	16
Tier 4		Only	28%	52

B. Alternate Response Warranted

Beyond arrest data, CERN Tier assignment is modified based on NICJR's assessment of call types that would benefit from an alternate response. Some Serious Violent Felony call types typically move from Tier 4 to Tier 3 pursuant to this aspect of the analysis, in order to allow for a CERN response with an officer leading. For example, the call type *assault, gang related* has been downgraded from a Tier 4 to a Tier 3 in order to allow the CERN to assist officers involved. Warrants have similarly been downgraded from a Tier 4 to a Tier 3 with this rationale in mind. These call types would be led by police only, but members of the CERN would be present to provide family members with information and support. Conversely, some call types have been moved from lower to higher Tiers as a result of this aspect of the default Tier assignment modification methodology. Various events that fall under the assist call type, for example, are allocated to Tier 4 even though these CFS are Non-Criminal in nature. The rationale here is that if the BPD is being asked to assist another law enforcement

agency, for example, a BPD response is required. Additionally, traffic-related calls are in Tier 3 or 4 due to current state law requiring sworn officers, but in the event that state law is amended as envisioned in some of the discussion related to BerkDOT, the calls would move to Tier 1. Appendix D includes calculations of calls and expenses with traffic calls shifted to Tier 1.

Table 6. CFS CERN Tier Assignments After Alternate Response Review

Crime Category	CERN	BPD	% of Call Types	# of Call Types in Each Tier
Tier 1	Only		50%	92
Tier 2	Lead	Present	10%	19
Tier 3	Present	Lead	18%	33
Tier 4		Only	21%	39

Based on NICJRs analysis, and as reflected in Table 6, 50 percent of BPD CFS could be handled by a community-response, only. A detailed breakdown of Berkeley CFS by CERN Tiers can be found in Appendix B.

FISCAL IMPLICATIONS OF CERN ASSIGNMENT

A major driver of the police reform conversation has been the desire to shift resources from traditional law enforcement to alternative, more appropriate, responses for specific types of calls for service. As Table 6 illustrates, the City can realistically expect to divert nearly 50 percent of call types from the BPD to an alternate response that requires no law enforcement involvement. In order to understand the potential fiscal impact of the adoption of this type of alternate response model, various analyses of the BPD budget were conducted.

As outlined in Table 7, the BPD budget grew from approximately $61 million to $69 million during the period of CFS review, reflecting a nearly 15 percent increase; CFS remained steady during the same period, experiencing a slight decline of approximately 4 percent. The Police Operations Division budget, which houses costs associated with Patrol, comprised between 52 and 60 percent of the Department's budget during the review period; Patrol is responsible for responding to CFS in the City of Berkeley.

Table 7. BPD and Patrol Operations Division Budget, 2015-2019

	FY15	FY16	FY17	FY18	FY19
Total Budget	$60,832,054	$63,115,430	$66,428,530	$66,351,534	$69,567,103
General Fund (GF)	$57,057,838	$59,074,465	$62,156,096	$62,628,518	$65,493,664
Police Operations (OPS) Division	$34,781,350	$37,050,106	$39,867,224	$39,673,087	$36,284,878
OPS Division % of Total Budget	57.2%	58.7%	60.0%	59.8%	52.2%

In order to determine the proportion of Operations Division expenses that are directly attributable to responding to CFS, NICJR undertook several analyses:

Calculating Officer Time:

- **Responding to CFS:** On-Scene to Close. The time between when an officer arrives on-scene to a particular CFS and closes the call. This time frame is used to measure the actual time officers spend on calls for service. This calculation does not include travel time; the time officers take to write incident reports is only accounted for if the officer does this before a particular CFS is closed.
- **Responding to CFS:** Event Creation to Close. The time between when a call comes in and is created in the Computer Aided Dispatch (CAD) system and when an officer closes the call. This time period is used to capture the total amount of time from when a caller calls into the Communications Center to when an officer closes the call, accounting for the totality of time it takes to complete a CFS.
- **Officer Time.** Under either the On-Scene to Close or Event Creation to Close approaches, officer time is calculated based on the number of responding officers to a unique call multiplied by the amount of time spent on the call.

Identifying Median Officer Hourly Rates:

- Median hourly rates were generated from the City of Berkeley's Salary List for benefited employees. The minimum salary (step 1) in that schedule is $49.73/hr and the maximum, (step 7), $61.90/hr. The median salary is $56.24 (step 4).

Applying Applicable Overhead Rate to Median Officer Hourly Rate:

- As of the City's 2021 Benefits and Compensation Matrix, this rate was 110 percent.

The results of this analysis are provided in Table 8.

Table 8. Cost of Responding to CFS: On-Scene to Close and Create to Close

Officer Costs Associated with Responding to CFS: On-Scene to Close	
Total Hours 2015 - 2019, CERN Tier 1 Calls (BPD Response Hours)	98,119
Total Hours 2015-2019, All other CERN Tiers (BPD Response Hours)	89,525
Median BPD Officer Salary	$56.24
BPD Officer Salary Range	$49.73 - $61.90
Berkeley Composite Fringe Benefit Rate	110%
Calculation of CERN Tier 1 Costs (# of hours * Median Salary * Benefit Rate)	$11,587,854
Calculation of All other CERN Tier Costs (# of hours * Median Salary * Benefit Rate)	$10,572,903
Average Annual CERN Tier 1 Officer Costs, On-Scene to Close	**$2,317,571**
Average Annual Officer Costs Tiers 2-4	**$2,114,581**

Officer Costs Associated with Responding to CFS: Create to Close	
Total Hours 2015 - 2019, CERN Tier 1 Calls (BPD Response Hours)	266,832
Total Hours 2015-2019, All other CERN Tiers (BPD Response Hours)	367,422
Median BPD Officer Salary	$56.24
BPD Officer Salary Range	$49.73 - $61.90
Berkeley Composite Fringe Benefit Rate	110%
Calculation of CERN Tier 1 Costs (# of hours * Median Salary * Benefit Rate)	$31,512,859
Calculation of All other CERN Tier Costs (# of hours * Median Salary * Benefit Rate)	$43,392,538
Average Annual CERN Tier 1 Officer Costs, Create to Close	**$6,302,572**
Average Annual Officer Costs Tiers 2-4	**$8,678,508**

*Note: Berkeley PD salaries used for this analysis are based on the MOU which expired June 30, 2021. A new MOU has resulted in a salary increase not reflected in this report.

Depending on the officer time calculation used, and using 2019 budget data alone, the costs associated with responding to Tier 1 CFS range from between **approximately 7 (On-Scene to Close) and 19 (Create to**

Close) percent of the Police Operations Division budget, and **4 and 10** percent of the total BPD budget. Costs associated with responding to CFS Tiers 2-4 comprise between approximately **5 (On-Scene to Close) and 23 (Create to Close)** percent of the Police Operations Division budget and **3 and 12** percent of the total BPD budget.

Table 9. Tier 1 CFS as % of Operations Division and BPD Overall Budget

Implementation converts the estimated number of officer hours saved into FTEs as reflected in Table 10 on the following page.

Table 10. CFS FTE Analysis

CERN Tier	Total Hours (Create to Close) (Avg Annual)	Average Hours[4], 1 FTE Officer	Estimated # of FTE Per Tier
1	53,366	2080	25.7
2	24,012	2080	11.5
3	32,331	2080	15.5
4	17,140	2080	8.2

Redirection of Tier 1 CFS to a CERN would thus generate approximately $6.8 million in annual BPD savings annually, equating to slightly less than 26 FTE.

4 2080 is the standard number of working hours per year for a full-time equivalent position; BPD actual annual hours/FTE may vary.

BUILDING THE ALTERNATIVE RESPONSE INFRASTRUCTURE

In order to facilitate the development of Berkeley's own alternate response network or CERN, NICJR further analyzed the 92 CFS in CERN Tier 1. Although an alternate response is also contemplated in response to CFS in Tiers 2 and 3, as the CFS category which contemplates no corresponding police response, Tier 1, is an appropriate focal point for initial alternate response analyses.

To facilitate this assessment, Tier 1 CFS were divided into 11 topical/activity- based sub-categories as outlined in Table 11.

Table 11. CERN Sub-Category

CERN Category	Definition	Example Call Type(s)
Administrative	Calls that involve administrative duties	subpoena service; VIN verification; information bulletins, test call, report writing
Alarm	Calls that involve activation of alarms	residential alarm, commercial alarm, bank alarm, audible alarm, GPS alarm
Animal	Calls that involve animals	stray animals, barking dogs, cat in a tree
Investigation	Calls that require some form of investigation to ensure all is in order	investigating an open door, residential welfare checks, business premise checks, follow up on previous crime to collect evidence (witness statements, video footage, etc.)
Medical or Mental Health	Calls that require or involve medical or mental health assistance	mutual aid medical support, gunshot victim, suicide, 5150 transport
Municipal	Calls that involve municipal issues	fall on city property; COVID-related violations; BPC violations - signage, lighting, etc.; sidewalk regulations
Other	Call types that do not fit into any of the other CERN categories	create new call; no longer used, wireless 911 call got dropped
Public Order	Calls that interfere with the normal flow of society	demonstrations, civil unrest
Quality of Life	Calls that create physical disorder or reflect social decay	loitering (homeless), panhandling, noise, trash/dumping, urinating in public

CERN Category	Definition	Example Call Type(s)
Substance Use	Calls that involve substance use	open air drug use and distribution, overdose related, down and out, public intoxication
Traffic	Calls that involve traffic or vehicle related concerns	abandoned vehicles

Leveraging Existing and Planned City Resources and Ideas from New and Emerging Models Report

CERN Team Types

The Community Emergency Response Network may need to have different types of teams that respond to certain calls.

- **SCU:** Respond to Mental Health & Drug issue calls
- **Mediation Team:** Respond to Disturbance and Noise calls
  - Possibly include specialists in Family Disturbance calls
- **Report Takers/Technicians:** Take crime reports
  - Specialists for evidence collection as the City has now
- **Outreach:** Respond to non-MH homeless calls, welfare checks, etc.
- **BerkDOT:** Respond to traffic calls
  - Including technology

In an effort to identify existing and planned resources by Tier 1 Category, NICJR reviewed:

- The list of City-funded community-based organizations (CBOs) provided in the City Manager's Proposed Annual Budget Fiscal Year 2022, submitted to the City Council on May 25, 2021
- City Boards, Commissions, and Departments, as identified on the City's website
- Relevant examples of potential programs or approaches as provided in the New and Emerging Models of Community Safety and Policing Report
- Other relevant local CBOs/resources

Table 12, which can be found on the next several pages, summarizes the results of NICJRs services scan; a list of the specific CBOs identified by Tier 1 sub-category can be found in Appendix C. A detailed description of each Table 12 organizing category follows.

Table 12. CERN Build Out: CBO's, City Departments, Other Resources

CERN Category	Call Type(s)	Existing City-Contracted CBOs	Existing City Departments	Planned City Resources	Other Relevant Resources	Potential Oversight Commission/Board	Innovations, New and Emerging
Administrative	subpoena service; VIN verification; information bulletins, test call, report writing			BerkDOT (VIN verification)	Private subpoena servers		
Alarm	residential alarm, commercial alarm, bank alarm, audible alarm, GPS alarm	The Downtown Berkeley Association/ Downtown Ambassadors Street Team provides alarm assistance services			UCPD Community Service Officers provides alarm assistance services		
Animal	stray animals, barking dogs, cat in a tree etc.	Animal Rescue	City Manager's Office: Berkeley Animal Care Services			Animal Care Commission	

CERN Category	Call Type(s)	Existing City-Contracted CBOs	Existing City Departments	Planned City Resources	Other Relevant Resources	Potential Oversight Commission/Board	Innovations, New and Emerging
Investigation	investigating an open door, residential welfare checks, business premise checks, follow up on previous crime to collect evidence (witness statements, video footage, etc.)	Downtown Berkeley Association/ Downtown Ambassadors Street Team: investigating open doors, residential welfare checks, business premise checks			UCPD Community Service Officer (CSO) Program: investigating open doors, residential welfare checks, business premise checks		

CERN Category	Call Type(s)	Existing City-Contracted CBOs	Existing City Departments	Planned City Resources	Other Relevant Resources	Potential Oversight Commission/Board	Innovations, New and Emerging
Medical or Mental Health	mutual aid medical support, gunshot victim, 5150 transport, mental illness, suicide attempt, threat of suicide, mental health	4 CBOs contracted for health services; 1 CBO contracted for mental health services (Alameda County Network of Mental Health Clinics); several homeless oriented CBOs include a mental health component	Fire Department; Mental Health Division Mobile Crisis Team, and Crisis, Assessment, and Triage Team (loitering, panhandling, urinating in public); Health, Housing, and Community Services Department	SCU	Bonita House's Bridges to Recovery In-Home Outreach Team (IHOT) Bonita House's Community Assessment & Transportation Team (CATT) program New Bridge Foundation: drug and alcohol rehabilitation center in Berkeley, California that offers inpatient and outpatient services as well as detoxification treatment	Community Health Commission; Mental Health Commission	Crisis Response Unit (CRU), Olympia, Washington
Municipal	fall on city property; COVID-related violations; BPC violations - signage, lighting, etc.; sidewalk regulations		City Manager's Office: Code Enforcement, Public Works			Public Works Commission	

CERN Category	Call Type(s)	Existing City-Contracted CBOs	Existing City Departments	Planned City Resources	Other Relevant Resources	Potential Oversight Commission/Board	Innovations, New and Emerging
Other	create new call; no longer used, wireless 911 call got dropped	NA	NA	NA	NA	NA	NA
Public Order	Demonstrations, civil unrest	Downtown Berkeley Association's Safety Ambassadors Program: provides public order services/ assistance			UCPD Community Service Officer (CSO) Program: provides public order services/ assistance		
Quality of Life	loitering (homeless), panhandling, noise, trash/ dumping, urinating in public	16 CBOs contracted for homeless services, approximately 50% with case management component. These resources could be leveraged to address loitering, panhandling, and public urination/ intoxication complaints. Other CBOs (Eden Information and Referral as well Telegraph Business Improvement District) assist with quality of life calls as well. Downtown Berkeley Association's Safety Ambassadors Program: all Quality of Life CFS	Mental Health Division, Mobile Crisis, and Crisis, Assessment, and Triage Team (loitering, panhandling, urinating in public); City Manager's Office: Code Enforcement (trash/dumping)		UCPD Community Service Officer (CSO) Program: all Quality of Life CFS	Homeless Commission; Human Welfare and Community Action Commission	Mayor's Action Plan (MAP) for New York City

CERN Category	Call Type(s)	Existing City-Contracted CBOs	Existing City Departments	Planned City Resources	Other Relevant Resources	Potential Oversight Commission/Board	Innovations, New and Emerging
Substance Use	open air drug use and distribution, overdose related, down and out, public intoxication	1 CBO directly contracted for substance abuse services (Options Recovery Services); other homeless-oriented CBO's provide various substance abuse related services	Mental Health Division Mobile Crisis Team, and Crisis, Assessment, and Triage Team (loitering, panhandling, urinating in public)		New Bridge Foundation: drug and alcohol rehabilitation center in Berkeley, California that offers inpatient and outpatient services as well as detoxification treatment Bonita House's Bridges to Recovery In-Home Outreach Team (IHOT) Bonita House's Community Assessment & Transportation Team (CATT) program	Health Commission, Community; Homeless Commission; Mental Health Commission	Arlington Opiate Outreach Initiative
Traffic	abandoned vehicles, speeding, reckless driving		City Manager's Office: Code Enforcement (abandoned vehicles)	BerkDOT		Transportation Commission	NYPD Staten Island's Motor Vehicle Accident Program

CERN Category	Call Type(s)	Existing City-Contracted CBOs	Existing City Departments	Planned City Resources	Other Relevant Resources	Potential Oversight Commission/Board	Innovations, New and Emerging
Weapon	person with a gun				Building Opportunities for Self-Sufficiency appears to be only City-contracted CBO with significant experience with and focus on incarcerated/ formerly incarcerated. May be a resource for this particular CFS and others in that vein.	Peace and Justice Commission	

Existing City-Contracted Community Based Organizations

NICJR reviewed all City-contracted CBOs and, where possible, aligned CERN Tier 1 sub-categories with community-based organizations; identified organizations are those that could potentially be leveraged to build out the CERN approach. Although the City has contracts with a number of CBOs, there is a significant concentration in homeless services, with few contracted providers in many of the other CERN Tier 1 sub-categories. Where able to identify, NICJR has lifted up those CBOs working in any area that appear to be doing some type of case management or street outreach work, as well as those that have experience with a criminal justice population. These organizations are likely best positioned to serve as the starting point for the development of the CERN infrastructure. There is at least one City-contracted CBO that NICJR is aware of that engages in case management and outreach work *and* has extensive experience with justice-involved community members; that organization, Building Opportunities for Self Sufficiency (BOSS), is an obvious candidate to serve as one of the City's anchors and foundational CERN partners. BOSS is an example of a capable organization, but there are others in Berkeley as well. The City would need to conduct a Request for Proposals process to select the most appropriate service provider(s).

The Downtown Berkeley Association (DBA), an independent non-profit organization that has recently contracted with the City, provides a variety of services including but not limited to cleaning and beautification, hospital and outreach, marketing and business support, and prevention of crime and other threats to merchants.[5] Positions encompass hospitality workers, cleaners, social workers, and trained guards, known as Safety Ambassadors. Safety Ambassadors carry batons, pepper spray, and handcuffs and are outfitted with neon vests.

Safety Ambassadors often have backgrounds in law enforcement and are required to undergo an 8-hour general training along with additional trainings covering topics such as sexual harassment, mental illness, and de-escalation tactics. The stated objective of this program is to increase the quality of life in downtown Berkeley and ensure that any potential disturbances are curtailed.[6] Low-level municipal or quality of life violations, open use of illicit drugs, and threats to businesses are all addressed by the Safety Ambassadors. As such, the DBA itself may serve as an important CERN resource. However, it is important to note that many community members and organizations have expressed concerns with the enforcement-type equipment that Safety Ambassadors carry.

Lastly, the Mental Health Division's (MHD) Mobile Crisis Team provides immediate crisis intervention services for the community and supports BPD in capacities including co-responding to calls for service upon BPD request. This Team, as well as the MHD's Crisis, Assessment, and Triage Team, are obvious foundations for the SCU which is currently under development. The Mobile Crisis Team has very limited resources and available hours. At the time of this report, the Team only has two members. In Listening Sessions held with BPD officers, many expressed the need to expand the work of the Mobile Crisis Team.[7]

Existing City Departments

There are a number of City Departments that are either currently deployed, or could be deployed to address CERN Tier 1 sub-categories. For example, the BPD currently partners with the Mental Health Division's Mobile Crisis Team, and the Code Enforcement Unit within the City Manager's Office is responsible for addressing illegal dumping. The roles and responsibilities of existing City Departments could be expanded to support absorption of specific Tier 1 CFS. BPD also employs civilian technicians who could be used to take reports or collect evidence in cold CFS that may not need an officer present.

5 https://www.downtownberkeley.com
6 https://www.berkeleyside.org/wp-content/uploads/2020/09/Safety-Ambassador-Pilot-Program-2-Month-Report.pdf
7 Community members have expressed concerns about the Mobile Crisis Team's ability to properly assist with calls for service.

Existing Berkeley Commissions, Boards and Departments

NICJR reviewed the City's Boards and Commissions to identify those that might be most appropriate for supporting the development and oversight of various components of the CERN. While ultimately the effort is likely most effectively administered by a single oversight body, the development of various components of the alternate response model may lend itself to disaggregation by topic, although an effective coordination and overall project management approach should be employed from the outset.

Planned City Resources

The City has two significant alternative response initiatives currently underway: the Berkeley Department of Transportation (BerkDOT) and the Specialized Care Unit (SCU). While the scope of these efforts is unclear, NICJR has assigned Tier 1 sub-categories to these City-initiated alternate responses as follows:

- **BerkDOT:** All traffic CFS
- **SCU:** All mental health and drug use CFS

The following relevant excerpts from the City Manager's *Proposed Annual Budget Fiscal Year 2022* suggest that the 2021-2022 budget year is a planning period for BerkDOT, while the SCU is on more accelerated implementation timeline:

BerkDOT

"The Public Works Department is evaluating the potential to create a Berkeley Department of Transportation to ensure a racial justice lens in traffic and parking enforcement and the development of transportation policy, programs, and infrastructure.[8]

- **Estimated Budget:** $75,000
- **Description:** Develop plans for establishing a Berkeley Department of Transportation to ensure racial justice and equity in Transportation policies, programs, services, capital projects, maintenance, and enforcement. Coordinate this with the Reimagining Public Safety effort."

Current state law does not allow non-law enforcement to conduct traffic stops. Given the City's decision to establish BerkDOT, in Appendix D we have assigned all traffic CFS to CERN Tier 1.

SCU

"The Health, Housing and Community Services Department is working with a steering committee to develop a pilot program to re-assign non-criminal police service calls to a Specialized Care Unit."[9]

- $8 million is currently allocated for programs addressing community safety and crisis response.[10]
- Before the SCU is deployed, community safety concerns have been proposed to be addressed through:
  - Expanding prevention and outreach
    - Leverage existing teams and CBOs
    - Address basic needs (i.e., wellness checks, food, shelter)
    - Equipment and supplies

8 Page 24, *Proposed Annual Budget Fiscal Year 2022*
9 Page 24, *Proposed Annual Budget Fiscal Year 2022*
10 https://www.cityofberkeley.info/uploadedFiles/Clerk/Level_3_-_City_Council/FY%202022%20CM%20Proposed%20Budget%20Recommendations.pdf

  - Estimated budget: $1.2 million
- Crime prevention and data analysis to support data driven policing and identify areas of community need
  - Establish data analysis team (2 non-sworn positions)
  - Deploy Problem Oriented Policing Team (overtime)
  - Estimated budget: $1.0 million

Other Relevant Resources

NICJR has identified three non-City funded CBOs as potential alternate response providers related to Tier 1 sub-categories: the New Bridge Foundation (NBF); Bonita House's Community Assessment and Transport Team (CATT) and Bridges to Recovery In-Home Outreach Team (IHOT); and the University of California's Community Service Officer Program. Again, these are examples, the City would need to conduct a Request for Proposals process to select the most appropriate service providers.

Members of the RPSTF have compiled a master list of local community-based organizations to assist in the CERN build-out process as well. This list can be found in Appendix E.

New Bridge Foundation

NBF was identified as a possible alternative solution by Berkeley Reimagining Public Safety Task Force Members. NBF is a residential and outpatient addiction treatment center that provides comprehensive services and has a community outreach component to their program. NBF was assigned to the Tier 1 sub-category, substance use.

Bonita House

While Bonita House receives City funding for its Creative Wellness Center (CWC) which serves as an entry point for recovery and supportive services for people with mental health needs and co-occurring conditions, it does not currently receive financial support for its *Community Assessment and Transport Team (CATT)*; a crisis response system to get clients "to the right service at the right time", or its *Bridges to Recovery In-Home Outreach Team (IHOT)*; a short-term outreach, engagement and linkage to community services program for individuals with severe mental illness. Both of these teams could potentially play important roles in a new alternate response network.

University of California Police Departments (UCPD)

Most University of California Police Departments (UCPD) have some type of Community Service Officer (CSO) Program.[11] CSOs are uniformed, civilian personnel comprised of students that assist the UCPD in a variety of ways. They provide evening and night escorts, patrol campus buildings and residence halls, perform traffic control duties, and act as liaisons between university students and their corresponding police departments.[12] CSOs generally carry pepper spray and work anywhere from 10-20 hours each week. The majority of UCPD CSO Programs also employ tasers.[13] Some are trained to aid in cases of medical emergencies.[14] General security and deterrence of crime are the goals of the CSO program.[15]

11 It's important to note that there have been use of force concerns expressed by UC students about the UCPD CSOs. This should be taken into account by the City when allocating Tier 1 responsibilities.
12 https://www.police.ucla.edu/cso
13 https://dailybruin.com/2006/11/28/a-closer-look-uc-campuses-exhi
14 https://police.ucsd.edu/services/cso.html
15 https://www.police.ucla.edu/cso/about-cso

At UC Berkeley, the CSO Program is made up of 60 part-time students. CSOs offer the BearWalk, a night escort for all faculty and students at the University. Berkeley CSOs are also contracted to patrol residence areas and university buildings. Often, CSOs assist in special events or sports games to promote safety and security. Applicants to the CSO Program must be in good academic standing, undergo a background check, and an oral board interview as part of the hiring process.[16] Because the CSO program is already established in the campus area, it may make sense for the City to partner with the University to expand the responsibilities of this student-staffed community service to include for example responding to suspicious circumstances or vehicles CFS. Other example CSO activities include processing complaints and taking reports.

New and Emerging Models

In addition to reviewing existing and planned local resources, NICJR reviewed the New and Emerging Models of Community Safety and Policing Report, to identify programs that might be appropriate for Berkeley implementation. Five initiatives were identified pursuant to this review: San Francisco's Street Crisis Response Team (SCRT); Olympia, Washington's Crisis Response Unit (CRU); Mayor's Action Plan (MAP) for New York City; The Arlington Opiate Outreach Initiative; and NYPD Staten Island's Motor Vehicle Accident Pilot Program. Seattle, Washington's new Specialized Triage Response System is also highlighted.

The Street Crisis Response Team (SCRT) is a pilot program administered by the Fire Department in San Francisco, California, for individuals experiencing a behavioral health crisis. SCRT Teams consist of a behavioral health specialist, peer interventionist, and a first responder who work in 12-hour shifts. 911 calls that are determined to be appropriate for the SCRT are routed to SCRT by dispatch. A team responds in an average of fifteen minutes.

The City of Olympia, Washington implemented their **Crisis Response Unit (CRU)** in April of 2019 to serve as an option for behavioral health calls for service. The CRU teams consist of mental health professionals that provide supports such as mediation, housing assistance, and referrals to additional services to their clients. Calls for service for the CRU originate from community-based service providers, the City's 911 hub, and law enforcement personnel.

The Mayor's Action Plan (MAP) for New York City (NYC) was launched in 2015 in fifteen NYC Housing Authority properties with high violence rates in order to foster productive dialogue between local residents and law enforcement, address physical disorganization, and bolster pro-social community bonds. MAP's focal point is NeighborhoodStat, a process that allows residents to have a say in the way NYC allocates its public safety resources. Early evaluations show a reduction in various crimes as well as increased perception of healthier neighborhoods.

The Arlington Opiate Outreach Initiative was established in 2015 in Arlington, Massachusetts and brings together social workers, community-based organizations, and public health clinicians housed in the Arlington Police Department in order to foster relationships with residents of the community and then connect them to treatment and supports. Individuals in the community are identified for possible treatment after frequent police encounters, prior history of drug usage, or previous hospitalization related to overdoses.

NYPD Staten Island's **Motor Vehicle Accident Pilot Program** is aimed at reducing the number of calls for service related to minor collisions. When a call for service comes in regarding a collision, dispatch will determine if the collision is minor or serious enough to merit police response. If the collision is deemed to be minor, all individuals involved in the crash will simply complete a collision report and then exchange contact information.

In partnership with the City of Seattle, NICJR produced a report analyzing the 911 response of the Seattle Police Department and suggested CFS that can be addressed by alternative community response. This analysis

16 https://ucpd.berkeley.edu/services/community-service-officer-cso-program

was instrumental in Seattle's new commitment to a Specialized Triage Response System, a response that at full operational capacity will be able to potentially respond to 8,000 to 14,000 non-emergency calls. This new department will be receiving training from CAHOOTS and STAR staff.[17]

17 https://durkan.seattle.gov/2021/07/mayor-jenny-durkan-announces-proposal-to-create-a-new-specialized-triage-response-to-provide-alternative-to-sworn-police-response/

COMMUNITY SURVEY

In partnership with the City of Berkeley's (City) Reimagining Public Safety Task Force and the City Manager's Office, Bright Research Group (BRG) conducted an online-based community survey (survey) in both English and Spanish between May 18 and June 15, 2021. The survey was disseminated by the City of Berkeley, the Reimagining Public Safety Task Force, community-based organizations, and other key partners. The survey was designed to gather insight into residents' perceptions and experiences in three primary areas: the Berkeley Police Department (BPD) and crisis response; priorities for reimagining public safety; and recommendations for alternative responses for calls for service. A total of 2,729 responses were collected.

SURVEY SUMMARY

Community Safety

While most survey respondents indicated that they view Berkeley as safe or very safe, these results were not consistent across all demographic groups. Slightly over 30 percent of respondents perceived Berkeley as safe or very safe; an additional 46.4 percent of respondents perceived Berkeley as somewhat safe. White residents were more likely to perceive Berkeley as safe or very safe; Black, Latin, Asian and Other Non-white residents were more likely to perceive Berkeley as unsafe or very unsafe.

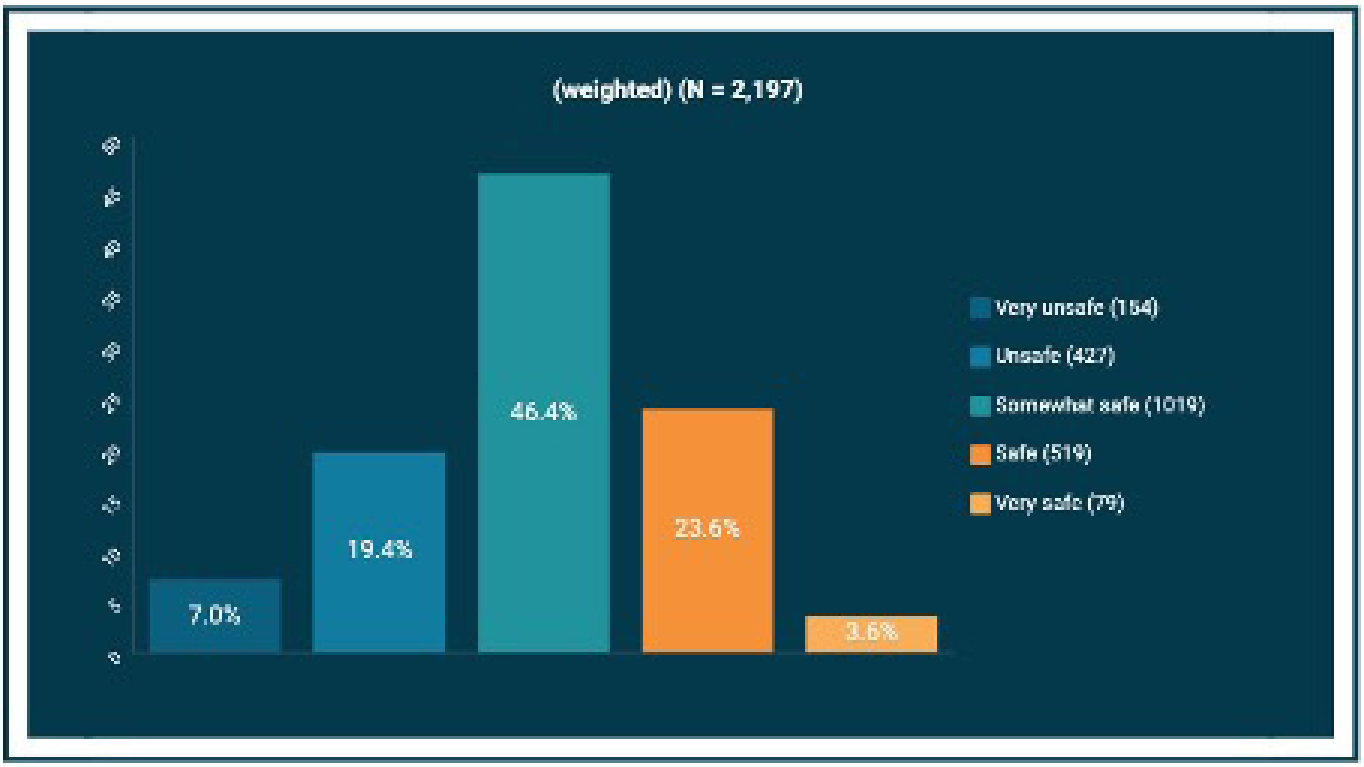


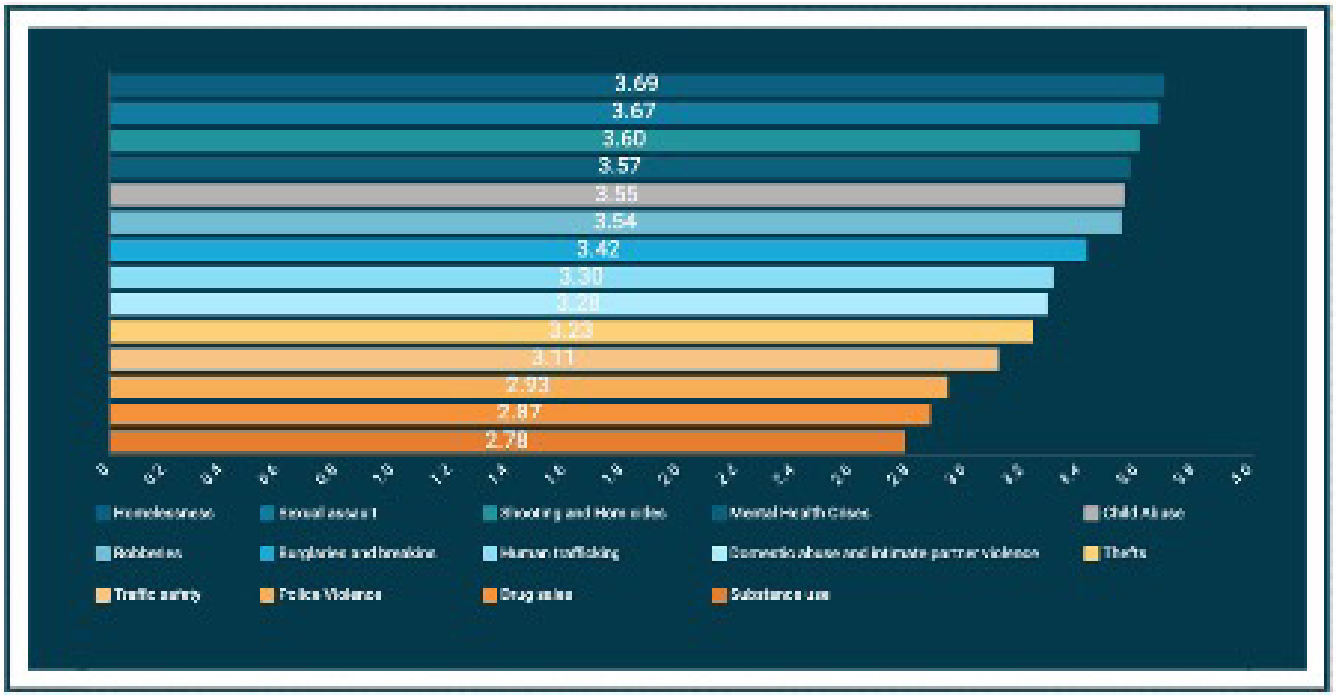
Table 12. How safe do you think Berkeley is? By race and ethnicity.

	White N = 1,622	Black N = 139	Latin N = 103	Asian N = 159	Other Nonwhite N = 168	Undisclosed N = 478
Very unsafe	4.0%	14.4%	9.7%	7.5%	15.5%	19.5%
Unsafe	14.7%	25.9%	25.2%	24.5%	23.2%	34.9%
Somewhat safe	50.5%	36.0%	46.4%	45.3%	46.4%	33.1%
Safe	26.2%	22.3%	13.1%	20.8%	13.1%	10.0%
Very safe	4.6%	1.4%	1.8%	1.9%	1.8%	2.5%

Key Public Safety Concerns

Survey respondents ranked homelessness and sexual assault as the most important public safety concerns. These were followed by shootings and homicides and mental health crises. The lowest priorities were substance use, drug sales, and police violence.

