San Gabriel Valley Council of Governments

Regional Homeless, Mental Health, and Crisis Response Study

RDA CONSULTING

SGVCOG
San Gabriel Valley Council of Governments

San Gabriel Valley Council of Governments Regional Crisis Response Planning

Crisis Response Models Report

RDA Project Team:

Gina Martinez
Nimisha Narayanan
Stacey Smith
Sonia Urquidi

With support from:

Caroline de Bie
Jamie Dorsey
Sarah Ferrell
Nicole Gamache-Kocol
Sasha Gayle-Schneider
Kevin Wu

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Introduction

To inform the development of a regional crisis response program, the San Gabriel Valley Council of Governments (SGVCOG) contracted with RDA Consulting (RDA) to conduct a feasibility study that includes current state findings, alternative crisis response model research, and community-informed recommendations and considerations. This report presents RDA's synthesized findings from speaking with and collecting data from a myriad of San Gabriel Valley and Los Angeles County agencies, community-based organizations (CBOs), local stakeholders, and community members. In addition, this feasibility study summarizes nearly 40 existing alternative crisis response programs in the United States and internationally.

With the guidance and support of a Steering Committee (including members from the San Gabriel Valley city governments, police departments, fire departments, community services departments, and libraries) and a Community Advisory Group (including community members, behavioral health and homelessness services providers, health professionals, and social workers), RDA conducted community outreach and qualitative data collection activities between April and August 2021. The goal of this undertaking was to understand the variety of perspectives in the local community regarding current mental health and homelessness-related crises response services as well as the community's desires for a different crisis response system that would better serve its populations and needs.

This report contains three main sections: 1) The San Gabriel Valley's current mental health crisis response system and findings from RDA's data collection efforts across the region; 2) Common themes that emerged from across the RDA's research of crisis response programs, how they were implemented, considerations and rationale for design components, and overall key lessons learned; and 3) Recommendations and considerations for piloting a program in the San Gabriel Valley based on RDA's primary research as well as best practices from across alternative crisis response models. It is important to note that the quantitative data available regarding the San Gabriel Valley's crisis response calls was limited, so this report focuses on RDA's community forums and survey with local agencies, CBOs, stakeholders, and utilizers of crisis response services.

Overview of the San Gabriel Valley

The San Gabriel Valley is located in the southeast area of Los Angeles (LA) County, south of the San Gabriel Mountains and bordering both Orange County and San Bernardino County. The region is home to approximately two million residents across more than 30 cities and unincorporated areas covering about 375 square miles, from Diamond Bar to La Cañada Flintridge. The region contains a fifth of the population and a third of the municipalities in LA County. In addition to its size, the San Gabriel Valley is one of the most racially and ethnically, linguistically, and economically diverse regions in the United States. The majority of the residents in the San Gabriel Valley identify as Hispanic or Latino (44.7%), followed by 25.7% who identify as Asian, 24.8% as white non-Hispanic, 2.4% as Black, and 2.4% as either Native American, Alaskan Native, Native Hawaiian, or another race.[1] These racial and ethnic groups are unevenly distributed

[1] San Gabriel Valley Council of Governments. January 21, 2021. *United We Stand: Supporting a comprehensive, coordinated structure and strategy to meet the homelessness crisis in Los Angeles County*.

in the region, forming geographic pockets in the San Gabriel Valley densely populated by a singular racial, linguistic, or socioeconomic status.

Through a strategic planning process in 2019, the SGVCOG and cities within the region have identified homelessness and mental health as priorities. According to the 2020 Homeless Count, there are 4,555 people experiencing homelessness in the San Gabriel Valley.[2] The region accounts for about 10% of unhoused individuals countywide. Furthermore, an estimated 28% of this population lives with serious mental illness and 33% have a substance use disorder.[3] Homelessness response teams are housed across the City Manager's Office, community/neighborhood/human services, and economic development, police, and fire departments. The SGVCOG collaborates with several State and County departments, nonprofits, service providers, and other municipalities. These partners include the Los Angeles Homelessness Service Authority (LAHSA), the LA County Homelessness Initiative, LA County Department of Mental Health (LACDMH), and the LA County Sheriff's Department. The cities of Claremont, Pomona, and La Verne are also served by Tri-City Mental Health.

Mental Health and Homelessness

Across California, there is a shortage of both licensed mental health professionals and mental health inpatient beds, which contributes to a cycle in which the same individuals, unable to receive appropriate treatment, repeatedly go from the hospital, to jail, to unstable housing. Many unhoused individuals have chronic and co-occurring health conditions, mental health conditions, and substance use disorders. Along with insufficient services to meet the needs of these populations, there is a lack of services that integrate homelessness and mental health issues, which can result in inappropriate or even harmful treatment for people experiencing both. In response to the need for an alternative crisis response system, California will institute a new federal alternative emergency response number, 988, for mental health crises and suicide prevention. The hotline will be live by July 16, 2022, with states reaching full implementation by 2027.[4]

There are several services and agencies in the San Gabriel Valley and LA County that support individuals experiencing mental health emergencies or are in need of homelessness services, however, the region is not immune to the same challenges faced by other California regions. RDA's recent research in the San Gabriel Valley with first responders, providers, and community members revealed that current resources and first responder availability are insufficient to support the needs of the community.

Furthermore, both individuals and providers noted that the current system of mental health, substance use, and homelessness services is difficult to navigate. Services are geographically diverse and disparate and have multiple access points (e.g., 911, contacting providers directly, LACDMH, LAHSA, Veteran Affairs, and others). Additionally, services and providers are not sufficiently integrated with one another to streamline referrals or provide wraparound services. Without access to appropriate and timely behavioral health and homelessness services, an individual experiencing an emergency is often placed in the care of law enforcement or emergency department (ED) staff.

[2] ibid.
[3] ibid.
[4] S.2661 - 116th Congress (2019-2020): National Suicide Hotline Designation Act of 2020. (2020, October 17). https://www.congress.gov/bill/116th-congress/senate-bill/2661.

Unfortunately, interactions with police or at an ED may further escalate a crisis and lead to additional trauma. While trainings on mental health emergencies are available, many police officers and medical professionals feel ill-equipped to assess and support an individual experiencing a mental health issue.[5] Reliance on law enforcement and EDs for mental health emergencies also disrupts the ability of each to provide care to their community as they are intended and required to do.

Like many California regions, the San Gabriel Valley has experienced an increased number of people experiencing homelessness. In some cases, law enforcement may be called to support a situation related to homelessness or may encounter an unhoused person through their work. However, because the system is difficult to navigate, police officers are not always able to connect these individuals with appropriate services. Unhoused individuals or their loved ones may seek assistance through providers or related organizations directly, such as LAHSA or Union Station, if they are successful in navigating the system. Unfortunately, most of the supportive services for people experiencing homelessness in the region are located in Downtown LA, making them difficult to access for individuals in the San Gabriel Valley.

Given the demonstrated need to strengthen mental health and homelessness supports in the San Gabriel Valley as well as the common overlap between homelessness, mental health, and substance use issues, this report focuses on alternative crisis response models that touch on all of these challenges.

