



City of Berkeley
**Specialized Care Unit
Crisis Response Recommendations**



City of Berkeley

Specialized Care Unit (SCU)

Crisis Response

Recommendations

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Executive Summary

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

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

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

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

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

Key Recommendations

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



Introduction

Project Background

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

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

The Need for Specialized Mental Health Crisis Response

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

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

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

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

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

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

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

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

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

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

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

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

⁶ Ibid.

⁷ Ibid.

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

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

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

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

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

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

¹⁰ Ibid.

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

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

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

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

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

Inputs to the Recommendations

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

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

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

¹³ Ibid.

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

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

Crisis Response Models Report

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

Mental Health Crisis Response Services and Stakeholder Perspectives Report

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

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

The synthesis of the City of Berkeley’s current mental health crisis system and themes from qualitative data collection can be found in the [Mental Health Crisis Response Services and Stakeholder Perspectives Report](#)



The SCU Model: Planning & Implementation

Core Components

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

- The SCU responds to mental health and substance use crises.
- The SCU responds with providers specialized in mental health and substance use.
- The SCU model does not include police as a part of the crisis response.
- The SCU is not an adjunct to nor overseen by a policing entity (e.g., Police, Fire, or CERN¹⁴).

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

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

A System-wide Change Initiative

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

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

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

The SCU model requires not only collaboration, but also structural changes and integration across other entities. For one, the SCU's ability to respond to crises relies in large part on the 911 Communications Center ("Dispatch"). However, in 2019, a Berkeley City Auditor's report¹⁵ elevated that the understaffing of Dispatch has led to staffing levels that cannot meet the call volume of residents and has increased call wait times. Increased wait times for 911 callers have negative implications for the safety and well-being of service utilizers and community members. Increased wait times also have negative implications for service providers and crisis responders that are responding to a potentially more advanced state of crisis. Additionally, inadequate staffing levels rely on overtime spending to fund Dispatch, which increases the cost of the entity.

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

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

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

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



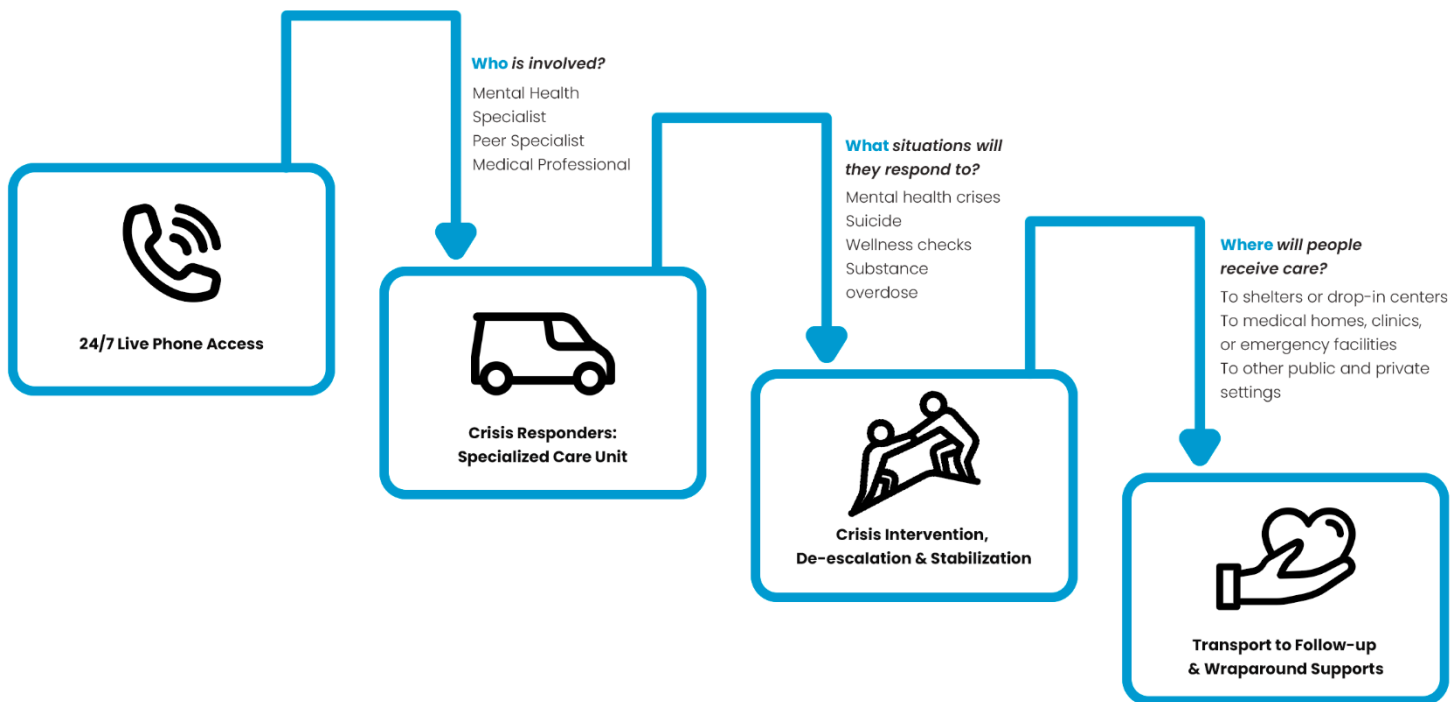
Recommendations

Overview

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

The Specialized Care Unit: Crisis Response

Figure 1: An overview of the SCU crisis response.

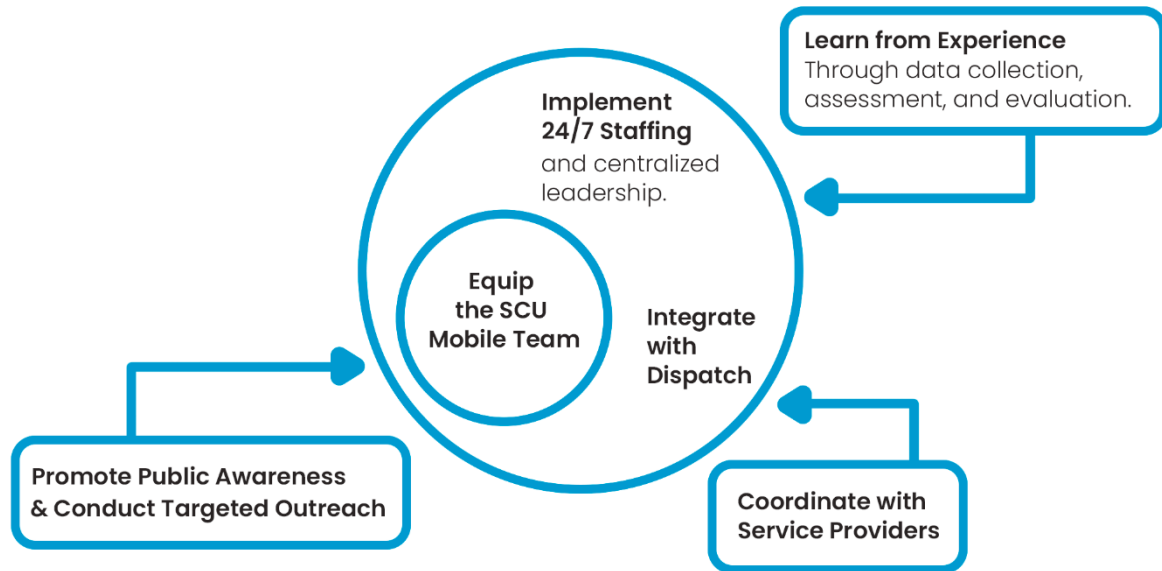


Community members experiencing or witnessing a mental health or substance use crisis will be able to call the SCU through a 24/7 live phone line, from which the SCU mobile team will be deployed to the crisis. The SCU mobile team will include specialists who support a person in crisis with intervention,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



The SCU Model: A Comprehensive 24/7 Crisis Response

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



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



Phased Implementation

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

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

Figure 3: An overview of the phased implementation approach.

PHASE 0	PHASE 1		PHASE 2
Nov 2021 – Aug 2022	Sept 2022 – Aug 2023	Sept 2023 – Feb 2024	Feb 2024+
<ul style="list-style-type: none"> Engage SCU Steering Committee & community stakeholders on RFP; launch RFP SCU staff: Contracting, hiring, training Dispatch: Planning & assessment Establish preliminary triage criteria, workflows and protocols Launch public awareness campaign 	<ul style="list-style-type: none"> SCU implements crisis response services Dispatch implements integration or components based on Phase 0 planning Conduct rapid assessment, monitoring, and iteration Engage centralized leadership in coordination 	<ul style="list-style-type: none"> Review annual evaluation and rapid assessments Prepare for Phase 2 	<ul style="list-style-type: none"> Implement changes based on evaluation and community need



SCU Mobile Team

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

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

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



Key Recommendations

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

Recommendation #1

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

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

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

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

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

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

Location of calls SCU should respond to:

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

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

Why isn't the SCU responding with police?

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

Why is the SCU responding to calls at public and private locations? Is that safe?

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

How were the types of calls decided?

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

Considerations for Implementation

Safety & Weapons:

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

Coordinating with Other Entities

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

Recommendation #2

The SCU should operate 24/7.

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

Why does the SCU need to be available 24/7? Why can't it operate only during peak hours?