Figure 6. How important are the following issues to community health and safety in Berkeley to you? (weighted)[18]



Nearly half of survey respondents reported experiencing street harassment, and 41 percent reported being the victim of a crime. Black survey respondents reported experiencing higher rates of mental health crisis, homelessness, and family victimization, as well as police harassment and arrest, than did other survey respondents.

Patterns in priorities for safety were consistent across race and ethnicity, except for survey respondents with an undisclosed race and ethnicity.

When assessing the findings on priorities of Berkeley residents for community health and safety, survey respondents ranked investments in mental health, homeless and violence prevention services highest. There are differences along race and ethnicity for investment priorities, with White respondents rating all listed programs higher overall. Black respondents were also rated an investment in mental health services higher in comparison to other prevention services.

18 4: very important; 3: important; 2: somewhat important; 1: not important

Figure 7. How important is it to you for the City of Berkeley to invest in each of these programs and services to ensure a public safety system that works for all? (weighted)[19]

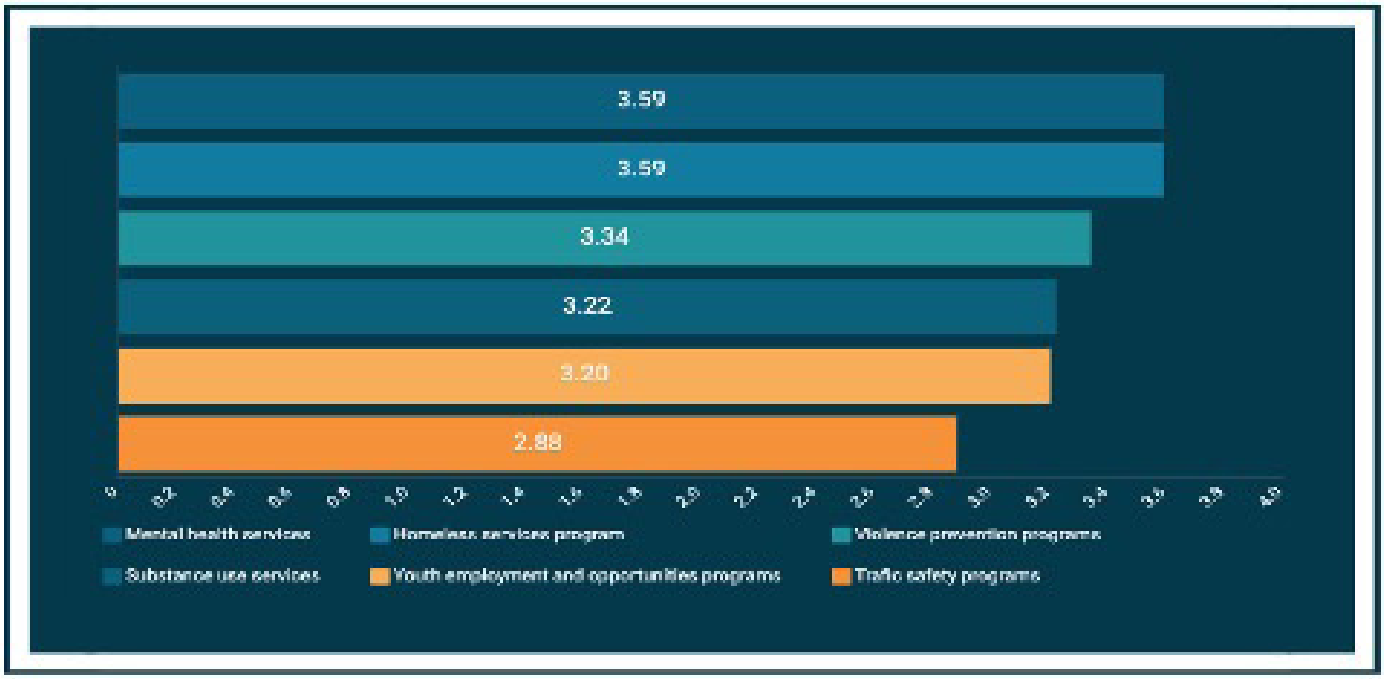


Table 13. How important is it to you for the City of Berkeley to invest in each of these programs and services to ensure a public safety system that works for all? By race and ethnicity.[20]

	White N = 1,599	Black N = 136	Latin N = 103	Asian N = 154	Other Nonwhite N = 167	Undisclosed N = 462
Not important at all	6.8%	8.8%	4.9%	5.2%	10.2%	5.2%
Somewhat Important	36.3%	36.0%	41.7%	43.5%	30.5%	35.9%
Important	43.4%	27.2%	32.0%	35.1%	39.5%	34.0%
Very Important	13.4%	27.9%	21.4%	16.2%	19.8%	24.9%

Views on the Berkeley Police Department

A majority of respondents (53.3 percent) perceived the BPD as being effective or very effective. Only 6.7 percent of respondents perceived BPD as being not effective at all. Nonwhite respondents were more likely to indicate that BPD is not effective at all, while White respondents were more likely to indicate that BPD is effective.

19 4: very important; 3: important; 2: somewhat important; 1: not important
20 4: very important; 3: important; 2: somewhat important; 1: not important

When assessing experiences of residents when contact is made with BPD, survey results found that almost 75 percent of respondents who indicated they've had contact with BPD indicated their experience was positive or very positive, while Black and Asian residents were more likely to report negative experiences with BPD.

Table 14. When it comes to public safety, how effective is the Berkeley Police Department? By race and ethnicity.

	White N = 1,599	Black N = 136	Latin N = 103	Asian N = 154	Other Nonwhite N = 167	Undisclosed N = 462
Not effective at all	6.8%	8.8%	4.9%	5.2%	10.2%	5.2%
Somewhat effective	36.3%	36.0%	41.7%	43.5%	30.5%	35.9%
Effective	43.4%	27.2%	32.0%	35.1%	39.5%	34.0%
Very effective	13.4%	27.9%	21.4%	16.2%	19.8%	24.9%

Views on Alternative Responses to Calls for Service

A large majority of survey respondents (81 percent) among all racial and ethnic groups indicated a preference for trained mental health providers to respond to calls related to mental health and substance use, with most also indicating that police should be available to support a response to those calls if needed.

An even greater percentage (83.6 percent) of survey respondents indicated a preference for homeless services providers to respond to calls related to homelessness, with police present when necessary.

Figure 8: Who should respond to calls related to mental health and substance use?

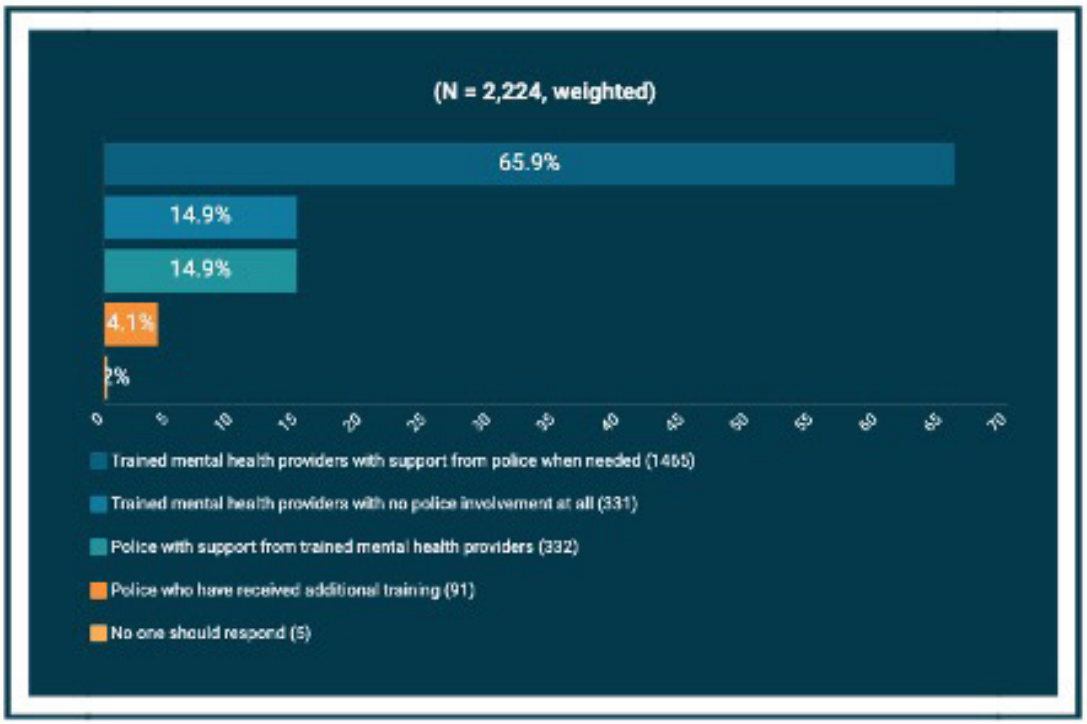
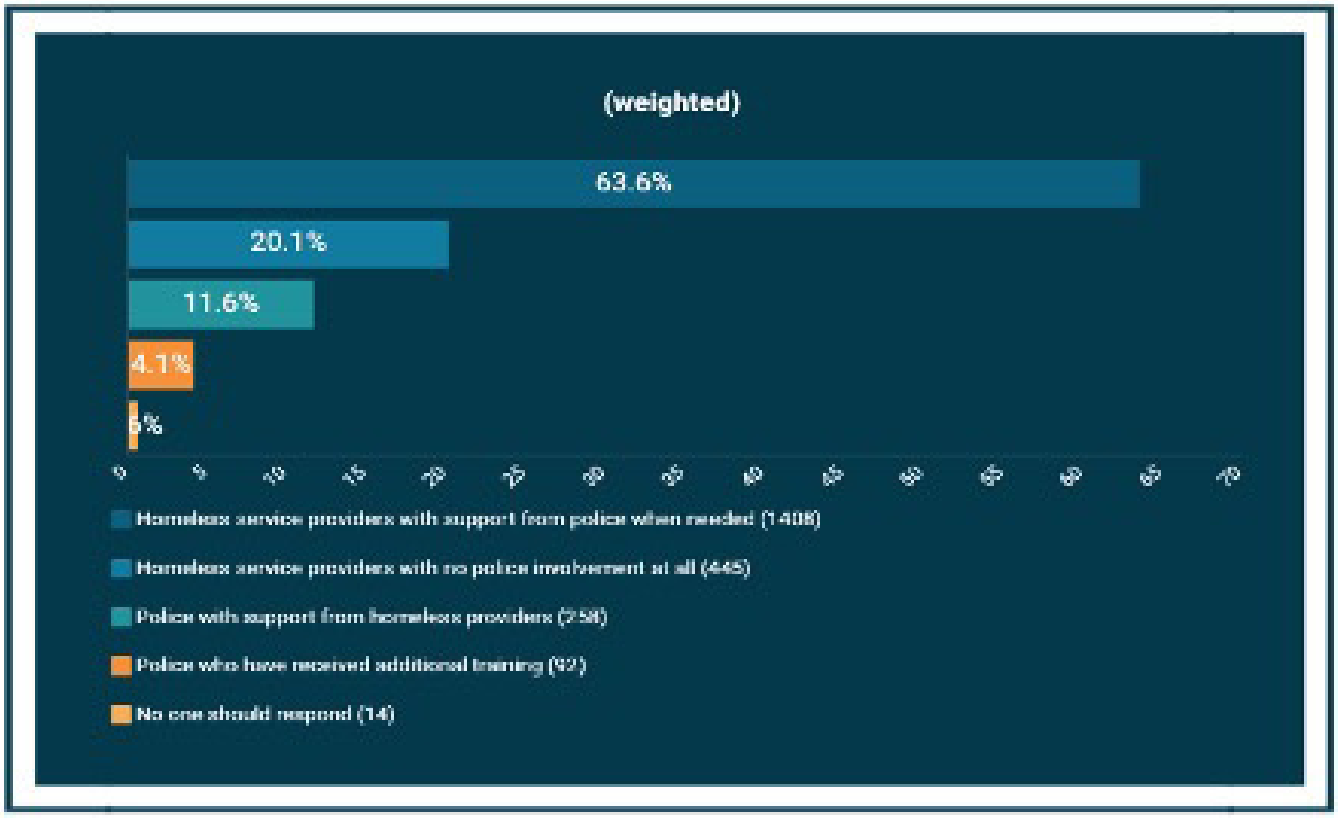


Figure 9. Who should respond to calls related to homelessness?



Focus Group Feedback

In collaboration with NICJR, Bright Research Group facilitated a series of focus groups to gather data on community sentiment regarding the current state of public safety, the role of the Berkeley Police Department (BPD), and the future of public safety. Outreach to Black, Latino, system-impacted, and unstable housed/ food-insecure residents was facilitated by the McGee Avenue Baptist Church, Center for Food, Faith, and Justice, and the Berkeley Underground Scholars. Researchers conducted four focus groups comprised of 55 individuals.

Youth under the age of 18 and Latino residents are underrepresented in the focus groups. The qualitative data collected is also not necessarily representative of Black. Latino, formerly incarcerated, or housing-insecure residents.

Table 15. Focus Group Participants

Focus Group Description	Number of Participants
Black Residents	18
Housing- / Food-Insecure Residents	27
Black and Latin Youth	4
Justice-System-Impacted Students	6
Total Stakeholders	**55**

Focus group participants shared concerns regarding gang involvement, racism, and the availability of guns in Berkeley. Black and Latino youth and Justice-System-Impacted students expressed significant concerns about their personal safety and police violence. Participants identified homelessness and the housing crisis as critical public health and safety issues. Black residents, housing-insecure residents, and system-impacted individuals all expressed distrust in the City government. Black residents, youth, system-impacted students, and low-income residents also expressed that policing in Berkeley allows for race and income-related profiling. Focus group participants also stated that police resources are mismanaged.

Diverse perspectives were collected regarding the future role of BPD. Youth would like police officers who are part of the community and interact positively with young people. Participants who discussed divestment from police recommended investment in trained peacekeepers and community safety patrols as alternatives.

With regard to mental health crises and homelessness, focus group participants across demographic groups suggested that clinicians and social workers play a role in interventions. Focus group participants expressed broad support for the power of community-driven crime prevention strategies and expressed trust in community-based and faith-based organizations; conversely, there was some suspicion expressed regarding the idea that BPD functions would simply be performed by another government agency.

PROPOSAL: TIERED DISPATCH SYSTEM

Based on the information and analysis described above, and in accordance with City Council ordinances and the Berkeley Reimagining Public Safety Process, NICJR and its team recommends that Berkeley initiate a phased implementation of a Tiered Dispatch system, reflecting the CERN framework described above, and tailored to the needs of the City.

The Tiered Dispatch model contemplates diverting a substantial portion of calls for service that are currently handled by BPD sworn officers to a newly-established CERN that leads with a non-law-enforcement response. This diversion includes "Tier 1" responses, which do not include dispatch of law enforcement officers (at least at the outset), and "Tier 2" responses, which are led by alternative responders but include presence of officers as a precaution. The model also includes non-law-enforcement participation in "Tier 3" responses that are led by sworn officers.

The CERN – which should be robust, structured, and well-trained – will have radio connection directly into BPD dispatch in order to be able to call for an officer if needed. On Tier 2 responses, the alternative responders leading the team will determine the necessity for active engagement of the on-site officers. During the pilot phase, the frequency of active police assistance can be assessed and certain call types can be moved to different tiers based on the assessment.

Our analysis of call-for-service data indicates that over 80 percent of the calls are for non-criminal matters (see Fig. 3, above). A substantial subset of these calls can be handled as Tier 1 and Tier 2 responses, led by alternative responders.

Alternative responders may include: non-governmental entities, including community-based organizations retained by the City through service contracts; City employees, who are staff of departments other than BPD; and/or BPD employees who are not sworn officers. Each arrangement presents a variety of benefits and challenges, and different approaches can be adopted for different elements of the Tiered Dispatch program. The new BerkDOT and the SCU may be integrated as appropriate, as these new arms of City government get off the ground. These decisions can be made during the phased implementation described below.

Alternative responses should be piloted and scaled after proven effective. As the Tiered Response system is built out, BPD budget needs will be reduced, and more funds should be available to support alternative responses, whether performed by City staff or community-based organizations under contract with the City.

Development and implementation of the Tiered Dispatch advances the Berkeley City Council's July 14, 2020, direction "to evaluate initiatives and reforms that reduce the footprint of the Police Department and limit the Police's scope of work primarily to violent and criminal matters."[21] In addition, phased implementation of the Tiered Dispatch model would reflect substantial public and community sentiment expressed in the surveys described above, and in Task Force discussions to date. Finally, the model builds on innovative best practices being advanced in various cities around the country; Berkeley can learn from initial experiences in this rapidly-changing field, and develop an approach suitable to the City's needs.

21 Berkeley City Council, Omnibus Motion on Public Safety Items (Council Agenda Items 18a-e, Recommendation #2), approved July 14, 2020.

Implementation of Tiered Dispatch System

As described above, we recommend that the Tiered Dispatch system be implemented on a phased basis over time, commencing with a pilot program. This will enable assessment for efficacy; give time for administrative, employment, and contracting structures to be put in place; and allow for thorough and focused program development. NICJR will provide detail on a proposed implementation plan in its final report, but includes some initial thoughts at this stage for public consideration.

Pilot Program

As a first step, we recommend establishment of an Alternative Response Pilot Program, focused on a subset of the "Tier 1" calls. The following subset of BPD call types can be used in the pilot phase in order to work out logistical and practical challenges.

Table 16. Tier 1 Subset of Call Types

	2015	2016	2017	2018	2019
Abandoned Vehicle	403	449	481	476	496
Disturbance	6741	6955	7447	7540	6709
Found Property	900	914	888	779	726
Injury Accident Report	–	–	–	31	29
Inoperable Vehicle	–	–	–	1	6
Lost Property	16	16	17	15	14
Noise Disturbance	3359	3307	3239	3158	2709
Non-Injury Accident	561	617	571	564	492
Suspicious Circumstances	2586	2354	2254	2184	2041
Suspicious Person	1628	1698	1756	1653	1479
Suspicious Vehicle	1560	1687	1626	1385	1448
Vehicle Blocking Driveway	–	–	–	345	953
Vehicle Blocking Sidewalk	–	–	–	15	45
Vehicle Double Parking	–	–	–	6	14
Total	**17754**	**17997**	**18279**	**18152**	**17161**

Once the pilot has been initiated then we recommend the following steps:

1. Assess the pilot program, including response times, resolution of emergency, how often officers are being requested to the scene by the CERN, and other measures;
2. Evaluate administrative, budget, and staffing implications from the transfer of services;
3. Expand additional alternative response programs, over time, to achieve City Council's direction of concentrating police response on violent and criminal matters;

With the implementation of alternative responses through the phased in Tiered Dispatch approach, we anticipate that a hiring freeze and natural attrition will reduce the numbers of sworn officers employed by BPD, as the alternative response system is built out. NICJR is not recommending layoffs of officers. As alternative response is implemented, BPD should concentrate its officers' efforts on serious, violent felonies, with a top priority on gun crimes. We also recommend shifting BPD resources and staff time (sworn and non-sworn) to investigations, with a focus on solving violent crimes and improving clearance rates.

CONCLUSION

Berkeley is a relatively safe and well-resourced city. However, thefts, robberies, and incidents involving people with potential mental health and/or substance use challenges are of significant concern. By reducing BPD's focus on non-criminal and low-level CFS, the Department can improve its response, investigation, and prevention of more serious crime. Over time, a transition of responsibility for response to Tier 1 CFS could generate between $2-$6 million of annual savings to the BPD budget.[22] If invested in the build-out of the alternative response network, these funds would comprise a 35 percent increase in the City Manager's proposed FY22 funding level for community-based organization, or alternative City staffing. This type of targeted redirection of BPD resources would represent a significant and meaningful step in the City's efforts to reimagine public safety.

These new, reimagined ideas will take time and effort to implement successfully. Any reduction in policing services should be measured, responsible, and safe. A Final Report and Implementation Plan will be submitted to the City that includes detailed recommendations. Financial and organizational impacts and resources for implementation recommendations as well as a detailed timeline and plan for implementation will be included.

22 See Fiscal Implications section above, estimating Tier 1 savings at $6.3 million.

APPENDIX

*Courtesy of Janny Castillo, boona cheema, and Margaret Fine

APPENDIX J

Community Engagement Report

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OVERVIEW

The Reimagining Public Safety process in Berkeley includes comprehensive outreach and engagement of local community members. The National Institute for Criminal Justice Reform (NICJR) and our partners Bright Research Group (BRG), with significant support and input from the Reimagining Public Safety Taskforce, developed a multi-pronged community engagement strategy. The process included a broadly distributed survey along with a series of listening sessions designed to engage marginalized, hard to reach, or communities with high rates of police contact. With guidance from the City Manager's Office, BRG focused on four populations for listening sessions: Black, Latinx, formerly incarcerated and low-income individuals struggling with food and/or housing insecurity. The following report includes initial findings from these events and the survey.

Additional Community Engagement efforts were organized and facilitated by Task Force members with the support of NICJR in an effort to include additional marginalized populations: LatinX, those who have experienced mental health challenges, the LGBTQIA+ community, and those who have experienced partner violence. Following the initial release of the draft final report, three community wide virtual listening sessions were held to gather feedback and input from the broader Berkeley community. Information and perspectives garnered from this wide array of community engagement provide valuable information for the work of the Taskforce and the City of Berkeley moving forward.

Berkeley Reimagining Public Safety Process Community Engagement Timeline

Community Engagement Event	Lead Entity	Date	Attendance	Status of Summary Data
BPD focus group with command staff	NICJR	May 6, 2021		In report
Community Survey	BRG	May 14, 2021	2,729	In report
Listening Session/Community meeting – focus on Black community	BRG-Pastor Smith	May 25, 2021	18	In report
BPD focus group with line staff	NICJR	June 2, 2021 & June 3, 2021		In report
Berkeley Merchant Association Focus group	NICJR - In coordination with Telegraph BA and Downtown BA	June 2, 2021	6	In report
Listening Session/Community meeting – Housing Unstable and Formerly Incarcerated (focus on POC)	BRG-Center for Faith Food and Justice	June 9, 2021	27	In report
Vulnerable Youth Listening Session (ages 13-17)	BRG-Pastor Smith	Jun 28, 2021	4	In report

Community Engagement Event	Lead Entity	Date	Attendance	Status of Summary Data
Listening Session for residents experiencing mental health challenges	NICJR - In coordination with CE TF Commissioner Fine	June 29, 2021	14	In report
BIPOC students Listening Session	BRG-Underground Scholars	Jun 30, 2021	4	In report
LGBTQ/Trans Community Listening Session	NICJR - In coordination with CE TF Commissioner Fine	July 1, 2021	0	In report
Develop Report on process and findings from Community Engagement/Outreach and Community Survey results	BRG	Jul 6, 2021		In report
Latinx Listening Session	TF Commissioner Malvido-with support from NICJR	July 8, 2021		Pending submission of notes from TF members
Latinx Listening Session Youth from Berkeley High School	TF Commissioner Malvido-with support from NICJR	no updates as of 10/25/2021		Pending submission of notes from TF members
Gender-Based Violence	Gender-Based Violence Subcommittee	8/19/2021	8 organizations represented	In report
Gender-Based Violence	Gender-Based Violence Subcommittee	9/21/2021		In report
Citywide Community Meetings: 3 virtual 1 in-person (The in-person Community Meeting was canceled due to public health/safety concerns)	NICJR/Task Force CE Subcommittee/City Mgr's office	11/10/2021 11/15/2021 11/23/2021 In-person 11/30/2021		In report
A toll free number will be available for community members to add additional feedback on the Final report	888-299-1118			Two messages have been received as of the publication of this report. Both messages left were related to procedural matters; i.e. Task Force meeting schedules and postings on the City website.

BRIGHT RESEARCH GROUP

City of Berkeley Reimagining Public Safety Survey— Summary Report

Moira DeNike, PhD., and Alice Hu-Nguyen, MSPH
Bright Research Group | July 1, 2021

INTRODUCTION

The City of Berkeley is developing a community safety model that reflects the needs of the community and creates increased safety for all. In collaboration with the City of Berkeley's Reimagining Public Safety Task Force and the City Manager's Office, Bright Research Group (BRG) developed and conducted a community survey to gather residents' experiences with and perceptions of the Berkeley Police Department and crisis response; their perspectives on and priorities for reimagining public safety; and recommendations for alternative responses for community safety. This report summarizes the key quantitative findings from the City of Berkeley's Reimagining Public Safety Survey.

METHODS AND SAMPLE

A total of 2,729 responses were collected between May 18 and June 15, 2021. The City of Berkeley, the Reimagining Public Safety Task Force, community-based organizations, and other key partners disseminated the community survey through various online channels and websites to those who live, work, and study in Berkeley, in English and Spanish. Respondents completed the survey online.

Descriptive and statistical analyses were conducted. To allow for disaggregated analysis by race and ethnicity, the survey responses were recoded into six discrete race and ethnicity categories: white, Black, Latin, Asian, Other Nonwhite, and Undisclosed. For all the findings provided below in aggregate (i.e., not disaggregated by race and ethnicity), the analysis includes weighting by the race and ethnicity factors in order to correct for the disproportionate representation among some racial and ethnic groups in the sample. Cross-tabulations and a chi-square test for significance were conducted to examine the relationship between race and ethnicity and categorical survey responses. A comparison of means and an analysis of variance (ANOVA) test for significance were also used. Both of these tests look at differences across the independent variables as a whole. These tests can show whether the differences observed on the basis of race and ethnicity are different from one another in general, but cannot tell us if answers from one racial and ethnic group are specifically different from another. Given that race and ethnicity have been shown to be substantive factors associated with perceptions of community safety (Whitfield, et al., 2019), and given the limitations with respect to the representativeness of this sample, this analysis is particularly attentive to racial and ethnic differences in responses. All reported differences by race and ethnicity in the findings are statistically significant ($p<.05$) for both chi-square tests and ANOVA test.

LIMITATIONS

The survey sample was not representative of the Berkeley population with regard to race and ethnicity, sexual orientation, zip code, and age. White, older (45 years and older), women, and LGBTQ residents, as well as those who live in the 94702, 94705, and 94707 zip codes, were overrepresented in the sample. Black, Latin, Asian, male, and younger residents were underrepresented in the sample. The nonrepresentative nature of the sample should be noted when interpreting the findings from this survey. The results of this survey are likely to be biased and may not truly reflect community impressions of safety.

See the Appendix for detailed methods and a sample profile.

Summary of Findings

Community Perceptions and Priorities for Safety in Berkeley

Perceptions of Safety in Berkeley

The respondents expressed a range of perspectives regarding the safety of Berkeley, with a plurality selecting "Somewhat safe" in response to this item. Respondents who indicated they are white were more likely to perceive Berkeley as safe and very safe. Respondents who are Black or Other Nonwhite were significantly more likely to perceive Berkeley as unsafe and very unsafe. Respondents who identified as Latin and Asian were more likely than white respondents, but less likely than Black and Other Nonwhite respondents, to perceive Berkeley as unsafe and very unsafe. Unexpectedly, respondents who declined to indicate their race and ethnicity were the most likely to perceive Berkeley as unsafe and very unsafe.

It is worth noting that while Middle Eastern / North African and Native Americans each represented a small number of the respondents (42 and 33, respectively), they were substantially more likely to perceive Berkeley as unsafe and very unsafe than most other racial and ethnic groups (52% and 42%, respectively). Similarly, Pacific Islander / Native Hawaiian respondents represented a small number (N = 22) but were substantially less likely to perceive Berkeley as safe and very safe (0%), but they were not more likely to indicate it as unsafe with 60% selecting somewhat safe.

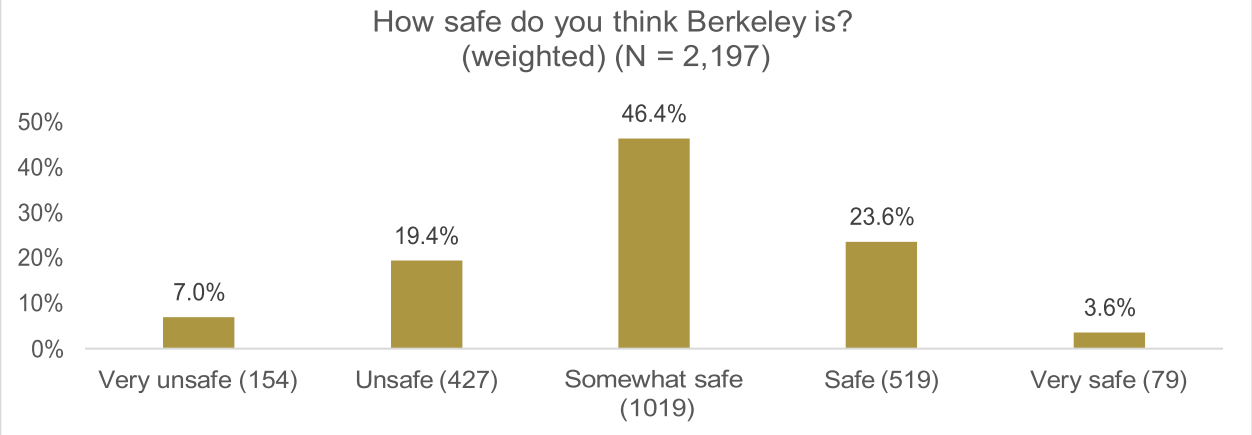


Table 1. How safe do you think Berkeley is? By race and ethnicity.

	White N = 1,622	Black N = 139	Latin N = 103	Asian N = 159	Other Nonwhite N = 168	Undisclosed N = 478
Very unsafe	4.0%	14.4%	9.7%	7.5%	15.5%	19.5%
Unsafe	14.7%	25.9%	25.2%	24.5%	23.2%	34.9%
Somewhat safe	50.5%	36.0%	46.4%	45.3%	46.4%	33.1%
Safe	26.2%	22.3%	13.1%	20.8%	13.1%	10.0%
Very safe	4.6%	1.4%	1.8%	1.9%	1.8%	2.5%

Resident Priorities for Safety

Survey respondents ranked homelessness and sexual assault as the most important public safety concerns, followed by shootings and homicides and mental health crisis. Respondents ranked substance use, drug sales, and police violence as their lowest priorities.

Some responses varied on the basis of the respondents' race and ethnicity—although the differences were not large—and patterns were fairly consistent across the array of race and ethnicity groups, with the exception of the respondents with an undisclosed race and ethnicity. Notably, this group collectively rated police violence substantially lower in importance to community health and safety as compared with other groups. This group was also far more likely to indicate that theft was an important issue in Berkeley.

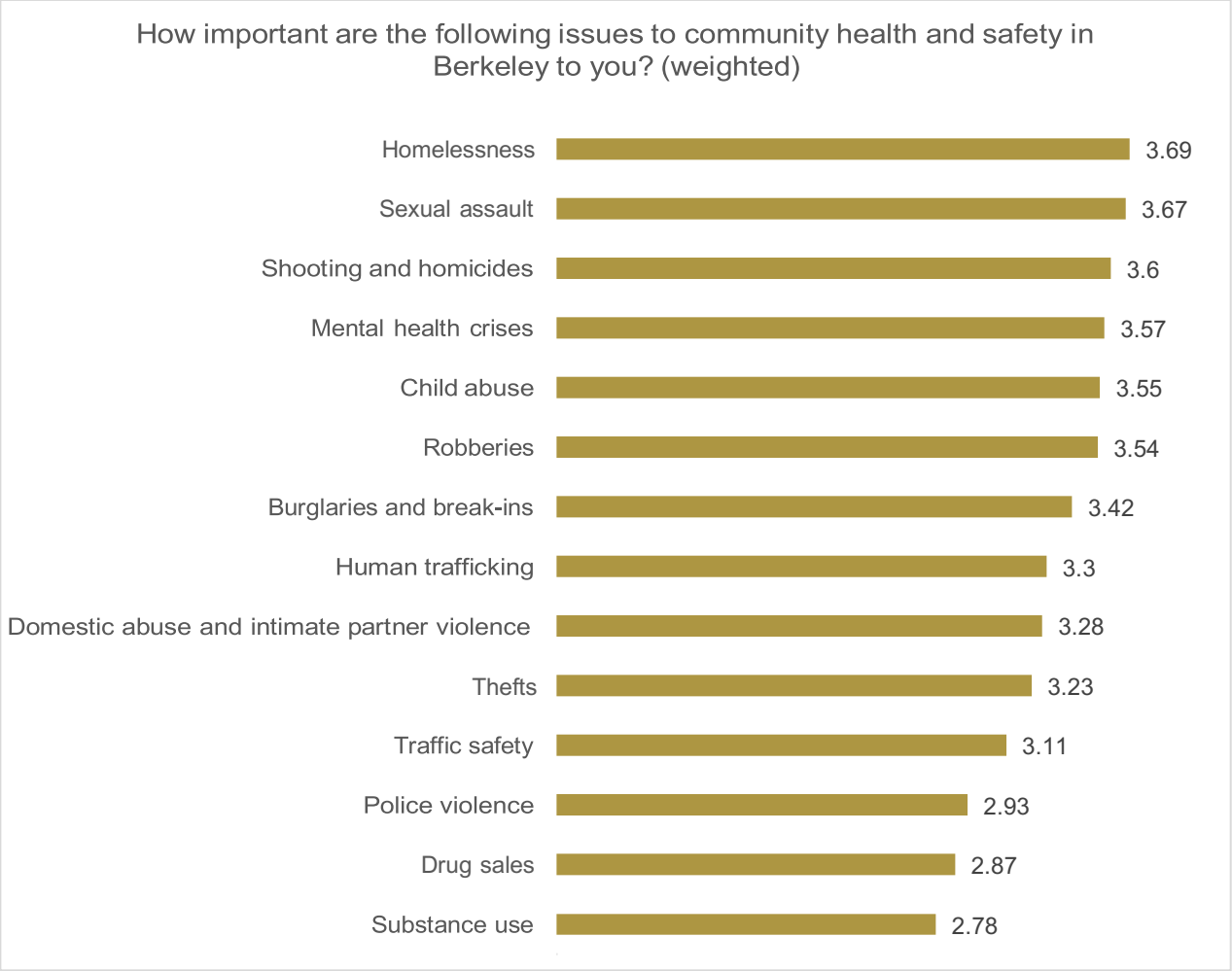


Table 2. How important are the following issues to community health and safety in Berkeley to you? By race and ethnicity.

	White	Black	Latin	Asian	Other Nonwhite	Undisclosed
Substance use	2.68	2.97	2.73	2.91	2.95	2.97
Drug sales	2.77	3.00	2.86	3.01	3.03	3.14
Police violence	3.00	2.90	2.74	2.95	2.76	2.34
Traffic safety	3.07	3.24	3.09	3.13	3.22	3.18
Thefts	3.16	3.35	3.26	3.32	3.25	3.57
Domestic abuse and Intimate partner violence	3.28	3.31	3.34	3.23	3.24	3.18
Human trafficking	3.27	3.48	3.38	3.23	3.42	3.27
Burglaries and break-ins	3.35	3.51	3.46	3.50	3.46	3.73
Robberies	3.46	3.67	3.59	3.64	3.56	3.82
Child abuse	3.54	3.68	3.63	3.47	3.63	3.55
Mental health crises	3.59	3.68	3.50	3.54	3.48	3.45
Shooting and homicides	3.51	3.77	3.69	3.67	3.68	3.77
Sexual assault	3.61	3.80	3.77	3.70	3.77	3.71
Homelessness	3.71	3.59	3.65	3.73	3.59	3.60

Priorities for Community Health and Safety

The mean responses show the highest community support for investment in mental health services, with investment in homeless services programs and violence prevention program also rating fairly high. There are some differences along race and ethnicity in terms of investment priorities, with white respondents rating all listed program investments higher overall, and those with an undisclosed race and ethnicity rating all listed program investments lower overall. While all racial and ethnic groups rated mental health services higher than the other listed program investments, Black respondents rated it particularly high in comparison to other investment options.