Overview of Report

This report contains three main sections:

- A picture of the current state of the San Gabriel Valley's mental health, substance use, and homelessness crisis response system based on the research and community-wide stakeholder engagement, including an overview of the methods and research activities undertaken;
- A report summarizing successful alternative mental health crisis models based on research of best-practices and benchmarking interviews; and
- A discussion of key recommendations and considerations for piloting and eventually expanding to a regional crisis response program.

[5] First Responder Interview. RDA. 2021.

Crisis Response in the San Gabriel Valley

While several services and agencies in the San Gabriel Valley support individuals experiencing emergencies, the SGVCOG recognized a clear need to improve crisis mental health response in the region with a particular focus on people experiencing homelessness. The SGVCOG engaged RDA to execute crisis system research and support the develop a regional crisis response model.

Three overarching research questions guided this crisis response study:

- What is the current landscape of the San Gabriel Valley crisis system?
- What recommendations or needs are emphasized by different populations in the region?
- What crisis system models have been successful elsewhere?

The research and planning team carried out a set of information-gathering activities, engaging stakeholders and the community throughout the region to reflect their experiences and suggestions.

Activities and Methods

To ensure this study was driven by the needs of local communities throughout the San Gabriel Valley region, two groups were convened to help guide the process, contribute to outreach and engagement efforts, provide their perspectives and understanding of the crisis system, and support the development of a regional crisis program. These groups provided valuable knowledge as well as guidance by reviewing study materials, providing input on activities, and supporting necessary outreach.

Steering Committee members represented city staff from across the San Gabriel Valley region. They included police lieutenants & officers, city homeless program supervisors, housing directors, firefighters and paramedics, recreation and community services staff, and human services representatives.

Community Advisory Group members represented the San Gabriel Valley community and had lived experience of the mental health, homelessness, and crisis systems. They included behavioral health providers, homeless services providers, social workers, librarians, and community advocates

To understand the complex crisis, behavioral health, and homelessness systems within the region, RDA leveraged the local experience of a variety of stakeholders, agencies, and public sectors. The findings in this report are informed by their input along with rigorous forum, interview, and survey data collection and analysis.

Stakeholder Interviews: RDA conducted seven interviews with key stakeholders who provided an overview of the crisis system in the region, any potential collaboration and implementation facilitators and barriers that may arise from the regional model, and the goals and objectives for this project as well as the vision for the mental health emergency response system in the San Gabriel Valley.

Community Forums: RDA conducted five forums with providers, first responders and LACDMH staff to gather in-depth information to better understand their experiences with

the San Gabriel Valley crisis response system as well as the behavioral health and homelessness systems of care. In addition, RDA planned to conduct two forums with consumers, family members, and other community members with lived experience, but had limited success in reaching this population. One individual with lived experience participated in a community forum.

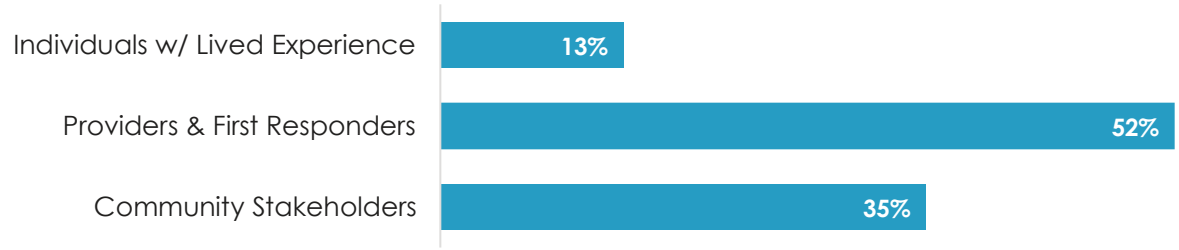
Community Survey: RDA developed and launched a survey in July 2021 available to all San Gabriel Valley first responders, providers, consumers and family members, and other interested community stakeholders. The purpose of the survey was to understand what is working well and identify opportunities for improvement in the crisis response system.

Participants in these data collection efforts are detailed below.

Table 1. Participation in SGVCOG Regional Crisis Study Activities

Activities	Timeframe	Participants
Steering Committee	March – November 2021	19
Community Advisory Group	April – November 2021	21
Stakeholder Interviews	April – June 2021	16
Community Forums	June – July 2021	37
Community Survey	July – August 2021	47[6]
TOTAL PARTICIPANTS		**140**

Figure 1. Interview, Forum, and Survey Participants by Type[7]



Limitations

Crisis Call Data. RDA and the SGVCOG sought quantitative data on crisis calls and individuals served from agencies across the region. Given cities' differing systems and the limited data available, RDA was unable to accurately assess the volume of calls and the demographics of callers across the San Gabriel Valley. As cities opt to participate in a regional crisis response program, it will be necessary to secure data sharing agreements and accurately assess the needs in the region based on historical crisis response calls as well as reassess the ongoing needs as the program is launched.

COVID-19 and Virtual Engagement. Similar to many projects taking place during the global pandemic, this capacity assessment was impacted by shelter-in-place measures. While RDA would typically conduct most community engagement efforts in person, all project activities were

[6] The survey received 47 complete responses; however, 30 partial survey responses were also included in the analysis when available.
[7] Includes both full and partial survey responses.

changed to a virtual setting. A virtual and online environment created benefits and greater accessibility for some, however, other community members had limited access or comfort with this environment. RDA employed multiple outreach and engagement activities to address this anticipated challenge. However, certain groups may still be underrepresented in the data collected.

Community Perspective. The virtual engagement undertaken likely had the largest impact for those with lived experience of the crisis response system. RDA, the Steering Committee, Community Advisory Group, and the SGVCOG reached out to a wide range of advocates, service providers, and CBOs to meet with individuals with lived experience of the crisis system. However, it was particularly difficult to reach individuals who have experienced or are currently experiencing homelessness. Therefore, the research has limited perspectives and input from those who have used mental health crisis and homelessness services themselves. Further exploration of community voices, particularly those with lived experience, will be necessary as the SGVCOG continues to develop the crisis response program in order to develop appropriate supports for those being served.

Current State of the San Gabriel Valley Crisis System

At present, the San Gabriel Valley is composed of a network of mental health, substance use, and homelessness services and interventions that can be difficult for consumers, families, providers, and community members to navigate. Within this system, the region's cities and communities have adopted a wide variety of crisis response approaches with varying results. These approaches and service availability, often based on the availability of resources and funding, can have a significant impact on the ability of first responders and others to support an individual during a crisis.