A mental health or substance use crisis can happen at any time. Stakeholders stressed the importance of having mental health crisis response services available 24 hours per day and 7 days per week. If community members are to trust in the SCU as an ongoing and authentic alternative to police involvement, services need to be available whenever someone calls.

Considerations for Implementation

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

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

Recommendation #3

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

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

1. A Mental Health Specialist

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

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

2. A Peer Specialist

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

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

3. A Medical Professional

This role should be able to identify physical health issues that may be contributing to or exacerbating a mental health crisis, including psychosomatic drug interactions. They should be able to administer single-dose psychiatric medicines and have training in harm reduction theory and approaches. They can also assess and triage for higher levels of medical care as needed.

- Recommended position: Psychiatric Nurse Practitioner (Psych-NP)
- Other possible positions: Nurse Practitioner (NP), EMT, Paramedic

Why a three-person team?

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

Why is the mental health specialist conducting 5150 assessments?

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

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

Why is there a peer on the team?

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

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

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

Considerations for Implementation:

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

Recommendation #4

Equip the SCU mobile team with vans.

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

SCU vans should include:

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

SCU vans should **not** include:

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

Why not use an ambulance?

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

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

Why were these specific features chosen?

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

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

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

Considerations for Implementation

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

Recommendation #5

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

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

The SCU will transport service utilizers to:

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

Considerations when deciding transport location:

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

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

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

Considerations for Implementation

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

Recommendation #6

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

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

- Medical supplies**
- First aid kit
 - Personal protective equipment
 - Wound care supplies
 - Stethoscope
 - Blood pressure armband
 - Oxygen
 - Intravenous bags
 - Single-dose psychiatric medications

- Client engagement items**
- Food and water
 - Clothing, blankets, and socks
 - Transportation vouchers
 - "Mercy beers" and cigarettes
 - Tampons and hygiene packs

- Community health supplies**
- Safe sex supplies and pregnancy tests
 - Naloxone
 - Clean needles and glassware
 - Sharps disposal supplies

- Technology**
- Cell phones
 - Data-enabled tablets
 - Computer Aided Dispatch (CAD)
 - Police radio

- Uniforms**
- Casual dress: polo or sweatshirt with the SCU logo

Why does the SCU need to carry client engagement items?

These items can help initiate an interaction while also meeting the basic needs of clients while they are experiencing a crisis.

Why does the SCU need to carry community health supplies?

These supplies can help address an underlying physical health need or provide harm reduction for substance use crises.

Why does the SCU need technology and uniforms?

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

Considerations for Implementation

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

Clearly distinguish the SCU from MCT.

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

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

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

If there's an SCU, why should the MCT still exist?

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

Why is it important to distinguish MCT from the SCU?

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

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

Considerations for Implementation

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

Accessing the SCU Crisis Response: Dispatch & Alternative Phone Number

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

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

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



Key Recommendations

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

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

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

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

If this is a non-police response model, why is Dispatch involved?

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

Will another assessment and planning process delay the launch of the SCU?

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

Considerations for Implementation

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

¹⁶ Berkeley City Auditor. (2019, April 25). 911 Dispatchers: Understaffing Leads to Excessive Overtime and Low Morale.

https://www.cityofberkeley.info/uploadedFiles/Auditor/Level_3_-_General/Dispatch%20Workload_Fiscal%20Year%202018.pdf

Recommendation #9

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

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

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

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

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

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

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

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

Option A (Recommended)

Option B

Option C

Safety Promotes Safety

Evaluate and compare each option's ability to establish protocols or infrastructure to support the safety of crisis responders and community members.

Dispatch already has established protocols and technology to track the crisis responder's location/position through CAD.

Assess the resources and timing required for a CBO to ensure sufficient training on the use of the CAD system and radio communication.

Assess the ability for existing Alameda CSS and 988 technology to integrate with Dispatch's CAD system and radio communication.

Dispatch already has established protocols and technology to maintain radio communication between Dispatch and crisis responders, especially during rapid changes in a situation.

Assess workflows and processes that would affect the number of times a caller must repeat triage/assessment; estimate whether there will be an increase in dropped calls.

Evaluate the effectiveness of existing processes to transfer calls between Alameda CSS and Dispatch.

Dispatch already has established protocols and technology to streamline the handling and transfer of calls so that a person in crisis does not have to repeat their story multiple times, thereby reducing the number of dropped calls.

Consider if a non-911 entity will more effectively reduce police-community interactions during mental health and substance use crises.

Consider if the 988 entity will more effectively reduce police-community interactions during mental health and substance use crises.

Risks to Safety

Evaluate and compare the potential risks to the safety of crisis responders and community members across each option.

Consider whether Dispatch will be more likely to deploy the police than the SCU during initial model implementation.

Consider whether alternative phone line personnel will be more likely to deploy the SCU than transferring calls to 911.

Consider whether community members will be confused about 988 and may believe it is only for suicide prevention rather than the full spectrum of mental health and substance use crises, and therefore be less likely to call 988.

Evaluate whether community members' fear of a police response, will reduce the utility, acceptability, and accessibility of the SCU.

Evaluate whether community members will be more likely to call an alternative phone number than 911 if they are experiencing a mental health or substance use crisis.

Option A (Recommended)

Option B

Option C

System Integration

N/A
(911 is already integrated with Berkeley Fire, Falck, and Alameda County CSS)

Explore the process for a CBO to assess and prepare callers if they need to transfer the call to 911, such as if the presence of weapons is confirmed. Evaluate the effects, such as a slowed response time or increased risk of a dropped call.

Consider whether the transfer of calls to 911 (i.e., calls ineligible for SCU) will undermine community trust in the alternative phone line.

Determine the feasibility of integrating a CBO's technology to allow for the transfer of calls between Alameda CSS and Dispatch.

Determine the feasibility of a CBO's technology to receive calls from Fire and Falck if they request the SCU.

Determine whether Alameda County will be able to deploy a Berkeley-specific team (the SCU) for only Berkeley residents as a component within the larger 988 model.

Assess what will be required for a county system to deploy a model administered by a CBO, such as additional contracts, MOUs, or staff licensure requirements.

Public Awareness

Consider what will be required of a public awareness campaign to build community trust in 911 to deploy the SCU as a non-police response.

Consider what will be required of a public awareness campaign to inform Berkeley residents both about the SCU as a non-police crisis response and promote an alternative phone number to access the SCU.

Assess the public awareness and education planned for 988.

Assess whether the Alameda County 988 public awareness campaign can be adjusted for Berkeley to communicate the availability of the SCU through 988.

Why consider different options for phone access to the SCU?

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

Why is Option A elevated as the recommended option?

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

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

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

Why might the model implement an alternative phone number? (Option B or Option C)

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

Do other cities use multiple phone numbers?

From the reviewed models, at least seven use two or more lines for emergency crisis calls:

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

If the model uses an alternative phone line, what happens if people still call 911 when they are having a mental health crisis?

Dispatch should have the option to forward calls to the SCU alternative phone line, where those staff can triage the call and deploy the SCU. Establishing these protocols will be part of the assessment and planning process. It is also important that a public awareness campaign promotes access to the SCU team (*refer to recommendation #24*).

Additional Considerations for Implementation:

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

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

Recommendation #10

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

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

Why should Dispatch have a clinician in the call center?

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

How does having a clinician in Dispatch promote community or crisis responder safety?

Berkeley Dispatch is deeply committed to the safety of crisis responders. In interviews for this project, Austin's EMCOT program¹⁹ shared that embedding a clinician within their call center increased communication around safety and risk assessment during triage, including increased deployment of the crisis response team. They also shared that this integration improved handoffs for telehealth conducted by the clinician. Berkeley should plan for embedding a clinician in Dispatch to support with de-escalation and determinations because it could promote safety.

Why does the clinician need to be part of planning in Phase 0 if implementation is in Phase 1?

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

Considerations for Implementation:

- Calls that do not require an in-person response should continue to be sent to Alameda County CSS for phone support.
- Staffing structures will need to be adapted, such as determining which roles supervise the clinician and which roles the clinician supervises.
- The clinician may be able to provide training and ongoing professional development to support call takers to identify and address mental health calls.
- There may be a need for multiple clinicians depending on their role and the call volume.
- This recommendation will need to be adapted based on how recommendations #8 and #9 are implemented.

¹⁸ Velazquez, T & Clark-Moorman, K. (2021). New research suggests 911 call centers lack resources to handle behavioral health crises. *ResearchGate*.

https://www.researchgate.net/publication/355684339_New_Research_Suggests_911_Call_Centers_Lack_Resources_to_Handle_Behavioral_Health_Crises

¹⁹ Read more about the EMCOT program here: <http://www.austintexas.gov/edims/pio/document.cfm?id=348966>

Implement a Comprehensive 24/7 Mental Health Crisis Response Model

There are many considerations for realizing the full implementation of a 24/7 model including hiring personnel, establishing clear roles, and providing office space and required materials. Staffing a comprehensive model should seek to address the perceived challenges of existing crisis response systems throughout Berkeley, such as not having 24/7 availability or sufficient staff capacity.