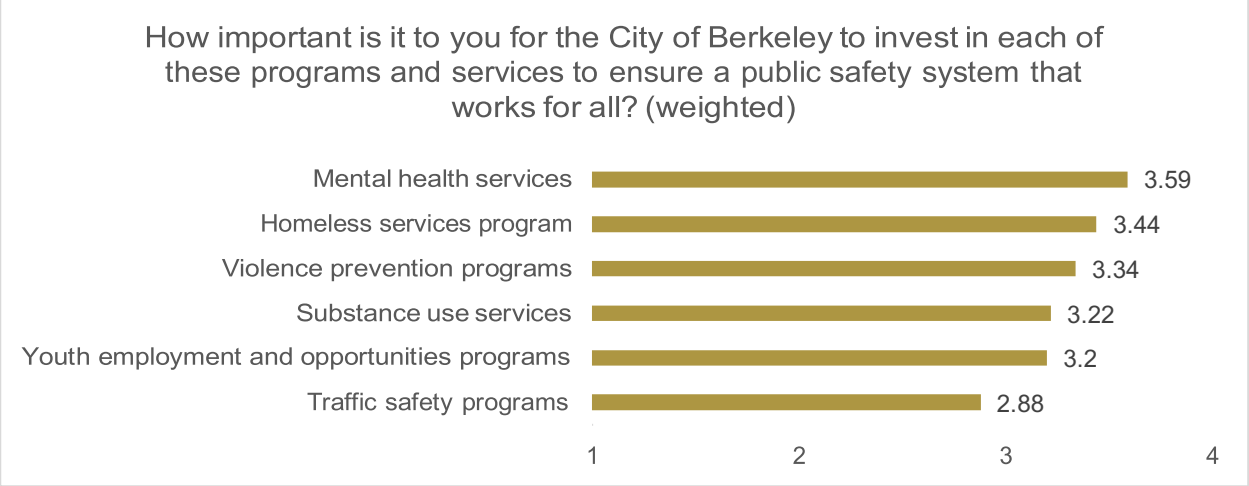


Table 3. How important is it to you for the City of Berkeley to invest in each of these programs and services to ensure a public safety system that works for all? By race and ethnicity.

	White	Black	Latin	Asian	Other Nonwhite	Undisclosed
Traffic safety programs	2.91	2.90	2.77	2.84	3.02	2.81
Youth employment and opportunities programs	3.26	2.99	3.23	3.15	3.14	2.74
Substance use services	3.27	3.03	3.21	3.19	3.17	2.81
Violence prevention programs	3.35	3.19	3.32	3.33	3.41	3.06
Homeless services program	3.56	3.12	3.26	3.44	3.22	2.86
Mental health services	3.69	3.48	3.46	3.53	3.43	3.15

Experiences in Berkeley

Nearly half of the respondents reported experiencing street harassment, and 41% reported being the victim of a crime. Differences along race and ethnicity appear on a number of self-reported personal experiences. Black respondents were more likely to indicate that they have experienced multiple incidents and conditions, including arrest, police harassment, a mental health crisis, homelessness, family victimization, and crime victimization.

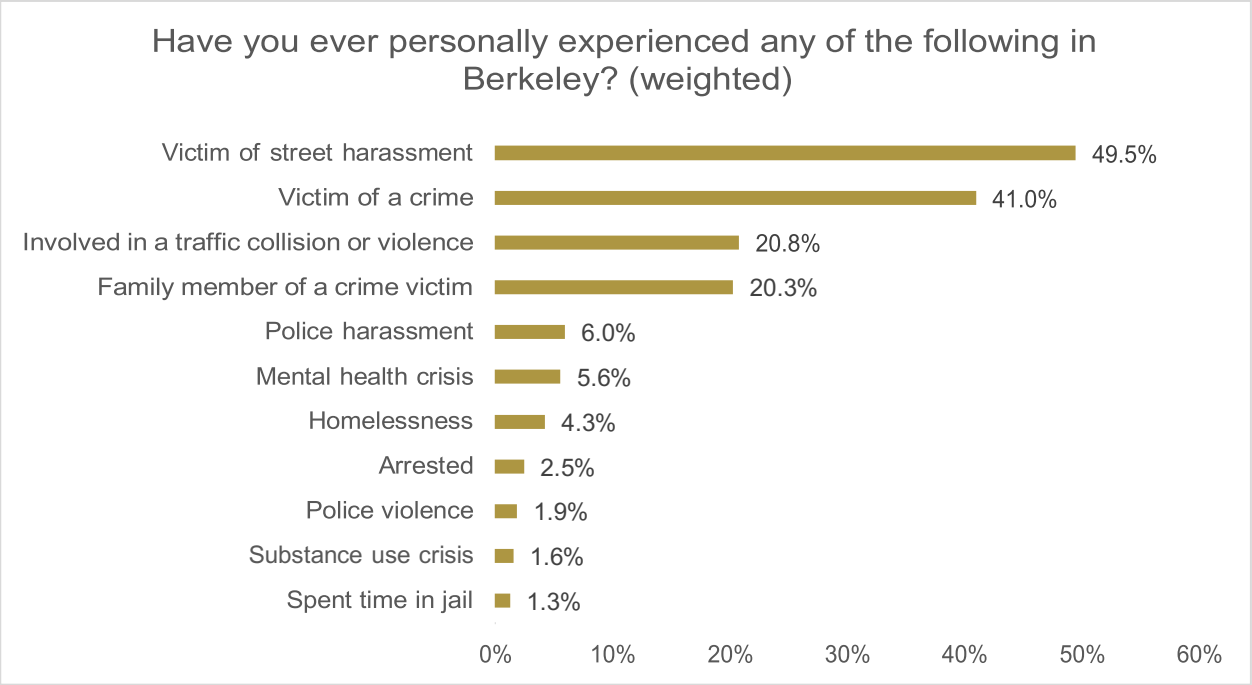
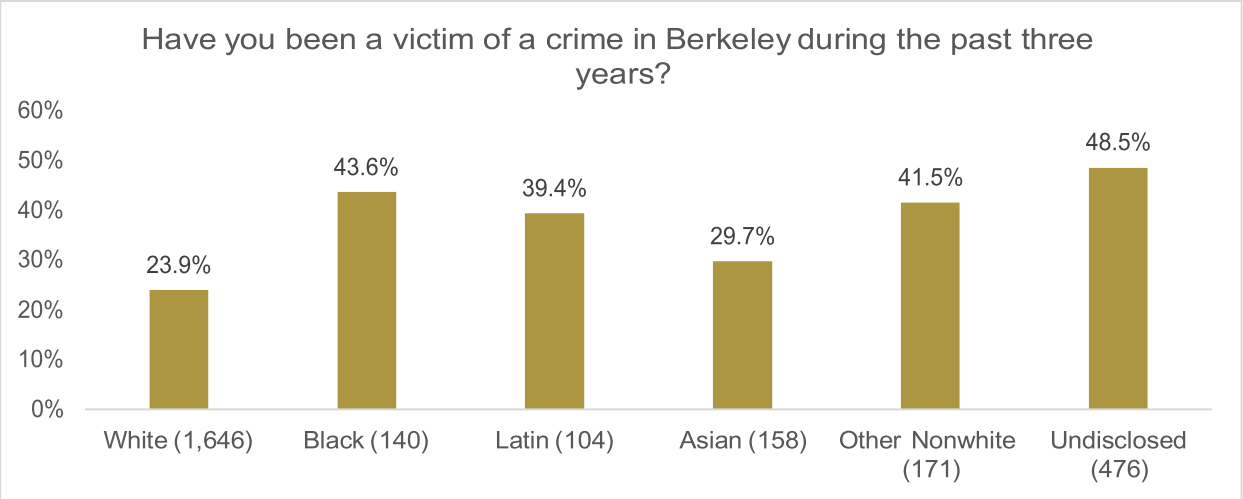


Table 4. Have you personally experienced any of the following in Berkeley? By race and ethnicity.

	White	Black	Latin	Asian	Other Nonwhite	Undisclosed
Spent time in jail	1.3%	5.0%	1.9%	0.0%	.6%	1.4%
Substance use crisis	1.3%	4.3%	4.8%	0.0%	1.7%	1.0%
Police violence	1.5%	2.1%	2.9%	2.5%	1.7%	.8%
Arrested	1.8%	7.1%	4.8%	1.9%	.6%	2.2%
Homelessness	3.1%	12.1%	7.6%	1.9%	6.4%	6.6%
Mental health crisis	5.1%	8.6%	7.6%	4.3%	5.8%	6.2%
Police harassment	4.3%	17.1%	7.6%	5.0%	6.4%	4.0%
Family member of a crime victim	17.0%	35.0%	24.8%	16.8%	32.0%	32.5%
Involved in a traffic collision or violence	20.5%	22.9%	20.0%	21.1%	20.3%	25.9%
Victim of a crime	40.2%	50.7%	43.8%	37.3%	43.0%	53.3%
Victim of street harassment	43.1%	55.7%	61.9%	52.2%	64.0%	64.1%

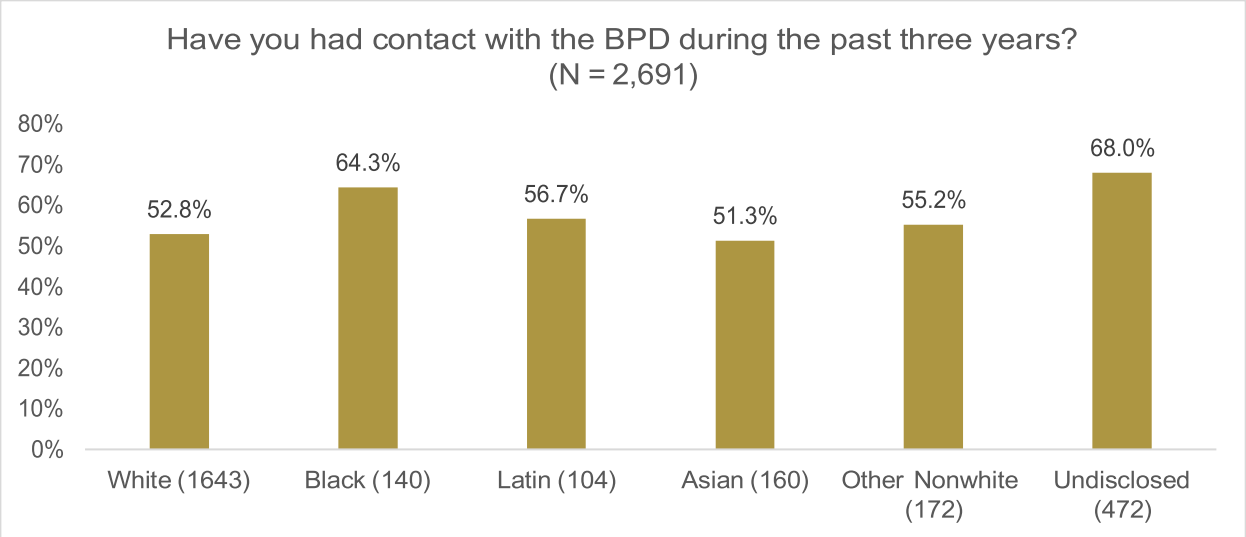
Crime Victimization

Approximately 30% of the respondents indicated having been a crime victim in the City of Berkeley during the past three years. Respondents who are Black and who declined to disclose race and ethnicity were the most likely to indicate that they have been the victim of a crime in Berkeley during the past three years. White respondents were the least likely to do so.



Experience with the Berkeley Police Department

Over half of the respondents (54%) indicated that they have had contact with the Berkeley Police Department (BPD) during the past three years. Respondents who are Black and who declined to disclose race and ethnicity were the most likely to report that they have had contact with the BPD during the past three years.



Perceived Effectiveness of the Berkeley Police Department

Many respondents (38%) perceived the department to be somewhat effective and over half (55.3%) perceived it to be effective or very effective. Only a small number and percentage of the respondents (6.7%) indicated that the Berkeley Police Department is not effective at all.

Some differences in perceived effectiveness of the Berkeley Police Department emerged when the data were disaggregated by race and ethnicity. Nonwhite respondents were more likely to indicate that the

BPD is not effective at all; Asian and Latin respondents were more likely to indicate that the BPD is somewhat effective; and white respondents were more likely to indicate that the BPD is effective. Black residents held diverse views regarding the BPD, and the analysis found that they were more likely to view the BPD as either very effective or not effective at all compared to other groups. Those with undisclosed race and ethnicity were more likely to indicate that the BPD is very effective.

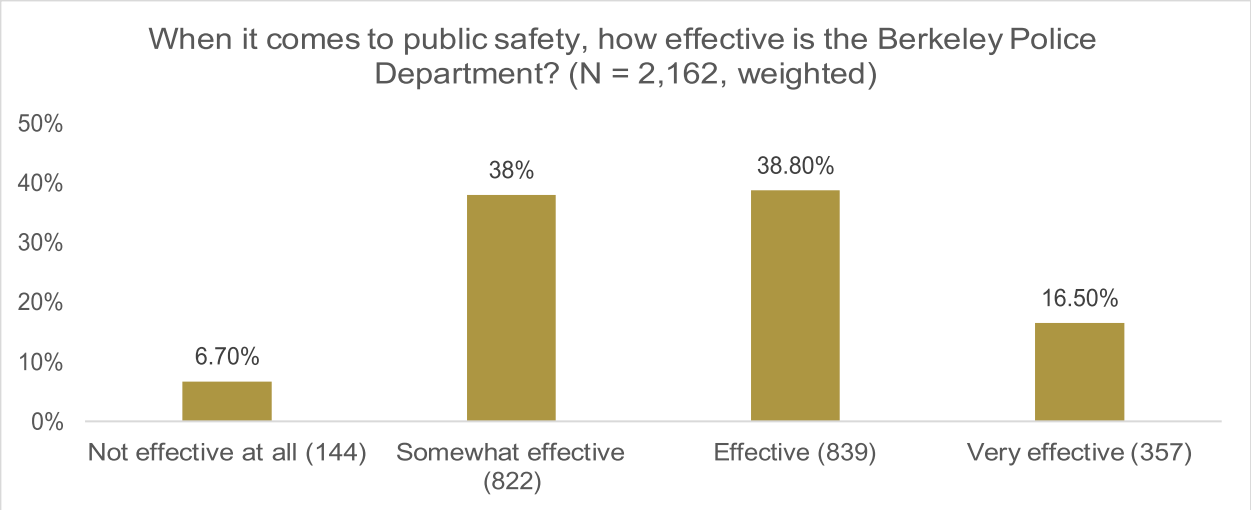


Table 5. When it comes to public safety, how effective is the Berkeley Police Department? By race and ethnicity.

	White N = 1,599	Black N = 136	Latin N = 103	Asian N = 154	Other Nonwhite N = 167	Undisclosed N = 462
Not effective at all	6.8%	8.8%	4.9%	5.2%	10.2%	5.2%
Somewhat effective	36.3%	36.0%	41.7%	43.5%	30.5%	35.9%
Effective	43.4%	27.2%	32.0%	35.1%	39.5%	34.0%
Very effective	13.4%	27.9%	21.4%	16.2%	19.8%	24.9%

Trust that the Berkeley Police Department treats all people fairly and equitably

A little over half of the respondents trust the BPD to usually treat people fairly and equitably, with the remaining 26% demonstrating low confidence in the police on this measure. A minority of the respondents (22%) always trust the BPD to treat people fairly and equitably. Some differences emerged along race and ethnicity with respect to confidence in the BPD to exercise fairness and equity. Black and Latin respondents hold a variety of perspectives on police. They were more likely than other groups to either not trust the BPD or to have confidence in them. Respondents with an undisclosed race and ethnicity were the most likely to demonstrate confidence in the BPD in this regard, and the least likely to demonstrate low confidence.

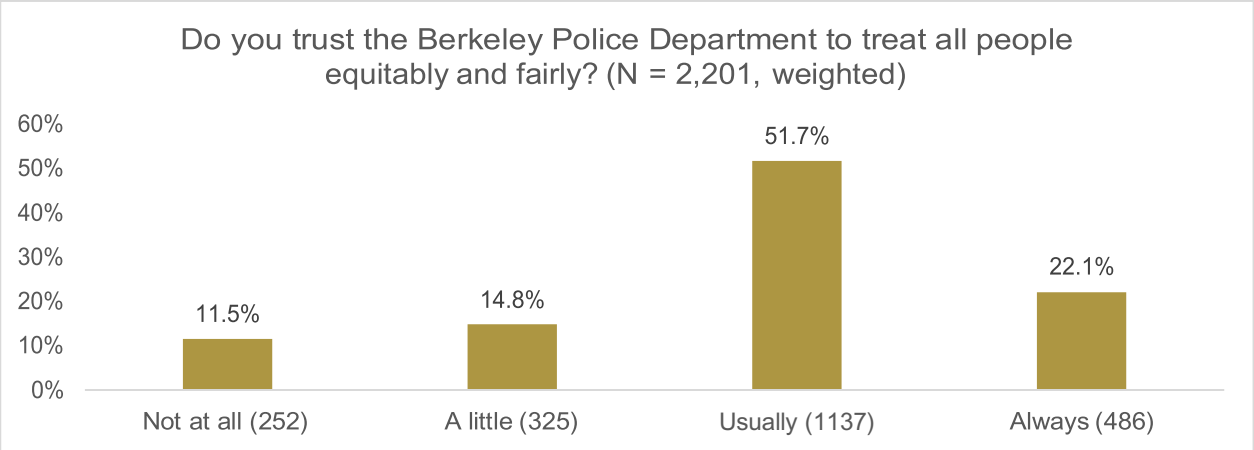


Table 6. Do you trust the Berkeley Police Department to treat all people equitably and fairly? By race and ethnicity.

	White (N = 1,632)	Black (N = 139)	Latin (N = 102)	Asian (N = 159)	Other Nonwhite (N = 169)	Undisclosed (N = 474)
Not at all	10.3%	16.5%	16.7%	10.1%	10.7%	3.0%
A little	16.1%	12.9%	12.7%	13.9%	12.4%	8.2%
Usually	55.0%	38.8%	37.3%	56.3%	48.5%	44.9%
Always	18.6%	31.7%	33.3%	19.6%	28.4%	43.9%

Quality of Experience with the Berkeley Police Department

Among the respondents who indicated that they've had contact with the BPD and chose to report on the quality of those experiences, three out of four (74.8%) indicated that the experience was positive or very positive. Differences in experiences with police across race and ethnicity include Black and Asian respondents as the most likely to report negative experiences, and respondents with undisclosed race and ethnicity as the least likely to report negative experiences and the most likely to report positive experiences with the BPD.

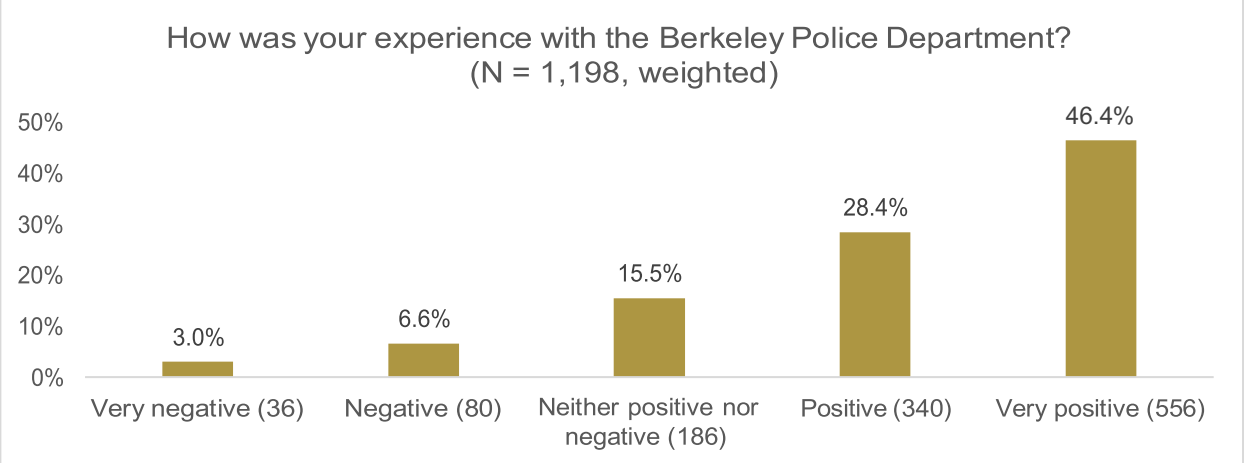


Table 7. How was your experience with the Berkeley Police Department? By race and ethnicity.

	White N = 864	Black N = 90	Latin N = 59	Asian N = 82	Other Nonwhite N = 95	Undisclosed N = 318
Very negative	2.3%	4.4%	5.1%	2.4%	4.2%	0.6%
Negative	6.1%	6.7%	1.7%	11.0%	5.3%	3.8%
Neither positive nor negative	17.0%	13.3%	20.3%	11.0%	13.7%	12.6%
Positive	31.0%	21.1%	18.6%	31.7%	25.3%	15.1%
Very positive	43.5%	54.4%	54.2%	43.9%	51.6%	67.9%

Likelihood to call Emergency Responses

Respondents are far more likely to call 911 in response to an emergency situation *not* involving mental health or substance use (86.2%) than they are to an emergency that does relate to a mental health or substance use crisis (57.9%). Over half of the respondents did, however, indicate that they are likely or very likely to call 911 in response to a mental health or substance-use-related crisis (57.9%).

Black and Latin respondents indicated a wide range of responses to the question regarding their likelihood of calling the 911 in response to a mental health or substance use crisis. On the other hand, racial and ethnic groups responded similarly in response to the question about calling 911 when there's an emergency *not* related to mental health or substance use. Substantially more Black respondents indicated extreme reluctance as compared with other groups.

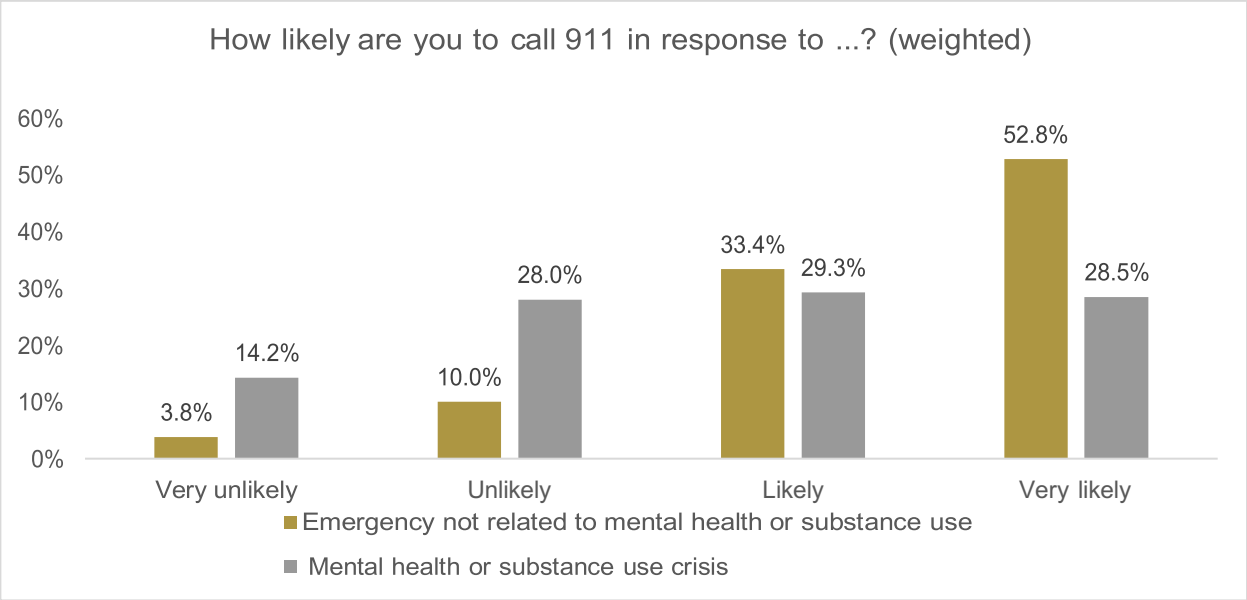


Table 8. How likely are you to call emergency services (911) in response to an emergency NOT related to a mental health or substance use crisis? By race and ethnicity.

	White N = 1,632	Black N = 140	Latin N = 104	Asian N = 156	Other Nonwhite N = 171	Undisclosed N = 468
Very unlikely	3.7%	9.3%	3.8%	1.9%	2.9%	4.1%
Unlikely	10.9%	11.4%	7.7%	8.3%	10.5%	9.8%
Likely	33.8%	27.9%	33.7%	34.6%	32.2%	26.7%
Very likely	51.5%	51.4%	54.8%	55.1%	54.4%	59.4%

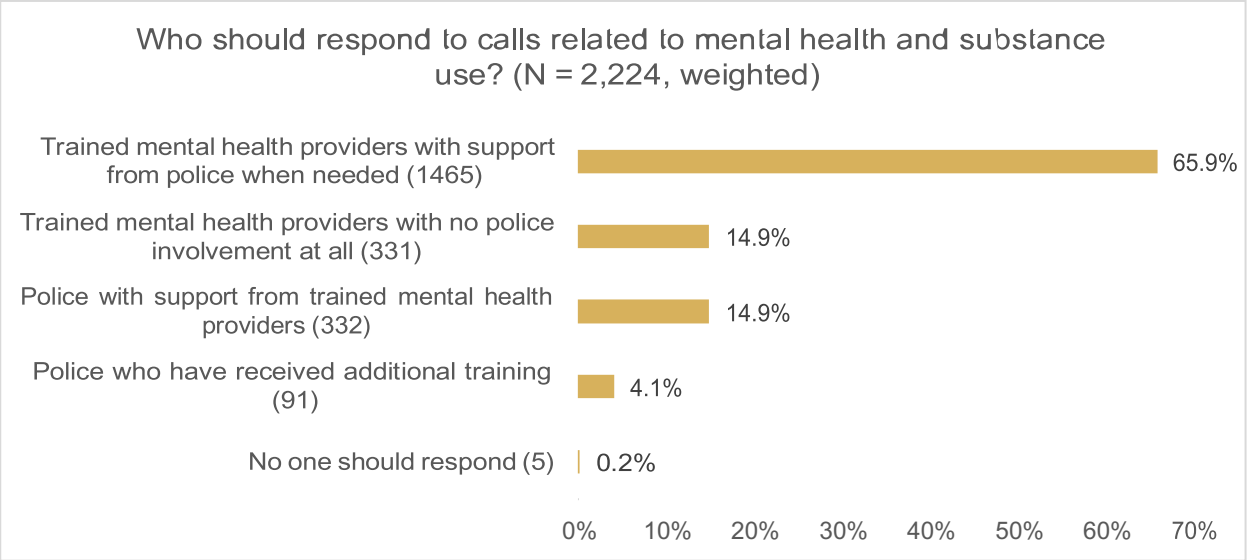
Table 9. How likely are you to call emergency services (911) in response to a mental health or substance use crisis? By race and ethnicity.

	White N = 1,628	Black N = 140	Latin N = 104	Asian N = 158	Other Nonwhite N = 170	Undisclosed N = 471
Very unlikely	15.2%	20.0%	20.2%	6.3%	14.7%	15.9%
Unlikely	26.7%	25.0%	20.2%	35.4%	31.2%	22.9%
Likely	30.8%	20.7%	21.2%	32.9%	28.8%	28.5%
Very likely	27.4%	34.3%	38.5%	25.3%	25.3%	32.7%

Preference for crisis response

A large majority of the respondents (80.8%) indicated a preference for trained mental health providers to respond to calls related to mental health and substance use, with most among those respondents indicating that police support should be available when needed. Some respondents (19%) indicated a preference for a police response, with over two-thirds of those respondents indicating that mental health providers should be available for support.

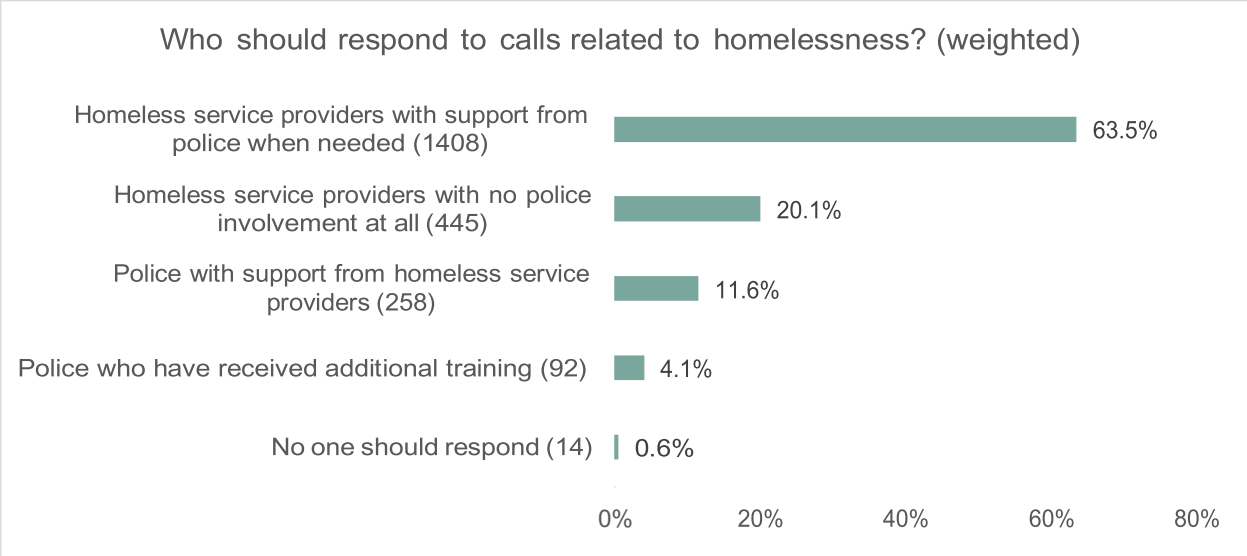
All racial and ethnic groups show a preference for "Trained mental health providers, with support from police when needed" to respond to calls related to mental health and substance use. Respondents whose race and ethnicity were undisclosed were the most likely to prefer a police response (42%) in comparison to other groups.



Preference for response to homelessness

A large majority of the respondents (83.6%) indicated a preference for homeless services providers to respond to calls related to homelessness, with most among those respondents indicating that police support should be available when needed. Some of the respondents (15.7%) indicated a preference for a police response, with the majority of those respondents indicating that homeless services providers should be available for support.

All racial and ethnic groups show a preference for homeless services providers, with support from police when needed to respond to calls related to homelessness. Respondents whose racial and ethnic were undisclosed were the most likely to prefer a police response (41%) in comparison to other groups.



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APPENDIX

SAMPLE PROFILE

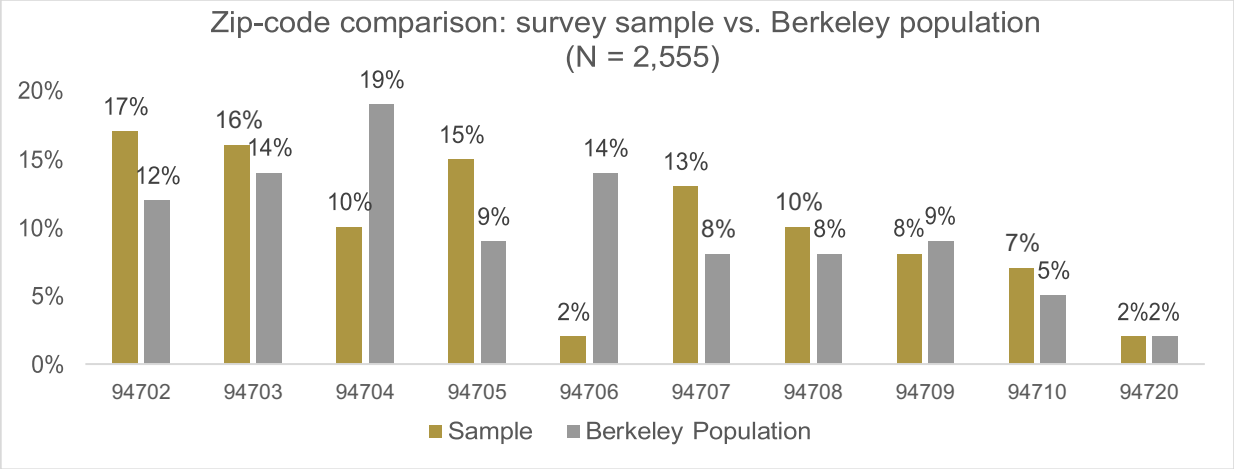
Relationship to City of Berkeley

The vast majority of the survey respondents live in Berkeley (84.4%). A portion work in Berkeley (but don't live there), and a small number have other situations or provided no information. Notably, very few houseless residents responded to the survey.

Live or work in Berkeley (N = 2,729)	**Percent**
Live in Berkeley	84.4%
Work in Berkeley	12.0%
I am currently experiencing homelessness	0.1%
I do not live or work in Berkeley	2.3%
No information	1.1%

Zip Code

The Berkeley population is spread out primarily across the 10 zip codes listed in the table and chart below, which compare the survey responses with Berkeley population figures.[1] These data show that certain zip codes are overrepresented in the sample (e.g., 94702, 94705, 94707), while others are underrepresented (e.g., 94704, 94706).



Age

The sample skews significantly toward older respondents, with approximately 70% of the respondents who provided information on their age identifying themselves as 45 years or older, and over 40% of the respondents identifying themselves as 60 years or older. By comparison, among the adult population of

[1] Zip-code data for the residents of Berkeley from Zip-code.com. Retrieved on 6/24/21 from https://www.zip-codes.com/city/ca-berkeley.asp.

Berkeley, 42% is estimated to be 45 or older, and only 25% is estimated to be 60 or older.[2] Note that there were 55 respondents who did not respond to this question.

Age Range (N = 2,674)	Percent
Under 14 years (1)	0.04%
14–17 (3)	0.1%
18–29 (182)	6.8%
30–44 (21)	23.2%
45–59 (788)	29.5%
60+ years (1,079)	40.4%

Sexual Orientation

Of the respondents who responded to the question pertaining to sexual orientation (84 respondents declined to answer the question), 67% indicated that they are heterosexual or straight; nearly 17% indicated a preference not to disclose; and approximately 16% indicated a sexual orientation generally classified under the umbrella of LGBTQ. While there are no reliable existing figures to show the percentage of the LGBTQ population among Berkeley residents, it is reasonable to speculate that the LGBTQ population is overrepresented in the sample on the basis of recent figures estimating that the LGBTQ population in the wider Bay Area is 6.7% (Conron, et al., 2021). Furthermore, new analyses show that younger populations are more likely to indicate an LGBTQ identification as compared with older populations (Jones, 2021). Given this research and the age of the sample, one would anticipate a lower-than-average LGBTQ percentage in the sample rather than a higher-than-average percentage—which again suggests over-sampling of the LGBTQ population.

Sexual Orientation (N = 2,645)	Percent
Heterosexual or straight (1,771)	67.0%
Prefer not to say (447)	16.9%
Gay or lesbian (155)	5.9%
Bisexual (133)	5.0%
Queer (72)	2.7%
Questioning or unsure (16)	0.6%
Other, please specify (51)	1.9%

[2] Population estimates from Census Reporter. Retrieved on 6/24/21 from https://censusreporter.org/profiles/16000US0606000-berkeley-ca/.