There are several entities in the San Gabriel Valley that provide services for those experiencing mental health crises. These include programs based out of the LA County Department of Mental Health (LACDMH), Police Departments, the Sheriff's Office, Fire Departments, and local behavioral health providers. Existing crisis call centers include 911, LACDMH ACCESS Center, and the Didi Hirsch Suicide Prevention Center (SPC). Didi Hirsch SPC powers the National Suicide prevention Line (NSPL) alongside the Disaster Distress Helpline receiving about 130,000 individuals a year. Run by law enforcement, the 911 call center network manages crisis calls through 77 public safety answering points (PSAPs). Screening, triage, handoffs, and dispatch are varied across these entry points, operating without clear standards for streamlining operations and dispatching the appropriate personnel. LACDMH is working with Didi Hirsch on the implementation of 988 in the County to support appropriate assessment from call centers and awareness from the community.[8]

Other local providers include the Los Angeles Homeless Services Authority (LAHSA), which "coordinates and manages over $800 million annually in federal, state, county, and city funds for programs that provide shelter, housing, and services to people experiencing homelessness."[9] For those experiencing homelessness, LAHSA acts as a singular entry point to appropriate services and collects data to improve service provision. In addition, the nonprofit Union Station Homeless Services (Union Station) works with over 1.5 million people across 36 cities and communities in the

[8] Sherin, Jonathan E. and Robert Ross. (2020) *Los Angeles County Alternative Crisis Response: Preliminary Report and Recommendations,* Los Angeles County Department of Mental Health.
[9] LAHSA. (n.d.). *About LAHSA.* Retrieved October 19, 2021, from lahsa.org/about

San Gabriel Valley. With nearly fifty years of experience, they strive to provide individuals and families with housing and other assistance that supports their stability.[10]

Although there are providers and emergency personnel engaged on issues around crises and homelessness in the San Gabriel Valley and LA County, the region still experiences capacity and coordination challenges. An Alternative Crisis Response report put out by the LACDMH in August 2020 recommends integrating the 911 call center network with the behavioral health crisis call center network to establish protocols around screening, triage, and dispatch of non-law enforcement personnel or co-response teams as appropriate. This would include budgeting for additional resources and creating a media campaign to address concerns around racial equity and community hesitancy toward 911. LACDMH concludes that the interdisciplinary approach will only be successful with additional capacity, coordination, and resources. Furthermore, the report recommends adopting an "opt-in" framework in which triage is led by health and lived experience professionals, who may or may not opt to include law enforcement in a crisis response. This is in contrast to an "opt-out" model in which law enforcement is dispatched by default.[11]

The research findings presented in the following section are to be understood in the context of this overview of the current state of the San Gabriel Valley's crisis response system.

Key Themes from Community Stakeholders

An analysis of interview, forum, and survey data yielded five key themes, which are summarized below. These findings are highly interrelated, underscoring the need for a regional understanding of both the crisis response system and the continuum of care available pre- and post-crisis.

The window of opportunity for successful crisis response and intervention in the San Gabriel Valley is often missed.

A person experiencing a mental health or substance related crisis may have distressing thoughts or other challenging feelings that make it difficult to function or take care of one's basic needs. In these situations, the individual or a witness may need to call 911, a doctor, social worker, or other support for assistance. However, according to providers and first responders, individuals experiencing mental health, substance use, or other functional challenges often quickly change their attitude toward accepting help. Therefore, it is critical that providers or first responders arrive and assist immediately, but many factors contribute to missing the window of intervention.

The consumer in crisis may not want to accept help. Several first responders cited the importance of the consumer's state of mind at the time of contact. Many factors can influence an individual's decision to decline treatment including fear, previous negative experiences, lack of appropriate services, and more. Both providers and first responders indicated that those who use drugs, particularly meth, were more likely to refuse services. One first responder also inferred that refusal of services may be influenced by the limited alternatives for support available. Unless the consumer is arrested or placed on a psychiatric hold, first responders must respect this decision.

Response times are too long. First responders stated that the sheer volume of calls placed increases pressure on the system and can result in delayed response times. In particular,

[10] Union Station Homelessness Services. (2021). *About Us.* Retrieved October 19, 2021, from unionstationhs.org/about/
[11] Sherin, Jonathan E. and Robert Ross. (2020) *Los Angeles County Alternative Crisis Response: Preliminary Report and Recommendations,* Los Angeles County Department of Mental Health.

paramedics and other first responders report fielding a substantial, and increasing, number of 911 calls related to homelessness. Furthermore, some of the calls received may not be an imminent health or safety threat. Several survey respondents also gave examples of calls related to where an unhoused person was located or other non-violent behavior. One first responder estimated that they took no action in approximately 80% of calls related to homelessness, mental health, or substance usage.

> *"People will say they have chest pain, but they need a warm bed, and we know that, and we'll play along. We transport them to the ER. They get a bed and a meal there." – First Responder*

Delays in response time can be linked to capacity issues, including providers serving a large geography or responders having to provide transport out of the area. Several stakeholders discussed the length of time from request to service connection, citing that many supportive services are only available, or fully staffed, during business hours. Many crises, however, take place outside these times. These delays can further exacerbate a crisis and/or lead to loss of contact with that individual. As one provider noted, some unhoused individuals move around, making it harder to find them and offer services after the initial contact.

> *"[An unhoused person] may say, 'I'll go into treatment right now' but can't get people in right away. By [the time services are available] they're gone. If you don't strike when iron's hot, if you can't get them when they're ready, you're going to miss out on that [window]. Very rarely do they follow up if you wait even a day. It's a huge challenge." – First Responder*

First responders are not always adequately trained to respond to the crisis. Responders' lack of training and knowledge of appropriate services for those experiencing homelessness or mental health crises can lead to missed opportunities to get consumers appropriate help. When lacking this training and system of care knowledge, responders may take too long to connect a consumer with resources, refer a consumer to the wrong services, or further traumatize the consumers they are intended to help. These issues can deter a consumer from accepting help.

> *"There are times law enforcement is critical for a response situation, but we have also seen that not all of our law enforcement officers are trained in how to make those crises smaller; to de-escalate." – Provider*

Traditional crisis response models deploy law enforcement by default; however, they often receive limited to no training in the necessary de-escalation and trauma-informed techniques for mental health or homelessness crises. Some cities throughout the San Gabriel Valley have adopted crisis response models that include robust and ongoing training for first responders, including law enforcement. For example, one forum participant noted that calls that "don't go well" are used in monthly trainings, however, this approach is atypical. Both first responders and the community

expressed frustration for the lack of training to support people experiencing homelessness or mental health issues.

Regardless of the type of call, a missed window of opportunity often results in a cycle where the same conditions that led to the crisis persist. As a result, crises can, and do, reoccur.

The current patchwork of services and interventions can be difficult to navigate, pointing to the need for a more regional or coordinated approach.

While a majority of survey respondents felt that the services in the San Gabriel Valley were not meeting the needs of consumers, the landscape is complex and varied. RDA concluded that a consumer's experience of the crisis response system in the San Gabriel Valley is influenced by where the individual lives.

Some cities within the region have developed effective, supportive, and interdisciplinary crisis response services. From regional initiatives to local collaboration, the San Gabriel Valley has developed services that prevent or respond to crises. First responders are building homelessness engagement teams and trainings based on previous calls to develop community-centered approaches. For example, a provider from Union Station recounted an instance where public diversion funding was funneled into funding motel vouchers, and others mentioned instances where they established relationships with first responders to close the gap between the crisis episode and the continuum of care. One provider even participated in ride-alongs to understand the landscape of encampments in their city, which led them to foster personal connections with unhoused citizens and bring care to them.

The Volunteers of America and American Recovery Center were both mentioned as regional organizations that coordinate and facilitate crisis assistance. For example, the American Recovery Center is currently working with the Pomona PD to establish a methadone clinic in the area. Tri-City (the public mental health system for the cities of Pomona, La Verne, and Claremont) became more multifaceted during the pandemic, initiating rental assistance and new referral programs. Providers also worked with schools and churches in their cities to coordinate care, such as using bus route detours to locate unhoused communities and cooperating with church charity resources.