The following recommendations are designed to leverage the lessons learned from other cities implementing non-police crisis response models and be responsive to the needs and concerns expressed by community stakeholder participants. Each recommendation should be further explored as launch and implementation progresses:



Key Recommendations

- 11. Fully staff a comprehensive model to ensure the success of the SCU mobile team, including supervisory and administrative support.**
- 12. Operate one SCU mobile team per shift for three 10-hour shifts.**
- 13. SCU staff and Dispatch personnel travel to alternative crisis programs for in-person observation and training.**
- 14. Prepare the SCU mobile team with training.**

Recommendation #11

Fully staff a comprehensive model to ensure the success of the SCU mobile team, including supervisory and administrative support.

In addition to the three-person SCU mobile team (*recommendation #3*), the 24/7 live phone line (*recommendation #9*), and the clinician in Dispatch (*recommendation #10*), the SCU will require supervisory and administrative support roles. These roles will support the day-to-day services and operations of the SCU mobile team. They also will participate in case management meetings (*recommendation #18*), rapid assessment and monitoring (*recommendation #22*), and model evaluation (*recommendation #23*).

Recommended Personnel Roles & Types of Responsibilities²⁰:

Program Manager

- Review data from implementation, lead rapid assessment process, support changes and iteration to model
- Liaise with city, Dispatch, and central leadership around implementation, rapid assessment, and coordination
- Manage contract and budget
- Manage scheduling and shifts

Clinical Supervisors

- Oversee and support SCU mobile team, provide consultation for medical and mental health services
- Plan and lead training and professional development for SCU mobile team
- Collaborate with peer specialist supervisor on how to best support SCU mobile team
- Share client and staff feedback to program manager for rapid assessment and monitoring

Peer Specialist Supervisor

- Oversee and support peer specialists on SCU mobile team with an emphasis on emotional support for peers
- Plan and lead training and professional development for SCU mobile team, with an emphasis on utilizing peer specialists and other forms of team communication and support (e.g., advocacy, equal value, communication)
- Collaborate with clinical supervisor

Call Takers / Call Center (*pending implementation of recommendations #8-10*)

- Receive calls from the 24/7 live phone line; triage calls and deploy SCU mobile team, as required
- Receive calls from Dispatch
- Transfer calls that do not require in-person services to Alameda County CSS
- Participate in case management care coordination meetings, as relevant

²⁰ Refer to **Appendix B** for the number of personnel, availability, shifts, and a sample shift structure

Considerations for Implementation

Availability or shift structure for roles:

- The program manager and peer specialist supervisor roles should be available during traditional business hours.
- The clinical supervisor role should be available 24/7 and will require redundancy in hiring.
- The call center will need to be staffed to ensure a 24/7 live phone line. If Option B is pursued (*refer to recommendation #9*), the call center should be situated within the SCU model rather than a separate CBO. This could promote morale and team identity and will increase the quality and efficiency of communication.

Office & Equipment Needs:

- The SCU model will need an office space that accommodates all personnel and their roles, such as daily huddles, desks, and equipment.²¹
- Stakeholders suggested that the SCU would benefit from developing relationships with service utilizers and their families. If these opportunities are pursued as part of the SCU's function, then office space could also accommodate service utilizer and family consultations and/or open "office hours" for relationship building.

²¹ Refer to **Appendix C** for the budget and additional office equipment needs, such as computers, phones, printers, etc.

Recommendation #12

Operate one SCU mobile team per shift for three 10-hour shifts.

In order to staff a crisis response model that operates 24/7, the SCU should staff one mobile team per shift for three 10-hour shifts. We estimate that the SCU would respond to three to six incidents per 10-hour shift, with each incident requiring 20 to 120 minutes for response and closure. This should generally be manageable by one SCU mobile team.²²

Why 10-hour shifts?

Based on feedback from those operating similar models as well as from community stakeholders, 10-hour shifts are common in residential settings and tend to work well for clinical and mental health staff. There are often labor union protections for shifts longer than 10 hours. Three 10-hour shifts would provide 24/7 coverage while allowing for some overlap before and after each shift.

Why should shifts overlap?

The SCU mobile team shifts should overlap so that the team can conclude engagement with a person in crisis before their shift ends. The next shift would be able to respond to a crisis call that comes in towards the end of the preceding team's shift. The overlap also supports team huddles for care coordination. The shift structure and overlap should include time for the required paperwork at the end of the shift so that there is not an expectation that paperwork is completed during off hours.

Will one SCU mobile team be sufficient?

This estimate is comparable to the call and incident volume reported by Denver's STAR pilot, Portland's Street Response pilot, and Eugene's CAHOOTS program. Though the city population of Denver and Portland are 5.8 and 5.3 times larger than Berkeley's population, respectively, their pilots are restricted to smaller geographic units of the city; Denver and Portland both operate only 1 mobile crisis response team per shift. Eugene's city population is 1.4 times the population of Berkeley, and Eugene operates 1 crisis team per shift, with an additional team during peak hours of 10am-12pm and 5pm-10pm.²³

Considerations for Implementation

- Staffing structure will require redundancy to allow for personnel to take vacation and sick days, and in anticipation of periodic vacancies.²⁴
- Staffing structure may need to plan for on-call or floater shifts.

²² Estimates for SCU call volume are based on analysis of call and service volume by MCT from 2015 to 2019, the Auditor's Report and analysis of Berkeley Police Department's call and service volume from 2015 to 2019, and analysis of Berkeley Fire's and Falck's transport volume and time on task from 2019 to 2021. Please refer to **Appendix D** for more specific analysis and estimates.

²³ The City of Eugene (2019-03240). <https://www.eugene-or.gov/DocumentCenter/View/56579/2019-03240-White-Bird-CAHOOTS-Services---SIGNED>

²⁴ Refer to **Appendix B** for the number of personnel, availability, and a sample shift structure.

Recommendation #13

SCU staff and Dispatch personnel should travel to alternative crisis programs for in-person observation and training.

Although Berkeley's SCU model will be uniquely designed and tailored for the Berkeley community, there are many opportunities to learn from successes and challenges of other models that have implemented non-police mental health crisis response programs. For example, the Denver STAR team shared that their Dispatch team benefited greatly from traveling to Eugene, OR to observe and learn about the CAHOOTS model and plan their deployment protocols.

Options for city programs to visit:

- CAHOOTS: Eugene, OR
- STAR: Denver, CO
- EMCOT: Austin, TX

Recommended personnel to attend:

- Dispatch: Supervisor
- SCU: Clinical Supervisor and Program Manager
- Phone line staff, as relevant (refer to recommendation #9)

Potential program components to observe during site visit:

- Triage criteria and workflows
- Assessing for risk and safety
- Working with the mental health clinicians embedded in Dispatch
- Coordinating and prioritizing calls between 911 and an alternative phone number
- SCU mobile team services and team coordination
- Role clarification

Why should Dispatch and SCU staff travel to these sites together?

This training opportunity would support the collaboration between the SCU and Dispatch in planning for the phased integration. By traveling to the sites together, SCU and Dispatch will not only hear the same questions and answers but can ideate and collaborate on adaptations for the Berkeley SCU model. Finally, this is an important opportunity for relationship building between SCU staff and Dispatch, which is essential to this systems-change initiative.

Considerations for Implementation

- Travel costs will need to be included in the initial budget; estimates for consulting fees from the sites are already included.²⁵

²⁵ Refer to **Appendix C** for the estimated SCU model budget.

Recommendation #14

Prepare the SCU mobile team with training.

The SCU will require training in a set of specific skill areas to be best equipped to provide mental health crisis response. The personnel hired should already have demonstrated their specialized skill set in previous employment settings; training will therefore support the team to align on how to implement their skills. Training also supports teams to work together and with other entities effectively, such as Dispatch, which is essential in crisis response.

The SCU mobile team should be trained in the following topics:

- General de-escalation techniques
- Disarming without use of weapon
- Substance use management
- Naloxone administration
- Harm reduction theory and practice
- First aid
- Situational awareness and self-defense
- Radio communication
- Motivational interviewing
- Implicit bias, cultural competency, and racial equity
- Trauma-informed care
- Training on data collection protocols and data integrity (refer to recommendations #17 and #18)
- Compliance with confidentiality and HIPAA when interacting with Police and/or Dispatch

How long will it take to train staff?

Eugene's CAHOOTS program includes at least 40 hours of classroom training and 500 to 600 hours of field training for all new staff.²⁶ This equates to 12.5 to 15 weeks of training when calculated on a full-time basis.

What informed these suggested training topics?

These training topics were generated from a variety of alternative model program recommendations and input from Berkeley service providers and community stakeholders.

Considerations for Implementation:

- The phased approach timeline incorporates an estimate aligned to CAHOOTS' model, with room for adaptation.
- Training should be provided to all new SCU staff as they are added to the team, regardless of start date.
- Additional training topics may be identified by the SCU team.

²⁶ Beck, J., Reuland, M., & Pope L. (2020). Case Study: CAHOOTS. Vera. <https://www.vera.org/behavioral-health-crisis-alternatives/cahoots>

Administration and Evaluation

There are many considerations for effectively administering and monitoring implementation of a new, 24/7 mental health crisis response model. Effective implementation includes ongoing collaboration and decision-making at both the structural and provider levels.

At a structural level, the SCU model will require cross-system coordination for implementing new processes and therefore will require leadership across the City of Berkeley and SCU to collaborate around ongoing program monitoring, data review and transparency, and system integration. At a provider level, the SCU model will require collaboration and communication to support care coordination and case management for people that have experienced crisis as well as to elevate emerging challenges and successes.