Gender Identity

In terms of gender, men are underrepresented in the sample. A substantial portion of the respondents (nearly 10%) preferred not to disclose their gender identity.

Gender Identity (N = 2,662)	**Percent**
Woman (1,439)	54.1%
Man (893)	33.5%
Genderqueer / nonbinary / other (73)	2.7%
Prefer not to say (257)	9.7%

Race and Ethnicity

The table below represents all survey responses to the question of race and ethnicity before any recoding or weighting, so the total number exceeds the number of respondents. Please note that for this survey, respondents were invited to select all racial and ethnic categories that applied to them. In other words, an individual who selected White, as well as Black or African American and South Asian is counted three times in the table below.

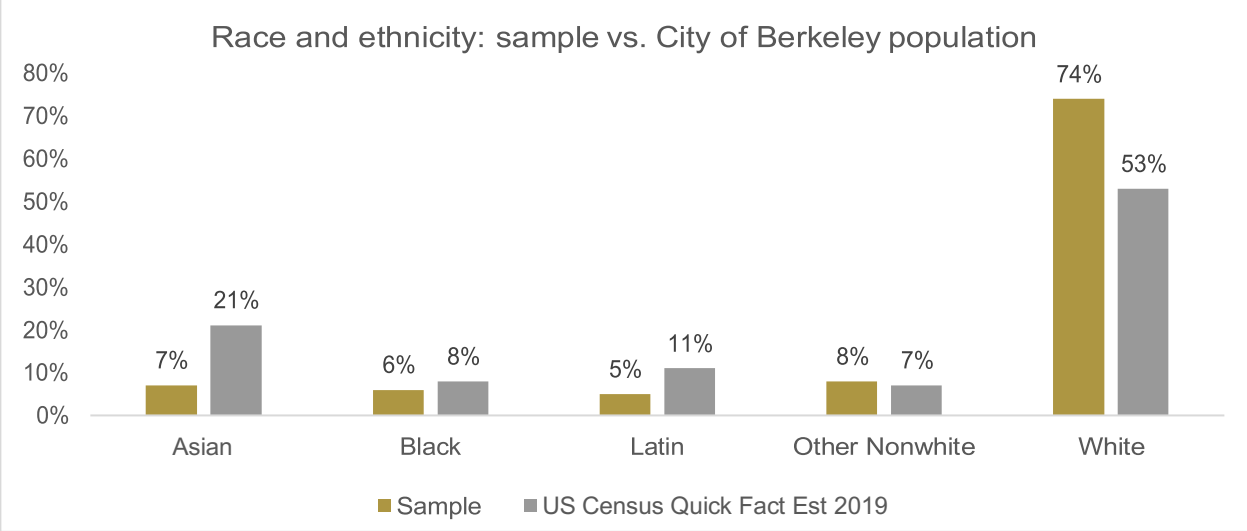
Race and ethnicity	**Number**	**% of Total**
White	1787	65.5%
Black or African American	137	5.0%
Latin	126	4.6%
East Asian	168	6.2%
South East Asian	53	1.9%
South Asian	47	1.7%
Middle Eastern / North African	42	1.5%
American Indian / Native American / Alaskan Native	33	1.2%
Pacific Islander or Native Hawaiian	22	0.8%
Other	113	4.1%
Prefer not to say	409	15.0%

In order to simplify the data to allow for disaggregated analyses and to enable the creation of a weighting scheme, the analysts created a reduced number of discrete (i.e., not overlapping) racial and ethnic categories. To condense the data into discrete categories, the data were recoded in the following manner:

- White: Respondents who selected only White as their race and ethnicity were coded as white; respondents who selected “Other” and then wrote in only an ethnicity that is considered white (e.g., European, Irish, Jewish, etc.) were coded as white.
- Black: Respondents who selected Black were coded as Black, even if they also selected other racial and ethnic identities.

- Latin: Respondents who had selected Latin were coded as Latin, even if they also selected other racial and ethnic identities (unless they also selected Black, in which case they were recoded as Black).
- Asian: Respondents who selected East Asian, Southeast Asian, or Other and then wrote in an ethnicity that is considered Asian (e.g., Japanese, Chinese, etc.) were coded as Asian, even if they also selected other racial and ethnic identities (besides Black or Latin)
- Other Nonwhite: All other nonwhite racial and ethnic categories were combined into a single "Other Nonwhite" variable, including Native American / Alaskan, South Asian, Arab / Middle Eastern, and Pacific Islander / Native Hawaiian, as well as anyone who selected multiple racial and ethnic identities that did not include Black, Latin, or Asian, and anyone who selected "Other" and then wrote in an ethnicity that was outside the aforementioned categories.

Notably, after White the most common response in the data set was "Prefer not to say," which was recoded to include blank responses as well as anyone who selected "Other" and then wrote in a nonresponsive category (e.g., "human race," "race does not exist," or "irrelevant"). These respondents comprise 18% of the sample (478 out of 2,708) and are listed as Undisclosed under race and ethnicity. In the disaggregated analyses, their responses are included to show how this group's answers differed from those of other groups, but for the purposes of devising a weighting scheme on the basis of race and ethnicity, these respondents are omitted, as the race and ethnicity data for them is essentially missing.



	Sample		Berkeley Population US Census QuickFacts Est. 2019	Weighting Factor
Asian	161	7%	21%	3
Black	140	6%	8%	1.333
Latin	105	5%	11%	2.2
Other Nonwhite	172	8%	7%	0.875
White	1652	74%	53%	0.716
Subtotal	2230	100%	100%	--

Undisclosed	478	18%	--	--
Total sample	2708	100%	--	--

The Berkeley Community Safety survey sample (respondent population) is not representative of the Berkeley population in terms of race and ethnicity. The table above shows the breakdown of race and ethnicity for the Berkeley population and the sample (for the respondents who provided race and ethnicity information).

For all findings provided below in aggregate (i.e., not disaggregated by race and ethnicity), the analysis includes weighting by the race and ethnicity factor (as listed above) in order to correct for the disproportionate representation of some racial and ethnic groups in the sample. So, for example, respondents who are Asian comprise only 7% of the sample but 21% of the Berkeley population. So in the frequency tables in the findings section, responses from Asian-identified respondents are amplified by a factor of 3. Similarly, white and Other Nonwhite respondents are overrepresented in the sample, so the value of their responses is discounted to 71.6% and 87.5% of their original value, respectively.

Race and ethnicity by Zip Code

Ethnicity		Blank	94701	94702	94703	94704	94705	94706	94707	94708	94709	94710	94712	94720	Not sure	Total
White	#	48	4	264	247	126	264	33	229	186	129	91	1	25	5	1652
	%	2.9%	.2%	16.0%	15.0%	7.6%	16.0%	2.0%	13.9%	11.3%	7.8%	5.5%	.1%	1.5%	.3%	100.0%
Black	#	4	0	31	24	16	11	2	6	9	7	24	0	4	2	140
	%	2.9%	0.0%	22.1%	17.1%	11.4%	7.9%	1.4%	4.3%	6.4%	5.0%	17.1%	0.0%	2.9%	1.4%	100.0%
Latin	#	3	0	18	15	15	22	7	7	5	4	6	0	0	3	105
	%	2.9%	0.0%	17.1%	14.3%	14.3%	21.0%	6.7%	6.7%	4.8%	3.8%	5.7%	0.0%	0.0%	2.9%	100.0%
Asian	#	7	0	27	27	19	14	2	10	18	19	11	0	7	0	161
	%	4.3%	0.0%	16.8%	16.8%	11.8%	8.7%	1.2%	6.2%	11.2%	11.8%	6.8%	0.0%	4.3%	0.0%	100.0%
Other Nonwhite	#	11	1	19	23	28	15	6	15	18	15	13	0	7	1	172
	%	6.4%	.6%	11.0%	13.4%	16.3%	8.7%	3.5%	8.7%	10.5%	8.7%	7.6%	0.0%	4.1%	.6%	100.0%
Undisclosed	#	63	3	72	75	56	56	8	53	32	25	30	0	8	18	499
	%	12.6%	.6%	14.4%	15.0%	11.2%	11.2%	1.6%	10.6%	6.4%	5.0%	6.0%	0.0%	1.6%	3.6%	100.0%
Total	#	136	8	431	411	260	382	58	320	268	199	175	1	51	29	2729
	%	5.0%	.3%	15.8%	15.1%	9.5%	14.0%	2.1%	11.7%	9.8%	7.3%	6.4%	.0%	1.9%	1.1%	100.0%

CITY OF BERKELEY REIMAGINING PUBLIC SAFETY SURVEY

If you would like to take this survey in Spanish, please select Spanish on the right (in the black bar above).

Si le gustaría responder a esta encueta en español, por favor escoja "Español" a la derecha (en la barra color negro que aparece arriba).

The City of Berkeley is looking to create a community safety model that reflects the needs of the community. We invite those who live, work, and study in the City of Berkeley to provide their input on the following:

- The current state of public safety in Berkeley
- The role of the Berkeley Police Department
- Your ideas for the future

Your participation in the survey will inform our decisions about funding and strategy for community safety in Berkeley.

We want your honest feedback and perspective. ***Your survey responses are completely anonymous and confidential.*** You can skip any questions and end the survey at any time. Only Bright Research Group, a third-party outside research firm, will have access to the survey responses. Bright Research Group will summarize de-identified survey responses in a report to the City of Berkeley.

If you have any questions, please contact David White at rpstf@cityofberkeley.info.

Community Safety

1) How safe do you think Berkeley is?

Very safe

Safe

Somewhat safe

Unsafe

Very unsafe

2) For you, what would make Berkeley a safer city?

3) How important are the following issues to community health and safety in Berkeley to you? Please rate each of the issues.

	Very important	Important	Somewhat important	Not important
Shooting and homicides				
Robberies				
Domestic abuse and intimate partner violence				
Sexual assault				
Child abuse				
Burglaries and break-ins				
Thefts				
Traffic safety				
Mental health crises				
Homelessness				
Drug sales				
Substance use				
Human trafficking				
Police violence				

4) Have you personally experienced any of the following in Berkeley? Please check all that apply.

Homelessness

Arrested

Spent time in jail

Victim of a crime

Family member of a crime victim

Victim of street harassment

Involved in a traffic collision or traffic violence

Mental health crisis

Substance use crisis

Police harassment

Police violence

None of the above

5) Have you been a victim of a crime in the City of Berkeley in the past 3 years?

Yes

No

6) Have you had contact with the Berkeley Police Department in the past 3 years?

Yes

No

7) How was your experience with the Berkeley Police Department?

Very positive

Positive

Neither positive nor negative

Negative

Very negative

8) What recommendations do you have to improve police response?

9) When it comes to public safety, how effective is the Berkeley Police Department?

Very effective

Effective

Somewhat effective

Not effective at all

10) Please share examples of how the Berkeley Police Department ***has worked well*** in your community.

If you feel it would be helpful, please describe your community (for example, by race and ethnicity, sex, gender identity or expression, sexual orientation, housing status, age, physical or mental disabilities, class, religion, immigration status).

11) Please share examples of how the Berkeley Police Department ***has not worked well*** in your community.

If you feel it would be helpful, please describe your community (for example, by race and ethnicity, sex, gender identity or expression, sexual orientation, housing status, age, physical or mental disabilities, class, religion, immigration status).

12) Do you trust the Berkeley Police Department to treat all people fairly and equitably?

Always

Usually

A little

Not at all

13) In what ways could the Berkeley Police Department work to build more trust with the community?

Reimagining Public Safety

14) How important is it to you for the City of Berkeley to invest in each of these programs and services to ensure a public safety system that works for all?

	Very important	Important	Somewhat important	Not important
Youth employment and opportunities programs				
Homeless services program				
Mental health services				
Substance use services				
Violence prevention programs				
Traffic safety programs				

15) What other programs and services do we need to invest in within our community to ensure a public safety system that works for all?

As part of the city's Reimagining Public Safety Initiative, the city is developing a pilot program to *reassign noncriminal police service calls to a Specialized Care Unit.*

This Specialized Care Unit (SCU) will consist of trained crisis-response workers who will respond to calls that are determined to be noncriminal and that pose no immediate threat to the safety of community members and/or responding personnel.

Your answers to the following questions will help the city in the design of the pilot program.

16) How likely are you to call emergency services (9-1-1) in response to a mental health or substance use crisis?

Very Likely

Likely

Unlikely

Very unlikely

17) How likely are you to call emergency services (9-1-1) in response to an emergency **not related** *to mental health or substance use ?*

Very likely

Likely

Unlikely

Very unlikely

18) Who should respond to calls related to mental health and substance use?

Trained mental health providers, with no police involvement at all

Trained mental health providers, with support from police when needed

Police, with support from trained mental health providers

Police who have received additional training

No one should respond

19) Who should respond to calls related to homelessness?

Homeless service providers, with no police involvement at all

Homeless service providers, with support of police when needed

Police, with support from homeless service providers

Police who have received additional training

No one should respond

20) Please share any experiences you have had with mental health and/or substance use crisis response services in Berkeley.

21) What recommendations do you have to improve mental health and/or substance use crisis response in Berkeley?

Demographic Information

22) What best describes you?

Live in Berkeley

Work in Berkeley

I am currently experiencing homelessness

I do not live or work in Berkeley

23) Which City of Berkeley zip code do you live or work in?

94701

94702

94703

94704

94705

94706

94707

94708

94709

94710

94712

94720

Not sure

24) How old are you?

Under 14 years

14–17

18–29

30–44

45–59

60+ years

25) What is your race and ethnicity? (Check all that apply.)

Black or African American

Latinx

White

East Asian

South Asian

South East Asian

Pacific Islander or Native Hawaiian

American Indian, Native American, or Alaskan Native

Middle Eastern or North African

Prefer not to say Other—

please specify:

26) Do you identify as transgender?

Yes

No

Unsure / prefer not to say

27) What is your gender?

Woman

Man

Genderqueer

Nonbinary Other—

please specify:Prefer

not to say

28) How would you describe your sexual orientation?

Gay or lesbian

Bisexual

Queer

Questioning or unsure

Heterosexual or straight

Other—please specify: *

Prefer not to say

29) Are you familiar with the City of Berkeley's efforts to reimagine public safety?

Yes

No

30) Would you like to know more about the city's efforts to reimagine public safety?

Yes

No

Thank you!

Thank you for taking our survey! Your response is very important to us. You can find more information about the City of Berkeley's ongoing efforts to reimagine public safety at https://berkeley-rps.org.

CITY OF BERKELEY:
REIMAGINING PUBLIC SAFETY—COMMUNITY PERCEPTIONS

Summary of Findings—July 2021

Bright Research Group
1211 Preservation Park Way
Oakland, CA 94612
www.BrightResearchGroup.com

Introduction

The City of Berkeley is working to develop a community-safety model that reflects the needs of the community and creates increased safety for all. In collaboration with the National Institute for Criminal Justice Reform, Bright Research Group (BRG) facilitated a series of focus groups to gather community perspectives on the current state of public safety, the role of the Berkeley Police Department (BPD), and the future of public safety. The McGee Avenue Baptist Church; the Center for Food, Faith & Justice; and the Berkeley Underground Scholars facilitated outreach to Black, Latin, system-impacted, and unstably housed / food-insecure residents. This report summarizes the key findings from the focus groups conducted in the spring and summer of 2021.

Methodology

Bright Research Group worked with the National Institute for Criminal Justice Reform and the Berkeley City Manager s Office to identify several priority populations for community focus groups—Black, Latin, formerly incarcerated, and low-income individuals struggling with food and/or housing insecurity. The research aimed to gather community insights from those most impacted by disparate policing and was guided by the following research questions:

- How do community members view public safety in Berkeley? How safe do they feel in Berkeley, and what are their most pressing public-safety priorities?
- What ideas does the community have when it comes to reimagining public safety? How should public safety issues be addressed and by whom?
- How do community members experience and view the BPD? How does the BPD currently operate in communities, and what role should they play in future public safety efforts?

Data Collection and Analysis

Bright Research Group researchers conducted four focus groups and spoke with 55 individuals. The focus groups ran for 60–90 minutes and included questions about the participants' perceptions of public safety in Berkeley, including their opinions about existing and proposed responses to crime, mental health crises, homelessness, traffic safety, priorities as they relate to increasing public safety, and their experiences with and opinions about the role of the BPD.

Focus Group Description	**Number of Participants**
Black Residents	18
Housing- / Food-Insecure Residents	27
Black and Latin Youth	4
Justice-System-Impacted Students	6
Total Stakeholders	**55**

BRG analyzed the data from the focus groups and conducted a thematic analysis by research question. The themes uncovered during the thematic analyses are documented in this report as findings and recommendations, and they are intended to support the City of Berkeley and the Reimagining Public Safety Task Force as they work to develop a community safety model that reflects the needs of the community, creates increased safety for all, and reduces inequities and disparities about access to safety.

Limitations: The focus groups reached 55 individuals. A key limitation is that the qualitative data is not necessarily representative of the perspectives of Black, Latin, formerly incarcerated, and houseless residents. Additionally, youth under age 18 and Latin residents were not well-represented in the focus groups.

As part of the community-engagement process, BRG developed a community-safety survey that was distributed by the Berkeley City Manager's Office, the Reimagining Public Safety Task Force, and other community partners. As a group, focus group participants were more critical of the Berkeley Police Department than survey participants.

Findings

Community Perceptions and Priorities for Safety in Berkeley

When it comes to feelings of safety from crime, the focus group participants described Berkeley as a city divided. The focus group participants agreed that many areas of Berkeley are relatively safe but pointed to significant disparities in neighborhood safety. Black residents named the neighborhoods below Martin Luther King Boulevard as unsafe and the hills and neighborhoods above Martin Luther King Boulevard as safe. They indicated that feelings of safety for some come at the expense of younger adults, Black people, and unhoused residents, who are targets of greater surveillance and looming displacement. Black residents and students who participated in the focus groups emphasized that gentrification is detrimental to community safety, erodes community cohesion, and negatively impacts their sense of belonging in their own neighborhoods.

Focus group participants shared concerns about gang involvement, racism, and the availability of guns in Berkeley. Black residents expressed concerns about low-income Black youth s involvement in regional gang and group activity connected to Oakland and Richmond and described a need for deeper recognition of the vulnerability of Black youth. They called for increased investments in community-based and peer-led violence-prevention programs and named a specific need for Black-centered and Black-led mentorship interventions.

Black and Latin youth and students expressed significant concerns about their personal safety and worry most about being victims of robberies, shootings, and police violence. When asked about how safe Berkeley is, students and youth said they do not feel comfortable while walking the streets or enjoying public spaces in Berkeley and therefore move through the city cautiously. Black and Latin students and youth feel hyper visible while living in Berkeley. The students described feeling equally surveilled by neighbors and police and shared that living under a

> "A lot of people in our community don't feel safe around Black bodies and the reality is that there are less Black bodies in Berkeley That may be the plan from the perspective of those who don't feel safe around Black bodies..."
> —Resident

constant veil of suspicion is stressful, makes them feel like outsiders in their own city, and prevents them from fully engaging in the community. Black students pointed to the decreasing number of Black residents and the racism expressed by some locals as a source of stress. One Black student shared a story of being profiled by a neighbor who accused her of stealing packages from his porch.

In addition, the Black youth who participated in the focus group expressed dismay at the ease with which children and teenagers can purchase guns in the City of Berkeley. They spoke about a bustling, well-known, and easily accessible illegal gun market operating in the city and were troubled by the inability of the police and city leaders to stop the flow of guns into their communities. They named ending gun violence and police harassment of youth of color as Berkeley s most pressing community safety priorities.

The focus group participants lifted homelessness and the housing crisis as one of the most critical public safety issues in Berkeley; they feel strongly that the city is responsible for providing for the basic needs of every resident. The participants expressed dissatisfaction with the city s current management of homeless services and supports. When asked about the existing crisis system and the approach to homeless services, many of the participants explained that the police should have limited or no involvement in the issue. They cited the need to provide wraparound supports, including long-term housing, mental health care, drug treatment, and skills training for homeless residents. Residents across the focus groups believe that most crimes in Berkeley are crimes of survival or the result of mental health issues and asserted that building an infrastructure to support a higher quality of life for homeless and low-income residents would make Berkeley safer. They called for more investment in housing, health care, and youth programs.

> "It's not as safe as it used to be. It's too many people on the streets with severe mental health issues and nobody to monitor them."
>
> —Resident

During the focus group with housing-insecure residents, the participants shared their critiques of the current approach to public safety advanced by city leadership. From their perspective, the city leadership prioritizes investments that fulfill the demands of wealthy residents. As examples, they cited the installation of speed bumps on roadways and the placement of surveillance cameras on city streets, while the critical needs of homeless, low-income, and formerly incarcerated residents are ignored. They recommended 24-hour street teams to provide medical and mental health care in communities, safe indoor and outdoor public spaces that stay open late, more community-run drop-in programs with the capacity to meet their basic needs, and expanded access to education, job training, and healing arts.

The focus group participants rely on each other and community-based organizations for safety and support. Black residents, housing-insecure residents, and system-impacted students expressed significant distrust in the city government. When asked about who or what makes them feel safe in Berkeley, they emphasized that they do not feel seen, heard, or protected by government entities. Instead, they rely on one another and community-based organizations for safety and supports. At the same time, they have an expectation that the government should care about, work for, and be accountable to them as tax-paying and contributing residents of Berkeley. They were frustrated by what they see as the failure of city leaders to recognize their value, voice, and legitimacy when it comes to

influencing the way the city is run. They called for greater decision-making power when it comes to how resources are deployed in their communities.

Community lens on the Berkeley Police Department

The focus group participants do not view the BPD as* a community resource *and instead rely on themselves and their communities for safety. Black residents, youth, system-impacted students, and low-income residents experiencing housing/food insecurity agreed that the current practices of the BPD are not in alignment with the needs and priorities of their communities. When it comes to crime and violence, the focus group participants across the demographics indicated that officers are largely absent in their communities and questioned the police department s commitment, skill, and capacity to prevent, intervene in, and solve serious crimes.

Focus group participants believe that police resources are mismanaged. They explained that the police currently prioritize high-income residents' low-level calls for service and spend too much time enforcing quality-of-life issues and recommended that the city prioritize improvements in police response times to emergencies identified by residents, as well as building relationships with the communities who experience both the disparate impacts of policing and violence/crime.

When asked about their experiences with and perceptions of the BPD, the participants in the focus groups shared a common perception that policing in Berkeley is racist and classist. They said that they do not look to the BPD for protection and instead feel targeted and unsafe when in their presence. They asserted that the city leadership is complacent in the BPD's racism and allows racial profiling and the harassment of Black, brown, and low-income residents to go on unchecked in the city. Many long-time Black residents described an increasingly aggressive style of policing and militarization in recent years that stands in sharp contrast to the friendlier community policing style they experienced while growing up in Berkeley. Black men, women, and youth shared recent personal experiences of being racially profiled and stopped by the BPD and expressed feelings of anger about their experiences. Similarly, individuals struggling with housing insecurity reported being targeted by the police due to their race and income level. Two Latin students explained that they and their friends are often stopped on and near the campus by both the campus police and the BPD because they do not fit the profile of the average UC Berkeley student. In addition, the youth who participated in the focus group said they'd witnessed the police harassing homeless people and immigrants working as street vendors. In response, the Black, housing insecure, student, and youth participants attempt to avoid the police whenever possible.

> *"They {police} were people persons back in the day and now they are not. It was a different mentality."*
>
> *—Resident*

The focus group participants shared a range of perspectives regarding the future role of the BPD. Although they agree on the current state of policing in Berkeley, there are diverse opinions regarding the future role of the police. Some of the focus group participants believe the city should focus on police reform, while others think significant divestment from policing is needed. For those who discussed reforms, increased police training—including de-escalation, trauma-informed response, and racial-bias curriculum—were lifted as priorities along with a focus on hiring Black officers and officers of

color from the community to improve police-community relationships and increase trust. During the focus groups, Black participants, youth, and people experiencing food/housing insecurity lifted the importance of expanding community policing in the form of foot and bicycle patrols. In addition, residents named a need for increased police accountability in the form of mandatory body-worn-camera policies; community-led police commissions staffed with low-income people of color; the proactive, regular release of police performance and misconduct data; and swift terminations of officers who practice racially biased policing.

> *"The police are supposed to be superheroes who protect us, but they've turned against us."*
>
> *—Youth, age 13*

Youth recognized and named the power of the BPD and wish the police would use their power to protect them and support their communities. They would like to have police officers who are part of the community, live in the community, and interact positively with young people through sports and mentoring.

The focus group participants who discussed divesting from policing recommended that the city invest in trained peacekeepers and community safety patrols focused on crime prevention and intervention strategies. They lifted relationship building, cultural competency, de-escalation techniques, and restorative justice as the core strategies to be deployed by these community patrols.

Overall, the focus group participants believe that investing in community health and ensuring that all residents have equitable access to quality education, food, shelter, and jobs should be the priority over investments in and reliance on the police to create community safety.

Community Ideas about Alternative Responses

When it comes to mental health crises and homelessness, the focus group participants across the demographic groups suggested that clinicians and social workers play a role in interventions and responses. While most of the focus group participants characterized the police as not fit or qualified to respond to these calls and wanted police response limited to situations involving violence, they described an expectation that when police do respond, they are skilled in crisis intervention, de-escalation, and cultural competency.

> *"They need more street teams; they drive around looking for tents and sign people up for services. Back then there used to be street teams, but now there's not as many. They need mental health teams, not the police"*
>
> *—Resident*

> *"Police ask if they can search the car, if you are on probation or parole, and if there are any drugs or guns in the car before they even tell the driver why they were pulled over."*
>
> *—Resident*

The focus group participants across the demographic groups viewed traffic enforcement as a low- priority public safety issue in Berkeley. They recommended that the role of the police be streamlined and believe that officers currently spend too much time involved in car stops, which disparately target Black residents. When presented with the idea of unarmed staff handling traffic enforcement, most were open to the idea, but some expressed concerns about the safety of civilian staff. Although Black residents expressed support for non-police responses, they have little confidence in the city s ability to decrease racism and disparate stops through the creation of unarmed civilian units.

The Black residents who participated in the focus group do not trust that the city s proposed alternative programs will reduce racial oppression and racial disparities, noting that the racism and anti-blackness that exists within the police department exists throughout the city government. They feared that without a true commitment to an antiracist approach to program design and implementation, as well as an authentic process to co-create these programs with the most impacted communities, the new programs will simply replicate the racist abuse, oversurveillance, and lack of responsiveness to community needs currently practiced by the police department. They explained that hiring local Black social workers, mental health clinicians, and traffic-enforcement staff will be essential to ensuring equitable interactions between Black residents and any new programs or city departments.

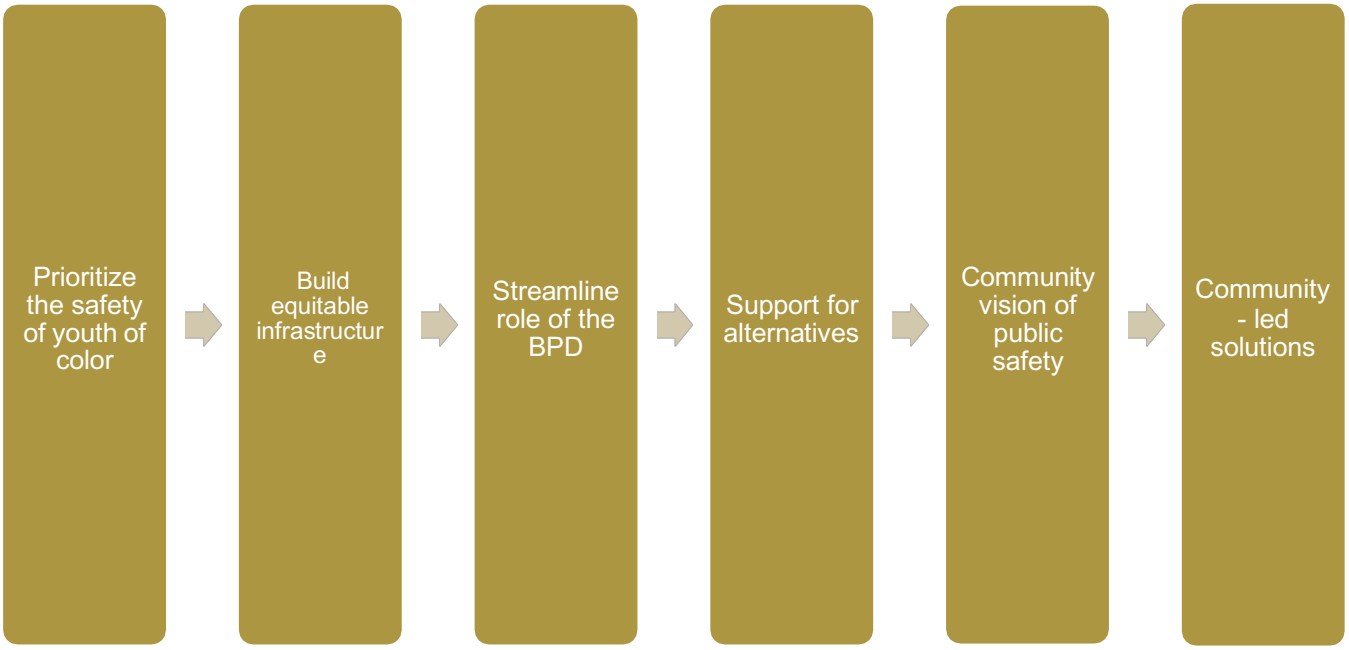
Community-Centered Vision of Public Safety

The focus group participants shared a common vision of public safety beyond the absence of crime as the presence of community health and equitable access to a higher quality of life for low-income, homeless, and Black and brown residents. The focus group participants expressed hope in the future of Berkeley and a desire to build close-knit, inclusive communities capable of taking care of all residents. Across the focus groups, the residents called for the city to make long-term investments in housing, educational enrichment, mentoring, health care, and job-training programs for youth and low-income residents. These, they maintained, would create authentic community safety. Other investment priorities include drug-treatment services, programs to interrupt recidivism, and prevention and advocacy to address gender-based violence and intimate-partner abuse.

Black residents expressed willingness to work collaboratively with the City of Berkeley and the BPD on relationship building, reform, and reimagining efforts, but in the meantime, they named a need for safety ambassadors who can act as a bridge between the Black community and the police. They expressed frustration about what they see as the city government's failure to listen to and act on their experiences and expertise when it comes to designing public safety strategies. Black residents believe they have a lot to offer when it comes to creating and implementing new programs and strategies and see their involvement in reimagining efforts as essential to increasing equity, reducing harms, and increasing safety.

The focus group participants expressed broad support for and belief in the power of community-driven crime prevention strategies and expressed trust in community-based and faith-based organizations. They believe the city government should make deeper investments in the community-based organizations run by leaders of color from the community. In addition, marginalized communities want increased access to power in the city in the form of representation. They explained that seeing more Black, Latin, and people from low-income backgrounds who share similar experiences in city-leadership positions, on committees, and within the police department will make Berkeley a safer city.

Summary of Findings



Recommendations

The following recommendations represent a compilation of the focus group participants' ideas for improving public safety.

Key Recommendations

- Expand the city's definition of public safety to include community health and equity
- Prioritize long-term investments in housing, mental health care, and drug treatment for homeless residents
- Increase investments in community-based and peer-led crime prevention programs
- Create 24-hour street teams to provide medical and mental health care in communities
- Invest in community-based drop-in centers
- Train community peacekeepers and create community safety patrols
- Hire local Black social workers, mental health clinicians, and traffic-enforcement staff to support equitable interactions between Black residents and any new public safety programs
- Streamline the role of the police to focus on violence prevention and intervention and responses to emergency calls for service
- Increase transparency and accountability of the BPD regarding racially disparate policing
- Increase opportunities for positive police engagement with Black and Latin community members and youth
- Identify opportunities to partner with impacted communities on reimagining public safety strategies

- Prioritize the representation of Black, Latin, youth, and criminal-justice-impacted individuals, as well as people who've experienced homelessness, in city leadership, police-department staffing, and committee appointments

Conclusion

The City of Berkeley and the Reimaging Public Safety Task Force are well-positioned to use their power and positionality to develop a community safety model that reflects the needs of the community, reduces inequities and disparities, and creates increased safety for all. This report summarizes the key findings from the focus groups conducted in the spring and summer of 2021 and represents an important step in building understanding of community strengths, needs, and public safety priorities.

CITY OF BERKELEY:

REIMAGINING PUBLIC SAFETY SURVEY—COMMUNITY PERCEPTIONS

Latin Community Perceptions Summary of Findings—July 2021

Bright Research Group
1211 Preservation Park Way
Oakland, CA 94612
www.BrightResearchGroup.com

Introduction

The City of Berkeley is working to develop a community-safety model that reflects the needs of the community and creates increased safety for all. In collaboration with the National Institute for Criminal Justice Reform, the City of Berkeley, and the Reimagining Public Safety Task Force, Bright Research Group (BRG) developed and conducted a community survey to gather residents' experiences with and perceptions of the Berkeley Police Department and crisis response, perspectives on and priorities for reimagining public safety, and recommendations for alternative responses for community safety. This report summarizes the key qualitative findings from survey respondents who identified as Latin.

Methodology

A total of 2,729 survey responses were collected between May 18 and June 15, 2021. The City of Berkeley, the Reimagining Public Safety Task Force, community-based organizations, and other key partners disseminated the community survey through various online channels and websites to those who live, work, and study in Berkeley, in English and Spanish. Respondents completed the survey online.

The survey included the following six open-ended questions related to community perceptions of safety and preferences regarding public safety strategies:

- What recommendations do you have to improve police response?
- Please share examples of how the Berkeley Police Department has *worked well* in your community.
- Please share examples of how the Berkeley Police Department has *not worked well* in your community.
- In what ways could the Berkeley Police Department work to build more trust with the community?
- What other programs and services do we need to invest in within our community to ensure a public safety system that works for all?
- Please share any experiences you have had with mental health and/or substance use crisis response services in Berkeley.

During the research design, Bright Research Group worked with the National Institute for Criminal Justice Reform and the Berkeley City Manager's Office to identify several priority populations for engagement beyond the community survey. The McGee Avenue Baptist Church; the Center for Food, Faith & Justice; and the Berkeley Underground Scholars facilitated outreach to the identified priority populations. Bright Research Group conducted a series of focus groups to gather their perspectives on the current state of public safety, the role of the Berkeley Police Department (BPD), and the future of public safety. Although the focus groups engaged 55 individuals, Latin residents were not well-represented. In order to learn more about the priorities of Latin residents, BRG analyzed the qualitative data responses from survey respondents who identified as Latin. Of the 2,729 survey respondents, 126 individuals identified as Latin. BRG conducted a thematic analysis by qualitative research question. This report documents the key findings and recommendations from this thematic analysis.

Limitations: Of the 126 Latin respondents, only 2 completed the survey in Spanish. This suggests that the opinions, experiences, and preferences of recent immigrant, monolingual Spanish speakers are under-represented. Latin respondents were under-represented in the survey responses and these results may not be generalizable to the city as a whole.

Findings

Community Perceptions and Priorities for Safety in Berkeley

When it comes to feelings of safety in Berkeley, the survey respondents expressed significant concerns related to their safety and the safety of their family members and were dissatisfied with the city's response. Many Latin survey respondents associated the homeless crisis with feeling unsafe in Berkeley. Respondents described homelessness as the source of crime and reason that Berkeley is unsafe. Respondents recounted instances of street harassment by unhoused residents and expressed frustration that many parks, streets, and neighborhoods including downtown are not usable due to blight and on-going street harassment associated with the homeless population. The current state of public spaces in Berkeley negatively impacts Latin residents' quality of life and influences their decisions about how they and their children move through the city. In addition, some Latin respondents expressed concerns about traffic safety and violent crime including gang violence, robberies, and shootings in Berkeley.