Despite regional successes, many cities, particularly those that are smaller and less well-funded, struggle to provide adequate services alone. Multiple forum members spoke of wanting to add additional programs or expand the capacity (e.g., staff, extended hours) of existing programs, however, they or their city lack the funds to create these changes. As one participant noted,

> *"We need to be regional because we can't do nine small cities, and it wouldn't be the wisest use of grant money. …You have to match it to the need." – First Responder*

Furthermore, the number of mental health or homelessness-related incidents the San Gabriel Valley police departments respond to varies greatly with respect to cities' population size. Some smaller cities, such as San Marino, receive less than five of these calls per month on average. Contrastingly, the Pomona Police Department averages about 3,700 mental health or homelessness related calls per month. This variation in needs has impacts the services available in cities across the San Gabriel Valley.

A lack of collaboration between agencies and sub-regions leads to redundancy and gaps in services. This results in both inefficiently used resources and funds (e.g., separate programs instead of resource sharing), as well as a greater likelihood that a consumers' path to recovery will be disjointed and more difficult. Half of providers and 82% of community members who responded to the survey believe coordination across providers needs improvement. As one first responder noted in a forum, "every city kind of runs their interventions differently." The lack of collaboration and coordination can make services difficult, especially when consumers are supported by more than one agency and in more than one area of the valley. Providers and first responders cited challenges around data sharing and following the trajectory of a consumer through the system and the region. One provider gave the example when they were unaware that a consumer had been housed by another agency,

> *"As a member of law enforcement, it is extremely difficult to provide services to those in need. The different organizations, Union Station and LAHSA for example, do not talk to each other. We need clear communication, focused assistance, and the ability to house people and provide follow up." – Law Enforcement Officer*

The lack of established coordination makes it difficult to understand what resources are available, when they should be used, and who to call for help. According to the survey, 66% of community members believe coordination between systems needs improvement both across the San Gabriel Valley and within their city. Choosing from a list of agencies, respondents were asked who they would and would not go to for help in a crisis. Comments from community members indicated a lack of awareness and discomfort around knowing who to contact. Most community members believe crisis education needs improvement in their cities (67%) and in the San Gabriel Valley as a whole (73%). One family member noted that the COVID-19 pandemic, and resulting changes to services, exacerbated confusion about how to find help.

> *"We don't know who to call specifically in such cases, and the homeless outreach person won't just come down at the drop of a hat to assist. Who are we supposed to call for immediate assistance without trying to escalate things?" – Community Member*

Providers and first responders were also sometimes uncertain what resources were available to consumers and who to contact. One provider noted the challenges associated with staffing, organizational, and funding changes, and different program requirements. Both during the crisis and throughout the continuum of care, additional coordination and collaboration across providers and programs are necessary to ensure consumers receive appropriate support in a timely manner.

Local and culturally competent services and resources are imperative, but often unavailable. Consumers, family members, and community members who responded to the survey discussed a lack of culturally and linguistically specific services available in the San Gabriel Valley as a whole and in their respective cities. Half of the community members surveyed believe respect of individuals' cultures and backgrounds needs improvement in crisis response system. One

community member noted that few materials were translated into locally spoken languages, leading to further lack of clarity and knowledge of who to call for help.

However, some programs have been successful. For example, the Chinatown Service Center in Monterey Park provides mental health support to the Chinese community. Providers support the community with education and family assistance while working to reduce stigma related to mental health. When a consumer is discharged, staff also provide linkage to local services, including a warm hand-off to someone who speaks their language.

Although there is much work to do, providers and first responders interviewed by RDA understand cultural competency is an integral part of crisis response and emphasized the need for region-specific programming and peer services.

Limited resources impact the effectiveness of both crisis response services and the post-crisis continuum of care, which are dependent upon one another.

Prevention, crisis response, and post-crisis care are highly interconnected. This came up frequently by interview, forum, and survey participants. Despite focused questions, most participants' answers strayed from crisis response itself to discuss the full system of mental health, substance use, and homelessness services. Many providers repeatedly pointed to gaps in post-crisis services. Providers, first responders, and community members called for more case management, engagement with unhoused individuals, more abundant wraparound services, "one stop shops", and access centers. When asked to provide suggestions on how to improve the crisis response system in the San Gabriel Valley, 44% of survey respondents expressed the need for more services. Twenty-three percent of respondents wanted to see more mental health services and 18% called for "services" in general.

> *"Every part of the system has to expand with crisis response… [it's the] most important way to move forward."- First Responder*

An individual in crisis needs support and services right away, yet there are often limited to no resources that first responders can offer immediately. The San Gabriel Valley lacks adequate in-patient treatment options, particularly for crises that require an immediate response (e.g., detoxing, medical intervention, crisis stabilization). Forum participants highlighted that establishing a physical space for respite would benefit consumers, as many facilities are ill equipped to support emergencies while the individual is being connected with their next destination. Frequently, individuals experiencing a mental health and/or homelessness related crisis end up in jail or the emergency department for the night. One frustrated first responder said, "It's just not fair to those individuals."

> *"These people need our help, and we walk away from these interactions when these people are suffering. It's frustrating that we are not given the tools that we need. We want to be able to find [resources and supports] so that we can help people." – First Responder*

Inconsistent resources across the region create additional problems, as the few available resources can be overloaded and have more restrictions. Many services are not available 24/7 and lack the capacity to increase their service provision. Some crisis response programs, such as LA County's 24/7 Psychiatric Mobile Response Teams (PMRTs), are heavily impacted and may not be able to respond quickly. According to providers and first responders, this is particularly challenging late at night or in the early morning hours when homelessness and mental health emergencies are more likely to occur.

The lack of resources and supports has a direct negative impact on the consumer. When asked if they believe it was true that the "available crisis response services keep everyone in the community safe," over half (55%) of community members responded "not at all true." The research indicates a severe lack of locally available resources for unhoused individuals and families. Consumers and crisis responders sometimes face difficult choices between seeking assistance outside of their city/region or relying upon limited local choices. For example, one first responder spoke of wanting to take consumers under the influence to a sobering center, but doing so would require transporting them from San Gabriel Valley to Downtown LA. In other cases, consumers are referred to services that are not available at the moment of crisis, which may cause additional harm if those supports are delayed or unavailable.

"Do not refer to agencies, organizations, temporary housing, and mental health services that are unavailable. This practice increases trauma." – Family Member

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Logistical and capacity issues consistently limit service provision. Small city staff, for example, expressed how the absence of a full-time staff member has impacted their team by requiring them to take on outreach duties in addition to their designated responsibilities. One provider spoke of providing rides to consumers who lack the capacity to take a Lyft or Uber to the doctor, leaving less time to support others. Another provider highlighted that consumers often remain unhoused because they do not want to go to LA or leave their area without a housing option in place. Finally, a family member noted that families of consumers also need more resources, including support for related trauma they undergo as a witness to a crisis.

"We have consumers that have left Project Homekey sites because they are not in the desired city. The people experiencing homelessness would rather sleep on the streets in their town instead of being housed somewhere they are not familiar with." – Provider

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There are mixed and sometimes competing views on the role of law enforcement in mental health, substance use, and homelessness response.