Moreover, the community can—and must—provide essential advisory capacities. The community should be actively engaged to provide input and feedback throughout the planning and implementation of the SCU, including through the SCU Steering Committee and ongoing opportunities for the general public.

The following recommendations were informed by the lessons learned from other cities implementing alternative crisis models and aim to be reflective of the perspectives shared by the project's stakeholder participants. Each recommendation should be a starting point to promote cross-sector collaboration, adjusting to accommodate the evolution of the SCU:



Key Recommendations

- 15. Contract the SCU model to a CBO.**
- 16. Integrate the SCU into existing data systems.**
- 17. Collect and publish mental health crisis response data publicly on Berkeley's Open Data Portal.**
- 18. Implement care coordination case management meetings for crisis service providers.**
- 19. Implement centralized coordination and leadership across city agencies to support the success of mental health crisis response.**
- 20. Continue the existing SCU Steering Committee as an advisory body.**
- 21. Solicit ongoing community input and feedback.**
- 22. Adopt a Rapid Monitoring, Assessment, and Learning process.**
- 23. Conduct a formal annual evaluation.**

Recommendation #15

Contract the SCU model to a CBO.

The administrative structure of crisis response systems across the country varies significantly. Some are administered by government agencies, some are run in collaboration between a government agency and CBO, and some are entirely operated by CBOs. There are several reasons why the SCU model should be contracted to a CBO, at least through Phase 2 of the phased implementation approach.

The SCU crisis response model would benefit from being contracted to a CBO for several reasons:

- **Supports a quick launch:** CBOs are often able to move more nimbly than government agencies, especially as it relates to hiring; adequately staffing the SCU mobile crisis team is a critical element in timely implementation. Given the urgent need, the ability to launch the SCU quickly and provide non-police mental health crisis response services is critical.
- **Established relationships with community members:** Stakeholders made it clear that CBOs have developed strong relationships with service utilizers accessing mental health support, homelessness resources, street medicine, and system navigation and referrals. CBOs in Berkeley have expertise in the community that can be leveraged to advance the SCU's crisis response efforts.
- **Referral networks and partnerships:** A CBO with established networks and partnerships would be well positioned to support service utilizers with referrals as well as transport to community-based resources. Additionally, these relationships can support warm handoffs at transport locations.

Considerations for Implementation

- To contract with a CBO, the City of Berkeley will have to issue a Request for Proposals (RFP). The RFP process will need to evaluate a CBO's capacity to develop and implement a model of this size on this timeline.
- The City should identify a backup plan if no qualified CBOs respond to the RFP.
- The CBO's practices should align to the values and principles of the SCU. The City may need to use contracts and MOU specifications to require:
 - Adequate and equitable wages for all SCU staff and crisis responders, especially peer specialists and peer specialist supervisors.
 - A representative and equitable hiring process that prioritizes staff who are reflective of those most marginalized and harmed by existing crisis response options and the criminal legal system.
 - Necessary data and metrics to collect and report as well as ensuring sufficient technological systems to meet these needs.
- CBOs may face challenges inherent in the contract structure, which should be evaluated and protected against as these challenges can undermine sustainability and longevity.
 - Short-term funding: only funding the SCU in one-year increments can reduce staff retention and inhibit investments in operations (*refer to Section V*).
 - Overhead costs: allocate enough funds for overhead costs (e.g., salary, training, and office equipment), which are critical to SCU success.
 - Contract monitoring: data collection, monitoring, and evaluation are essential to the success and iteration of the SCU but should not be prohibitive to the work.
- There may be additional needs or considerations around data and system integration (*refer to recommendation #16*) and the collaboration across administration and leadership if a CBO implements the SCU; these may need to be included in the contract.
- All recommendations are written with a contracted CBO in mind; additional implications may arise during planning and Phase 0.

Recommendation #16

Integrate the SCU into existing data systems.

Having access to patient data will support the SCU to provide tailored, informed, and equitable services for those experiencing mental health and substance use crises. Access to existing data systems, such as an EHR, will not only ensure that the SCU has access to relevant patient information, but also that other providers are aware when, how, and why their client might be interacting with crisis response. Finally, integrating the SCU into existing data systems will ensure aligned and consistent data collection, which is essential for the rapid assessment monitoring (*refer to recommendation #22*) and evaluation (*refer to recommendation #23*).

There are many factors outside of the purview of the SCU, HHCS, or even that City of Berkeley that affect whether data and system integration can be achieved. These factors include patient privacy and legal protections (i.e., HIPAA), technological capabilities, available funding, logistics across private and government entities, and more. As a result, this recommendation is included as an aspiration that should be planned for in future phases and may not be realized during Phase 1 of implementation.

- Bidirectional, live data feeds should be integrated between the SCU and other data sources, including but not limited to:
 - EHRs used by major medical systems and Federally Qualified Health Centers (FQHC)
 - Alameda County's Community Health Record (CHR)
 - Alameda County's YellowFin

Why does the SCU need to access service utilizers' records, such as EHRs?

Access to an EHR allows crisis responders to make informed decisions based on a service utilizer's health history. This access also enables crisis responders to communicate directly with a service utilizer's existing support team, such as psychiatrists or case managers, when providing crisis response or referring the service utilizer for follow-up care.

Is it common for crisis responders and clinicians to have access to service utilizer records?

Many other crisis response programs enable access to these sources of data. For example, the Alameda County Community Assessment and Transport Team (CATT) has access to the county's CHR. Providers at FQHCs, including programs like Lifelong's Street Medicine Team, have access to an integrated EHR. Berkeley Mental Health (BMH) is already integrated with the county's YellowFin reporting system. Other city models, such as Denver STAR, enable their crisis responders to access existing data systems.

Why should the data feeds be bidirectional?

Not only do crisis responders need to access service utilizer medical history, but the data they collect during a crisis response should be entered into the centralized data systems so that a service utilizer's existing support team has an updated and complete case history. The county's CHR has live data feeds from many providers and so the SCU's data should also have bidirectional capabilities when possible.

Considerations for Implementation

- The Berkeley City Attorney and IT have signed onto the county's CHR, and many CBOs and medical providers have also already signed onto the CHR, which could facilitate the SCU's integration into this system.
- The SCU will need access to EHRs and the CHR to participate in client case management meetings (*refer to recommendation #18*).
- SCU team members will need training and support to accurately enter data into these platforms, which is essential to data integrity.
- Legal protections for confidentiality and consent will have to be carefully assessed to determine the feasibility of this recommendation and implementation approach.
- Many health conditions can be criminalized and prosecuted. The SCU data must be separate from Dispatch and CAD data because Dispatch is situated within Berkeley Police Department. Presently, Dispatch does not have access to EHRs or the CHR, and in the future, this separation should continue.

Recommendation #17

Collect and publish mental health crisis response data publicly on Berkeley's Open Data Portal

Data collection is essential to monitoring and evaluation and spans across the SCU mobile team and supporting personnel, Dispatch and/or the alternative phone line, and central leadership. Given how many different personnel and agencies will be collecting and reviewing data, it is essential that data collection be planned for early in Phase 0 to ensure alignment, accuracy, and data integrity.

- Types of data that should be collected and published:
 - Call volume
 - Time of calls received
 - Service areas
 - Response times
 - Speed of deployment
 - Determinations and dispositions of Dispatch (including specific coding for violence, weapons, and emergency)
 - All determinations and deployed teams from Dispatch
 - Percentage of calls responded to by SCU of all calls sent to SCU
 - Type or level of service needed compared to the initial determination at the point of Dispatch
 - Service utilizer outcomes
 - Number of 5150 assessments conducted
 - Number of 5150s confirmed and involuntary holds placed
 - Number of transports conducted
 - Location of transport destinations
 - Type of referrals made
 - Priority needs of clients served (housing, mental health)
 - Number of requests for police involvement
 - Racial demographics of service utilizers
 - Other relevant characteristics of service utilizers, such as homelessness status or dementia

Note: not an exhaustive list.

- Examples of public data dashboards from alternative crisis models:
 - [Portland's Street Response data dashboards](#)
 - [NYC's B-HEARD monthly data reports](#)

How does data collection promote community safety and health?

Nationally, many emergency call centers lack consistent data collection and internal sharing and review, suggesting city administrators and leaders are unable to effectively use data to understand the scope of behavioral crisis and response in their communities.²⁷ Collecting data in a way that can be used among program administrators will be essential in supporting the success of the SCU and positive outcomes for the community. Moreover, during this project, it was impossible for RDA to conduct an “apples-to-apples” analysis between data from any of the contributing agencies (Police, Fire and Falck, MCT, Dispatch/Auditor’s Report) because the data entry practices across each agency are inconsistent. Specifically, the variables that each agency records for each call response are not the same. In instances where there were similarities in the types of variables used between agencies, the values that they each used to enter or code their data were not comparable.

Why does publishing data publicly matter?

Publishing data through Berkeley’s Open Data Portal could promote transparency around crisis response services, address community stakeholders’ distrust of the system, and keep the community informed about the SCU and the city’s crisis response services.

Considerations for Implementation

- Multiple agencies are likely to engage in data collection that contributes to the SCU model. All data variables and definitions should be aligned to ensure system integration and data integrity, including:
 - CAD data
 - Additional 911 and Dispatch data (as applicable)
 - Alternative phone number data (as applicable)
 - SCU mobile team data
 - EHR data
 - CHR data
- Personnel will need ample training on data collection, including variable definitions and data entry processes, to ensure a high degree of data integrity.
- Staff will need adequate technology to collect and report on data (*refer to recommendation #6*).