> "The city needs to have actual housing with requirements for homeless and facilities that can actually deal with mental health issues as well as drug and alcohol issues. The current county systems do not work."
>
> —Resident

> "The level of people experiencing homelessness that are directly affecting people's day to day lives has gotten to a tipping point. From being accosted on the street to having to swerve while driving from people in encampments….we need to address the homeless issue immediately!"
> —Resident

Overall, Latin respondents expressed dissatisfaction with the city's current approach to public safety and shared a common expectation that city leaders should prioritize cleaning up streets and public parks, installing additional lighting in neighborhoods, improving traffic control, and urgently address the issue of a growing homeless population in Berkeley. Additionally, they called for increased gun control, investments in youth prevention and intervention programs, and more visible police presence, such as officers patrolling on foot and bicycles.

Latin survey respondents *lifted homelessness and the housing crisis as the most critical public safety issues in Berkeley but expressed divergent views about the best way to address the issues.* Many respondents expressed dissatisfaction with the city s current response to homelessness in Berkeley. While residents concurred that the city's current response to homelessness is inadequate and needs to be reconstructed, they offered a wide range of solutions. Recommendations ranged from enforcing a zero-tolerance approach to illegally parked RV's, criminalizing substance use and removing encampments to investing in upstream efforts to tackle homelessness and mental illness, such as investments in affordable housing, therapeutic services, and living wage employment.

When asked about the crisis response system, Latin residents offered few perspectives related to the current crisis system. Instead, they wanted the city to address the root causes of homelessness such as affordable housing, economic opportunity and treatment options. When asked specifically about their experiences with the existing crisis system and the city's response to calls for service associated with homeless services, mental health, and substance abuse, a small number of respondents offered feedback on the existing crisis response system. Many responses

collapsed mental health, substance use, and homelessness and expressed frustration with the city's inability to identify and implement solutions. For those who did share personal experiences with the current crisis response system, there was a range of opinions about its effectiveness. Some respondents dealt only with the police during a mental health crisis and felt that they were professional and efficient while others expressed an unmet need for a counselor or clinician. A few respondents described positive regard for a collaborative team that includes the police and a mental health professional during crisis situations.

Overall, respondents focused on the need for long range solutions that prioritize early intervention, prevent crisis from occurring, and support people in achieving and maintaining sobriety, stability, and housing. They expressed frustration with what they see as a revolving door of people in and out of justice and mental health systems and called for strategies that effectively stop cycles of violence and recidivism, chronic homelessness, and drug abuse. When it comes to investments, respondents expressed diverse views. Some articulated growing frustration with the tax burden associated with program investments and believe that Berkeley attracts people from out of town struggling with homelessness, mental health issues, and substance abuse because of the city's tolerant attitudes and readily available supports. Others named the need to increase investments in long-term care facilities, treatment programs, therapeutic services, and job training.

Community lens on the Berkeley Police Department

Latin respondents expressed a wide range of perspectives regarding their overall satisfaction with the police with many expressing positive perceptions of the police. Many respondents held favorable views of the police and experienced positive interactions with BPD; they described the police as responsive, professional, effective, and supportive of community safety. Some respondents with favorable views of the police expressed a belief that the current political climate and movement to divest from policing does not represent the majority of residents' views. Additionally, respondents conveyed frustration with the city council who they characterized as a hindrance to effective policing. They believe that the BPD should focus on increasing community safety through crime prevention, intervention, and response. Some promoted a tough on crime perspective and expressed a belief that the BPD are mismanaged, over-controlled, and under-appreciated by city government. These respondents called for increased police presence, more investment in community policing, and proactive policing.

> *"The department needs to be supported by our community and allowed to do their jobs rather than being hamstrung by members of the city council…."*
>
> *—Resident*

Latin respondents who held unfavorable views of the police, cited slow response times, inability to prevent and solve crimes, and harassment of residents as the most salient features of the BPD.

> *"The police have stopped members of my family in West Berkeley in what was clearly racial profiling (Hispanics) on several occasions ."*
>
> *—Resident*

Respondents expressed concerns about racial profiling by the Berkeley Police and named it as a priority public safety issue. This sentiment was expressed by respondents supportive and unsupportive of the

police and was recognized as an issue that must be addressed by the Berkeley Police Department. Many respondents described specific instances of racial profiling and overly aggressive interactions between Black and Latin residents and the BPD. Although a few respondents called for divestment from the police department, the majority of respondents expressed an expectation for a high-functioning, service-oriented, police department responsive to the needs of communities of color and capable of equitable interactions. They recommended training on implicit bias, racial profiling, cultural competency, community policing, and de-escalation and expressed an unmet need for increased transparency, greater community engagement, and positive interactions between the police and communities.

Summary of Findings

Recommendations

The following recommendations represent a compilation of the focus group participants' ideas for improving public safety.

Key Recommendations

- Prioritize clean-up of streets and public parks
- Install additional lighting in neighborhoods
- Increase traffic control, create car free zones and areas where speed limits are reduced
- Focus on long-term planning to address homelessness
- Identify early intervention and prevention strategies to prevent mental health crisis and substance abuse issues
- Increase police visibility via walking and bicycle patrols

- Reduce police response times to calls for service
- Expand community policing initiatives and increase opportunities for positive engagement between the police and communities
- Address racial profiling and aggressive police encounters by the BPD with cultural competency, anti-bias, and de-escalation trainings and deepened relationships between the police and communities of color

Conclusion

The City of Berkeley and the Reimaging Public Safety Task Force are well-positioned to use their power and positionality to develop a community safety model that reflects the needs of the community, reduces inequities and disparities, and creates increased safety for all. This report summarizes the key findings from the Latin survey respondents' answers to open-ended questions and represents an important step in building understanding of community strengths, needs, and public safety priorities.

ABBREVIATED SUMMARIZED RESPONSES BERKELEY POLICE DEPARTMENT LISTENING GROUPS

Facilitator Question: *How do you respond when you hear the phrase or idea "Reimagining Public Safety"?*

Strong themes emerged around officer's feeling a lack of voice or input, the Berkeley Police Department being compared to or attacked for incidents that happened elsewhere, or not being recognized for policies and programs that have been in place for years that other departments are just now enacting. Officers recognized the community may have ideas as to how to change processes in the police department but wanted to be able to share their successes and efforts and not be seen as defensive especially around low numbers of complaints and uses of force. Officers expressed a clear desire to be a meaningful part of the reimagine process, and for their expertise and efforts to be heard, considered and valued.

Facilitator Question: *Officers we have talked with have agreed that police are asked to do too much, including non-police work. What do you think of this and are there responsibilities that should be taken off of your plate?*

Some officers felt there are definitely some calls, such as civil matters that police would like to remove themselves from, however we are not sure the public understands the nuances of the job and the fact that BPD are currently the only operational response to many of society's emergencies. Police investigations of crimes demand a great deal of department resources, as does the investment in police community engagement; we have to find the best way to do both with the limited resource of police officers.

Officers understand and appreciate that there may be alternative responses and services other than the police. While the infrastructure is created to possibly access those alternatives the community demand of emergency calls to the police will continue, and the police response will be necessary. We need to continue to support the police department, while investigating possible alternatives that are realistic and viable, long-term solutions.

Facilitator Question: *What are your thoughts on having trained mental health providers/responders respond to disturbance incidents, like someone screaming outside of a business, but is not harming or threatening anyone?*

BPD currently works with Berkeley Mobile Crisis Team (MCT) members, who have been part of our culture at BPD for over 40 years. MCT members are a valued part of our organization, and they will not go to calls without the police. MCT members are concerned for their safety without police presence, in fact a few years ago a suspect was charged with the attempted murder of an MCT member who was responding to a call of a person exhibiting symptoms of being in a mental health crisis.

Many officers regularly work with MCT and believe it is an effective and proven approach.

We need to fix the back end of the mental health system, the aftercare for a patient once they are placed on a 5150 hold has to be addressed. We will continue to see the cycle of hospitalization until the overburdened Mental Health system receives the support it so desperately needs.

Facilitator Question: *What do you think is the biggest crime problem in Berkeley?*

Property crime is a significant crime in the city, however of great concern to the community is the quality of life crimes which many times stem from mental health and/or addiction. People who are afflicted by mental health and/or addiction, are repeatedly contacted by the police because they are quickly released from custody/hospitalization, and

never have the opportunity to receive the proper interventions or support necessary to create the positive behavior change they may desire.

Facilitator Question: *What is the greatest need for improvement in BPD?*

We need a crime analysis unit to track and identify the who, what, when, where and why of crimes in our city, so that we may deploy the most precise and appropriate police intervention, thereby addressing the crime while leaving the smallest police footprint. We need police officers, as our police department is shrinking, the city population is increasing and those numbers just don't work as greater demands are put onto fewer officers.

Facilitator Question: *Comments from PEOs related to BerkDoT:*

The PEOs are the most diverse group of officers in the department and just moving the PEOs from the police department to transportation is not genuinely reimagining. The community shows more respect to the badge of the PEO, as the badge indicates we have gone through a validated hiring process which means we get quality people who are working as PEOs. When PEOs came to be under the police department in 1991 it changed the culture of PEOs and made the department more professional. Maintaining PEOs in the police department produces a more professional and respected workforce both internally and externally.

REIMAGINING PUBLIC SAFETY BERKELEY MERCHANTS ASSOCIATION LISTENING SESSION

NICJR facilitated a Listening Session with the Berkeley Downtown Merchants' Association and the Telegraph Merchants' Association on June 2, 2021. Thirteen people attended the listening session. Following closely to the guidelines defined by BRG, the facilitators engaged in a robust discussion with participants. Below are summary findings from the Listening Session:

Concerns over the Safety of Berkeley and the most pressing public safety issues:

Participants shared concerns over the safety of the City, the most pressing concerns their employees and patrons face, as well as their perceptions on how these concerns are being addressed. They expressed their disheartening perception that the city council and mayor are less than responsive to the needs of the business community and have allowed a permissive environment that creates the opportunity for crime to take place with an "apathetic enforcement policy". Some participants feel as though businesses deal with a lot of problematic street behavior with ambassador staff regularly called upon to respond to situations where merchants and shopkeepers can't deal with the situations. Sharing specific stories of people experiencing homelessness and/or substance use addiction attacking employees and customers and creating unsafe and unhealthy conditions, participants feel that the current environment has definitely had an impact on people who visit local businesses because they have to park around the corner, and walk to businesses.

> ***"It does not feel safe especially during the later hours of the day."***

Addressing how these public safety issues should be approached:

Participants feel there is a contradiction in saying that we stand united against hate and we are reimagining public safety and allow people to smoke crystal methamphetamine on our streets. There is a fear that with continued acceptance of specific drugs being used on the streets that the incidents of people experiencing mental health breakdowns will increase and that a stronger use of punishment to deter this behavior is warranted. Some participants expressed the need for there to be a choice: we can choose to allow those drugs to be used and then we can expect more violence or we can actually take a stand against that.

Additionally, members of the business association feel that prevention is what's going to shift the environment. They recognize that the City of Berkeley has mental health services but feel they are really not getting support from the city, when they have seen the mobile crisis unit drive away from a situation because it was deemed that no one was an immediate danger to themselves or others. There is a perception that there is no follow through with identifying a person with a problem and then going forward with next steps.

> ***"We need to focus on Berkeley Mental Health as an institution and get them more deeply involved with the police department and the community."***

Community investments that would support increased public safety:

The participants engaged in a discussion around the complexity and depth of the issues that need to be addressed, for example, where do those experiencing

homelessness go? At the same time, there is an acknowledgement that businesses are seeing a drop in patrons and employees because of safety concerns.

In response to questions regarding a trained, alternative, civilian response that was trained to be able to engage with this population and might include people who have had similar experiences of being unhoused, the Berkeley Mental Health department was identified as already available, but having been less visible downtown, limited in their ability to take valuable, sustainable steps to help someone in crisis unless there is a direct and immediate threat of harm and/or unsupported by the city in recent years. A participant identified the call center now under construction near a local synagogue and expressed the desire to see the community do more of that type of thing. A suggestion was also made that the City should look into a policy that can allow the mental health units to take more initiative.

Addressing the ways in which the Berkeley Police Department currently works in the community:

A general sentiment was that merchant interactions with the police have been very positive, yet there is often a hesitation to call on them for concern over unnecessarily escalating a situation. Concern was expressed that there is a national narrative demoralizing police departments as a whole and police departments are not given the tools they need to do their jobs. In Berkeley it was expressed that there was a shift in the amount of police presence and response in the community and that police officers were told by the City to not do anything.

In addressing some areas where the Berkeley Police Department's presence has been particularly effective, the bike detail was mentioned with the sentiment that this unit is about community policing and they get to know the street population and merchants which is helpful in problem solving and helping people. The Ambassador program was also identified as a unit that is helpful in de-escalating individuals in crisis, and working well in collaboration when police officers are present. With the CAHOOTS model and the SCU - the biggest issue participants feel the City faces is beds and how to get people into care 'with a little bit of tough love'. The possibility was raised of mental health professionals and police officers working together when responding to a situation.

> ***"I have great support for what the bike detail is doing since they have been back on the force. They have a calming effect for a lot of the folks out there that get a little wild, actually seeing a person in a position of authority calms them down."***

BerkDOT and SCU Program Opportunities:

There was a desire to learn more about exactly how these programs would be able to best serve the community with the current policies in place. Additional concern was expressed with the national narrative and how the City of Berkeley needs to ensure that whatever changes are being made, need to address the specific issues and needs facing the residents of Berkeley.

With respect to the BerkDOT program a participant shared: "I don't understand why that was even thought of. It just seems like we are focusing energy away from the problem, which is the fact that we have a ginormous mental health, drug, and homelessness problem in Berkeley. I do not agree that adding that additional agency would help the problem."

For the SCU, the specific need for case management and a presence in the community later at night was discussed. An overlap with the Police Department to partner with mental health workers in responding to situations and help assess whether SCU is reducing the number of calls and can cut back on the overload of the work of the Police Department. A suggestion was made for the SCU to work with both the Downtown and Telegraph Business Associations to identify the handful of folks that are causing a majority of the problems.

> ***"Until we enforce our sidewalk ordinances, until we make people go to sanctioned encampments, stop the revolving door of violent crime and until we stop the hard drug use and open-air Drug Market this is an absolute waste of your time and our tax dollars. Prevention first."***

Visioning community-centered public safety:

Considering what public safety can and should look like, a question was raised asking for better use of vacant space to set up housing and full services that could be helpful for as many Berkeley residents as possible. It was expressed that Berkeley has an abundance of laws and ordinances currently that don't get enforced, which is helping to create the unsafe environment that exists. Therefore compiling new variables instead of using existing laws to address the foundational issues did not sound like a good idea. There was frustration that participants themselves have invested hundreds of hours into issues of public safety and nothing ever gets done.

> ***"If you look at the relationship between what we pay in taxes and regulations and everything else versus what we get back, the disparity is anything but equitable and people love to throw the word Equity around in Berkeley."***

PEERS LISTENING SESSION REPORT

by Janavi Dhyani and Margaret Fine[1]

The Peers[2] Listening Session raised fundamental questions about how people who live with mental health challenges experience and perceive "safety" in the Berkeley community.

Throughout the Peers Listening Session the participants described their notions of "safety" in terms of their own safety; the safety of people who they observed in the community living with mental health challenges; their "safety" as a collective group of people in the "Peers community;"[3] and "public safety" at-large as a pressing societal issue such homelessness.[4] The participants spoke about their interactions and perceptions of Berkeley police, and how that impacts their feelings of "safety" in their community as Peers. Primarily they expressed their fears, based on lived experiences, interacting with police during a mental health crisis[5] in the community, and how a policing response generally had a negative impact on their ability to feel "safe" in Berkeley. Peers offered several recommendations about how they would like to experience "safety" including increasing their involvement as responders to mental health crises. It is noteworthy that additional research with Peers would be highly useful to account for the role of race, ethnicity, gender identity and expression, sexual orientation, disability, age, class and other factors, and their impact on a policing response to a mental health crisis.

Additionally during this Listening Session participants expressed the need for police to acknowledge when they are "wrong" in their treatment of Peers, particularly for purposes of establishing trust and rapport with the overall Peers community. Moreover, when discussing a non-police crisis response through a Specialized Care Unit (SCU) to non-violent events in the community, one participant said they "like the idea but it takes the onus off the cops to do better" and that it "still feels troubling, seems like a Band-Aid," as opposed to addressing systemic mistreatment by police of people living with mental health challenges and overall within the Peers community. Based on the lived experiences expressed during this Listening Session, it is indicated there is a need for a reconciliation process, particularly as a response to traumatic experiences with police. A reconciliation process, as well as a restorative justice process, with people living with mental health challenges may help build trust and rapport with police officers in the future.

1 Janavi Dhyani is the Associate Executive Director for the Alameda County Network for Mental Health Clients, and Project Manager and Youth Empowerment Consultant at the Mosaic Collaborative, LLC. She was also a Peace Corps Volunteer in KwaZulu-Natal, South Africa from 2018-2020. Janavi has dual Bachelor degrees in Economics and International Relations. Margaret Fine is a Commissioner on the Reimagining Public Safety Task Force and Chair of the Mental Health Commission for the City of Berkeley. Since 1991, she has worked as a legal aid lawyer and a deputy city attorney in child welfare for the Philadelphia Law Department. She earned a master's degree in criminal justice and human rights in 2010, and a PhD in sociology (and human rights) in 2016 in the UK. Janavi and Margaret have written this report in their individual capacities and do not represent any organization or the City of Berkeley.

2 A **Peer** is a person who self-identifies with lived experience with mental health challenges, substance use experience, and/or someone with experience navigating the public behavioral health care system.

3 The **Peer Community** is composed of diverse people who use their lived experience with mental health challenges, substance use experience, housing challenges, and/or navigation of the public behavioral health care system to increase peer-led support and services for people in the mental health community. The Peer Community is also active in de-stigmatizing mental health challenges, and normalizing wellness and recovery.

4 For the purposes of this report, **homelessness** is defined as housing insecurity ranging from being at risk of losing housing, being in transition of unstable housing (i.e. staying temporarily in a housed location like a friend's house or shelter, but not maintaining a personal address), or living in a location not intended to house humans (i.e. a car, an underpass, or in a tent).

5 A mental health crisis is an umbrella term that may refer to: 1) different levels of personal distress such as anxiety, depression, anger, panic and hopelessness; 2) changes in functioning including neglect of personal hygiene, unusual behavior; and/or 3) life events which disrupt personal relationships, support systems, living arrangements, and result in victimization and loss of autonomy.

It is also important to recognize that the Public Safety Dispatch Operators in the Communications Center located at the Berkeley Police Department address emergency and non-emergency dispatch calls for service, including for people experiencing a mental health crisis in the community. It is understood that police act on their own accord responding to these crises in Berkeley; some police have CIT training (Crisis Intervention Training) and in some instances police co-respond with the Mobile Crisis Team (MCT) of the Division of Mental Health to assist people experiencing a mental health crisis in the community. The MCT currently operates in Berkeley for 10.5 hours/day, 5 days/week, excluding holidays (see City of Berkeley, MCT webpage). In the systems currently in place, it appears protocol mandates that police first secure the scene before an MCT clinician can step up and support the person experiencing a crisis (including to interact with an individual experiencing an "altered state of consciousness").[6] Please kindly inform if incorrect. It is noted that the Fire Department, including an EMT, may also respond to mental health crises in the community with other first responders or on their own accord.

In addition, there were participants at the Listening Session who have used emergency services to address a person experiencing a mental health crisis, saying that "I've had to call the police on people with mental health issues and it broke my heart and that is something I would not like to do." Indicating that folks did not feel proud of their decision to call emergency services, knowing that police would arrive, but did so because they did not feel like they had alternative options to provide that person with appropriate support.

There is a need for clarification about how Public Dispatch Operators and the police use their discretion to make decisions about "public safety threats." It is not clear if the current protocol is designed to not only determine if someone is a "danger to themselves or others," or "gravely disabled" to meet the standard for a 5150[7] involuntary hold, and/or if the assessment offers a more nuanced evaluation for persons who do not meet this standard, particularly to assist with next steps in care if needed. There is a need for people with mental health challenges to provide nuanced input about their perceptions and experiences in this context, particularly given that a "crisis" can be used as an umbrella term for diverse array of human behavior; and the role of race, ethnicity, gender identity and expression, sex, sexual orientation, disability, age, class and their intersections can impact the nature of a policing or co-responder crisis response in the community.

Further participants talked about their own lived experiences with police during a time of crisis and whether they felt "safe," as well as their overall perceptions and feelings about them. Specifically, the main emerging themes included their perceptions and experiences about: 1) officers unease connecting with people experiencing a mental health crisis; 2) feeling stigmatized as dangerous and regarded so by officers; 3) the role of de-escalation if any; 4) feeling traumatized or re-traumatized by police during a mental health crisis; and 5) recommendations to improve mental health crisis response in Berkeley. At the outset it is noted one participant felt treated "pretty good" by police despite run-ins over four years.

Another participant talked about witnessing the police when someone was lying on the ground. He described how the police, fire, and ambulance showed up, "asked the person do they know where they are, asked them a variety of questions, stayed there with them, and even seen them give them a blanket before." However among many experiences and perceptions described during the Peers Listening Session, these experiences were outliers.

6 An altered state of consciousness may be defined as a temporary change in the overall pattern of subjective experience, such that the individual believes that his or her mental functioning is distinctly different from certain general norms for normal waking state of consciousness.

7 In the State of California, a 5150 is "when a person, as a result of a mental health disorder, is a danger to self or others, or gravely disabled, a peace officer, professional person in charge of a facility designated by the county for evaluation and treatment, member of the attending staff, as defined by regulation, of a facility designated by the county for evaluation and treatment, designated members of a mobile crisis team, or professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody for a period of up to 72 hours for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment in a facility designated by the county for evaluation and treatment and approved by the State Department of Health Care Services. See WIC 5150(a).

Section 1: Peers and Mental Health Crisis Response

I. *"Really important to speak their own language"*—participant

Peers indicated the importance of understanding and empathy during a crisis.

During the Peers Listening Session some participants raised questions about how police approach them and/or other Peers in the community. They discussed their perceptions and feelings about being seen as "public safety threats;" and generally as something to be controlled rather than human beings who need emotional "safety" to resolve their crisis. In

particular, the participants expressed their fears of being met with police violence instead of with compassion and empathy for their plights. The notion of "safety" ranged from people feeling exceedingly vulnerable and "unsafe" while experiencing a mental health crisis in the community to a wide variety of crisis responses (based on actions, words, physical harm, and/or lack of response/over response) by police to them. Overall participants mentioned that most people experiencing a mental health crisis are not violent.

Consequently, it is critical to further explore how Peers would describe developing a human connection, and develop trust and rapport, with a distressed person in terms of defusing a situation. People living with mental health challenges may experience a non-threatening altered state of consciousness and the police presence may exacerbate the intensity of their situation. Instead, Peers indicated that it would be more effective to make a human connection with the distressed person and de-escalate the situation so they felt "safe." Moreover, public safety dispatch operators and police officers may not be trained to understand the intersecting challenges and systems that may be contributing to and/or exacerbating the Peer in crisis and the mental health community as a group.

Specifically, one participant commented that Berkeley police are "not ready to deal with people who are upset with emotional disturbances," and that people in crisis "don't need violence when people are angry" to resolve their crisis. Another participant felt the police "get scared of mental health" and said they "need to not be afraid of people, people who are eccentric." This participant spoke to the stigmatization of the Peers Community, and

the need for additional training and public education about how to interact with community members who interact with the world differently than they do. Peers indicated the need to further explore the types of human behaviors that meet the 5150 standards and/or constitute criminal behavior, as opposed to other behaviors that may not fall within social norms but do not pose a threat to the public.

A second participant expressed concern that "some cops [do] not feel safe…don't speak a whole lot." She commented about feeling "really uneasy" when you need "someone to talk more, like hostage negotiator, convey sort of friendship and comradery." She discussed seeing someone "high energy, manic, talking real fast, as an opportunity for person in the crisis to grow rather than shut down with drugs, incarceration, hospitalization," and stated,

"we need to learn, develop a field of knowledge of people in altered states." This participant alluded to a common understanding in the Peers Community that mental health crises can bring about positive change for the person involved and should be allowed to occur in a safe setting when possible. There is a need to further explore perceptions and experiences of people living with mental health challenges to better understand the nature of stigmatization, and how it impacts a policing and mobile crisis response, especially when addressing intersecting identities of Peers based on race, ethnicity, gender identity and expression, sexual orientation, disability, age, class, and other factors.

This same participant attributed the lack of human connection exhibited by police with people experiencing a mental health crisis "as most cops [are] not trained that way." The participant went on to say that police officers "use major tool like [a] gun and bullets; something startles them, go for the gun." The point was further underscored by another participant, who stated based on their experience with police, "that it is always with guns;

it's a threat, always a threat of violence out there, police come with their guns," and that we are "much better served with people not heavily armed, I don't know how, I think the conversation and non-violent tactics." It is noted that the lack of Peer involvement in the training of police officers, and the resistance to use Peers in the response to mental health crises, can inhibit responders from understanding how Peers would like to experience "safety" in a time of crisis.

Participants talked about the lack of Peers in crisis response, that Peers have been left out of the conversation, and that for crisis response to improve, trained Peer Specialists[8] need to be involved. This perspective became clearer when talking about the Specialized Care Unit (SCU) program that Berkeley will be implementing as a non-police crisis response in the community. Everybody in the group generally liked the idea of non-police responders to non-violent calls, however, with two exceptions: 1) one person named that without retraining police officers, police would still respond in public with the ability to cause harm; and 2) that Peers would feel safer if the SCU team included Peers. The importance of Peer staffing on the SCU team was highlighted by different participants.

> ***"Facilitator: Who do you think should do the training for the SCU?***
>
> ***Participant 1: Someone with lived experience.***
>
> ***Participant 2: I agree.***
>
> ***Participant 3: I agree. I totally agree."***

During the Listening Session, it became clear that the Peer participants could clearly identify that it was important for the crisis response training to include people who have lived experiences alongside other first responders as a team. Another participant explained the importance of peer specialists for training by saying, ***"What better person can teach them how to respond, body language, than someone who is on the other end and who has walked the walk, and already been through it."*** The participants seemed to be in agreement that one Peer could not respond to crisis situations alone, but was an essential part of the team in both training and in-person response situations. Moreover, participants underscored the importance of Peer-involvement in ongoing post-crisis support to ***"Make sure there is continuity of care"*** and pointed out that ***"The peer specialists are helpful for transition to a wellness center or the next social service."*** This continuum of care would include: wrap-around services and support in navigating the intersecting and often complicated systems of care (i.e. housing, public benefits [SSI, SSDI, SNAP, GA, Medi-Cal, Medicare]; disability; health, mental health, and substance use support; meal assistance; support groups; drop-in services; community programming; employment support). There is a need for further input from people living with mental health challenges about the community-based services they use in Berkeley and Alameda County, particularly ones considered to be compassionate and effective in providing tailored culturally safe and responsive services.

II. *"When I see police, it can be triggering, it can be negative, not friendly"* – participant

Peers indicated a history of mistrust towards police officers.

In addition, there were emerging themes about how people living with mental health challenges have experienced police as threatening, which may perpetuate and reinforce trauma in responding to

8 A Peer Support Specialist is a peer (a person who draws on lived experience with mental illness and/or substance use experience and recovery) who has completed a specialized training to deliver valuable support services in a mental health and/or substance use setting and/or in the community. According to the Peer Certification Fact Sheet from Senator Jim Bael on SB 803: "Studies demonstrate that use of peer support specialists in a comprehensive mental health or substance disorder treatment program helps reduce client hospitalizations, improve client functioning, increase client satisfaction, alleviate depression and other
symptoms, and diversify the mental health workforce. " As of SB 803 Peer Support Specialist Certification Act of 2020, Peer Support Specialists in the State of California will have a standardized certified body to regulate and certify Peer Support Specialists. SB 803 will allow Peer Support Specialists to bill Medi-Cal for the services they offer to their peer partners in the State of California. With SB 803 California will join 48 other states in the country that have peer certification programs as part of their Medicaid behavioral health network. https://namisantaclara.org/wp- content/uploads/2020/09/SB_803_Beall_Peer_Certification_2020_Fact_Sheet.pdf https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB803

mental health crises. One participant stated that "many people have negative feelings on police" and when they see police "it can be triggering, it can be negative, not friendly, open." Another participant "witnessed police in action in Berkeley," and said they did not want police on mental health calls, as they were traumatized to the point of seeing police in a "whole different light." Yet another participant stated that "So many of us have been harmed when we are treated when we are in crisis" and mentioned Soteria House, a community service that provides space for people experiencing mental distress or crisis, as a recovery model. Other participants also discussed how drop-in centers can offer this space, provide a restroom, a cup of coffee, and a welcoming space in which the person can get their basic life needs met and make meaningful connections with other Peers. Peers indicated that distress could be better met by safe spaces in which a person is allowed to move through the emotions they are feeling without fear of judgment, retaliation, or incarceration while being met with basic life needs (food, water, bathroom, a sense of safety, and human connection). There is an essential need to explore how a Peer can feel "safe" transitioning from experiencing a crisis in the community to a respite space with the support of a Peer specialist and other responders, as opposed to feeling treated as dangerous and in need of social control and being subdued.

Participants further talked about how the presence of police could exacerbate the intensity of personal distress and create feelings of extreme terror and instant fear of extinction, as opposed to creating ones of emotional "safety." While the participant did not describe the basis for officers' arriving at the scene, he described his feelings about a police response by stating "it is multiple police cruisers, you feel like the world out to get you and annihilate you, officers are intimidating, 3-4 cruisers with multiple cops, very, very troubling and high-risk situation." This feeling of being responded to, instead of being met *with*, is a sentiment people shared. One participant said that "If someone is having a mental health crisis, sit **with** them and let them be." Peers indicated that they are not "safety threats" that need to be responded to, rather they are humans that need to be met and supported *with* and *through* a situation they are not able to safely endure alone. It would be beneficial to further understand when Peers perceive their own behavior as threatening and how they expect first responders to interact with them as a result.

III. Policing and mental health crisis response

During the Listening Session, it was clearly conveyed by the majority of the participants that police officers should not be the first responders to mental health crises. When asked what situations police would be able to respond to appropriately, the Peer participants discussed when they would feel police intervention may be necessary. Overall there was a range of different perspectives about the role of the police officers in the mental health community. Initially, Peers felt police officers need specific training for crisis response. One participant questioned the amount of de-escalation training that police receive as he regarded it as the "major pain point" in defusing a mental health crisis. In this light, another participant asked about situations where a person may have a weapon and the type of response to them.

Another participant indicated having a mental health person upfront and police shadowing if needed. A fourth participant stated he would want police if his car was burglarized, but he wants a skilled person with lived experience to respond and police second to ensure safety if needed. This area deserves considerably more exploration about the nature of situations where people with mental health challenges may feel police need to respond. Generally, participants suggested that there may be different people and/or teams responding depending on the type of situation. There is a further need to explore the nuances of specific situations among people living with mental health challenges in order to better understand from Peers when they perceive certain types of teams responding to a mental health crisis in the community. Moreover, there is a need for Peers to discuss their lived experiences and perceptions of crisis response; the role of race, ethnicity, gender identity and expression, sexual orientation, disability, class, and age; and its impacts on police response to those living with mental health challenges.

IV. *De-escalation is the "Major Pain Point"*—participant

Further research is needed with people who live with mental health challenges, including the PEERS community for understanding peer-informed/peer-created de-escalation practices.

There is a critical need to have a nuanced understanding about how people with lived experience of the mental health crisis in the community describe levels of personal distress such as anxiety, depression, anger, panic, and hopelessness and how to meet their needs for "safety," as well as how changes in basic functioning can impact the capacity to stay "safe" and not be a danger to themselves or others, or deemed gravely disabled—the 5150 involuntary hold standard in California. Depending on the type of crisis response provided to individuals experiencing distress, the physical and psychological impacts on "safety" may vary widely. They can range from de-escalating crises using specific mental health practices to using coercive controls and force to restrain individuals in crisis. In the latter circumstance, an individual may be restrained, arrested, taken into custody, transported, put in secure detention and there may be violence, brutality, or even death. It is critical to extending this research in order to clarify the levels and types of personal distress, and how they impact functioning according to Peers who are living with mental health challenges, and the types of crisis response that work for them in the community.

There is a specific critical need to explore the degree to which police approach a distressed person and defuse the situation versus using coercion, particularly during 5150 assessments. Both commissioned consultants, National Institute for Criminal Justice Reform and Research Development Associates, should account for the role of police and policing interactions when conducting research with people experiencing mental health challenges and providers, particularly to understand how people can work collaboratively with providers in order to facilitate productive relationships. Whether the research focuses on police interactions with people experiencing mental health challenges in the community on their own accord or when corresponding with the Mobile Crisis Team of the Division of Mental Health, police play a significant role and impact the nature of crisis response. Without this key data, the consultant researchers will be gathering unrepresentative pieces about a comprehensive crisis response system that operates at all times with the police. Moreover, people living with mental health challenges may have lives that interplay among multiple systems, including policing and mobile crisis response systems, and it is critical to understand the overarching impacts and how to support their well-being and recovery.

During the Peers Listening Session, participants had overriding concerns about police choosing to use violence and guns as a first resort during a mental health crisis in the Berkeley community and not communication and non-violent tactics to de-escalate the situation. It is further important to gather data about policing behavior and accountability during Mobile Crisis Team calls. Gathering this data is essential to the Reimagining Public Safety Initiative and the Specialized Care Unit for the City of Berkeley and the overlap among systems means we need to include not only these inherently critical pieces but analysis about how the systems interplay and impact people living with mental health challenges and their well-being and recovery.

Overall crisis response to people experiencing mental health challenges in the community requires a commitment to conducting empirical research that is nuanced so we understand the complexities required to properly serve and protect all of our community members. It is clearly evident that the role of police during a mental health crisis is a turning point for people with mental health challenges in the community and we must thoroughly understand the nature of their police behavior in order to begin healing. It is further important again for people with lived experience of mental health challenges to have restorative justice and reconciliation processes to describe events such as police responses to their crisis and how they can disrupt relationships, social networks and communities, living arrangements, and other mainstays of personal life, as well as to understand when a police crisis response is necessitated for "public safety" reasons in the Berkeley community.

Section 2: Peers and Homelessness

Several participants considered "homelessness" as one of the most pressing public safety issues both in Berkeley and generally. Participants shared their perspectives based on: 1) lived experiences of homelessness in the past; 2) living as a housed person with unhoused neighbors and/or 3) being Peer advocates for partners with housing challenges. One person saw the homeless conditions such as lack of safe water, toilets, rodents and other problems impacting both those housed and homeless. She had mixed feelings about the encampments, particularly given the chaos and havoc at night. Another participant talked about how he "enjoyed living on fringe of society without any accountability, really free, [but said] looking back, I was really incarcerated." He is now housed.

Generally the participants felt it was "unsafe" to be homeless and even harder for people living with mental health challenges. For people living with mental health challenges and homelessness, one participant described their difficulties: "the ones that have had problems, have gone through what they have gone through, makes [it] harder to want to be in a home…." Another participant further talked about the intricate nature of homelessness, and the intersectional approach necessary to meet the needs of unhoused folks. He was someone who experienced homelessness, as well as mental health and substance use challenges. This participant clarified how organizations may offer a free shower and food to "clean people up;" but are not designed to house people (using a Housing First model); provide wrap-around services; or job training for work.