Interview, forum, and survey participants had a wide range of opinions on the role of law enforcement in the San Gabriel Valley's crisis response program. Some providers were adamant that law enforcement uninvolved while others felt their role would be crucial to the crisis response program. Community members cited instances of police brutality (e.g., sending a dog into bushes after a consumer, violently addressing unhoused encampments), but providers spoke to the dangers of crisis response that could be addressed by law enforcement.

Providers saw the presence of law enforcement as more helpful than family and community members. In fact, almost half of community members surveyed said they would not call law enforcement (44%) during a crisis while more than half of providers surveyed (61%) would call law enforcement. On the other hand, 79% of community members and 83% of providers said they would call an alternative crisis response if available. Providers expressed concern about sending armed, and potentially untrained, officers to certain types of crises (e.g., someone who is suicidal). However, most providers felt safer having law enforcement respond to potentially dangerous situations in some capacity. Based on a history of police violence, family and community were more likely believe that law enforcement does not always "solve" the problems they are called to "fix".

"Last month, it just seemed like every call I got was extreme paranoia, aggression, killing family members, family feeling unsafe… This may be a law enforcement call, but if we speak to the family, they don't want their child to be killed, so we go out and talk to them first, but we do let them know that we might have to call law enforcement. Triaging and assessing…safety is a huge factor." – Provider

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Law enforcement agencies themselves had varying views on the role they can, and should, play in crisis response. In the community forums, some officers made positive comments about their agencies' programs and supports for people experiencing homelessness. One stated that police are better at getting individuals to accept services than providers. This was corroborated by a provider, who said that police know the communities better because of their outreach efforts. One family member made a similar comment about how some officers have built trust over time. Other police officers expressed frustration with having to respond to these types of crisis calls.

"The current system is a revolving door and is inefficient. It is utilizing an inordinate amount of law enforcement resources to address a non-criminal issue. The majority of an officer's day is now spent addressing issues they have little to no training to solve, rather than focusing on public safety." – Law Enforcement Officer

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There was a clear desire to collaborate with law enforcement to develop a regional crisis program. Despite the varying perspectives on law enforcement involvement during a crisis, almost all participants noted the need to involve local law enforcement agencies in some capacity. Even if police officers are not directly involved in a new crisis response team, they will continue to be implicated in any community safety issues. Therefore, law enforcement from both the city and county will need to be committed to ongoing collaboration with the new program and included in the planning process.

While there is frustration with the current situation, stakeholders are invested in building a more effective and appropriate crisis response system.

Residents, service providers, first responders, and government officials whose input contributed to this report all recognized the need to improve the crisis response system in the San Gabriel Valley.

There was frustration with the present system, although the level of frustration varied depending on the participant's role in the community and the quality and availability of local services. For example, consumers, family members, and community members who responded to the survey believe the current crisis response system 'needs improvement'. Only one survey comment reflected the belief that a consumer was well-served and treated with dignity by responders. In contrast, providers who responded to the survey felt the system was 'acceptable' in their cities. Providers believe their own organizations connect consumers to appropriate services, are respectful of consumers' cultures/backgrounds, provide services that consumers wish to use, and coordinate effectively with other providers. Outside of their own organizations, however, providers find these qualities to be lacking both in their own cities and the broader the San Gabriel Valley region.

The frustration expressed by multiple types of stakeholders was linked to the knowledge that better alternatives exist elsewhere, either within or outside of the San Gabriel Valley. Interviewees frequently pointed to Pomona as an effective model for wraparound homelessness support services. Some local police departments have partnered together to share a case manager from Union Station, which has been effective for homeless outreach when they are available. The CAHOOTS (Crisis Assistance Helping Out On The Street) model, which started in Oregon and has been replicated across the country, was also cited by a variety of stakeholders as a potential option for the region. Notably, most of the models that were referenced use collaborative, interdisciplinary teams composed of multiple members such as clinicians, law enforcement, and peers. Adapting similar practices is a possibility for the San Gabriel Valley. Multiple stakeholders in RDA's study identified key community partners (one individual noted the effectiveness of the Veterans Administration, for example). Providers and first responders shared their commitment to change. For some, change has involved building upon the services and staffing already in place. Others have pursued change by seeking funding and creative ways to build and bolster their ability to respond.

Alternative Crisis Response Models

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[12]	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
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

[12] Additional information about these programs can be found in Appendix C.

Program Name[12]	Location
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
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.

Mental health crises are varied - they affect individuals across their lifespans, manifest in a variety of behaviors, and exist on a spectrum of severity and risk. A crisis response system ultimately seeks to provide care to individuals during 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 crises 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.[13] A November 2016 study published in the American Journal of Preventive Medicine estimated that 20% to 50% of fatal encounters with law enforcement involved an individual with a mental illness.[14] 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. To understand the current models that exist, RDA reviewed nearly 40 national and international crisis response programs and specifically interviewed staff from nine 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 San Gabriel Valley.

[13] Szabo, L. (2015, December 10). People with mental illness are 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/

[14] 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

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 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 consumers 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 SGVCOG's development and implementation of its regional crisis response program.

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.[15] 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

[15] 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

of other system-level changes.[16] 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 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

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

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 incidents 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.[17] 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 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;[18] 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 de-escalated 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

[17] 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

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

the person in crisis.[19] 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 prioritize the calls based on pre-established criteria, such as acuity and risk of harm.

Crisis Response Teams Increase Community Safety

New York'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.[20] 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 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 responds 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

[19] 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)
[20] 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.

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 received 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 crises 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.

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.

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.[21] 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.

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 consumer might have, and gives the consumer 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 consumer's more acute physical health and substance use needs is a beneficial diversion away from an EMS or police response.[22] 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."[23] 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

[21] 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

[22] *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

[23] *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

support specialists are able to connect with consumers 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 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 consumer 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. Most 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 consumer 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 consumers, 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 consumer 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 consumers 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 consumer.

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 consumer'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 consumer 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 consumers 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 consumers to a subsequent location varies in many ways, including when the transport is allowed, who is doing the transport, where consumers are transported, and who is affected by the transport decision.

While some programs have the capability to transport consumers 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 consumers, 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 consumer's location of choice. If consumers 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 consumer'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 consumers, 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, consumers may be transported to short- or long-term service providers as well as the consumer'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 consumers 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 consumer to receive services.

There are many things to consider about consumer and provider safety when transporting a consumer. 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 consumer 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 consumer wants linkages or additional follow-up supports. While referrals and linkages are important to consumer 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 consumers for a referral to a peer navigation program for linkage to care. Additionally, many programs have relationships with community-based organizations and refer consumers 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 consumers 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 consumers.

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, Oregon estimates it would cost the Eugene Police Department $8.5 million to serve the volume and type of calls that are directed to CAHOOTS.[24] The EMCOT (Expanded Mobile Crisis Outreach Team) program in Austin, Texas has a budget of $3.15 million for 24/7 crisis services, which includes follow up for an average of 21 days, but can extend up to three months. Alameda County's CATT (Community Assessment and Transport Team) program, which provides assessment and transport, has a budget of $10 million for 5 years -- with more than 75% of its budget allocated for salaries. The Crisis Response Unit in Washington, which provides crisis services to a cohort of individuals who contacted the PD frequently, costs about $500,000 to $600,000 a year to operate daily from 7am to 9pm.

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.

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

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

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 funded 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 consumers' 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 where they can enter their contact notes – having access to a centralized data collection portal like this can greatly aid a program's evaluation efforts.