²⁷ Velazquez, T & Clark-Moorman, K. (2021). New research suggests 911 call centers lack resources to handle behavioral health crises. *ResearchGate*.

https://www.researchgate.net/publication/355684339_New_Research_Suggests_911_Call_Centers_Lack_Resources_to_Handle_Behavioral_Health_Crises

Recommendation #18

Implement care coordination case management meetings for crisis service providers.

Service utilizers often receive care across multiple agencies and individual service providers, but transparency and visibility of service utilizers that move in and out of these agencies is a challenge. Regular case management coordination meetings across organizations and providers could help to address the perceived lack of coordination across different services and to improve the care coordination for service utilizers, such as those discharged from inpatient facilities.

Who should participate:

- SCU mobile team
- Service providers and case managers identified through CHR and EHRs
- Partners and those receiving referrals at CBOs
- A designated meeting coordinator (e.g., SCU program manager, city staff)

What the meetings should achieve:

- Discuss care for shared service utilizers
- Discuss needs of high service utilizers, services provided
- Discuss successes or challenges with warm handoffs and referral pathways

How is care coordination relevant to crisis response?

Care coordination supports providers in making informed decisions about the services to provide and can prevent future crisis. Throughout the project's qualitative data collection, service providers in Berkeley commonly provided the idea of care coordination meetings between the SCU and providers; they expressed that if their clients access SCU crisis services, they would benefit from collaborating with the SCU. The REACH Edmonton program also shared that meetings for frontline workers to discuss shared clients increased positive client outcomes. Finally, Berkeley's Transitional Outreach Team (TOT) shared challenges they have encountered when providing follow-up care after MCT responds to an incident, especially communicating with the many external providers that interact with a single service utilizer.

Why is there a coordinator role in these meetings? Who is that?

Based on the lessons learned from other cities implementing alternative crisis response models, such as the REACH Edmonton and Denver STAR programs, care coordination meetings will require a centralized coordinator or leader from the SCU. Frontline workers do not have the capacity to manage these meetings, which includes scheduling, note taking, preparing data, following up on items as necessary, and other duties. The care coordinator may be an administrative staff member of the SCU, such as the program manager, or a staff member from the City of Berkeley who oversees many of the relevant contracted providers (beyond the SCU).

Considerations for Implementation:

- These meetings will require a clear owner to manage meeting topics, prepare data, identify non-urgent items for follow-up, and ensure equitable power and time talking, especially for peer specialists. The SCU program manager may be best poised for this role.
- Integrated data systems that allow for sharing data and reviewing case history across providers would enhance care coordination and case management (*refer to recommendation #16*).
- There may be a benefit to call takers joining these meetings if they identify and document who is in crisis.

Recommendation #19

Implement centralized coordination and leadership across city agencies to support the success of mental health crisis response.

Overall, programs benefit from ensuring there are one or more people responsible for coordinating the program at a birds-eye view. As a new mental health crisis response initiative, the SCU model will require cross-system coordination for implementing new processes, training, monitoring, and evaluation. Moreover, because these initiatives span across Dispatch and/or an alternative phone number, the SCU mobile team, and other referral entities like Fire, Police, MCT, TOT, and mental health and social service providers, a centralized coordinating body will be essential to the success of this far-reaching initiative.

Who should participate:

- Berkeley Dispatch
- Berkeley Department of Public Health
- Berkeley Mental Health (BMH)
- Berkeley Health, Housing & Community Services Department (HHCS)
- SCU Program Manager
- Berkeley Fire Department
- Berkeley Police Department
- Other relevant parties as the project evolves

What the meetings should achieve:

- Progress along the phases of implementation
- Lead the rapid assessment processes and regularly review data
- Review SCU Steering Committee feedback
- Review service utilizer and stakeholder feedback
- Prioritize issues
- Make decisions

Additional outcomes:

- Increase open communication across city agencies
- Build trust across crisis responders and city departments
- Align all partners on shared values for increasing community health and well-being

Why is the Berkeley Police Department involved in this leadership body if the SCU is a non-police response?

Because the police currently respond to all mental health calls received through 911, any decision about shifting specific call and service types from police to SCU will require BPD buy-in, communication, and planning. Moreover, Dispatch is currently situated within BPD, and therefore, BPD leadership will be required to assess and approve changes to Dispatch. For instance, to ensure that all SCU data is kept confidential and separate from police, BPD will need to support planning for CAD data to integrate with SCU in a compliant manner. Finally, police may be able to request SCU deployment, so these types of protocols will need BPD's input.

Considerations for Implementation:

- These meetings will need a clear owner to schedule meeting times, prioritize agenda topics, prepare data, identify non-urgent items for follow-up, and coordinate follow-up communication to relevant stakeholders.
- A data dashboard will support data review and rapid assessment processes.
- Some agencies may have strong bargaining presence or positional power, such as BPD. It is important that these meetings uphold equitable power and weight in making decisions.
- Throughout Phase 0 and Phase 1, this group may need to meet on a weekly basis.
- Additional stakeholders may need to be added to this group (permanently or ad hoc for specific topics), such as representatives from emergency departments, John George Psychiatric Hospital, or other city or county stakeholders.
- As the model progresses, this group may discuss opportunities to improve the mental health crisis system at a broader scale, beyond the scope of the SCU's crisis response, such as more inter-county and inter-city coordination on systemic issues related to housing.

Recommendation #20

Continue the existing SCU Steering Committee as an advisory body.

Presently, the SCU Steering Committee has representatives with ties to community groups and stakeholders. The SCU Steering Committee should continue as an advisory body to incorporate into decision-making spaces the perspectives that may otherwise be neglected in government spaces.

The SCU Steering Committee should continue to advocate for marginalized communities in the SCU model design and delivery by taking on an advisory role through Phase 0 and Phase 1 of implementation, at a minimum.

The current participants should remain, if they choose, including:

- Berkeley Community Safety Coalition
- Representatives from the Mental Health Commission
- HHCS staff
- BMH staff
- Berkeley Fire

Additional participants should be added, including:

- Relevant staff from the SCU or administrative CBO, such as the program manager or clinical supervisor
- Dispatch personnel, particularly someone in a leadership position who can both promote change and holds expertise relevant to implementation

Considerations for Implementation

- HHCS staff should maintain the role of coordinating the SCU Steering Committee, even if a contracted CBO leads the SCU, because HHCS will lead other aspects of oversight including contract management.
- Additional participants may be added to the SCU Steering Committee at different times. For example, Dispatch personnel should join earlier in Phase 0 of implementation, while SCU personnel will join once that team is fully staffed in Phase 1.

Recommendation #21

Solicit ongoing community input and feedback.

Governments often face barriers in hearing from community members that are the most structurally marginalized. However, engaging existing coalitions and networks designed to represent marginalized service users' perspectives can support more equitable engagement. Intentional outreach for these opportunities is essential because, historically, government institutions and other structures have prevented the full and meaningful engagement of Black people, Indigenous people, people of color, working class and low-income people, immigrants and undocumented people, people with disabilities, unhoused people, people who use drugs, people who are neurodivergent, LGBTQ+ people, and other structurally marginalized people. Prioritizing the engagement, participation, and recommendations of the community members most harmed by existing institutions, including those most harmed by police violence, will ensure that systems of inequity are not reproduced by a crisis response model.

Instead, community engagement can support the SCU to address structural inequities. In addition to the SCU Steering Committee, ongoing opportunities for the community to provide input to decisions as well as feedback about their experiences will be valuable to the SCU model throughout Phase I.

Suggested methods to receive community input and feedback:

- Focus groups
- Town halls or community forums
- On-site outreach
- Questionnaire
- Online feedback "box"

Modalities should ensure equitable access to participation:

- Online and in person
- Large groups, small groups, and one-on-one
- Anonymous
- Written and verbal
- Translation and interpretation

Encourage participation among:

- Service utilizers
- Community members with mental health and behavioral health needs who have not yet engaged with the SCU
- Service providers at CBOs, especially those receiving SCU transports and referrals

Address structural barriers to participation by:

- Using convenient, accessible, and geographically diverse locations
- Offering events at varying times to accommodate different schedules
- Providing financial compensation
- Providing childcare

Why is more community engagement needed if community input informed the model?

The robust community engagement that contributed significantly to the development of this model demonstrates the valuable perspective and knowledge held by community members about the types of services needed and how to make them more accessible and acceptable. Soliciting ongoing feedback once the SCU is launched will provide insight to how well the model is meeting community members' needs and where barriers to crisis care persist, servicing both quality improvement and evaluative needs.

Why should ongoing community engagement be conducted?

Community input and feedback should not be limited to the end of Phase 1 as part of a summative evaluation, but instead be ongoing to account for the changing landscape of SCU model implementation and the needs of both service utilizers and the broader community. It will also support ongoing iteration of the SCU throughout Phase 1, while planning for more complex modifications in Phase 2.

Considerations for Implementation

- The opportunities for community input and feedback should be held regularly, such as monthly, or quarterly.
- Frequent service utilizers, perhaps identified during the SCU's first three months of implementation, could be the primary recruitment base for feedback.
- Address barriers to equitable participation in feedback, such as by providing childcare, transportation vouchers, or financial compensation for time.
- Community feedback should be evaluated as essential data points that directly inform the rapid assessment processes (*refer to recommendation #22*).