A third participant talked about how homelessness does not "build healthy [a] community" as you're "living where you shouldn't really live," while another pointed to issues like

"deprivation and exhaustion that these poor people go through." Potentially further research with people living with mental health and housing challenges could inform how homelessness impacts the nature of people's mental health challenges, and the type of services needed—one person suggested crisis management and conflict resolution. Another person had sympathy for folks' experiences of homelessness and having their possessions thrown away. Participants generally described the grinding efforts needed to survive, including constantly dealing with lack of necessities and fear of having their household belongings abruptly discarded.

In addition another participant talked about one of the driving forces of homelessness being the increase of housing prices in Berkeley, saying "gentrification and homelessness…Some people can't afford to live in a home on their own." This participant indicated that homelessness is not a challenge that can be met by services alone, but that economic disparity continues to play a role in people becoming unhoused. Another participant echoed this comment by saying, "most homeless people not [the] problem, situation drives it, it's an economic thing." He indicated that homelessness cannot be met with social services, but needs to also look at through an economics-informed lens.

A few participants discussed other services that were offered in San Francisco that they did not believe are currently available in the City of Berkeley. One participant liked that "In San Francisco they are doing foot patrol" and indicated it would be helpful to have people who provide services going directly to the unhoused in their community too. Another participant mentioned that in San Francisco "they have peers in the library" and said they liked that idea and that Berkeley might also benefit from having Peers in public spaces where unhoused people congregate. More about San Francisco's street crisis response, that the participants may have been indicating, can be found here: https://sfmayor.org/article/san-franciscos-new-street-crisis-response-team-launches-today

It is important to indicate that further research is needed with the unhoused population to understand the intersecting nature of mental health and substance use challenges and homelessness, particularly to explore the nature of policing and crisis response and whether the systemic responses are service-oriented and/or designed to stigmatize and criminal human behavior or both. It is also important to further understand this intersectional approach as including exploration about the role of race, ethnicity, gender identity, and expression, sexual orientation, disability, age, class, and potentially other factors.

Although it is indicated that further research is recommended, the Peers Listening session did provide considerable insight on the intersection between mental health challenges and homelessness. The majority of the participants agreed that the most important pressing public safety concern is homelessness. One participant pointed out that "mental health crisis[es] and homelessness are synonymous," and as such should not be treated as completely independent challenges. Within the challenge of housing insecurity, several other sub-concerns were addressed including: (1) the lack of intervention by systems of safety in Berkeley; (2) economic disparity and increasing housing prices driving long-time residents out of their homes; (3) lack of wrap-around services, and systems of care addressing challenges in isolation instead of as addressing homelessness as a product of other underlying challenges, which are often intersecting and multi-dimensional.

Peers Recommendations

1. The first and most important recommendation is to outreach and includes Peers who have worked on mental health reforms since the 1990s, when this movement began. There are trained Peers in Berkeley who are experts in crisis response, and they would be invaluable to developing responses to mental health crises and supporting the transition to new systems of safety in Berkeley. This role is, especially, crucial for unpacking the scope and nature of mental health crises to provide a nuanced understanding, approach, and framework for responding with appropriate levels of care to people with mental health challenges in the community—particularly for a non-police crisis response through a Specialized Care Unit. Peer participants discussed the San Francisco Crisis Response Street Team, and how this city is employing Peer Specialists on foot patrol as part of its team.

2. Drop-in and wellness centers for people living with mental health challenges need sufficient funding and staff with full-time Peer Support Specialists where folks experiencing non-threatening altered states and/or mental health crises can move through their crisis is a safe and supported state (in opposition to tactics which aim to shutdown mental health and/or altered states at any means necessary). It would be essential to make drop-in and wellness centers available 24/7 and on holidays, and to make sure there are also Peers involved in the transit from the mental health crisis to the Peer staffed drop-in/wellness center. Peer navigators are also key to assisting people in navigating complex systems, including how to get appropriate services in the City of Berkeley and Alameda County.

3. There is a need to account for intersectionality and the role of race, ethnicity, gender identity and expression, sexual orientation, disability, age, class and other factors that can impact the scope and nature of crisis response for diverse people living with mental health challenges in the community. It is, particularly, important to address the stigmatization of diverse people living with mental health challenges and how the role of these additional demographic characteristics may or may not perpetuate and/reinforce problems during a mental health crisis (including as to the roles of people such as police, fire, mental health clinicians, peer specialists responding in the community). There is a specific need to focus on interviewing diverse people with mental health challenges who are unhoused in order to explore the nature of policing and systemic responses to people, particularly to examine if human behavior is criminalized and/or met with service delivery.

4. There is a further need to account for overlapping systems of care, including medical, mental health, substance use, social services and other systems. Participants in the Peers Listening Session, who identify with homelessness, discussed how current systems are not set up in a way that enables long-term sustainable wellness of the mental health community. Housing-first methods, for instance, are only successful in addressing homelessness if the other factors that contribute to housing insecurity are also addressed such as mental health and substance use services. Overall creating comprehensive wrap-around services may be the key to addressing public safety concerns. Moreover, including people with lived experiences of mental health, substance

use, and homelessness will enable systems to be consumer-informed, and in turn more sustainable in the long term.

5. There is a further need to conduct research with people who use alcohol and drugs and have lived experiences with policing and mobile crisis response, as this qualitative research focused almost solely on people living with mental health challenges. It is crucial to consider the nature of trauma-informed, de-escalation and harm reduction approaches for people who use alcohol and drugs during crisis response in order to discern how service-oriented practices may reduce harms from alcohol and drug use and avoid punitive measures resulting from criminal legal and incarcerations involvement due to alcohol and drug use. Specifically there is a need to assess how systemic responses to people who use alcohol and drugs may result in fluctuating among multiple systems without well-integrated coordination of care.

PACIFIC CENTER FOR HUMAN GROWTH

LGBTQIA+ Staff/Provider Listening Session[9]

Note: The following information represents an LGBTQIA+ mental health provider's perspective that serves Berkeley and other cities in Alameda County. It is important to note that by-proxy information can be useful in providing context for the systems that LGBTQIA+ people may navigate in order to obtain services, however, it cannot be used to assume the exact lived experiences of the individuals/clients using them.

The Pacific Center for Human Growth

The Pacific Center for Human Growth, or namely the Pacific Center, is a LGBTQIA+ mental health provider serving LGBTQIA+ people, or Queer and Trans people including QTBIPOC, with individual, peer support and community mental health programs and services. The Center is designed to serve LGBTQIA+ people with mild to moderate mental health needs, and not those who are experiencing severe, persistent mental illness or substance use disorder, or in crisis. The Center operates from a Victorian house on Telegraph Avenue south of the University of California in Berkeley, California in Berkeley. Clients and community members come from Berkeley and other cities in Alameda County. Currently the Pacific Center offers a full range of programs and services remotely due to COVID.

The Pacific Center as a Socially Constructed Space

The Pacific Center is well-known as the largest regional LGBTQIA+ mental health provider, including for its physical space located in a Victorian house and the LGBTQ+ and Trans flags flying from outside of it. While the Pacific Center's programs and services are designed to support Queer and Trans people, including QTBIPOC, with their mental health and substance use struggles, there have been incidents in front of the Pacific Center. There has been hate crime by people outside of the community that can be perceived as violently challenging the legitimacy of LGBTQIA+ people, as well as a negative incident from a person within the community who did not feel as though they were served.

In one instance a person burned a flag and punched one of the Pacific Center staff, and they called the police as a result of feeling scared for their safety—although the staff did not want to call. In another instance, a man yelled "You should have bi groups for people like me, for men like me." He was a community member and upset that the Pacific Center staff did not meet his needs. This man seemed to feel unsafe and marginalized as a result of perceiving the Pacific Center's services as excluding him. The Pacific Center staff felt threatened by people both inside and outside its own community. Likewise a Pacific Center provider mentioned people can feel scared entering a building marked with flags—some even wait in their cars until they enter the building. The socially constructed meaning of the Pacific Center space can challenge notions of "safe" space for Queer and Trans people who are seeking a sense of belonging to people violently challenging the existence and cultural representation of LGBTQIA+ people as a group in the community at-large.

More than one provider talked about the lack of Queer and Trans "safe" spaces in the community at-large, especially for transgender women of color, unhoused, youth and BIPOC. Historically the Pacific Center's service model resembled more of an LGBTQIA+ community center (1980s-1990s). The Center had a men's night and a hotline to call for assistance. Now the Pacific Center is closer to a mental health

9 This report is developed from the Pacific Center's Listening Session and a qualitative interview with a staff member who could not attend that session. Please contact Margaret Fine and Janavi Dyhani with questions or concerns: margaretcarolfine@gmail.com.

and medical model, although one person mentioned interest in a hybrid model. There is a further need to know more about how organizations, outside of the Pacific Center, can support and respect Queer and Trans people, and ways that they can be educated to include LGBTQIA+ community members and groups—from posting material in organizational settings to hiring experienced people from the Queer and Trans community, particularly for QTBIPOC. It was noted the Berkeley Wellness Center has not created time/space for Queer and Trans groups

Crisis Response/Intervention, De-Escalation and the Presence/Role of Police

The Pacific Center staff had several comments and recommendations about crisis response and the presence/role of police:

This LGBTQIA+ provider listening session highlighted the critical need to have a nuanced understanding about how Queer and Trans people, particularly QTBIPOC people, describe their lived experiences with crisis response. There is a need to understand their levels of distress and how crisis first responders met their needs for "safety" or do not meet them. Specifically the providers discussed the role of police and how there may be psychological impacts as a result of the mere presence of police, or further escalation of a crisis due to the presence or role of the police.

One provider described how crisis response with police presence made her immediately think of trauma, including for everyone involved. She stated, "I think of families, traumatic for everyone, police show up, it makes a huge scene for the neighborhood, flashing lights, and then having to unpack it with families, clients…." She further commented about how people are resistant to services because of traumatic experiences, and how they need a calm, peaceful approach to addressing crisis and to abide by the ethical standard, "do no harm." She mentioned it may require a lengthy time period to unpack the trauma.

In addition there was also a provider who dreaded if police were present and thought they tend to escalate a situation for a person who is feeling fearful and unsafe. Another provider commented that it takes time to de-escalate a crisis by talking to someone in order to calm down at the scene, particularly so people in crisis do not perceive the team as seeking to incarcerate or institutionalize them. This provider described the "need to get rid of the urgency" or the notion of an "immediate solution" during the crisis response. The provider discussed how they should not immediately think about removing the person from public space, and avoid "twisting" the situation into a public safety and policing issue. Overall the provider stated there is a need for a "triage" approach to crisis management and not "moving from 0 to 60" in record time. This provider also had concern about how the "urgent" approach was "rubbing off" on the crisis management team/mobile crisis team.

One provider, who was very explicit about their feelings about the police, said: "I stay away from the Berkeley Police Department and advise young people to do the same. The Berkeley Police Department are not my friends, they are not people who I trust as an entity, and not people I say should be called for help. There are difficult situations in which there is a Queer Black Femme Cis Woman and warm violence, but the person does not want to call the police. Every single interaction will not lead to hot violence, but we know statistically that Queer Trans BIPOC people with mental health issues, who are disabled or developmentally challenged, are far more likely to experience violence, be harmed and be killed."

This provider further brought up an important note that providers with lived experience similar to clients they serve (in this case Queer and or/Trans BIPOC provider serving diverse Queer and/or Trans clients) may also be shielding their clients from the police based on their own lived experiences. The provider brought up the importance of intersectionality when talking about police response, and additional identity markers that statistically place QTBIPOC people at risk—which is different from factors based solely on race and ethnicity and reflects non-binary gender identity and expression and non-heterosexual orientation. This provider indicated that the role of police would be that they support services to the community, especially LGBTQIA+ police officers supporting LGBTQIA+ community members.

Moreover, the provider recommended that crisis response workers have an accumulation of direct experience with Queer and Trans people including

QTBIPOC. In this regard, one provider gave an example about how there is a need for a crisis team member to recognize a meth-induced episode, and understand the cycle of peaking and coming down in order to inform the crisis response, including to know the options for follow-up and the next step in care. The provider mentioned Herrick and John George will not individuals for substance use treatment.

One provider also commented on how diverse crisis team members can provide multiple opportunities for a person in crisis to: 1) gravitate towards one person and 2) feel a sense of safety, human connection and community. Some of the recommendations for crisis team members included people with different identity markers, lived experiences, and professional training (such as an EMT, peer support specialist, and a mental health clinician—noting that developing the critical rapport is not necessarily tied to education).

A provider added that having "a few different eyes to have different perspectives" can allow for assessing and consulting continually to help the person in crisis to feel safe and calm down. Another provider mentioned how peer support specialists are "great at telling when someone is triggered," building rapport and being a role model for change, particularly when they represent the community served—and do not misgender people and create emotionally damaging experiences. Another provider recommended that the Specialized Care Unit, a non-police crisis response program, should be as separate from the police as possible. It was recommended to house the SCU in a human services department or other city department and not the Berkeley Police Department.

"Public Safety"

Note: Providers cannot represent their clients' perspectives in determining the most pressing "public safety" concerns in our community. One provider pointed this out by

saying, "I think that one of the most important factors is group determination, or rather the group's ability to determine what feels like safety as a group. The violence is systemic, and the group must hold responsibility for telling us what the issues are, and what would be helpful solutions, to feel safety." The upcoming listening session with LGBTQIA+ community members will likely provide better understanding about the most pressing "public safety" concerns.

In terms of violence being a threat to "public safety," this provider talked about the two kinds of violence currently inhibiting "safety" for the LGBTQIA+ community: "There is hot and cold violence happening for LGBTQ folx and most marginalized Black and Brown people, especially Trans Femme Black and Brown people—most susceptible." This provider was able to define the terms "hot violence" and "cold violence" as the following:

> Hot violence is immediate, active, perceptible violence that touches you. It can be physical or verbal, very loud, aggressive, and immediately unsafe. Hot violence can change the dynamic in the situation instantly.
>
> Cold violence is a more underlying source of violence than hot violence, and is more than a microaggression, like an intentional micro aggression. An example is a Queer Trans BIPOC looking for an appropriate bathroom and being surveilled by police. Cold violence reflects the way in which systems are set up by police to surveil and monitor human behavior where it does not feel safe to move around fear freely.

On the topic of intersectionality, one provider explained the importance of factoring in additional identity markers by saying "it is hard to conceptualize intersectionality, especially to understand how Queer Black women are different from Queer women and from heterosexual normative women. If you do not have lived experience, it is hard to conceptualize how positionality—how you present to the world—changes everything." Given this perspective, it is important to ensure diverse Queer and Trans community members have the opportunity to define and explore their lived experiences in terms of race, ethnicity, gender identity and expression, sexual orientation, disability, age, class and other identity markers in order to understand the impacts of policing and notions of "public safety"—which is different from solely racial, ethnic and heterosexual norms.

"Public Safety" as Having Resources and Support to Meet Basic Human Needs

In this Queer and Trans Listening Session, the providers discussed the conceptualization of "public safety" or "community safety" as not related to the police but rather to people having sufficient resources and support in order to have their basic human needs met and a stable life existence. Like many of the other providers, this provider recommends that the way to make Berkeley safer "is not rooted in police surveillance but rather rooted in resources and access to them." Access to resources was a clear emerging theme when talking about the topic of "public safety" in order to create a sense of security for LGBTQIA+ people in Berkeley. One provider saying "The main point is to have resources so that there is a way to decrease people from feeling unsafe".

Wraparound Services

The Pacific Center providers further talked about basic needs in terms of food security, housing, mental health, substance use, wellness, wraparound services. There was a discussion about what constitutes wraparound services, and efforts to fully provide them. One provider referred to formally working at GLIDE where they had food, a free clinic, health services, acupuncture, and housing vouchers. One provider mentioned the term "wraparound" may be a misnomer; that it may mean referrals; and that organizations are pressured to use the term. It was also acknowledged that substance use is a significant problem in the Queer and Trans community, and that emergency rooms cannot provide tailored care for substance use problems.

Housing and Homelessness

In addition one provider further noted that Queer and Trans people will arrive on the Pacific Center's front porch from other states and need support to find housing. The provider described the individuals as very vulnerable and marginalized, and shelters as not designed for low-income, non-binary and transgender people. The staff mentioned how Queer and Trans people need a sense of autonomy and agency in order to feel safe in a shelter environment, and choosing a women's or men's side of a shelter does not necessarily respect gender, much less prevent discrimination against non-binary, transgender people. (Note: There may also be gay, lesbian or bi-sexual people with another perspective, and it is noted that gender identity and expression are not separate or mutually exclusive from sexual orientation. A transgender person may also be gay, lesbian or bi-sexual.) In fact, one provider further described how police can raid encampments, which is very stressful and creates trauma, and results in more instability for the unhoused population than any sense of protection.

Moreover, it seemed people are not having a seamless entry into the government systems designed to serve them, and the Pacific Center does not have case management services to guide them in an ongoing, consistent relationship to meet these needs. The staff discussed how they're understaffed, there are more referrals than staff available, and they're under resourced for serving the Queer and Trans community. Sometimes they indicated it can prove difficult to connect to case management services in the wider community. Ultimately, the provider indicated LGBTQIA+ people may use an emergency room for ongoing services. They may also potentially become destabilized from being "pushed around" as a result of emergency room visits with no continuity of care and vulnerability to experiencing crisis—particularly for low-income, unhoused QTBIPOC.

We spoke to Queer and Trans mental health and community program professionals who are trained and educated to guide clients in navigating these systems; however they also described the systems as "not really clear" and that there are "blockages" due to grant specifications, which can deny service delivery to people who need them. Specifically, there were frustrations with how the narrow grant criteria could eliminate access to services for a person that is nominally above the income eligibility line. Other difficulties reflected the challenges that vulnerable, marginalized LGBTQIA+ people face when attempting to navigate intricate systems that are designed, ostensibly, to provide for their needs.

It is noted that there is considerable need for mental health workers, such as peer navigators, who can directly guide clients in navigating these systems—

particularly given the shortage of case management services available from CBOs in the community at-large.

Ultimately, as one provider mentioned, collaboration among service providers is key in to become a more well-integrated system with coordinated services tailored to meet client needs, including ones that are culturally safe and responsive.

It is important to do a follow-up listening session with the Queer and Trans populations as providers can shed light on critical issues they are unable to speak on their clients behalf. Further it is important to move forward with reforms using an intersectional lens that accounts for the overlapping and intersecting identity markers, which create inequities, disparities and systems of oppression for Queer and Trans people of color.

Gender-Based Violence Subcommittee Report

Reimagining Public Safety Task Force, City of Berkeley

November 2021

"Gender-based violence is endemic in our communities. In the United States, about one in four women and nearly one in ten men reported being impacted by sexual violence, physical violence, and/or stalking by an intimate partner. Globally, one in three women across their lifetime are subjected to physical or sexual violence by an intimate partner or sexual violence from a non-partner."[1]

[1] https://www.whitehouse.gov/wp-content/uploads/2021/10/National-Strategy-on-Gender-Equity-and-Equality.pdf

Overview

This subcommittee formed to identify the needs of community members who often face the most barriers when seeking help and safety. Historically, intimate partner violence, also called "domestic violence" or "domestic abuse," was treated as a personal problem or family dispute. This view dismissed the community's role and obligation in addressing these issues. In the last few decades, federal and state laws have passed, including the Violence Against Women's Act (VAWA), to recognize the role the government must play in preventing and intervening in gender-based crimes. In October of 2021, the first ever report was released by the Biden/Harris Administration on a national strategy to address gender equity and gender equality.

And change starts here, at the community level. The City of Berkeley (the City) is uniquely situated to address gender-based violence in innovative ways. Berkeley has been seen as a place of change and progress, home to students, thought leaders, and academic experts at UC Berkeley, as well as its proximity to experts who call the Bay Area home. This subcommittee offers a number of recommendations that fall squarely within the City's reimagining priority areas, including domestic violence prevention, restorative justice programs, housing and homelessness services, and expanding partnerships and community organizations."[2]

Information Gathered

This subcommittee hosted two listening sessions for providers who serve domestic violence, human trafficking, and sexual abuse survivors. The first listening session, hosted in September of 2021, focused on alternative non-police responses—eight organizations were represented at this session. The second session was hosted in October of 2021 and focused on police response—three organizations were represented. It is important to note that this subcommittee did not host any listening sessions specifically for victims and survivors. Because of the COVID-19 pandemic, the subcommittee was not confident in its ability to provide a safe remote space. The subcommittee erred on the side of caution and instead hosted spaces for providers to share their ideas, on behalf of the clients they serve. This subcommittee strongly believes that any work done by the City in this area, must be done in partnership with providers, who can help facilitate direct feedback from victims and survivors in a safe and supportive way.

In addition, subcommittee members reached out to the Berkeley Police Department for information on existing policies, and training. Specific questions were sent by this subcommittee to the department. Those questions and the department's responses are included at the end of this report (see Appendix). All information gathered from this subcommittee, along with the expertise of subcommittee members, form the basis for the recommendations provided below.

Recommendations

All recommendations put forth by this task force should be centered around the needs of people in our community. This means that people in our community need options to choose from to

[2] [cite City resolution]

address their well-being and safety. Victims and survivors of domestic violence, human trafficking and sexual abuse can experience a number of barriers in accessing help and justice. Providing a range of options will ensure that these barriers do not prevent someone from achieving safety.

Barriers include:

- Limited or no English proficiency
- Impact of trauma
- Systemic racism and colonization
- Discrimination based on gender identity or perceived gender identity
- Discrimination based on sexual orientation or perceived sexual orientation
- Lack of affordable housing and access to other basic needs
- Being unhoused
- Fear of immigration consequences
- Lack of behavioral health resources
- Stigma and victim blaming

Prevention and Intervention: Non-Police Response Recommendations

Recognizing that some people will not look to the police for help, the City should provide alternative services for community members seeking help. The City should also invest in prevention efforts.

This subcommittee proposes the following to address prevention and non-police intervention and resources (estimated costs on page 8):

1. **Increase the capacity of community-based organizations** serving Berkeley residents, students, and employees by providing additional funding. The City should consider providing grants to various organizations. Funding should be flexible so providers can decide the best way to support victims and survivors. This would include using funds for housing, childcare, transportation, and other crucial resources.

   Rationale: Providers report that existing resources are insufficient to meet the needs of Berkeley community members, especially for those who require more care and resources including people who are unhoused and people with complex mental health issues. A person seeking to leave an abusive relationship will likely need a range of services, including advocacy/case management; legal services for child custody, restraining order or other family law issue; and other support services like housing and childcare. To provide effective intervention in domestic violence cases, the City should fund long-term solutions. Solutions should include legal services, intensive case management to individuals with high needs, advocacy services in languages other than English, restorative justice programs, healing practices, and job training.

2. **Train and provide technical assistance to faith-based leaders** on domestic and family violence issues.

   Rationale: Many people turn to faith-based leaders for help. These leaders, like others, need training to understand the complexities of domestic violence, identify effective tools to create safe spaces for those seeking help, learn about existing domestic violence resources to refer people to, and help change cultural norms that perpetuate domestic violence. In California, domestic violence agencies have partnered with faith-based leaders to address domestic violence in their communities. Examples include A Safe Place[3] in Oakland, and Korean Family Services in Los Angeles[4]. The latter has trained over 1700 faith leaders in the last 10 years.

3. **Provide services for people who cause harm**.

   Rationale: While survivor-centered services are essential, services for the person causing harm are also crucial to stopping gender-based violence. The City should invest in programs that target people who cause harm, including men and boys, to provide services and prevention efforts.

4. **Prevention education for K-12 to provide, and coordinate prevention work**

   Rationale: Breaking the cycle of violence requires changing cultural norms and practices that perpetuate violence and gender inequities. In addition to the recommendations related to intervention listed above, this subcommittee recommends additional funding for education for K-12 and to create peer-based models, when appropriate. Providers report that more education is needed to teach on toxic masculinity, consent, healthy relationships, and sex education, including sexual pleasure.

Intervention: Police Response Recommendations

The Yurok word for police translates into “they take people”[5] illustrating the deep distrust certain communities have not only with the police, but the police as an arm of the government that colonized, enslaved, and took their children. To move forward, this subcommittee recommends strengthening the relationships of those most impacted by police action and most in need of safe intervention. Specific actions that the Berkeley Police Department and the City should take include the following (estimated costs on pages 8–9):

1. **Provide City leadership to host regular meetings and coordinate services.** The City should create a forum for service providers, advocates, community members and response teams (police department, mental health crisis) to address issues related to domestic violence, human trafficking, and sexual abuse. This group should meet regularly. City

[3] https://www.asafeplace.org/
[4] https://www.kfamla.org/upage.aspx?pageid=u06
[5] https://www.theguardian.com/us-news/2020/sep/25/california-native-american-women-police-violence

leadership should also participate in county-wide efforts, like the Family Violence Council in Alameda County[6]

Rationale: Having the City serve as lead will institutionalize these much-needed partnerships. These meetings would be especially important if a tiered response system is adopted by the City, as victims and survivors of crime will be captured in all tiers (e.g. domestic violence may be reported by a caller as a noise disturbance). During the first listening session, many of the providers noted that the listening session was the first time that they had been asked for their feedback. Establishing a forum would forge new and ongoing partnerships between the City and providers. For survivors of intimate partner violence, a coordinated community response serves as a protective factor against future violence.[7] Outreach should be done to ensure that BIPOC leaders are at the table.

2. **Coordinate with court and other local law enforcement to implement new firearm and ammunition surrender laws.** Countywide coordination will be needed to implement Senate Bill 320[8], which would require law enforcement to act quickly to enforce firearm and ammunition restrictions for domestic violence restraining orders.

   Rationale: Starting January 1, 2022, local courts will be required to notify law enforcement when the court has found that a person is in possession of a firearm or ammunition, in violation of a domestic violence restraining order. Law enforcement would have to take all necessary actions to obtain the identified firearms or ammunition.

3. **At least once a year, update the police department's domestic violence policies and victim resource materials**, in consultation with domestic violence and community providers.

   Rationale: California law frequently changes in the area of domestic violence. For example, during the 2021-2022 state legislative cycle, at least five bills passed that change the law for domestic violence restraining orders, including SB 320 noted above. Updating these procedures regularly and in coordination with providers, will ensure that policies reflect current laws and address community-based concerns.

4. **Regular domestic violence and trauma-informed training for officers, dispatch and any community-based officer** who responds to 911 or non-emergency calls. These trainings should be designed in partnership with community-based providers so that the

[6] The Family Violence Council is led by the Superior Court of Alameda County, for stakeholders to improve coordination and cooperation between the court and public and private agencies. This body meets at least four times a year. For more information: http://www.alameda.courts.ca.gov/Resources/Documents/2020-04%20Family%20Violence%20Council(1).pdf

[7] https://www.cdc.gov/violenceprevention/intimatepartnerviolence/riskprotectivefactors.html

[8] https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220SB320

information is tailored to local needs and issues. This training would be in addition to statewide training requirements through POST (Peace Officer Standards Training).

Rationale: Providers report that victims and survivors seeking help from police often feel unheard and further traumatized by the experience with police. Examples include allowing other family members to speak or translate for the victim, when family members may be related to the abuser. This recommendation is consistent with NICJR's recommendation that the department increase its use of local community members to provide training.

5. **Victim resources should be in plain language and translated** into multiple languages, including, but not limited to, Spanish, Chinese (simplified), Tagalog, Vietnamese and Korean.[9] Other languages that are spoken in Berkeley should also be included.

   Rationale: Provides more access to people who have limited English proficiency, do not speak English, or have low literacy.

6. **Domestic violence should be screened** for in all 911 and non-emergency line calls and by the responding officer, including community-based officers (e.g. CERN). This would include collecting information regarding the alleged victim and alleged suspect's relationship to one another.

   Rationale: This would lead to better data on the number of domestic violence cases the police and others respond to in the city. Noting the penal code or city ordinance section alone would not capture all domestic violence cases.

7. **A female officer (over a male officer)** should be provided to interview, examine, or take pictures of an alleged victim, at the alleged victim's request.

   Rationale: This policy would acknowledge that some victims and survivors will feel uncomfortable with having a male officer examine or question them. This could result in the victim giving an incomplete statement (e.g. not disclosing sexual abuse or showing an injury) and further traumatize the victim.

8. **Police response to DV calls should be accompanied or coordinated with a DV advocate**. This could involve a victim advocate being present at the scene or a warm handoff to a victim advocate over the phone or immediately following a police response.

   Rationale: This practice is especially important in cases where there is a high risk of lethality, language or cultural barriers that could lead to miscommunication or further traumatization, and high needs cases where victim or family members require a number of services to achieve stability. Having a victim advocate present will help ensure that victims are heard and not further traumatized. Providers report that advocates sometimes must act

[9] These languages represent the top five languages spoken in the Bay Area and California. At a minimum, victim resources should be translated into these languages.

as a safe middle person between the victim and police, to ensure that the victim is not mistreated or further traumatized by the interaction with police. This feedback is consistent with information gathered from the community engagement process where black residents spoke of the need for a safety ambassador to act as a bridge between the community and police (see page 40 of Summary of Findings report from Bright Research Group).

Conclusion

Investments by the City to address gender-based violence could have a profound impact on the community, not only in preventing further abuse, but in building a future in which all community members feel safe at home, and in their communities. While this report in no way represents a complete list of actions the City could take to address gender-based violence, the subcommittee believes that these recommendations represent a significant step in the right direction. Of course, more information and input is needed, especially to address the impact of structural racism on victims, survivors and those that cause harm, as well as the experiences of LGBTQ+ members of our community. Forging partnerships and building meaningful community engagement will help support a response that is centered around the needs of the people.

Special thanks to the people who show up every day for victims and survivors. And many thanks to the organizations and individuals who participated in the listening sessions. Your time and expertise were crucial to this process. We could not and cannot do this work without you all.

Subcommittee members (in alphabetical order):
boona cheema
Barnali Ghosh
Frances Ho

Recommended Costs

Prevention and Intervention: Non-police response	
1. Increase the capacity of community-based organizations (Fund 3-4 organizations to provide the services and resources mentioned on page 2.)	$500,000
2. Training and technical assistance for faith-based leaders (This amount would be used to hire consultants to provide training and resources or provide funding directly to a number of faith-based organizations to hire experts directly).	$50,000
3. Services for people who cause harm (Fund 2-3 organizations to provide services to people who cause harm (see #3 on page 3).	$150,000
4. Prevention education for K-12 to provide, and coordinate prevention work (Fund one full-time person to increase prevention education by developing curricula and coordinating with all schools in the Berkeley School District. This would include working with student groups from Berkeley High School to develop peer-based education.)	$125,000
Intervention: Police response	
1. City leadership to work on gender-based violence issues, including leading a forum for community providers and members.	In-kind from the City
2. Coordinate with court and other local law enforcement to implement new firearm and ammunition surrender laws	In-kind from police department and the CIty

3. Update DV policies annually and as needed.	In-kind from police department
4. DV and trauma-informed training	$5,000 for contracted speakers In-kind from police department
5. Translation of DV resource cards into multiple languages (Cost to translate resource cards and other materials into at least five most common languages.)	$15,000 *(one-time investment with some funding needed to update resources)*
6. Screen for domestic violence for every call for help	In-kind from all responding agencies
7. Female officer available	In-kind from police department
8. Advocate to accompany DV call and provide crisis intervention	$125,000 (two advocates at 0.5FTE)
Total	$970,000

Appendix

Questions to Berkeley Police Department (BPD) from GBV subcommittee of Reimagining Public Safety Task Force

1. When an alleged victim or suspect needs language assistance, who provides interpretation?
BPD response: When an alleged victim or suspect needs language assistance, we first look to fellow officers for translation services. The Berkeley Police Department employs officers and other department personnel that speak many different languages - about 12 different languages are spoken. Berkeley Police Officers also use the AT&T "Language Line" for languages that are not spoken by fellow officers/Berkeley Police employees. When an exigency exists, officers also use family members and/or friends to translate, where appropriate.

2. If an alleged victim or suspect needs language assistance, is this noted in the police report, including the language spoken and who provided interpretation?
BPD response: Berkeley Police officers document when an alleged victim or suspect requires language assistance in their police reports. The documentation also includes what language the victim or suspect speaks, and who provided the translation. The Domestic Violence supplemental report specifically asks the officer to document whether the victim/suspect has difficulty with English, and if so, what language is preferred. The report also has a field for the officer to input who provided translation.

3. Are resources, like domestic violence pamphlets and resource cards, translated into different languages? If so, what languages?
BPD response: The Berkeley Police Department stocks Victims of Crime Resource pamphlets and Marsy's Rights cards in Spanish.

4. If an alleged victim is unhoused and does not have a phone, how does the department contact the victim if follow-up is needed?
BPD response: When an alleged victim is unhoused and does not have a phone, officers will try to obtain alternate means of communication for the

victim (e.g. email account, social media accounts, etc.). If the alleged victim does not have any means of contact, officers will try to obtain information about where the victim will be staying so that personal contact can be made by detective(s) conducting follow-up investigation. Patrol officers are often very knowledgeable about where specific victims live or areas they frequent. Officers are diligent about documenting various ways - unique to every victim - to contact them.

5. Can you provide a copy of any pamphlet or brochure that is provided to an alleged domestic violence victim by responding officers?
BPD response: [Pamphlet/brochures provided to DV victim] See attached.

6. How often does the department update its domestic violence policies?
BPD response: The Berkeley Police Department does not currently have a set revision schedule for updating its Domestic Violence policy and related policies. The Berkeley Police Department just migrated its policies to Lexipol. Policies are updated as revisions are needed. The DV policy was last updated October 5, 2018.

7. Are domestic violence advocacy groups consulted when the department updates its internal domestic violence policies?
BPD response: No, a domestic violence advocacy group was not consulted when the department updated its internal domestic violence policies. Per city protocol the domestic violence policy was written in conjunction with the Police Review Commission (now the Police Accountability Board). However, we are in weekly collaboration with our domestic violence advocate at the Family Justice Center. She helps coordinate all aspects of care and resource procurement for victims.

8. Does the department use the relationship between the alleged victim and suspect to indicate that a case involves DV allegations? For example, in some cases the alleged violation per the penal code would not reveal that the case involves DV, but knowing that the

parties are married or in a dating relationship would (e.g. PC 422, false imprisonment, annoying or harassing phone calls).
BPD response: Yes, the Berkeley Police Department uses the relationship between the alleged victim and suspect when investigating reports of criminal violations. The Department treats all reports of criminal activity seriously, however, those involving intimate partner violence are of particular concern due to the elevated emotional component and frequent volatility of such incidents. Domestic abuse/violence incidents tend to repeat and intensify in nature if the cycle of violence is not interrupted.

9. What training do responding officers and specially assigned detectives receive in the areas of domestic violence, sexual assault and human trafficking? How often is this training provided? Please provide examples of topic areas and the provider of the training, if possible.

BPD response: If the DV subcommittee is interested in topics that are trained for sexual assault and/or human trafficking we could work on this information in the future. Domestic Violence Related training topics for Officers and Detectives:

Academy POST Training:
Domestic Violence related laws
Batterer and victim characteristics
Victim Protections
Types of court orders
Emergency Protective Orders
Support Services for Victims
Reporting and Documentation

POST ICI Domestic Violence Investigations:
Search Warrants
Stalking
Strangulation
DA Presentation
Equality, power and control, abusive relationships
Power and Control for Lesbian, gay, bisexual and Trans Relationships
Abuse in Later life
People with Disabilities in Partner Relationships

Impact on Children
DV Injuries
Officer Involved DV
Lethality

RECURSOS PARA VÍCTIMAS DE CRIMEN

14

RECURSOS PARA VICÍMAS DE CRIMEN

Arresto Policial

El Departamento de Policía de Berkeley se compromete a proteger a las personas que sean víctimas de un crimen, incluyendo Violencia Doméstica. Los agentes policiales consideran la Violencia Doméstica como conducta delictuosa, cual se investigará como cualquier otro crimen. En los casos de delitos mayores o lesiones graves, el agente policial puede efectuar un arresto del sujeto en base al motivo fundado de que el sujeto cometió el delito.