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. Some programs are also planning for an external evaluation to assist them in developing a broader understanding of their program's impacts for their consumers and in the larger community.

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 consumer 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.[25]

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.

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.[26] 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.

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 consumers served (housing, mental health)
- Frequency of police involvement

[25] 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

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

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 consumer 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 consumer outcomes; therefore, coordination implicates every aspect of program planning, implementation, and evaluation. Overall, program administration benefits 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 consumer 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 consumer level, system coordination can support case management, referrals and linkages, and improved consumer 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 consumers. The program shared that for its most complex cases, this coordination significantly increased positive consumer 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 consumer 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 must 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[27] - 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.

[27] 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.

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.

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.

Recommendations and Considerations

With numerous stakeholders, organizations, and programs involved in implementing an alternative crisis response model in the San Gabriel Valley, RDA recommends that the SGVCOG use a phased approach. A pilot program, in a subset of cities with a smaller scale, would allow for testing and refinement before investing in a final regional program design. The proposed cyclical monitoring, assessment, and learning approach will help the SGVCOG quickly and effectively identify an optimal program design by testing, assessing, and iterating for improvement. By utilizing data and community feedback to continuously refine the pilot prior to scaling, the SGVCOG will establish a program that meets the community's needs as well as saving time and money when the full program is rolled out.

Based on the evidence discussed in this report, RDA has drafted four key recommendations to be incorporated into the pilot and, eventually, integrated into the program at scale. In addition, three considerations are highlighted which the SGVCOG and partners will need to discuss and plan for further. The final section provides an overview of rapid monitoring that will support assessment and iteration of the pilot program.

Recommendations

1. The San Gabriel Valley requires a regional, coordinated crisis response system that supports crisis response locally while leveraging the power of a larger regional system.

A regional approach to crisis response in the San Gabriel Valley would provide an integrated network of services and funding that can achieve greater efficiencies in resource distribution. As discussed in the research findings, this is crucial in such a socioeconomic, racially, and geographically diverse region as the San Gabriel Valley. This regional, integrated approach can lead not only to greater coordination and collaboration between cities and providers but would also remove capacity and resource barriers smaller cities face in meeting the needs of their communities. Additionally, a regionally coordinated crisis response system would provide greater consistency of services across the San Gabriel Valley.

At the same time, the expertise and knowledge of locally based providers and teams are better suited to meet the unique needs of specific communities. Culturally competent services are critical, particularly for many traditionally underserved populations. While coordination and resources should stem from a centralized system, consumer services should be available locally and meet consumers where they are, both literally and figuratively.

Given the region's location within Los Angeles County, county-level considerations and coordination are also necessary. LACDMH is currently undertaking an expansive alternative crisis response plan, which includes partnering with cities and regions to expand mobile crisis response. A partnership with LACDMH could provide support and guidance, capacity building, and access to additional funding streams as well as a broader network of care.

The program pilot phase will provide an excellent opportunity to address coordination within the San Gabriel Valley and with LA County by allowing time to build relationships and trust among partners. A phased approach with local and county-level input will provide greater clarity

regarding appropriate services and create space for the San Gabriel Valley's regional crisis response program to integrate into the larger network of services. The SGVCOG can then build upon these relationships and understanding of the system to expand their program to best meet the needs of the region. Additionally, a pilot offers time for program implementers, with support from the community and cities, to tailor the model to the cultural makeup of the communities served and incorporate consumer feedback along the way.

2. Crisis services should appropriately respond to the needs of the situation and provide timely, trauma-informed, and people-centered care.

Evidence from the literature, existing models, and primary research conducted by RDA makes clear the benefits of dispatching personnel with proper qualifications for assisting those with homelessness, mental health, and substance use-related emergencies. As noted in SAMHSA's recommendations, most individuals who have experienced mental health, substance use, or homelessness-related challenges have already experienced significant trauma. A crisis may be compounded, or an individual may be re-traumatized by inappropriate services or exacerbating environments (e.g., noisy, crowded, loss of freedom). However, trauma-informed services that provide safety, empowerment, and support can create a healthy environment for de-escalation and healing.

Instead of automatically dispatching law enforcement (whose core training is not typically in these areas), a thoughtful approach that sends a crisis response team based on the situation and individual needs would best serve the community. Dispatching multidisciplinary teams made up of clinicians, peers, and other relevant personnel will improve the quality of care, increase consumers' comfort, and decrease community hesitancy around calling emergency services.

During the pilot, implementors should track the types of calls received and situations the team experiences. Based on this information, adjustments can be made to the program, staffing, services, geographic and time availability, and other components to better met the communities' needs. Another area to explore will be any attitude and behavioral changes toward calling emergency services, which may influence the appropriate pathways for access to the crisis program.

3. The development of a regional crisis response system should strengthen the overall continuum of care.

The crisis response system in the San Gabriel Valley is part of a larger continuum of care that includes prevention, treatment, housing support, and other wraparound and post-crisis services and supports. As discussed, it is important to carefully consider the relationship between each of the components of the continuum of care as changes are made to the crisis response system. As expressed by multiple providers and first responders, additional changes may be required throughout the system to help support individuals' behavioral health and housing needs in the long term. For example, adopting a model that relies heavily on supporting consumers through linkage to wraparound resources will not be successful if those resources lack the capacity to take on new consumers.

Bolstering prevention services and follow-up services may reduce the volume of crisis response calls overall, which may also improve response times. The continuum of care must be considered and, where necessary, supported with additional funding and resources for true success. Ongoing evaluation of both the crisis response system and the relationship to the broader continuum of care is critical to ensure any adjustments occur in a timely manner and create a seamless experience without gaps for the consumer.

The need for additional services across the behavioral health and homelessness continuums of care is recognized and there are currently several initiatives, through the SGVCOG and others, to increase the availability of support services. Where possible, strategic thinking around new programs and the crisis response pilot could yield supportive partnerships and creative resourcing. For example, the SGVCOG has Measure H funding to address any gaps in homelessness services, which could potentially be used to fund an additional layer of support tied to the crisis response program.

The pilot program should prioritize establishing effective communication and collaboration systems across cities, with LA County, and with service providers to support an active continuum of care. Personnel will need to be aware of wraparound services in the area, consumer history, bed availability, and transportation to get consumers connected to services. Furthermore, the SGVCOG should monitor and be strategic regarding their other projects (i.e., other regional homelessness coordination efforts, additional Measure H funding, etc.) which could play a part in the crisis continuum of care. Establishing communication and coordination protocols across the continuum during the pilot phase will be a major advantage when starting to scale up the program.

4. Consumers, family members, and the community should be actively involved in program planning, implementation, and evaluation.

Despite multiple outreach efforts, only a small number of consumers, family members, and others with lived experience participated in this feasibility study. Those who did participate had striking stories and perceptions to share, which often differed from the views of other stakeholders. For example, survey results repeatedly revealed that this group of stakeholders felt more dissatisfaction with crisis response services and agencies than providers and first responders. The reasons behind these differences, and potential solutions to resolve the level of dissatisfaction, need to be carefully examined. This can only happen if more of these stakeholders, and consumers in particular, are a central part of any planning process.