Recommendation #22

Adopt a rapid monitoring, assessment, and learning process.

Many crisis response programs use data to monitor their ongoing progress and successes, modify and expand program pilots, and measure outcomes and impact to inform ongoing quality improvement efforts. Data collection, data system integration, centralized coordination across city leadership, the SCU Steering Committee, and ongoing input and feedback from community members and service utilizers (*recommendations #16, #17, #19, #20, and #21*) should all contribute to the monitoring that supports ongoing implementation, assessment, and iteration.

A rapid assessment process will likely need to:

- Develop a shared vision for the SCU model.
- Develop goals for the SCU model.
- Create assessment questions to guide the monitoring and learning process.*
- Define indicators or measures.
- Use a mixed-methods approach, including quantitative programmatic data and feedback from service utilizers, staff, and other stakeholders.

All model components will benefit from assessment, including:

- Availability of the team, accessibility of Dispatch and/or alternative phone line, response time
- Services provided, expertise of mobile team, training
- Equipment, vehicles, and supplies
- Transport, service linkages and handoffs, partnerships with CBOs
- Case management meetings and centralized leadership coordination
- Data collection, data integration, data integrity, and data transparency
- Public awareness campaign

Consider using the Results-Based Accountability (RBA) framework²⁸ to assess SCU performance aligned to:

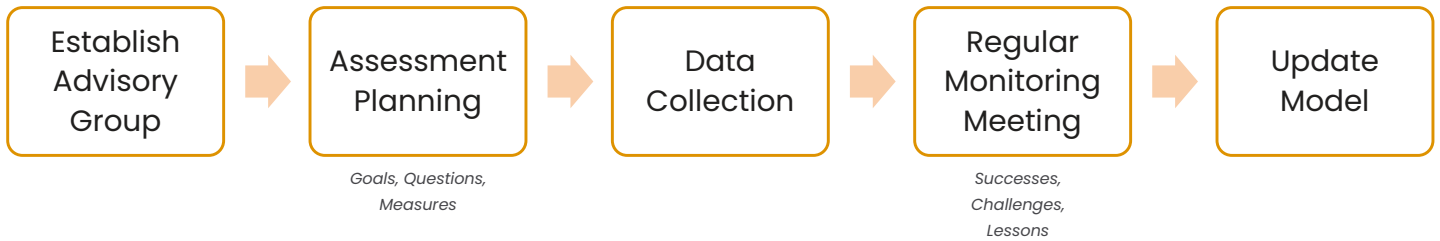
- Quantity of SCU services
- Quality of SCU services
- The impact or outcome of SCU services

*From the shared vision, create assessment questions to use throughout the duration of Phase 1, such as:

- Is there a need to scale and increase services?
- Are resources being used efficiently in the pilot? Will they be used efficiently with an increase in services?
- How effective is the current approach? Will it be effective with an increase in services?
- Is the current approach appropriately tailored to the Berkeley community? Is it appropriate for the Berkeley community?

²⁸ The City of Berkeley is using RBA for performance monitoring efforts and therefore may benefit from using RBA for the SCU model too.

Figure 4: Rapid Monitoring, Assessment, and Learning Process



A rapid monitoring, assessment, and learning process can happen in multiple venues. Some questions may be assessed on a quarterly basis, while others can happen on a monthly or weekly basis.

Considerations for Implementation:

- The rapid assessment process will need to establish clear roles for leading the meetings and decision-making, especially between the SCU program manager and central coordinating leadership.
- The rapid assessment process will benefit from clear timelines and processes for reviewing data, discussing changes and adaptations, and sharing findings across relevant stakeholders.
- The rapid assessment process may have multiple processes or venues based on specific data points or meeting frequencies. Clarify who should be attending, such as Dispatch, the alternative phone number (if applicable), the SCU mobile team, HHCS leadership, and others.

Recommendation #23

Conduct a formal annual evaluation.

Several components of the SCU – including the model’s services, the SCU mobile team’s training, the deployment determinations of Dispatch and/or the alternative phone line, and impacts and outcomes for service utilizers – offer potential for demonstrating the success of the model through formal evaluation. The evaluation should measure whether the SCU model is progressing towards the intended outcomes, as well as suggest opportunities for modifications and expansion. Design of a formal, annual evaluation is best done early in program planning.

Evaluation may define:

- A Theory of Change or Logic Model
- Short-term and medium-term goals

Evaluation could measure:

- Fiscal analysis, especially evaluation of progress towards the City’s aim of reducing BPD’s budget by 50%
- Systems change effectiveness, including evaluation of progress towards City’s goal of reducing the footprint of BPD to criminal and imminent threats
- Program efficacy/effectiveness, quality of service
- Service utilizer outcomes
- Ongoing barriers and challenges that Phase 2 can address
- Effectiveness of public awareness campaign, whether community members know about it
- Impacts aligned to a Racial Equity Impact Assessment²⁹

Evaluation should include:

- Qualitative and quantitative data
- Perspectives from SCU personnel
- Perspectives from service utilizers
- Perspectives from adjacent organizations, staff, and SCU Steering Committee

How is the proposed evaluation different than rapid monitoring?

Evaluation and rapid monitoring, or quality improvement, are complementary and should inform each other. Rapid monitoring is intended for more immediate quality improvement and occurs on more frequent cycles to guide iterative implementation of specific model elements. Evaluation asks broader questions from a greater degree of distance to guide adjustments to the model that will support ongoing effectiveness and sustainability. Staff are typically central to rapid monitoring to facilitate ongoing improvements, but an evaluation is generally conducted by an outside team that has some distance from day-to-day operations.

Considerations for Implementation

- If the City of Berkeley intends to contract out the evaluation, then the RFP and contracting process should be initiated early in Phase 0 to allow for adequate planning.

²⁹ To learn more about Racial Equity Impact Assessments, visit:

https://www.raceforward.org/sites/default/files/RacialJusticeImpactAssessment_v5.pdf

Promoting Public Awareness

Promoting public awareness of the SCU and its aims will be essential to the SCU's success. Public education efforts should be advanced through a variety of methods, including a far-reaching campaign and targeted outreach. These efforts should emphasize that the SCU is a non-police crisis response service and promote how to access the SCU (i.e., which phone number to call). Overall, promoting public awareness is essential to building trust and addressing fears or reluctance that might inhibit people to call for support during a mental health or substance use crisis.

Promoting awareness and establishing relationships with other providers in the response network is also important, especially staff at emergency facilities who may interact with the SCU during the transport of a person who has experienced a mental health or substance use crisis. This type of relationship-building and education can streamline processes to promote positive outcomes for people in crisis.

The following recommendations should be adapted and implemented to advance public education and awareness about the SCU model:



Key Recommendations

- 24. Launch a public awareness campaign to promote community awareness and education about the SCU.**
- 25. The SCU mobile team should conduct outreach and build relationships with potential service utilizers.**

Recommendation #24

Launch a public awareness campaign to promote community awareness and education about the SCU.

For the community to be able to call for an SCU response, they must know that it exists. Stakeholder input throughout this project has indicated that community members must trust that the SCU provides a crisis response without the use of law enforcement for the SCU to be a viable and sought-after crisis response option. For these reasons, promoting public awareness of the SCU and its aims will be essential to the SCU's success.

Aims of the campaign:

- Emphasize the SCU as a non-police mental health and crisis response option
- Distinguish the roles and responses of SCU, MCT, and police
- Promote how to access the SCU (i.e., through 911, an alternative number, or 988)
- Describe when SCU will not respond (e.g., social monitoring, weapons) and when it will (e.g., types of services).
- Emphasize the community engagement that informed the model
- Share the availability of Berkeley Open Data
- Promote opportunities for ongoing stakeholder input and feedback

Why is it important to launch a public awareness campaign?

To inform the community of this new resource and to distinguish the SCU as a non-police response. Stakeholder input throughout this project has indicated that community members must trust that the SCU provides a crisis response without the use of law enforcement for the SCU to be a viable and sought-after crisis response option.

How do other cities promote their crisis response model?

Other cities provided examples of promoting awareness outside of mass media. For example, Portland's Street Response team contracts with street ambassadors with lived experience (via a separate contract with a local CBO) who perform direct outreach to communities and work to explain the team's services and ultimately increase trust with potential service utilizers.

Considerations for Implementation

- The methods of the campaign may need to be tailored to the targeted stakeholder groups and may include:
 - Mass media, billboards, advertisements on public transportation, radio announcements, local newspaper announcements, updates to the city's social media and websites, updates to service providers' and CBOs' social media.
 - Business cards with contact information for potential service utilizers.
 - "Meet-and-greets" that the SCU mobile team hosts with service providers at CBOs and emergency facilities.
- The public awareness campaign may have multiple phases, such as first promoting awareness of the SCU and how to access it, and then promoting opportunities for stakeholder feedback.

Recommendation #25

The SCU mobile team should conduct outreach and build relationships with potential service utilizers.

In addition to a public awareness campaign that promotes the SCU as a community resource, shares how to access the SCU, and emphasizes the non-police design, many service utilizers may still be reluctant to engage with a new entity. As a result, to most equitably meet the needs of potential service utilizers and especially substance users, the SCU may need to conduct in-person outreach. This outreach should be targeted to specific groups who are most likely to call the SCU with the aim of establishing trusting relationships and sharing more about their harm reduction approaches.