Arresto Ciudadano

Bajo ciertas circunstancias, los agentes policiales no pueden efectuar un arresto directamente, pero le deben pedir hacer el arresto ciudadano (excepto en los casos de Violencia Domestica) al agente policial. Una persona particular puede arrestar a otra por un crimen cometido en su presencia. El agente pondrá bajo custodia al sospechoso cuando exista motivo fundado.

ATENCÍÓN: La persona sujeta a la acusación puede depositar una fianza o ser puestos en libertad con una citación. Las víctimas no deberán de depender en el arresto como garantía de su propia seguridad.

Presentar Cargos

Usted tiene el derecho de pedirle al Fiscal que entable una denuncia. Al siguiente día hábil después de su denuncia a la policía, debe de comunicarse con la División de Investigaciones al número escrito en su recibo del informe. Es muy importante que haga esto sin importar si el sospechoso haya sido arrestado.

En casos de Violencia Doméstica el Fiscal toma la decisión final para decidir si se presentan cargos o no en contra del agresor.

Usted tiene el derecho de que el Fiscal lo(a) escuche, y el derecho de pedirle al Fiscal que presente una denuncia penal.

Oficina de la Fiscalía del Condado de Alameda (510) 268-7500
Defensor de Víctimas de Violencia Familiar de la Fiscalía (510) 268-7276

INFORMACIÓN LEGAL

Programas de Asistencia para Víctimas
La oficina de la Fiscalía del Condado de Alameda tiene personal que puede brindarle información y asistir a víctimas de crímenes.

Fiscalía del Condado de Alameda – Servicios para Víctimas y Testigos
1401 Lakeside Dr., Ste. 802, Oakland, CA 94612 (510) 272-6180

Centro Familiar de Justicia del Condado de Alameda
470 27th St., Oakland, CA 94612 (510) 267-8800

La Oficina de la Fiscalía también tiene un Defensor de víctimas que le puede brindar información sobre el estado de casos penales. Se puede comunicar con la Oficina de la Fiscalía al (510) 268-7276.

BPD – Violencia Doméstica y Agresión Sexual
El Departamento de Policía de Berkeley tiene un equipo de Detectives y un Defensor de Víctimas que le puede brindar información sobre el proceso judicial y ofrecerle asistencia adicional.

Detective de Violencia Doméstica (510) 981-5736
Defensor de Violencia Doméstica (24 horas) (510) 757-5123
Detective de Agresión Sexual (510) 981-5735

Información para Víctimas y Notificación Diaria (VINE por sus siglas en inglés**)**
Para averiguar si un agresor está bajo custodia en el estado de California o para que se le notifique cuando un agresor es puesto en libertad, llame (877) 411-5588. Necesita un teléfono con teclado. También necesita saber el nombre de la persona que se encuentra bajo custodia.

Las víctimas no deberán de confiar en esto para garantizar su propia seguridad.

Visa U

La Ley Federal creó la Visa U para animar a víctimas de crímenes sin ciudadanía a cooperar con agencias del órden público proporcionándoles protección de deportación y un camino para obtener una Tarjeta de Residente Permanente. Puede encontrar más información en el sitio web del Departamento de Justicia de California Oficina de la Procuraduría www.oag.ca.gov al igual que en el sitio de Servicios de Ciudadanía e Inmigración de los Estados Unidos (USCIS por sus siglas en inglés) www.uscis.gov. También puede pedir ayuda comunicándose con el Centro Familiar de Justicia del Condado de Alameda (510)267-8800.

Visa T
La Visa T le permite a víctimas de trata severa de personas permanecer en los EE.UU para ayudar a las autoridades con su investigación. Puede encontrar más información en el sitio web de Servicios de Ciudadanía e Inmigración de los Estados Unidos www.uscis.gov. También puede pedir ayuda comunicándose con el Centro Familiar de Justicia del Condado de Alameda (510)267-8800.

INFORMACIÓN – ORDEN DE RESTRICCIÓN
Si lo han amenazado, acosado o agredido, puede solicitar un Orden de Restricción. Si el agresor es o fue su esposo(a), pareja o con quien tiene hijos en común, puede solicitar una "Orden de Restricción por Violencia Doméstica." Si está casado(a) con el agresor, no tiene que obtener un divorcio para obtener una Orden de Restricción. Si el agresor es un vecino, amigo, o conocido, puede pedir una "Orden por Acoso Civil." Hay un cobro por una Orden de Restricción por Acoso Civil. Si usted es de bajos recursos, puede solicitar una exención de pago.

Como solicitar. Puede solicitar una Orden de Restricción en el:
1. René C. Davidson Courthouse, 1225 Fallon St., Oakland, CA
2. George E. McDonald Hall of Justice, 2233 Shoreline Dr., Alameda, CA
3. Hayward Hall of Justice at 24405 Amador St., Hayward, CA

Puede obtener los documentos e instrucciones detalladas en el Tribunal o en línea www.courts.ca.gov. El Defensor de víctima al (510) 757-5123 o Centro de Derecho de Violencia Familiar al (800) 947-8301 también puede asistirle a obtener una Orden de Restricción por Violencia Doméstica.

Costo. No hay costo para obtener una "Orden de Restricción por Violencia Doméstica." Sí hay costo para obtener una "Orden por Acoso Civil." Si usted es de bajos recursos, puede solicitar una exención de pago. No necesita un abogado para obtener una Orden de Restricción, pero sí es buena idea tener uno si tiene uno disponible

¿Cuánto tiempo toma para obtener una Orden de Restricción?
Es posible obtener una Orden de Restricción Temporal dentro de 24 horas, o puede tomar hasta una semana. Es importante comenzar temprano el proceso para obtener una Orden de Restricción a largo plazo. Si el agente policial le da una "Orden de Protección de Emergencia", no espere hasta que se venza esta Orden antes de solicitar una Orden de Restricción a largo plazo.

¿Qué hace una Orden de Restricción?

1. Ordenar al acusado mantenerse a cierta distancia de usted, su familia, y/o miembros de su hogar.
2. Ordenar al acusado a mantenerse alejado de su casa, sitio de trabajo, casa de su familia, sitio de escuela/guardería de sus hijos, y si es necesario alguna otra dirección.
3. Ordenar al acusado a mudarse de su casa o departamento, aunque el nombre del acusado se encuentre en el contrato de alquiler o sea copropietario.
4. Que se le de custodia de sus hijos y exigir una orden de visitas.
5. Ordenar Manutención para sus hijos.
6. Ordenar al acusado que no acose, maltrate o se comunique con usted, su familia o miembros de su hogar.
7. Que se le dé uso de cierta propiedad.
8. El reembolso por la pérdida de ingresos y/o el gasto real causado directamente por la violencia como cobros médicos y daño a propiedad.
9. Ordenar al acusado que pague ciertas deudas.
10. Ordenar el acusado que cumpla con un programa de intervención para agresores de 52 semanas.

ATENCIÓN: No se puede hacer cumplir una Orden de Restricción hasta que sea emplazada, que significa que se le ha notificado al acusado en persona, en el tribunal o por un agente policial que están sujetos a una restricción.

Guarde la Orden de Restricción consigo.
Si usted obtuvo una Orden de Restricción la cual le prohíbe al agresor pegarle o acosarlo(a), y el agresor a sabiendas quebranta la Orden, pueden ser arrestados y en la mayoría de los casos encarcelados. A pesar de que el Departamento de Policía debe de tener su Orden de Restricción en el sistema de datos, es extremadamente importante que guarde una copia de su Orden de Restricción y Comprobante de Emplazamiento (Proof of Service) consigo en todo momento.

¿Qué debe hacer si el acusado quebranta la Orden de Restricción?
1. Llame a la Policía.
2. Pida que se prepare un informe formal, aunque se haya ido el acusado.
3. Si se le emplazó la Orden de Restricción al acusado y el(ella) sigue ahí cuando llegue la policía, pueden ser arrestados.
4. Comuníquese con la División de Investigaciones de BPD al próximo día hábil después de su denuncia policial para informarse sobre el procesamiento de su caso por el quebrantamiento de la Orden de Restricción.

Demandando al agresor
Usted puede tener el derecho a demandar al agresor en el tribunal civil aparte de presentar cargos penales. Si usted perdió ingresos, acumuló cobros médicos, tuvo daños de propiedad, u otras pérdidas debido al abuso, puede consultar con un abogado. Comuníquese con el Servicio de Recomendaciones de Abogados del Condado de Alameda (510) 302-2222.

LESIONES
Puede ser que encuentre más lesiones o el empeoramiento de lesiones después de que se haya ido la policía o de cuando tomaron su denuncia.

Por ejemplo, durante los días después de la agresión se pueden marcar más los moretes. Los Detectives le pueden pedir que se tome más fotos de sus lesiones.

ESTRANGULACIÓN
La estrangulación puede causar lesiones internas graves y se les sugiere a las víctimas que inmediatamente busquen atención médica. Infórmele al agente o al personal médico si el agresor lo(a) estranguló o trato de sofocarlo.

INFORMACIÓN DE AGRESIÓN SEXUAL

Como Pedir Ayuda.
La agresión sexual es un crimen grave y emocional. Puede implicar a alguien que usted conoce o a un desconocido. El denunciar una violación o agresión sexual a la policía puede ser una decisión difícil. Para recibir ayuda y orientación, llame al Centro de Crisis de Violaciones.

BAWAR (Bay Area Women Against Rape) –Mujeres contra la Violación
470 27th St., Oakland, CA 94612 24 horas al día (510) 845-7273

Centro de Justicia Familiar del Condado de Alameda
470 27th St., Oakland (510) 430-1298

RAINN (Rape, Abuse & Incest National Network)
(Red Nacional de Violación, Abuso e Incesto) (800) 656-4673

VÍCTIMAS DE AGRESIÓN SEXUAL: DERECHOS

Esta información se le debe proporcionar por escrito a las víctimas de agresión sexual antes de la investigación.

Como víctima de agresión sexual tiene los siguientes derechos específicos a la agresión sexual:

No se le requiere participar en el sistema judicial ni de reportarlo a la policía.

Tiene el derecho de tener un terapeuta/defensor de víctimas y por lo menos a una persona de apoyo que usted escoja que esté presente durante la examinación médica forense, examinación física, o entrevista de investigación a raíz de la agresión sexual. Los Terapeutas/Defensores de víctimas de agresión sexual están inmediatamente disponibles 24 horas al día.

No se le obliga participar en una examinación médica física o probatoria.

Las pruebas forenses de agresión sexual serán examinadas y analizadas en el laboratorio a menos que la víctima pida que no se examinen las pruebas.

Las víctimas pueden recibir información sobre los resultados de análisis de todas las pruebas forenses de agresión sexual del hospital que está llevando a cabo el examen o del Departamento de Policía de Berkeley.

Tiene el derecho de pedir que el agente policial sea hombre o mujer cuando lo entrevisten.

Las pruebas de agresión sexual se deterioran con el tiempo. Con el paso del tiempo podría ser imposible recuperar pruebas biológicas. Las pruebas biológicas se deben de recopilar y preservarse lo antes posible.

Las pruebas forenses de agresión sexual se conservan por 20 años por lo menos. Si la víctima es menor de 18, se conservan hasta que la víctima cumpla 40 años.

Tiene disponible Ordenes de Restricción y Ordenes de Protección y también en este folleto se incluye información de cómo recibir ayuda y obtenerlas.

Como víctima de un crimen, también tiene los derechos tal y como se describen al final de este folleto bajo **DECLARACIÓN DE DERECHOS DE LA VÍCTIMA SEGÚN LA LEY DE MARSY.**

Si tiene la intención de denunciar una violación o agresión sexual a la policía:

1. Ayuda preservar las pruebas. No se bañe, no use la ducha vaginal, no se cambie ni lave su ropa. Tampoco cambie nada en el lugar donde sucedió la agresión.
2. Comuníquese con la policía lo antes posible para que lo puedan llevar al hospital y preparar un informe.
3. Aunque la policía preparará un informe detallado, usted les puede pedir que su nombre no se incluya en la parte pública del informe.
4. Tiene el derecho de tener un Defensor y una persona que usted elija de apoyo durante su examen en el hospital y durante la interrogación policial.

RECURSOS EN LA COMUNIDAD PARA VÍCTIMAS

Servicios de Emergencia.

Los Terapeutas de Violencia Doméstica están disponibles 24 horas al día si necesita terapia profesional por situación de crisis, reubicarse de emergencia a un lugar seguro, buscar un plan de seguridad, o para obtener información sobre orden de restricción. Se puede comunicar con el equipo de respuesta móvil FVLC (Centro de Derecho de Violencia Familiar por sus siglas en inglés) al (800) 947-8301.

Asistencia Legal

Family Violence Law Center (FLVC)	(800) 947-8301 (510) 208-0255
Bay Area Legal Aid	(510) 250-5270
East Bay Community Law Center	(510) 548-4040
Alameda County Bar Association	(510) 302-2222
Legal Assistance for Seniors	(510) 832-3040
Asian Pacific Islander Legal Outreach	(510) 251-2846

Refugios y Líneas Directas

A Safe Place	(510) 536-7233
	(510) 836-2456
Building Futures w/Women & Children	(866) A-WAY-OUT
	(866) 292-9688
Safe Alternative to Violent Environments	(510) 794-6055
STAND	(888) 215-5555
Tri-Valley Haven	(800) 884-8119
Marin Abused Women's Shelter	(415) 924-6616
Asian Women's Shelter	(877) 751-0880
EDEN (shelter referrals)	(510) 537-2552
National Domestic Violence Hotline	(800) 799-SAFE
	(800) 799-7233
Narika Hotline (South Asian Languages)	(800) 215-7308
Shimtuh Hotline (Korean Center East Bay)	(510) 547-2662
Deaf Hope	hotline@deaf-hope.org
Community United Against Violence (LGBTQ)	(415) 777-5500
Bay Area Crisis Nursery	(925) 685-8052

Consejería para los Sobrevivientes

Ser víctima de un crimen puede ser extremadamente difícil y traumático. Es muy importante que obtenga el apoyo necesario para cuidarse. Las siguientes agencias proporcionan asesoría y asistencia.

Family Violence Law Center	(800) 947-8301
Clearwater Counseling	(510) 596-8137
A Safe Place	(510) 536-7233
Tri-Valley Haven	(800) 884-8119
SAVE	(510) 794-6055
Building Futures w/Women & Children	(866) 292-9688
La Clínica de la Raza (Español)	(510) 535-4170
Pacific Center for Human Growth (LGBTQ)	(510) 548-8283
Community United Against Violence (LBBTQ)	(415) 777-5500
Alameda Family Services	(510) 522-8363
Deaf Hope	hotline@deaf-hope.org
National Domestic Violence Hotline	(800) 799-7233

Asesoría para Niños

Family Violence Law Center	(800) 947-8301
Clearwater Counseling	(510) 596-8137
DOVES at Oakland Children's Hospital	(510) 428-3135
The Link to Children (TLC)	(510) 428-2028

Asesoría para Agresores

Alameda Community Recovery SVS	(510) 522-8363
John Hamel & Associates (Berkeley)	(925) 686-2921
Allen Temple Baptist Church	(510) 544-3914
Peace Creations	(510) 834-7088
Psychological Services Center	(510) 628-9065
West Oakland Health Council	(510) 465-1800

JUNTA DE COMPENSACION PARA VICTIMAS DE CALIFORNIA

El Estado de California le puede pagar a las víctimas de crimen o sus dependientes los gastos relacionados a actos criminales. Este Programa de Compensación para Víctimas de California le podría pagar los siguientes gastos:

- Tratamiento medico y dental
- Servicios de salud mental
- Reubicación por su seguridad
- Seguridad en el hogar
- Pérdida de ingresos

ATENCIÓN: El Programa de Compensación para Víctimas de California no puede pagarle gastos por daños a la propiedad.

Para obtener más información sobre este Programa o para obtener una solicitud por favor llame al:

Programa de Compensación para Victimas de California

Estado de California	(800) 777-9229
Condado de Alameda	(510) 272-6180

Programa para asistir a Víctimas/Testigos Fiscalía del Condado de Alameda
1401 Lakeside Drive, Suite 802
Oakland, CA 94612 (510) 272-6180

Centro Familiar de Justicia de Condado de Alameda
470 27th Street Oakland, CA 94612 (510) 267-8800

DECLARACIÓN DE DERECHOS DE LA VÍCTIMA SEGÚN LA LEY DE MARSY.
La Constitución de California, Artículo 1, Sección 28, confiere ciertos derechos a víctimas de crimen, según lo define la ley. Los derechos son:

1. **Justicia y Respeto**
A que se le trate con justicia y respeto a su privacidad y dignidad, no ser intimidado, acoso y abuso, durante todo el proceso penal o el proceso jurídico de menores.

2. **Protección del acusado**
A que se le proteja razonablemente del acusado y las personas que actúen en nombre del acusado.

3. **Consideración de la Seguridad de la Víctima para Fijar Fianza y Condiciones de Libertad**
A que se considere la seguridad de la víctima y de los familiares de la víctima al momento de fijarse el monto de la fianza y las condiciones de la liberación del acusado.

4. **Evitar la Divulgación de Información Confidencial**
A evitar la divulgación de información o registros confidenciales al acusado, al abogado del acusado o cualquier persona que actué a nombre del acusado, que se pudieran utilizar para ubicar u hostigar a la víctima o la familia de la víctima, o que divulgaran comunicaciones confidenciales llevadas a cabo durante el tratamiento médico o de consejería, o que de otra forma se consideren privilegiados o confidenciales ante la ley.

5. **Rechazar una entrevista por parte de la Defensa**
A reusare a una entrevista, declaración o petición de revelación de pruebas de parte del acusado, del abogado del acusado o cualquier persona que

actúe en nombre del acusado, y a establecer condiciones razonables para llevar a cabo dicha entrevista en caso de que la víctima acepte.

6. Consultar con la Agencia Acusadora y Notificación de la Resolución antes del Juicio

A recibir aviso razonable y a consultar razonablemente con la agencia acusadora, por solicitud, en cuanto al arresto del acusado si el procurador lo conoce, los cargos presentados, la decisión de extraditar al acusado y, de ser solicitadas, a que se le notifique e informe antes de cualquier resolución previa a un juicio del caso.

7. Notificación y Presencia en Procesos Judiciales

A recibir aviso razonable de todos los procesos judiciales públicos, incluyendo los procesos judiciales de delincuencia, de ser solicitado, en los que el acusado y el procurador puedan estar presentes, y de todos los procesos judiciales de libertad condicional u otras liberaciones posteriores a la condena, y a estar presente en esos procesos judiciales.

8. Presencia en Procesos Judiciales y Expresión de Opinión

A que se la escuche, de ser solicitado, en cualquier procedimiento, incluidos procedimientos de delincuencia, que incluya n una decisión de liberación tras el arresto, alegato, sentencia, decisión de liberación tras la condena, o cualquier procedimiento en el que esté en juego un derecho de la víctima.

9. Juicio con celeridad y Conclusión Inmediata del Caso

A un juico sin demora y a una conclusión inmediata y final del caso y cualquier proceso relacionado tras la imposición de la condena.

10. Proveer Información al Departamento de Libertad a Prueba

A brindarle información a un oficial del departamento de libertad a prueba que realice una investigación previa a la imposición de pena sobre el impacto del crimen en la víctima y la familia de la víctima, y cualquier recomendación de la pena antes de su imposición al acusado.

11. Recibir el Informe Previo a la condena

A recibir, de ser solicitudo, el informe previo a la condena disponible para el acusado, excepto aquellas partes que sean legalmente confidenciales.

12. Información de la Condena, Pena, Encarcelación, Libertad, y Escape

A recibir información, por solicitud, de la condena, la pena, el lugar y la hora de encarcelamiento u otra resolución del acusado, la fecha programada de liberación del acusado y la liberación o el escape del acusado de la custodia.

13. Indemnización

A. Es la intención inequívoca del pueblo del estado de California que todas las personas que sufran pérdidas como resultado de actividad criminal tengan derecho a buscar y asegurar la indemnización de las personas condenadas por los crímenes que causaron la pérdida que han sufrido.

B. La indemnización debe salir del malhechor condenado en todos los casos, sin importar la pena ni resolución impuesta, en los que una víctima de crimen sufra una pérdida.

C. Todos los pagos monetarios, fondos y propiedad recaudada de cualquier persona que deba resarcir se aplicarán primero al pago de los montos ordenados como indemnización a la víctima.

14. Devolución Rápida de Propiedad

A la devolución rápida de la propiedad cuando ya no se necesite como pruebas.

15. Aviso de Libertad Condicional y sus Procedimientos

A estar informada sobre todos los procedimientos de libertad condicional, a participar en el proceso de libertad condicional, a brindarle información a la autoridad de libertad condicional para que se le tenga en cuenta antes de la libertad condicional del acusado, y a que se le notifique, si así lo solicita, sobre la libertad condicional u otra liberación del agresor.

16. La Seguridad de la Víctima y de la Comunidad son Factores para la Libertad Condicional

A que se tenga en cuenta la seguridad de la víctima, la familia de la víctima y el público general antes de que se tome cualquier decisión de libertad condicional u otra liberación tras la imposición de la condena.

Información sobre estos 16 Derechos

A que se le informe sobre los Derechos enumerados en los párrafos (1) al (16).

Para más información sobre la Ley de Marsy, visite el sitio web del Procurador General de Justicia al: www.ag.ca.gov/victimservices.

Para obtener información sobre el Centro para Asistir a Victimas/Testigos más cercano a usted, llame:

Attorney General's Victim Services Unit (877) 433-9069
(Servicios para Victimas del Procurador General de Justicia)

Información Adicional para los Afiliados con la Universidad de California

Si usted está afiliado con UC Berkeley se le está proporcionando con este guía de recursos indispensable por que recientemente tuvo un impacto por actividad criminal, o tal vez necesite recursos que la Universidad le puede brindar. La Universidad de California en Berkeley tiene muchos recursos disponibles para ayudarle durante un momento difícil. Nos comprometemos a dar atención a sus necesidades en colaboración con nuestros socios en la comunidad.

UCPD Berkeley
Para más Información visite:
http://safetycounts.berkeley.edu

Reportar

Center for Student Conduct

(510) 643-9069, http://studentconduct.berkeley.edu

Office for the Prevention of Harassment and Discrimination

(510) 643-7985, http://ophd.berkeley.edu

University of California Police Department, Berkeley

(510) 642-6760, http://police.berkeley.edu

Apoyo

Gender Equity Resource Center

Sexual Harassment/Sexual Assault Resource Specialist

(510) 643-5727, http://geneq.berkeley.edu

University Health Services, Social Services

(510) 642-6074, socsrvs@uhs.berkeley.edu
http://uhs.berkeley.edu/students/counseling/socialservices.shtml

University Health Services, CARE Services

(510) 643-7754, careserv@uhs.berkeley.edu
http://uhs.berkeley.edu/facstaff/care/

Ombudsperson for Students and Postdoctoral Appointees

(510) 642-5754 for referral, http://sa.berkeley.edu/ombuds

Ombuds Office for Faculty

(510) 642-4226

The Staff Ombuds Office

(510) 642-7823

Division of Student Affairs, Student Legal Services

(510) 642-3916, http://sa.berkeley.edu/legal

Student Advocate

(510) 642-6912, http://advocate.berkeley.edu

MEDICO

University Health Services, Urgent Care Clinic

2222 Bancroft Way (The Tang Center)

(510) 643-7197 (advice after hours), www.uhs.berkeley.edu

Este material está disponible en formatos alternativos, de ser solicitados. Formatos alternativos incluye, formato audio, braille, de letra grande, texto electrónico, etc. Por favor comuníquese con los Especialistas de Servicios para los Discapacitados y permita que pasen de 7 a 10 días para producir el material en un formato alternativo.

Especialistas de Servicios para los Discapacitados
Correo Electronico: ADA@cityofberkeley.info
Teléfono: (510) 981-6418
TTY: (510) 981-6347

Revised February 2019 G:\p_admin\DD DV\2019 Resources for Victims - Spanish

NOTICE OF REPORT

Berkeley Police Department
Tsukamoto Public Safety Building
2100 Martin Luther King Jr. Way
Berkeley, CA 94704
(510)981-5900 VM#(510)981-5990
www.CityofBerkeley.info/police

Report number (Numero de Informe):

Date(Fecha):

Type of Report/Offense (Clase de Informe/Crimen):

Officer's name(Nombre del Agente Policial):

Badge #(Número de Placa):

Officer's duty hours (Horario de turno del Agente):

Days off (Días de descanso):

Si tiene alguna pregunta sobre el estado de investigación de su caso, por favor comuníquese con el Departamento Policial indicado abajo. Debe de hacer sus preguntas de lunes a viernes, de 8:00am a 4:30pm.

Crimes Against Property (Crimen de Propiedad)	(510) 981-5737
Domestic Violence (Violencia Doméstica)	(510) 981-5736
Sex Crimes (Crimen Sexual)	(510) 981-5716
Youth Services (Servicios para Jóvenes)	(510) 981-5715
Homicide/Assault (Homicidio/Agresión)	(510) 981-5741
Robbery (Robo)	(510) 981-5742
Traffic (Tránsito)	(510) 981-5980

RESOURCES FOR VICTIMS OF CRIME

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RESOURCES FOR VICTIMS OF CRIME

Officer Arrest

The Berkeley Police Department is committed to protecting persons who are victims of crime, including Domestic Violence. Officers shall consider Domestic Violence as criminal conduct, which shall be investigated as any other crime. In cases involving felonies or serious injuries, the officer may make an arrest on probable cause that the suspect committed the offense.

Citizen's Arrest

In certain circumstances, officers cannot make an arrest directly, but must ask you to make a citizen's arrest (with the exception of Domestic Violence cases). A private person may arrest another for a public offense committed in their presence. The officer will take the suspect into custody in circumstances where probable cause exists.

NOTE: Suspects may post bail or may be released on a citation. Victims should not rely on arrests as a guarantee of their personal safety.

Pressing Charges

You have the right to ask the District Attorney to file a criminal complaint. On the next work day after you have made a police report, you should contact the Investigations Division at the phone number listed on your report receipt. It is very important that you do this whether or not the suspect has been arrested.

In Domestic Violence cases, the ultimate decision as to whether a suspect is charged with a crime or not is made by the District Attorney.

You have the right to have your voice heard by the District Attorney, and the right to ask the District Attorney to file a criminal complaint.

Alameda County D.A.'s Office	(510) 268-7500
D.A.'s Domestic Violence Advocate	(510) 268-7276

LEGAL INFORMATION

Victim Assistance Programs
The Alameda County D.A.'s Office has staff members who are able to provide information and assist victims of crime.

Alameda County DA - Victim Witness Services
1401 Lakeside Dr., Ste. 802, Oakland, CA 94612 (510) 272-6180

Alameda County Family Justice Center
470 27th St., Oakland, CA 94612 (510) 267-8800

The District Attorney's Office also has an Advocate that can provide information about the status of criminal cases. The District Attorney's Advocate can be reached at (510) 268-7276.

BPD - Domestic Violence and Sex Crimes
The Berkeley Police Department has a team of Detectives and a Victim Advocate that can provide information on the criminal justice process and offer additional assistance.

Domestic Violence Detective	(510) 981-5736
Domestic Violence Advocate (24 hour)	(510) 757-5123
Sexual Assault Detective	(510) 981-5716

Victim Information & Notification Everyday (VINE)
To find out if and where an offender is in custody in the State of California or to be notified when an offender is being released from custody, call (877) 411-5588. You need a touchtone telephone. You will also need to know the name of the person in-custody. Victims should not rely on this as a guarantee of their personal safety.

U Visas
U Visas were created by Federal Law to encourage non-citizen crime victim cooperation with law enforcement by providing victims protection from deportation and a pathway to a green card. More

information can be found at the California DOJ's Office of the Attorney General website at www.oag.ca.gov as well as the US Citizenship and Immigration Services website at www.uscis.gov. You can also contact the Alameda County Family Justice Center for assistance (510)267-8800.

T Visas
T Visas allow victims of severe forms of human trafficking to remain in the US to assist authorities in their investigation. More information can be found at the US Citizenship and Immigration Services website at www.uscis.gov. You can also contact the Alameda County Family Justice Center for assistance (510)267-8800.

RESTRAINING ORDER INFORMATION
If you have been threatened, harassed, abused, or assaulted, you can apply for a Restraining Order. If the offender is your current or former spouse, partner, or someone with whom you have a child, you can apply for a "Domestic Violence Restraining Order." If you are married to the offender, you do not have to get a divorce to get a Restraining Order. If the offender is a neighbor, friend, or acquaintance, you may request a "Civil Harassment Order." There is a fee for Civil Harassment Restraining Orders. If you are low-income, you can apply for a fee waiver.

How to apply. You can apply for Restraining Orders at the:
1. René C. Davidson Courthouse, 1225 Fallon St., Oakland, CA 94612
2. George E. McDonald Hall of Justice, 2233 Shoreline Dr., Alameda, CA
3. Hayward Hall of Justice at 24405 Amador St., Hayward, CA.

You can obtain the paperwork and detailed instructions at the Courthouse or online at www.courts.ca.gov. The Victim Advocate at (510) 830-3663 or the Family Violence Law Center at (800) 947-8301 may also be able to assist you in obtaining a Domestic Violence Restraining Order.

Cost. There is no fee for obtaining a "Domestic Violence Restraining Order." There is a fee for obtaining a "Civil Harassment Order." If you are low-income, you can apply for a fee waiver. You do not need an attorney to obtain a Restraining Order, but it is a good idea to have one if one is available to you.

How long does it take to get a Restraining Order?
It is possible to get a Temporary Restraining Order within 24-hours, or it may take as long as a week. It is important to start the process of obtaining a long-term Restraining Order early. If the police gave you an "Emergency Protective Order," do not wait until this Order expires before applying for a more long-term Restraining Order.

What the Restraining Order can do?

1. Order the defendant to stay a specified distance away from you, your family, and/or members of your household.
2. Order the defendant to stay away from your home, your workplace, your family's home, your children's school/childcare location, and other addresses if necessary.
3. Order the defendant to move out of your home or apartment even if the defendant's name is on the lease or he/she is a co-owner.
4. Give you custody of your children and mandate a visitation order.
5. Order child support.
6. Order the defendant not to contact, harass, or abuse you, your family, and members of your household.
7. Give you the use of certain property.
8. Reimburse you for lost earnings and/or actual expenses caused directly by the violence such as medical bills and property damage.
9. Order the defendant to pay certain debts.
10. Order the defendant to complete a 52-week Batterer's Intervention Counseling Program.

NOTE: A Restraining Order is not enforceable until it has been served, meaning the defendant has been notified in person in court or by a police officer that they are restrained.

Keep your Restraining Order with you.
If you have obtained a Restraining Order which stops the offender from beating or harassing you, and the offender knowingly violates the Order, they can be arrested and, in most cases, taken to jail. Even though the Police Department should have your Restraining Order in their computer system, it is extremely important that you keep a copy of your Restraining Order and Proof of Service with you at all times.

What should you do if the defendant violates your Restraining Order?

1. Call the Police.
2. Ask that a formal report be taken even if the defendant has left.
3. If the defendant has been served with the Restraining Order and is still there when the police arrive, they can be arrested by the police.
4. Contact the BPD Investigations Division the next work day after you have made a police report to follow-up regarding prosecution of your Restraining Order violation case.

Suing the Offender

You may have a right to sue the offender in civil court in addition to pressing criminal charges. If you have lost wages, accumulated medical bills, property damage, or other losses because of the abuse, you may contact a lawyer. For assistance in locating an attorney, contact the Alameda County Lawyer Referral Service at (510) 302-2222.

INJURIES

You may notice additional or worsening injuries after the police have taken your report and left. For example, bruising may be more pronounced in the days following an assault. Detectives may ask for additional photos to be taken of your injuries.

STRANGULATION

Strangulation may cause serious internal injuries and victims are highly encouraged to seek medical attention right away. Tell officers or medical personnel if the suspect strangled or attempted to suffocate you.

SEXUAL ASSAULT INFORMATION

How to Get Help.

Sexual assault is a serious and emotional crime. It can involve someone you know, or a stranger. Reporting a rape or sexual assault to the police can be a difficult decision. For assistance, call a Rape Crisis Center for help and guidance.

BAWAR (Bay Area Women Against Rape) www.bawar.org
470 27th St., Oakland, CA 94612 24 hour (510) 845-7273

Alameda County Family Justice Center
470 27th St., Oakland (510) 430-1298

RAINN (Rape, Abuse & Incest National Network) (800) 656-4673

SEXUAL ASSAULT VICTIMS: RIGHTS

This information is to be provided to victims of sexual assault in writing before investigating further.

As a sexual assault victim you have the following rights specific to sexual assault:

You are not required to participate in the criminal justice system or to make a police report.

You have a right to have a sexual assault counselor/victim advocate and at least one support person of your choosing present at any initial medical evidentiary examination, physical examination, or investigative interview arising out of a sexual assault. Sexual assault counselors/advocates are available immediately 24 hours a day.

You are not required to participate in a medical evidentiary or physical examination.

You will not incur any out of pocket expenses for any forensic examinations.

Sexual assault forensic evidence will be sent to the lab to be tested and analyzed unless the victim requests the evidence not be tested.

Victims may request information about the results of analysis of any sexual assault forensic evidence from the hospital conducting the exam or the Berkeley Police Department.

You have the right to request to be interviewed by a male or female officer.

Sexual assault evidence deteriorates over time. Biological evidence may become impossible to recover as time passes. Biological evidence should be collected and preserved as soon as possible.

Sexual assault forensic evidence will be retained for at least 20 years, or if the victim is under 18, until the victim's 40th birthday.

Restraining Orders and Protective Orders are available to you and information on how to obtain them and get assistance is included in this pamphlet.

As a victim of crime, you also have the rights outlined at the end of the pamphlet in the **VICTIM'S BILL OF RIGHTS MARSY'S LAW** section.

If you intend to report a rape or sexual assault to the police:

1. Help preserve the evidence. Do not bathe, douche, change or wash your clothes, or alter anything at the location of the assault.
2. Contact the police as soon as possible so they can take you to a hospital and make a report.
3. Although the police will take a detailed report, you can ask that your name not become a matter of public record.
4. You have the right to have an Advocate and a support person of your choice with you during the hospital exam and police questioning.

COMMUNITY RESOURCES FOR VICTIMS

Emergency Services.

Domestic Violence Counselors are available 24-hours a day if you are in need of crisis counseling, emergency relocation to a safe place, seeking safety planning, or restraining order information. You can contact the Family Violence Law Center's Mobile Response Team at (800) 947-8301.

Legal Assistance

Family Violence Law Center	(800) 947-8301
	(510) 208-0255
Bay Area Legal Aid	(510) 250-5270
East Bay Community Law Center	(510) 548-4040
Alameda County Bar Association	(510) 302-2222
Legal Assistance for Seniors	(510) 832-3040
Asian Pacific Islander Legal Outreach	(510) 251-2846

Shelters and Hotlines

A Safe Place	(510) 536-7233
	(510) 836-2456
Building Futures w/Women & Children	(866) A-WAY-OUT
	(866) 292-9688
Safe Alternative to Violent Environments	(510) 794-6055
STAND	(888) 215-5555
Tri-Valley Haven	(800) 884-8119
Marin Abused Women's Shelter	(415) 924-6616
Asian Women's Shelter	(877) 751-0880
EDEN (shelter referrals)	(510) 537-2552
National Domestic Violence Hotline	(800) 799-SAFE
	(800) 799-7233
Narika Hotline (South Asian Languages)	(800) 215-7308
Shimtuh Hotline (Korean Center East Bay)	(510) 547-2662
Deaf Hope	hotline@deaf-hope.org
Community United Against Violence (LGBTQ)	(415) 777-5500
Bay Area Crisis Nursery	(925) 685-8052

Counseling for Survivors

Being the victim of a crime can be extremely traumatic and difficult. It is very important that you get the support that you need to take care of yourself. The following agencies provide counseling and assistance.