Every alternative crisis response program interviewed by RDA highlighted community engagement as essential to successful program implementation. During the planning phase, community engagement may inform existing needs, suggested priorities, and conversations hard-to-reach consumers. The community can identify real-time opportunities for program improvements during pilot implementation as well as outreach and educate the community about the program. This community feedback should continue beyond the pilot for continuous quality improvement.

To ensure an appropriate, human-centered, and culturally responsive system, participation from consumers, their families, and community members must be actively encouraged at the local and regional levels during the pilot and ongoing program. The current Community Advisory Group may serve as a starting place for community perspectives, but should also be expanded to include more voices and greater representation from those with lived experience.

Considerations

As with any new planning process, there remain unanswered questions and topics that require further exploration prior to program launch. RDA has highlighted three important areas not addressed in the recommendations above.

Dispatch. A key element of a crisis program is dispatch, or how a call for support is routed to a response team. Most crisis response programs use their community's existing 911 infrastructure for dispatch, which takes advantage of the existing infrastructure and community awareness. However, this would require crisis triage training on what calls are appropriate for the new program for all dispatch locations covered in the pilot. According to the Federal Communications Commission, the San Gabriel Valley has eight main Public Safety Answering Points (PSAPs) in local police departments along with four Sheriff's Department stations that receive 911 calls.[28]

Another option would be to use an alternative call line, which could be an existing number (e.g., 211) or a new hotline. An alternative number is helpful for individuals who are unlikely to call 911. However, in addition to training this dispatch team as mentioned above, an alternative call line may require a more intensive public awareness campaign. Ideally, the program will use the new 988 line when available, but that phone line may not be available when the SGVCOG pilot begins.

Community Awareness. In order for the community to access the pilot program, they must know the program exists and how to call for services. Based on dispatch decisions, a public awareness campaign, especially for groups who are most likely to call, will be essential to the program's success. This may include media advertisements, business cards, "meet and greets", or other outreach activities. The approach to community awareness should be guided and tailored by the pilot cities and community stakeholders.

This campaign should 1) provide information about the program and its services, 2) promote the dispatch phone line, and 3) build trust in the program. As some individuals may be reluctant to call for crisis services, an awareness campaign should work on building community trust and support of the program while providing information. The awareness campaign may also provide a way to promote opportunities for stakeholder feedback.

Funding. The SGVCOG has identified a number of potential funding sources for the crisis response pilot including Measure H, Medi-Cal reimbursement, and funding from cities. However, these funding streams are unlikely to be able to sustain a crisis response program on their own. Resources will therefore need to be braided in order to implement this program. By strategically and creatively weaving together various funds, the SGVCOG can develop a sustainable, comprehensive program model.

While braiding allows for maximizing of funding resources, it also requires clear and separate tracking of services based on funding requirements. With multiple funding streams, the target populations, reporting requirements, eligibility criteria, and performance measures can vary greatly. A braiding funding model, therefore, requires knowledgeable administrators as well as dedicate time and effort to manage. The SGVCOG and program provider will need to be very clear about the funding requirements and develop an appropriate system for ongoing tracking and reporting.

[28] 911 Master PSAP Registry. Federal Communications Commission. (2021, October 15). Retrieved November 9, 2021, from https://www.fcc.gov/general/9-1-1-master-psap-registry.

Rapid Monitoring, Assessment, and Learning

Realizing the benefits of the pilot program requires strategic and ongoing monitoring and assessment. Collecting data, both qualitative and quantitative, is a powerful tool for making informed decisions that will improve the pilot and, ultimately, the full-scale program. This section outlines how to incorporate monitoring, assessment, and learning into the pilot process and the program's continuing operations. Figure 2 depicts a summary of the process described in this section.

To support continuous quality improvement for the pilot and ongoing program, RDA recommends establishing an oversight and advisory group that includes representatives from the SGVCOG, program provider, pilot cities, local providers and first responders, dispatch, and community members. Through the crisis response study process, both a Steering Committee and Community Advisory Group were created. Members of these groups have already express interest in supporting this work and could be appropriate for an ongoing program advisory group. RDA would also recommend seeking greater representation from individuals with lived experience.

Once an advisory group is established, members should work together to plan for the pilot assessment. This would include developing a shared vision and goals for the program as well as interim outputs and outcomes, which may take the form of a theory of change or logic model. The overarching program goals will serve as a clear guidepost to evaluate program success while short- and medium-term goals will outline the steps to achieve the desired program impact.

From the shared vision, the advisory group should create some assessment questions. Some questions the advisory group may consider when assessing aspects of the pilot program are:

- Can the current approach be scaled? Will it be sustainable at scale?
- Are resources being used efficiently in the pilot? Will they be used efficiently at scale?
- How effective is the current approach in the pilot? Will it be effective at scale?
- Is the current approach appropriately tailored to the San Gabriel Valley region? Is it appropriate for the local context?

These questions, and others created by the advisory group, should not only be considered at the beginning of the pilot, but throughout its duration. The advisory group should evaluate the answers to these questions for the program as a whole as well as programmatic components, given the complexity and interconnected nature of the services provided. The program components that will be beneficial to assess will likely include:

- Dispatch
- Availability (hours and geography)
- Staffing
- Training
- Transportation
- Follow-ups and Coordination
- Funding
- Community Awareness

Assessing the full program and its specific components will help identify capacity building opportunities and challenges as well as a smooth phased implementation and expansion based on provider, city, the SGVCOG, and other partners' readiness.

To answer the questions posed on page 45, the advisory group will need to define indicators and establish ongoing, practical data collection protocols to monitor the program. Pairing quantitative programmatic data with feedback from stakeholders (services providers, consumers, community members, etc.) will provide the most accurate picture of the successes, challenges, and lessons from the pilot. This mixed-methods approach with multiple data sources will maximize validity by allowing for the examination of the same phenomenon in different ways. Examples of data to gather include the quantity and types of calls, the number of people served, consumer demographics, the type and amount of equipment used to serve them, and what services consumers were connected to after a crisis episode. Implementers will also want to ask consumers and other stakeholders about program satisfaction and how it can be improved.

Of course, data is only valuable if it is utilized. Establishing dedicated meetings every one or two months to review the data, and then brainstorm and act upon program feedback is the key to a valuable pilot. Considering that the pilot will be rolled out in various cities, the SGVCOG should keep in mind cities' flexibility and adaptability during the process. Staff buy-in to the rapid monitoring, assessment, and learning method is also crucial for the program's eventual regional expansion.

Figure 2. Rapid Monitoring Process

Conclusion

The findings from the research conducted by RDA and a review of existing alternative crisis response models reveal challenges in the current system, but also provide tangible opportunities for growth. There is a clear interest from providers, first responders, community members, and cities within the San Gabriel Valley to create a homelessness, mental health, and substance use mobile crisis response system. It is the hope that the research and best practices outlined in this report will provide a strong starting point for pilot implementation. Furthermore, by adhering to the proposed recommendations and employing a data-driven approach to ongoing improvement, the San Gabriel Valley will be on the path toward developing a comprehensive, community-centered, and evidence-based crisis response model.