Targeted sites for relationship building with potential service utilizers:

- Encampments
- Safe parking RV lots
- Drop-in centers
- Downtown Berkeley
- People's Park
- Emergency department waiting rooms

Why might service utilizers be reluctant to engage in services with the SCU?

Many community members have personally experienced the criminalization of substance use and mental health emergencies, whether through their own experiences or having witnessed the experiences of family, friends, or community members. Such carceral approaches include involuntary psychiatrist holds and unnecessary transport to hospitals. In particular, unsheltered residents and substance users may be more distrustful of a new team and be less likely to call during a crisis. In interviews, unsheltered residents shared that not all of their substance use management are being adequately addressed by current crisis responders and they experience high rates of transport to emergency departments. Many also shared that they fear police retaliation for their substance use. In general, there are several reasons why community members may be hesitant about engaging crisis responders, which could be addressed by individual, relational outreach.

Why would relationship building improve utilization of the SCU?

Despite many service utilizers reporting overall distrust of first responders, they also shared that EMTs have developed trusting relationships and strong rapport for handling overdoses. Because of this relationship, service utilizers are more willing to call for an EMT to respond to an overdose. Similarly, having strong relationships built on trust will be key to the success of the SCU.

Considerations for Implementation

- If there are periods of low call volume, the SCU may use those times as opportunities to build relationships in communities of potential service utilizers and proactively provide services.
- This outreach may also be implemented based on data and findings or in preparation for Phase 2 expansion and changes.



System-Level Recommendations

The development of a mental health crisis response model as a component of the City of Berkeley's emergency services should be understood as a systems-change initiative of great magnitude. There are several critical factors that must be attended to in order to realize the full implementation of the SCU and to progress towards its intended outcomes.

Addressing the Needs of Dispatch

There is an urgent need for a 24/7 mental health and substance use crisis response model that does not rely on law enforcement to provide specialized mental health care. To provide this service, crisis responders must be connected to those in crisis. Thus, the role of Dispatch is essential.

Dispatch needs a full assessment and planning process to address the complexity of the 911 response system. This assessment and planning, though urgent, cannot be done hastily. The SCU will benefit if Dispatch is able to:

- Address the understaffing, under-resourcing, and identified training needs of call takers.
- Plan for a sustainable integration.
- Plan for a variety of scenarios to ensure crisis responder and community safety.
- Participate in the SCU phased-implementation approach and ongoing collaboration with SCU leadership.
- Establish trusting relationships and rapport with the SCU so that call takers are confident in deploying the SCU for scenarios they previously would have deployed MCT or Police.

A Sufficient Investment of Resources

A lack of sufficient resources is not only a challenge for Dispatch, but is a common challenge expressed by service providers in Berkeley and in other locales. Within the City of Berkeley, both TOT and MCT have challenges meeting the needs of community members because their hours of operation are limited, and they do not have enough staffing and resources to provide 24/7 services. This results in the perception of slow or delayed response times and can decrease the likelihood that callers continue to seek that service. Efforts in other cities, such as the Mental Health First and MACRO initiatives in Oakland and the Street Crisis Response Team in San Francisco, have also had to restrict their hours of availability and services due to a lack of sufficient funding.

Mental health crisis response could be essential in promoting health equity in the City of Berkeley. However, if it is not sufficiently resourced to provide 24/7 crisis response without long wait times, it will not achieve trust, and will become utilized less often and will therefore not achieve the desired systems-change results. This resourcing includes not only the SCU mobile crisis team, but the entirety of the model and related infrastructure, from the call center to program manager. Sufficient resourcing also includes dedicated time by city leadership to support coordination, collaboration, and problem-solving.

The Role of Trust

Trust was one of the most discussed factors across stakeholder engagement and will be a critical ingredient to the success of this system-wide change initiative. The public awareness campaign and all Phase 0 planning processes must address the concerns and doubts that could undermine trust across community stakeholders, the service provider network, and city leadership.

Trust will shape whether community members utilize the SCU. Community members must trust that the SCU:

- Is a non-police crisis response.
- Is accessible and available 24/7.
- Is responsive to emerging needs and ongoing community input and feedback.
- Provides competent harm reduction and non-carceral approaches to mental health and substance use crisis intervention.

Trusting relationships affect the quality of referrals, warm handoffs, and service linkages across the service provider network. Service providers emphasized that trust plays a role in:

- Whether they will refer a client to another provider.
- The amount and type of information they disclose about a shared client.
- Whether systems will choose to share and integrate data.

- The quality of collaboration and communication during warm handoffs, care coordination, or at client discharge.

Trusting relationships are essential to centralized coordination and collaboration among city leadership.

The SCU model will require a variety of agencies and departments to work together in new ways and toward new ends. Other cities implementing alternative crisis models shared that trust was enhanced across leadership by:

- Aligning on shared values and commitment to improving health outcomes for people in crisis.
- Recognizing and adapting to the varied cultures of city departments, agencies, and CBOs.
- Ensuring decision-making power is allocated in alignment with the aims of the crisis model, such as ensuring that law enforcement does not have an unaligned or inequitable of voice or power in making decisions.
- Reviewing data to promote accountability and celebrate successful outcomes.
- Planning for sufficient time to prepare and participate in collaboration.



Conclusion: Next Steps & Future Considerations

This report presents recommendations for a model that is responsive to community needs. Still, there were numerous questions, issues, needs, and considerations that surfaced that were beyond the scope of the project. Decisions around those factors could significantly shape the types of services the SCU provides as well as how it is coordinated and administered across agencies. Such considerations are pertinent to the future of the SCU, crisis response, and the mental health service system in Berkeley, and therefore should continue to be discussed by city leadership and those implementing the SCU.

Long-Term Sustainable Funding

The SCU model requires long-term sustainable funding. A sound fiscal strategy must recognize the robustness of costs associated with the SCU and plan for institutionalizing and sustaining those costs. There are a number of potential funding sources for the SCU model, including Medi-Cal reimbursement, Medi-Cal opportunities through CalAIM, and DHCS grants. However, these funding streams are unlikely to sustain a crisis response model on their own. Other funding and resources may need to be braided into the SCU to effectively implement this model.

While braiding allows for maximizing funding resources, it also requires clear and separate tracking of services based on funding sources and requirements. With multiple funding streams, the target populations, reporting requirements, eligibility criteria, and performance measures can vary greatly. A braided funding model, therefore, requires knowledgeable administrators as well as dedicated time to manage. This can be especially resource-intensive for a CBO implementing the SCU. The SCU model will need to be very clear about the funding requirements and develop an appropriate system for ongoing tracking and reporting.

Different financing mechanisms provide varying levels of sustainability and predictability, considerations which should inform the development of a fiscal strategy for the SCU model. Unfortunately, these recommendations may not be fully realized if there is not a long-term sustainable fiscal strategy. Modifications to the SCU model could negatively impact the quality of service delivery or lessen the population impact.

Across the country, some cities have used a sales tax to fund their alternative crisis response models while others have redirected funds away from police departments. Rather than identifying new or short-term grant awards, a primary consideration for the City of Berkeley should be to look to dollars that can be reinvested from the Berkeley Police Department, in alignment with the Reimagining Public Safety initiative, to develop a sustainable and comprehensive SCU model.

Continue Planning for 24/7 Live Phone Access to the SCU

Significant planning will be required to fully realize the 24/7 live phone access to the SCU (*refer to recommendations #8, 9, and 10*). Reaching out to existing call centers—such as Alameda County CSS—or to other cities implementing similar crisis models could support the development of the phone access to the SCU. Additional planning is needed to determine, at a minimum:

- Equipment and technology needs
- Staffing requirements for the estimated call volume
- Recruitment, hiring, and training
- Workflow and protocol development
- Cost and funding availability

The Location of 911 Dispatch Within the Berkeley Police Department

The 911 Communications Center is currently operated by the Berkeley Police Department. This structure affects how Dispatch is funded and who makes decisions. As the role of Dispatch is broadened to coordinate a greater variety of responses to emergencies, there may be advantages to moving Dispatch outside of the Berkeley Police Department, such as improved communication and coordination across relevant agencies. For instance, it has been expressed that Dispatch call takers are currently more comfortable deploying the police than other crisis responders given their long tenure and rapport with police officers, so call takers' ability to establish rapport with the SCU team is needed for them to be comfortable deploying the SCU. Structural changes like this may also align to several of the Reimagining Public Safety initiative's aims. This consideration can be explored as part of the assessment and planning processes of the phased implementation approach.

Preventing Social Monitoring: Clarifying the SCU's Guiding Principles

The SCU model is designed to ensure that mental health specialists respond to people experiencing mental health crises. However, there is significant and justified concern that the SCU could be co-opted to support the social monitoring and enforcement of unsheltered residents. Clarifying the SCU's guiding principles could support in reifying the intentions of the model to ensure that all practices are aligned with those principles.

There are several elements within the model design where data, ongoing conversation, and service utilizer feedback can ensure that the SCU lives out its intention. One such example is whether and how the SCU would be deployed with the police and/or how the SCU is distinguished from MCT. For example, if a caller reports an unsheltered neighbor is residing on their sidewalk or driveway, this may not qualify for an SCU response. However, if that call is deployed to the police, then the response effectively criminalizes unsheltered Berkeley residents. Such scenarios should be explored as the SCU model is implemented, refined, and expanded.