Family Violence Law Center	(800) 947-8301
Clearwater Counseling	(510) 596-8137
A Safe Place	(510) 536-7233

Tri-Valley Haven	(800) 884-8119
SAVE	(510) 794-6055
Building Futures w/Women & Children	(866) 292-9688
La Clinica de la Raza (Spanish)	(510) 535-4170
Pacific Center for Human Growth (LGBTQ)	(510) 548-8283
Community United Against Violence (LBBTQ)	(415) 777-5500
Alameda Family Services	(510) 522-8363
Deaf Hope	hotline@deaf-hope.org
National Domestic Violence Hotline	(800) 799-7233

Counseling for Children

Family Violence Law Center	(800) 947-8301
Clearwater Counseling	(510) 596-8137
DOVES at Oakland Children's Hospital	(510) 428-3135
The Link to Children (TLC)	(510) 428-2028

Counseling for Offenders

Alameda Community Recovery SVS	(510) 522-8363
John Hamel & Associates (Berkeley)	(925) 686-2921
Allen Temple Baptist Church	(510) 544-3914
Peace Creations	(510) 834-7088
Psychological Services Center	(510) 628-9065
West Oakland Health Council	(510) 465-1800

STATE OF CALIFORNIA CRIME VICTIM COMPENSATION PROGRAM

Victims of crime or their dependents may be paid by the State of California for expenses relating to the criminal act. California's Victim Compensation Program may pay for expenses such as:

- Medical and dental treatment
- Mental health counseling
- Relocation for your safety
- Home security
- Lost income

NOTE: California Victim's Compensation Program cannot pay for property damages.

For further information about this Program or to get an application, please contact:

California Victim Compensation Program
Statewide (800) 777-9229
Alameda County (510) 272-6180

Alameda Co. District Attorney's Victim/Witness Assistance Program
1401 Lakeside Drive, Suite 802
Oakland, CA 94612 (510) 272-6180

Alameda County Family Justice Center
470 27th Street Oakland, CA 94612 (510) 267-8800

VICTIM'S BILL OF RIGHTS MARSY'S LAW
The California Constitution, Article 1, Section 28, confers certain rights to victims of crime as they are defined in the law. Those rights include:

1. Fairness and Respect
To be treated with fairness and respect for his or her privacy and dignity, and to be free from intimidation, harassment, and abuse throughout the criminal or juvenile justice process.

2. Protection from the Defendant
To be reasonably protected from the defendant and persons acting on behalf of the defendant.

3. Victim Safety Considerations in Setting Bail & Release Conditions
To have the safety of the victim and the victim's family considered in fixing the amount of bail and release conditions for the defendant.

4. The Prevention of the Disclosure of Confidential Information
To prevent the disclosure of confidential information or records to the defendant, the defendant's attorney, or any other person acting on behalf of the defendant, which could be used to locate or harass the

victim or the victim's family, or which disclose confidential communications made in the course of medical or counseling treatment, or which are otherwise privileged or confidential by law.

5. Refusal to be interviewed by the Defense
To refuse an interview, deposition, or discovery request by the defendant, the defendant's attorney, or any other person acting on behalf of the defendant, and to set reasonable conditions on the conduct of any such interview to which the victim consents.

6. Conference with the Prosecution and Notice of Pretrial Disposition
To reasonable notice of and to reasonably confer with the prosecuting agency, upon request, regarding the arrest of the defendant if known by the prosecutor, the charges filed, the determination whether to extradite the defendant and, upon request, to be notified of and informed before any pretrial disposition of the case.

7. Notice of and Presence at Public Proceedings
To reasonable notice of all public proceedings, including delinquency proceedings, upon request, at which the defendant and the prosecutor are entitled to be present and of all parole or other post-conviction release proceedings, and to be present at all such proceedings.

8. Appearance at Court Proceedings and Expression of Views
To be heard, upon request, at any proceeding, including any delinquency proceeding, involving a post-arrest release decision, plea, sentencing, post-conviction release decision, or any proceeding in which a right of the victim is at issue.

9. Speedy Trial and Prompt Conclusion of the Case
To a speedy trial and a prompt and final conclusion of the case and any related post-judgment proceedings.

10. Provision of Information to the Probation Department
To provide information to a Probation Department official conducting a pre-sentence investigation concerning the impact of the offense on the victim and the victim's family and any sentencing recommendations before the sentencing of the defendant.

11. Receipt of Pre-Sentence Report
To receive, upon request, the pre-sentence report when available to the defendant, except for those portions made confidential by law.

12. Information on Conviction, Sentence, Incarceration, Release, and Escape
To be informed, upon request, of the conviction, sentence, place and time of incarceration, or other disposition of the defendant, the scheduled release date of the defendant, and the release of or the escape by the defendant from custody.

13. Restitution
A. It is the unequivocal intention of the People of the State of California that all persons, who suffer losses as a result of criminal activity, shall have the right to seek and secure restitution from the persons convicted of the crimes causing the losses they suffer.
B. Restitution shall be ordered from the convicted wrongdoer in every case, regardless of the sentence or disposition imposed, in which a crime victim suffers a loss.
C. All monetary payments, monies, and property collected from any person, who has been ordered to make restitution, shall be first applied to pay the amounts ordered as restitution to the victim.

14. The Prompt Return of Property
To the prompt return of property when no longer needed as evidence.

15. Notice of Parole Procedures and Release on Parole
To be informed of all parole procedures, to participate in the parole process, to provide information to the parole authority to be considered before the parole of the offender, and to be notified, upon request, of the parole or other release of the offender.

16. Safety of Victim and Public are Factors in Parole Release
To have the safety of the victim, the victim's family, and the general public considered before any parole or other post-judgment release decision is made.

Information about these 16 Rights
To be informed of the Rights enumerated in paragraphs (1) through (16).

For more information on Marsy's Law, visit the Attorney General's website at: www.ag.ca.gov/victimservices.

To obtain information on the Victim Witness Assistance Center nearest to you, contact:

Attorney General's Victim Services Unit (877) 433-9069

Additional Information for University of California Affiliates

If you are affiliated with UC Berkeley you are being provided with this valuable resource guide because you have been recently impacted by criminal activity, or may need resources the University can provide. The University of California, Berkeley has many resources available to assist you during what may be a difficult time. Please know we are committed to addressing your needs in conjunction with our community partners.

UCPD Berkeley
For more information visit:
http://safetycounts.berkeley.edu
http://survivorsupport.berkeley.edu/
CARE Confidential Advocates: (510) 642-1988

REPORT

Center for Student Conduct

(510) 643-9069, http://studentconduct.berkeley.edu

Office for the Prevention of Harassment and Discrimination

(510) 643-7985, http://ophd.berkeley.edu

University of California Police Department, Berkeley

(510) 642-6760, http://police.berkeley.edu

SUPPORT

Gender Equity Resource Center

Sexual Harassment/Sexual Assault Resource Specialist

(510) 643-5727, http://geneq.berkeley.edu

University Health Services, Social Services

(510) 642-6074, socsrvs@uhs.berkeley.edu
http://uhs.berkeley.edu/students/counseling/socialservices.shtml

University Health Services, CARE Services

(510) 643-7754, careserv@uhs.berkeley.edu
http://uhs.berkeley.edu/facstaff/care/

Ombudsperson for Students and Postdoctoral Appointees

(510) 642-5754 for referral, http://sa.berkeley.edu/ombuds

Ombuds Office for Faculty

(510) 642-4226

The Staff Ombuds Office

(510) 642-7823

Division of Student Affairs, Student Legal Services

(510) 642-3916, http://sa.berkeley.edu/legal

Student Advocate

(510) 642-6912, http://advocate.berkeley.edu

MEDICAL

University Health Services, Urgent Care Clinic

2222 Bancroft Way (The Tang Center)

(510) 643-7197 (advice after hours), www.uhs.berkeley.edu

This material is available in alternative formats upon request. Alternative formats include audio-format, braille, large print, electronic text, etc. Please contact the Disability Services Specialist and allow 7-10 days for productions of the material in an alternative format.

Disability Services Specialist
Email: ADA@cityofberkeley.info
Phone: (510) 981-6418
TTY: (510) 981-6347
Revised February 2019 G:\p_admin\DD DV\2019 Resources for Victims Pamphlet

NOTICE OF REPORT

Berkeley Police Department
Tsukamoto Public Safety Building
2100 Martin Luther King Jr. Way
Berkeley, CA 94704
(510)981-5900 VM#(510)981-5990
www.CityofBerkeley.info/police

Report number:

Date:

Type of Report/Offense:

Officer's name:

Badge #:

Officer's duty hours:

Days off:

If you have questions regarding the status of the investigation of your case, please contact the Police detail indicated below. Inquiries should be made Monday – Friday, 8:00am-4:30pm.

Crimes Against Property	(510) 981-5737
Domestic Violence	(510) 981-5736
Sex Crimes	(510) 981-5716
Youth Services	(510) 981-5715
Homicide/Assault	(510) 981-5741
Robbery	(510) 981-5742
Traffic	(510) 981-5980

Edmund G. Brown Jr.
Attorney General
State of California

Victims' Bill of Rights
Marsy's Law

The California Constitution, Article 1, Section 28, confers certain rights to victims of crime as they are defined in the law. Those rights include:

1. **Fairness and Respect**
   To be treated with fairness and respect for his or her privacy and dignity, and to be free from intimidation, harassment, and abuse, throughout the criminal or juvenile justice process.

2. **Protection from the Defendant**
   To be reasonably protected from the defendant and persons acting on behalf of the defendant.

3. **Victim Safety Considerations in Setting Bail and Release Conditions**
   To have the safety of the victim and the victim's family considered in fixing the amount of bail and release conditions for the defendant.

4. **The Prevention of the Disclosure of Confidential Information**
   To prevent the disclosure of confidential information or records to the defendant, the defendant's attorney, or any other person acting on behalf of the defendant, which could be used to locate or harass the victim or the victim's family or which disclose confidential communications made in the course of medical or counseling treatment, or which are otherwise privileged or confidential by law.

5. **Refusal to be Interviewed by the Defense**
   To refuse an interview, deposition, or discovery request by the defendant, the defendant's attorney, or any other person acting on behalf of the defendant, and to set reasonable conditions on the conduct of any such interview to which the victim consents.

6. **Conference with the Prosecution and Notice of Pretrial Disposition**
   To reasonable notice of and to reasonably confer with the prosecuting agency, upon request, regarding, the arrest of the defendant if known by the prosecutor, the charges filed, the determination whether to extradite the defendant, and, upon request, to be notified of and informed before any pretrial disposition of the case.

7. **Notice of and Presence at Public Proceedings**
   To reasonable notice of all public proceedings, including delinquency proceedings, upon request, at which the defendant and the prosecutor are entitled to be present and of all parole or other post-conviction release proceedings, and to be present at all such proceedings.

8. **Appearance at Court Proceedings and Expression of Views**
   To be heard, upon request, at any proceeding, including any delinquency proceeding, involving a post-arrest release decision, plea, sentencing, post-conviction release decision, or any proceeding in which a right of the victim is at issue.

9. **Speedy Trial and Prompt Conclusion of the Case**
To a speedy trial and a prompt and final conclusion of the case and any related post-judgment proceedings.

10. **Provision of Information to the Probation Department**
To provide information to a probation department official conducting a pre-sentence investigation concerning the impact of the offense on the victim and the victim's family and any sentencing recommendations before the sentencing of the defendant.

11. **Receipt of Pre-Sentence Report**
To receive, upon request, the pre-sentence report when available to the defendant, except for those portions made confidential by law.

12. **Information About Conviction, Sentence, Incarceration, Release, and Escape**
To be informed, upon request, of the conviction, sentence, place and time of incarceration, or other disposition of the defendant, the scheduled release date of the defendant, and the release of or the escape by the defendant from custody.

13. **Restitution**
   A. It is the unequivocal intention of the People of the State of California that all persons who suffer losses as a result of criminal activity shall have the right to seek and secure restitution from the persons convicted of the crimes causing the losses they suffer.
   B. Restitution shall be ordered from the convicted wrongdoer in every case, regardless of the sentence or disposition imposed, in which a crime victim suffers a loss.
   C. All monetary payments, monies, and property collected from any person who has been ordered to make restitution shall be first applied to pay the amounts ordered as restitution to the victim.

14. **The Prompt Return of Property**
To the prompt return of property when no longer needed as evidence.

15. **Notice of Parole Procedures and Release on Parole**
To be informed of all parole procedures, to participate in the parole process, to provide information to the parole authority to be considered before the parole of the offender, and to be notified, upon request, of the parole or other release of the offender.

16. **Safety of Victim and Public are Factors in Parole Release**
To have the safety of the victim, the victim's family, and the general public considered before any parole or other post-judgment release decision is made.

17. **Information About These 16 Rights**
To be informed of the rights enumerated in paragraphs (1) through (16).

For more information on Marsy's Law, visit the Attorney General's website at: *www.ag.ca.gov/victimservices*

To obtain information on the Victim Witness Assistance Center nearest to you contact:

Attorney General's Victim Services Unit
1-877-433-9069
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BERKELEY COMMUNITY MEETING FEEDBACK

Overview:

The three virtual Community Meetings were the culmination of the Community Engagement process. Following the distribution of the survey and 15 listening sessions focused on vulnerable populations and stakeholders, the Community Meetings were scheduled after the submission of NICJR's Draft Final Report and Recommendations. The intention with the timing of these events was to offer the broader Berkeley community an opportunity to provide feedback on the Draft Final Report while also sharing thoughts and ideas on ways in which the City of Berkeley can continue this process of Reimagining Public Safety.

Each meeting identified a specific group of districts listed below:

January 13, 2022: Districts 1,2

January 20, 2022: Districts 3,4

February 3, 2022: Districts 5, 6, 7, 8

NICJR incorporated several ways in which feedback could be provided during the Community Meetings. In addition to a Question and Answer session the following pages include direct feedback from interactive platforms Mentimeter and Jamboard; which was utilized during the Breakout Rooms.

What are the most pressing public safety issues impacting you and your community?

Mentimeter

22

What are the most pressing public safety issues impacting you and your community?

Mentimeter

10

What are the most pressing public safety issues impacting you and your community?

Mentimeter

10

What are the most important investments in the community that would support increased public safety?

Mentimeter

14

What are the most important investments in the community that would support increased public safety?

Mentimeter

12

What are the most important investments in the community that would support increased public safety?

Mentimeter

10

Please share feedback on the presentation you just heard

Cheryl-some of your retorts are invalidating. *Listening* doesn't require a response. The purpose of these meetings should be *listening* to what the community's concerns, not railroading through your agenda

In my experience, the BPD have been professional and courteous. I do not agree with the premise that fewer officers will result in increased safety.

2017 through September 2021 shows the department responded to an average of 72,738 calls for service per year and averaged 2,804 arrests. = 0.038! Why are reiminging safety for such a small

It sounds like you are removing the ability of officers to be proactive - by reducing interactions, by reducing police, by reducing their ability to be effective. This is not what we want.

CIT left out of the report.

What additional ideas or recommendations do you have for the City to consider in the Reimagining Public Safety process?

made, Berkeley's Police Department needs to maintain the ability to respond to and investigate violent crime, they are an essential institution in Berkeley and have made me and my family safer as we have experienced

there are only ~50 people at this meeting out of ~120k Berkeley residents, how will this potentially dramatic departure from current policies be communicated to a much wider audience?

I am deeply concerned about the implementation of the CERN program. Replacing 911 calls with community personnel instead of police is extremely high risk.

triage of different calls relies on accurate information from callers- this is often not the case, and a well staffed call center, which Berkeley currently does not have. Will the proposed system work without this triage?

less- I am worried this "reimaging" process is being used as an excuse to raise taxes for more from an already overburdened tax base. I would feel much more comfortable supporting this initiative with a pledge for funding

we have CERN and SCU? Should be 1 entity. Seems problematic. We need 1 additional new phone line mental health crisis/ overdoses, etc. Only 1% of calls are actually violent crime in Berkeley. We need police out of mental

Please share feedback on the presentation you just heard

- Glad to see Advance Peace has been added to list of recommendations
- please don't reinvest further in police reform (such as the new police academy or new QAT bureau)
- council members have been for years talking about spending money for a cease fire program and it never happens. looking at our history and why there isn't better community engagement is important.
- didn't hear mention of the gangs which have been in the city for a long time
- Safety for all - without displacing is complicated and not a concept we actually understand well. A lot of it has to do with actually educating everyone. Berkeley schools hopefully will be engaged in this process and held
- While the study is very interesting and great - it takes a lot of effort and openess to change the status quo. How can we build that willingness amongst community members.
- we need buy in of city staff for any of the recommendations to work. our elected officials often make policies that staff often doesn't know how to implement and doesn't buy into. I didn't see suggestions for staff
- I agree we already have social programs for youth - Under-funding limits their impact.
- many of the "recommendations" from NICJR are things already in place/in progress in Berkeley - not sure how helpful they are (e.g., EIS, ending pretext stops)
- Very helpful presentation. I see a level of humility that is appropriate in any ground-breaking proposal like this. But we are also being appropriately ambitious due to the challenges we face in revisioning public
- Question. Is it possible to train responders into compassion? Compassion would have saved the life of the man who died this weekend just outside the police station.
- Training of CERN and who could fill those roles is not well researched/explained
- In addition to history of policing, it would have been helpful for report to describe how policing fails to actually prevent most crime and how police "reform" efforts are mostly unsuccessful
- concern about nonsworn officers handling DV and traffic stops. also concerned that police are needed to secure situations before mental health and others respond
- concerned that some alternatives like CAHOOTS have low percentage effectiveness. again, as i stated, 30-40% of crime in berkeley is committed by out of city offenders.
- An A/B pilot test seems reasonable. The other two seem like massive overkill in time, money, and effort in a town where there are mental health services, police review, etc.
- Planting trees and neighborhood clean up matters. I've seen research showing that it has a substantial impact on property crime and violence.
- Having appropriate non-police response to behavior problems will be a great improvement
- Very little here to actually "reimagine" and provide solutions to the underlying root causes of crime (e.g., lack of housing, health care, jobs)
- Lighting is a big issue in the city - it makes streets / parks and public spaces safer

What additional ideas or recommendations do you have for the City to consider in the Reimagining Public Safety process?

- we already have social programs for youth
- How do the CBOs access the money which supposedly exists for more interaction with the community?
- the guaranteed income is really not okay when so many community members are struggling to pay taxes here, which are about the highest in the area
- City needs to invest substantially in BerkDOT and self-enforcing streets
- I am glad to hear positive mention of the Fair and Impartial Policing plan proposed by the mayor's working group and adopted by the city council. However, the specifics of the program are vital for the "Improve"
- Are black community members in favor of these changes? elsewhere that has not been the case, I believe
- reflect reality of policing in Berkeley by including officers in your discussions. So far it all seems disrespectful to the folks who make life in Berkeley possible.
- Significant need for job training and opportunities for youth starting early (e.g., middle school)
- agree with writer about lack of mention of gang in Berkeley
- City already has many many programs. Are they working? How will new ones help?
- Should also think about traffic safety in terms of passive devices: red light camera; speeding cameras; speed bumps.
- Having lived many places, BPD seems like a good police department if under-staffed.

Please share feedback on the presentation you just heard

- What's the process for intervening with people who live outside the area who are committing (violent) crime within the City. How do we find the people who are causing the crime?
- The call types currently assigned to CERN have overlap with calls that the SCU should be responding to. CERN and SCU should be combined into one program that addresses non-criminal calls,
- It is confusing and rather unproductive to have CERN separated from the SCU and will likely lead to confusion with dispatch, overlapping jurisdiction and uncertainty within the community. Not to mention the
- The mayor asserted a "fair and objective data based" process. I haven't been hearing or seeing the data base for the need for an "alternative" scheme. Nor am I seeing or hearing a data base in terms of any expected results
- what does success look like here? What is the problem we're trying to solve? If we're a pilot and the metrics aren't achieved then what?
- Being sure things are adequately funded will be so important. CBOs are always underfunded. They will step up to be helpful but will not be able to succee w/o needed funding. Police are extraordinarily well
- Were there recommendations/solutions that are suggested/implemented in other cities, but weren't made to our city/Berkeley, and why?
- The problem we are trying to solve is systemic racism and injustices. Restate the facts/evidence of this in Berkeley. That is why we are here.
- I passionately support these solutions. We need to implement reimaging public safety in Berkeley
- The section on the history of policing in Berkeley doesn't include the history of corruption within the BPD
- The inclusion of police at any level will taint the CERN/SCU programs entirely. Rather than working in concert with police, the CERN/SCU should work solely on calls that do not require police assistance or backup.
- support the recommendations and curious to see the data the that shows what the issue is and how it is addressed through the recommendations
- How do we as a community define Public Safety?
- Can't find police when you need them.

What additional ideas or recommendations do you have for the City to consider in the Reimagining Public Safety process?

- Is this effort just a new way of framing police and fire and emergency services or are we really reimagining public safety?
- word cloud indicates general fear of Berkeley residents. What part of plan (particularly reinvest) addresses/mitigates community fear, thus helping community embrace change from the Reduce Improve and Reinvest
- CERN/SCU should not respond to misdemeanors as this will lead them towards being an enforcement power (aka policing power). It is crucial that CERN/SCU value safety over enforcement in order
- Suggest a Community Based Organization assessment, showing what the coverage in skills and areas already exists, and where there are gaps. So that reinvestment can proactively start building capacity in gap areas.
- The creation of a "progressive" police academy will adversely affect attempts to shrink the footprint and budget of BPD. Instead, create a Public Safety Academy to train CERN/SCU employees, other first responders,
- Casual reference to "programs" elseewhere does not provide us "data". Nor do advocacies for alleged "community members" wanting various things is not quantified. Nor results. WHERE IS THE DATA?

Please share feedback on the presentation you just heard

Click on the "sticky note" icon on the left side of the screen, fourth icon down. You will be able to write your feedback on the sticky note, click save and place it on the screen.

We've spent a lot on police and we still have rising crime! Time for a new approach! We need to address the root causes of crime.

Emphasize more how police attention to category 3 and 4 crimes will be enhanced

I have done a lot of podcast listening and reading on RPS and really support the NICJR report!

What additional ideas or recommendations do you have for the City to consider in the Reimagining Public Safety process?

Is there a recommendation for how the city should organize the implementation of the RPS process? There is a lot to do! Does there need to be a new Department of RPS?

How should the city track the progress of the pilot? What metrics should be used? This seems important to be able to show reduced calls, increased CBO budgets, etc. so we can track successes and lack of successes.

Who will train the CERN staff?

How is the savings going to be reinvessted? Transparency with how the 6 million mentioned will be spent is important.

I'm concerned about a lack of city focus on carrying this forward. Seems to me that it should be housed in the city, outside of the PD, with an RPS commission.

Please share feedback on the presentation you just heard

What additional ideas or recommendations do you have for the City to consider in the Reimagining Public Safety process?

Please share feedback on the presentation you just heard

Loved the question on How do we get ACTION from the City Council?

Will be effective IF implemented

How do we respond to South Berkeley concerns about gunfire?

Will be of no use if NOT implemented.

Great report, NIJCR!

Are there any pilot Phase 1 categories that BPD is on board with? If so, these seem like the ones most likely to move ahead quickly, assuming folks offer the RFP.

What additional ideas or recommendations do you have for the City to consider in the Reimagining Public Safety process?

Some aspects of these recommendations should be put under oversight of Police Accountability Board

Need a "czar" in city government whose job it is to KEEP THIS REIMAGINING EFFORT MOVING FORWARD!

Invest serious funding in Implementation!

Where to find clearer understanding of what police money is being used for other things, e.g. how much does parking enforcement cost - what kind of savings could there be.

What other ways can we ensure that South Berkeley's concerns about gunfire will be more effectively addressed under a re-imaginged framework? For example, funds for cameras.

effective traffic (safety) enforcement for several years. If CERN officers could respond to reported incidents AND follow-up that would likely result in many more reports (of dangerous drivers for example). As it stands now few are reported because nobody

Please share feedback on the presentation you just heard

I like the CERN rubric, but I think questions remain about how where the lines will be drawn and how exactly the decisions will be made on where calls for service should be assigned.

Strengthen focus on F&I and PAB

Concurrent processes like Fair and Impartial TF/ SCU. How to ensure programs are actually implemented?

More community outreach

What additional ideas or recommendations do you have for the City to consider in the Reimagining Public Safety process?

Please share feedback on the presentation you just heard

How do we go against a system that is inherently racist?

I worry that the police dept will not be willing to make change.

What additional ideas or recommendations do you have for the City to consider in the Reimagining Public Safety process?

The City is in the process of hiring a new Police Chief - what sort of background would be needed to implement the new program. Has there been discussion with the police union

The police is not cooperating with the Police Advisory Board. why will they cooperate with you?

Have the city council members been involved with contacting their constituents for these meetings

When are we going to hear from the most impacted people in Berkeley during this process? Meaning the most marginalized and oppressed groups.

What has been the outreach to POC?

Please share feedback on the presentation you just heard

Click on the "sticky note" icon on the left side of the screen, fourth icon down. You will be able to write your feedback on the sticky note, click save and place it on the screen.

Partnering seems to be missing in the process. The process seems adversarial and not a partnership with the police.

In 11.23 draft, fn. 7, p. 27, Appendix I "Community members have expressed concerns about MCT's ability to properly assist with calls for service." - seems overly judgmental and under-evidenced

in support of Charles and Cheryl on PD with mental health crisis successes with PD standing nearby

What additional ideas or recommendations do you have for the City to consider in the Reimagining Public Safety process?

Concern regarding a whole new way of training and providing EMS services. What impact will this have on the emergency communications center?

Having the last resort language in Policy 300 may be problematic. Look at what BPD actually has in their policy.

CIT is left out of the report

Seems like it has become a competition vs lay people take over MH CFS were people are in crisis

Having MH professionals respond to some calls for service seems somewhat appropriate

Community that seems to be resistant to the whole process fears that they will have less protection for public safety

Please share feedback on the presentation you just heard

Click on the "sticky note" icon on the left side of the screen, fourth icon down. You will be able to write your feedback on the sticky note, click save and place it on the screen.

How does the list of BPD "problems" in the Draft Report compare to other cities our size?

What is the BPD response to this report?

Does your process recognize that many crimes committed in Berkeley are by professional criminals who live in other cities?

My biggest question is no mention that Berkeley has a unified 911 Call Center. How do you propose dealing with that?

What is the expected effect on the crime rate in Berkeley?

As for a stronger restraint on use of force it was the BPD and council members that resisted a stronger policy so how do you advise changing that

The problem identified by the the policing equity report was disparate treatment by race. I didn't hear anything on racism

Does State Law allow civilians to do traffic stops?

Did your work cover the instance of the resident who called in a "trespasser" and was killed by the trespasser before the BPD arrived

What additional ideas or recommendations do you have for the City to consider in the Reimagining Public Safety process?

Deschutes county stabilization center https://www.deschutes.org

Please share feedback on the presentation you just heard

Good presentation. Would like to hear more about implementation obstacles re City Council etc.

police. This seems to be a longtime NICJR mission (which is OK), but it seems stuck in 2020's summer of rage. With violent crime spiking, most cities are trying to expand their police forces, with better training and

Using pilot project to learn -- but also to KEEP MOVING FORWARD -- makes a lot of sense.

Totally support using our public safety dollars more effectively to address root causes

To me, it's about efficient use of dollars, not hostility toward police

In many cases, the anticipated CERN people will be in potentially dangerous and escalatory situations. We need to protect THESE people as well as offenders. They will need police backup to stay safe.

Why do we have CERN and SCU when it could be all put under SCU?

Can our city reverse some effects of cash bail reform so offenders can be kept off the streets, rather than coming back and re-offending?

Agree with the intermediate objectives: End pretextual stops; make unarmed people the lead responders to low-hazard calls.

What additional ideas or recommendations do you have for the City to consider in the Reimagining Public Safety process?

Please share feedback on the presentation you just heard

Violent crime is in fact a problem in Berkeley (as in many cities). The number of shootings so far this year is appalling.

How can we pursue the reforms that are needed given the backlash stirred up by the supposed "crime tsunami"?

I appreciate the thoroughness of the report highlighting the most pressing issues within BPD and the fact that investment in violence prevention is critical.

Derek Chauvin did not work for the BPD. We need to focus on our local situation and not transfer our outrage about things happening in other places to our law enforcement folks.

public safety, we need to also realize that many of the people arrested for crimes, including violent crimes in Berkeley, live in other surrounding communities and we cannot provide services for them.

I recommend that the city looks within to fund organizations that are connected and have relationships with community members to be most effective.

other surrounding communities and we cannot provide services for them. Again, we need to focus on our actual local situation and what we can do to improve public safety

should be given to the BPD's feedback on types of calls that need police response. I'm sure officers would be glad to have other calls covered by appropriately trained responders, but many of the calls may need a police response at the outset regardless

What additional ideas or recommendations do you have for the City to consider in the Reimagining Public Safety process?

hope its recommendations can be implemented. I'm concerned that the UBI proposal, which is race-based rather than solely based on income, is a political liability. For example, a demagogue could readily use the racial

Our BPD should be supported for the challenging and mostly excellent work they do. We need to fully staff the police department to have the necessary resources to keep our city safe.

I think it would be valuable to specify the difference between CERN and the Specialized Care Unit because it seems like the default with CERN is to still have police on the scene

Traffic enforcement is a huge gap in current public safety. Too many dangerous drivers are endangering the public with no consequences. We need a much larger staff to handle traffic enforcement all over the city.

I would like to see the data that shows a problem with pretextual stops as an issue in Berkeley. Abandoning traffic enforcement leads to more problems and less safety.

Glossary of Terms

ACPD:	Alameda County Probation Department
ACPI:	American Crime Prevention Institute
ACR:	Alternative Crisis Response
ACS:	Albuquerque Community Safety Department
ANOVA:	Analysis of Variance
ASUC:	Associated Students of the University of California
APD:	Albuquerque Police Department
APD:	Austin Police Department
BACS	Bay Area Community Services
BAPA:	Bay Area Progressive Academy
BCSC	Berkeley Community Safety Coalition
BerkDOT:	Berkeley Department of Transportation
B-HEARD:	Behavioral Health Emergency Assistance Response Division
BI:	Business Intelligence
BIPOC:	Black, Indigenous People of Color
BOSS:	Building Opportunities for Self Sufficiency
BPC:	Business and Professions Code
BPD:	Berkeley Police Department
BPSA:	Black Public Safety Alliance
BRG:	Bright Research Group
BWC:	Body Worn Camera
BYA:	Berkeley Youth Alternatives
CAD:	Computer Aided Dispatch
CAHOOTS:	Crisis Assistance Helping Out on The Streets
CATT:	Community Assessment and Transportation Team
CBO:	Community Based Organization

CBTSim:	Counter Bias Training Simulation
CCD:	Crisis Call Diversion
CDC:	Center for Disease Control
CE:	Community Engagement
CEO:	Center for Employment Opportunity
CEO:	Chief Executive Office
CES:	Coordinated Entry System
CERN:	Community Emergency Response Network
CFS:	Calls for Service
CHP:	California Highway Patrol
CJC:	Community Justice Center
CPD:	Chicago Police Department
CPTCE:	Crime Prevention Through Community Engagement
CRU:	Crisis Response Unit
CSO:	Community Service Officer
CSP:	Community Safe Partnership
CWC:	Creative Wellness Center
DBA:	Downtown Berkeley Association
DJJ:	Department of Juvenile Justice
DMH:	Department of Mental Health
DPD:	Denver Police Department
DPN:	Delinquency Prevention Network
EIS:	Early Intervention Systems
EMCOT:	Expanded Mobile Crisis Outreach Team
EMS:	Emergency Medical Services
EMT:	Emergency Medical Technician
EPIC:	Ethical Policing Is Courageous
ESOP:	Ethical Society Of Police
EU:	European Union
EWIS:	Early Warning Intervention System

FAIR Girls:	Free Aware Inspired Restored
FBI:	Federal Bureau of Investigation
FOP:	Fraternal Order of Police
FTE:	Full Time Employee
FTO:	Field Training Officer
FY:	Fiscal Year
GF:	General Fund
GVRS:	Gun Violence Reduction Strategy
HACLA:	Housing Authority of the City of Los Angeles
HALO:	Highly Accountable Learning Organization
HPD:	Houston Police Department
HRC:	Housing Resource Center
HVIP:	Hospital Violence Intervention Program
IHOT:	In-Home Outreach Team
IPV:	Intimate Partner Violence
JJCPA:	Juvenile Justice Crime Prevention Act
LAPD:	Los Angeles Police Department
LEAP:	Leadership, Education, and Athletics in Partnership
LGBTQ:	Lesbian, Gay, Bisexual, Trans, Queer/Questioning
LGBTQIA+:	Lesbian, Gay, Bisexual, Trans, Queer/Questioning, Intersex, Asexual
MACRO:	Mobile Assistance Community Responders of Oakland
MAP:	Mayor's Action Plan for Neighborhood Safety
MCT:	Mobile Crisis Team
MHD:	Mental Health Division
MISD:	Misdemeanor
MISSSEY:	Motivating, Inspiring, Supporting & Serving exually Exploited Youth
NBF:	New Bridge Foundation
NC:	Non-Criminal
NCA:	Neighborhood Change Agent
NEED:	Needle Exchange Emergency Distribution
NEP:	Needle Exchange Program
NIBRS:	National Incident Based Reporting System
NV FEL:	Non-Violent Felony
NYC:	New York City
NYCHA:	New York City Housing Authority
NYPD:	New York Police Department
ONS:	Office of Neighborhood Safety
OPD:	Oakland Police Department
OPD:	Olympia Police Department
OPS:	Police Operations
PD:	Police Department
PERF:	Police Executive Research Forum
POC:	People of Color
Project ABLE:	Active Bystandership for Law Enforcement
PTSD:	Post Traumatic Stress Disorder
QAT:	Quality Assurance Training
QTBIPOC:	Queer, Trans, Black and Indigenous People of Color
RAMS:	Richmond Area Multi-Services
RIPA:	Racial Identity and Profiling Advisory
RPD:	Richmond Police Department
RPSTF:	Reimagining Public Safety Task Force
SARA model:	Scanning, Analysis, Response, Assessment

SCRT:	Street Crisis Response Team
SCU:	Specialized Care Unit
SEEDS:	Services that Encourage Effective Dialogue and Solutions
SIF:	Safe Injection Facilities
SNAP:	Supplemental Nutrition Assistance Program
SPARQ:	Social Psychological Answers to Real World questions
SSDI:	Social Security Disability Insurance
SSI:	Supplemental Security Income
SSP:	Syringe Services Programs
STAR:	Support Team Assisted Response
STAIR:	Stability, Navigation and Respite
SV:	Sexual Violence
SV FEL:	Serious Violent Felony
TAY:	Transition Age Youth
TF:	Task Force
TVIT:	Trafficking Victim Identification Tool
UCLA:	University of California, Los Angeles
UCPD:	University of California Police Department
UCR:	Uniform Crime Report
VOIP:	Voice Over Internet Protocol
WSCJTC:	Washington State Criminal Justice Training Commission YOBG:
YSA:	Youth Spirit Artworks