Appendices

Appendix A. SAMHSA's National Guidelines for Behavioral Health Crisis Care - Best Practice Toolkit Executive Summary[29]

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 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

[29] 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

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 consumers 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 consumer 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;

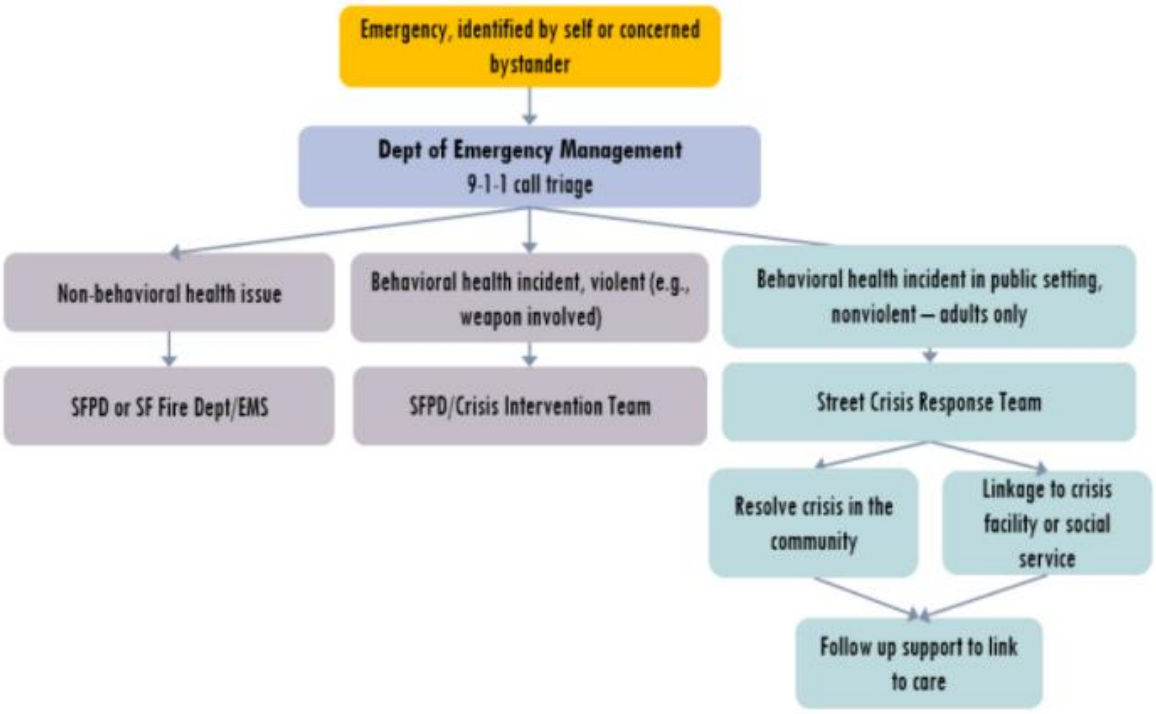
creating the need for additional training and supervision to ensure services are delivered in a manner that advances positive outcomes for those engaged in care. Verification of skills and knowledge of non-professional staff is essential to maintaining service delivery standards within a crisis program;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

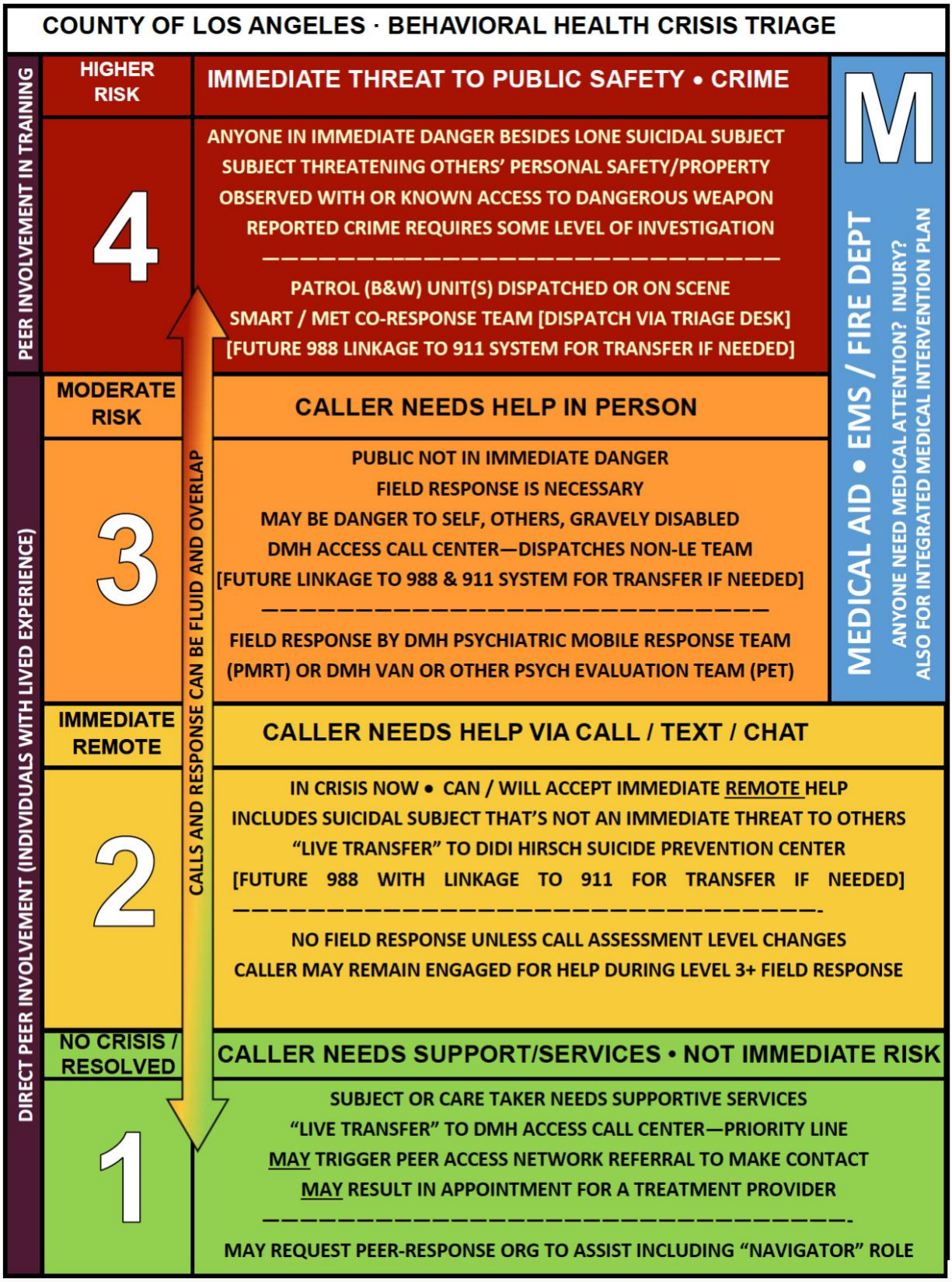
Crisis services must be designed to serve **anyone, anywhere and anytime**. Communities that commit to this approach and dedicate resources to address the community need decrease psychiatric boarding in emergency departments and reduce the demands on the justice system. These two benefits translate into 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
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 consumers 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
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	Alternate number	Mental health crises	Unknown	Psychiatric mobile response team	Unknown	Unknown

Health - Psychiatric Mobile Response Team (PMRT) – *Los Angeles County, CA*						
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
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
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 consumers
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