Address the Full Spectrum of Mental Health and Substance Use Crisis Needs

Mental health and substance use crises vary in severity along a spectrum. A crisis can present as someone in immediate danger to themselves or others, someone who needs regular support to address their basic needs, or someone who is generally able to manage their needs but needs occasional support to prevent a future crisis.

Throughout this project, many stakeholders expressed that in order to effectively address the challenges of the current system, solutions and changes must engage with the nuances and spectrum of mental health crises:

- Some forms of crisis are readily visible while others are not.
- Some forms of neurodivergence are reported as a mental illness or crisis, but they are not.
- Some forms of crisis occur because the person is unable to access services to meet their needs.
- Some forms of emergency service utilization stem from ongoing unmet basic needs such as food and affordable housing.

Stakeholder participants urged that the concept and definition of a mental health crisis and crisis services be expanded to not only support crisis intervention but also prevention, diversion, and follow-up. The following two considerations should be further explored because they may support the SCU model. Both considerations represent a form of

reimagined public safety and may be realized with additional resources, such as funds divested from Berkeley Police Department:

Expand the SCU Model to Include a Follow-up Care and Coordination Team

There will likely be a need for a team to receive referrals from the SCU mobile team and connect with service utilizers for follow-up care. Follow-up care could include referrals, system navigation, and case management support. This team may also need to conduct outreach to make contact with service utilizers and address barriers to care as needed. For example, some service utilizers may be unable to follow through with a referral if they do not have reliable access to transportation or experience challenges maintaining scheduled appointments. This team could potentially be funded by the 988 funding allocated to dedicated follow-up teams deployed from 988 crisis call centers.³⁰

There are many lessons that should be learned from the existing Transitional Outreach Team (TOT), such as challenges they face with adequate staffing and funding or constraints and limitations with who they can serve. Any initiatives around follow-up care should augment rather than duplicate the TOT.

Increase the Number of Sites for Non-emergency Care for Berkeley Residents

Throughout this project, stakeholder participants emphasized the need for sites for non-emergency care, such as drop-in centers, day centers, sobering sites, and respite centers. These services are important for harm reduction and crisis prevention, and as such would support the outcomes of the SCU model. There may be opportunities in Phase 0 or Phase 1 to reserve beds at a shelter or similar care facility as a temporary measure, ensuring persons in crisis have access to these beds after engaging with the SCU. However, increasing the overall number of sites for non-emergency care would require a longer-term investment

³⁰ Santos, M (2021). New suicide prevention hotline aims to divert callers from police. *Crosscut*. <https://crosscut.com/politics/2021/07/new-suicide-prevention-hotline-aims-divert-callers-police>

 **Appendix**

Appendix A: Launch Timeline & Phased Implementation Approach

Phase 0 – Launch Timeline

Nov 2021 – May 2022

System-Level: Planning, Launch, Implementation		HHCS	Steering Committee	Dispatch	Contracted CBO
	Engage community on feedback to SCU Model recommendations	X	X		
	Engage community on SCU RFP requirements	X			
Dec	Dispatch leadership communicates and champions (internally) the SCU change-initiative			X	
	Plan for Dispatch assessment (e.g., determine if RFP needed)	X		X	
Jan	Make decisions about 24/7, live phone line to SCU (option A, B, C)	X	X	X	
Feb	Issue RFP for SCU	X			
	<i>Issue RFP for SCU alternative phone line (TBD)</i>	X			
	RFP Deadline				
Mar	Review all RFPs	X	X		
	Select awardee for SCU	X	X		
	Begin planning for site visits	X		X	X
Apr	Contract process for SCU	X			
May	Hire SCU personnel (mobile team, supportive and administrative roles, Dispatch/phone staff)				X
	Hire mental health clinician to support Dispatch assessment & planning	X		X	
	Build relationships across all new personnel	X	X	X	X
June – Aug	<i>Plan & Implement Recommendations: Refer to Phase 0 Implementation Approach</i>				

Phased Implementation Approach

	Phase 0		Phase 1		Phase 2	Future, Beyond Phase 2
	Nov 2021 - Aug 2022		Implementation Sept 2022 - Aug 2023	Planning for Phase 2 Sept 2023 - Feb 2024	Feb 2024+	
SCU Mobile Team Recommendations						
1 The SCU should respond to mental health crises and substance use emergencies without a police co-response	Clarify specific factors and codes for all suggested SCU call types	Develop triage criteria and workflows across all SCU call-types and services.	<i>SCU mobile team goes live, providing services</i>		Consider additional types of calls for service that they can respond to where armed police officers are not needed or aligned to a reimagined definition of public safety, such as: - Completing documentation while providing crisis services where a traditional "police report" is needed, such as in cases of sexual assault, sexual harassment, and rape - Petty theft - Nonviolent conflicts, such as neighbor disputes or youth behavioral issues - Minor assaults, with no weapons present - Proactive support at events that may trigger a crisis (e.g., during an encampment sweep)	Integrate other SCU model elements (e.g., follow-up care team [Report Section V])
2 The SCU should operate 24/7						
3 Staff a 3-person SCU mobile team to respond to mental health and substance use emergencies						
4 Equip the SCU Mobile Team with vans	Procure vans					
5 The SCU Mobile Team should provide transport to a variety of locations	Introduce SCU to emergency facility staff at all transport destinations					
6 Equip the SCU mobile team with supplies to meet the array of clients' needs	Procure supplies					
7 Clearly distinguish the SCU from MCT	Develop clear roles and parameters for SCU and MCT teams by collaborating across Dispatch, the SCU Steering Committee, the current MCT team, and other relevant leadership <i>Note: These decisions are essential for developing triage criteria and workflows and for communicating to the general public in a public awareness campaign.</i>		Evaluate the role of MCT and the efficacy of having both teams. Make recommendations for Phase 2, such as changes to each team's scope or processes.	Communicate to general public and relevant service providers about changes relevant to the distinguished roles of MCT and SCU		

Phased Implementation Approach

Accessing the SCU Crisis Response

	Phase 0 Nov 2021 - Aug 2022	Phase 1		Phase 2 Feb 2024+	Future, Beyond Phase 2
		Implementation Sept 2022 - Aug 2023	Planning for Phase 2 Sept 2023 - Feb 2024		
8 Participate in the Dispatch assessment and planning process to prepare for future integration	<p>Decide the most effective method for 24/7, live phone access to the SCU (Option A, B, C)</p> <p>Dispatch makes investments in staffing and technologies, as needed</p> <p>SCU model discusses with Dispatch the necessary data (variables, definitions, timelines, privacy, etc.) to be collected during each Phase of implementation</p> <p>Dispatch begins planning for changes to CAD or other data systems</p>	<p>Dispatch makes investments in staffing and technologies, as needed</p> <p><i>Dispatch implements Phase 1 protocols, as determined by Phase 0 planning (Option A, B, C)</i></p>	<p>Implement new triage criteria and workflows</p>		
9 Ensure the community has a 24/7 live phone line to access the SCU	<p>Implement and adapt 24/7, live phone line access to SCU (Option A, B, C)</p> <p>Adapt protocols for other Berkeley crisis responders (Fire, EMS/Falck, MCT, Police) to request SCU support through the alternative phone number</p> <p>Dispatch and HHCS/SCU identify opportunities for Phase 1 implementation (based on Option A, B, C), such as: - Phase 1 call types for SCU deployment OR preliminary calls that Dispatch will transfer to the alternative phone line in early Phase 1 (e.g., welfare checks) - Dispatch supports alternative phone line to develop aligned triage criteria and workflows to support future integration</p>	<p><i>If Option B or C: Plan for how calls will be triaged and prioritized from the two separate sources (alternative number and 911) in deploying the SCU mobile teams in Phase 2</i></p>	<p>Determine if the SCU should respond to crises by sight ("proactive" deployment and intervention)</p> <p>Determine if the SCU should self-deploy by listening to the police radio (based on other models: Eugene's CAHOOTS, Denver's STAR, and San Francisco's Street Crisis Response Team)</p>	<p><i>If Option B or C: Integrate SCU into 911</i></p>	
10 Plan for embedding a mental health or behavioral health clinician(s) into Dispatch to support triage and SCU deployment	<p>Dispatch hires one clinician to support the Dispatch assessment process and to support triage criteria and workflow development for calls routed to SCU</p> <p>Clinician attends trainings and site observations with Dispatch and SCU</p> <p>Clinician(s) supports planning for triage criteria, call-types, etc. <i>(as relevant: Option A, B, C may affect timing of this)</i></p> <p><i>If Option A:</i> Dispatch prepares for fully embedding clinician(s), including clarifying their roles and supervision structure</p> <p><i>If Option B or C: implement this in Phase 2</i></p>	<p>Clinician(s) support Dispatch based on the assessment findings and next steps, such as: - supervises call-takers triaging mental health crisis calls - provides trainings to call-takers based on 2019 Auditor's Report and ongoing assessment</p>			<p>Assess whether clinician(s) can provide services beyond SCU deployment, including basic telemedicine and psychiatric screenings or psychiatric crisis assessment</p>

Phased Implementation Approach

	Phase 0 Nov 2021 - Aug 2022	Phase 1		Phase 2 Feb 2024+	Future, Beyond Phase 2
		Implementation Sept 2022 - Aug 2023	Planning for Phase 2 Sept 2023 - Feb 2024		
Implement a Comprehensive, 24/7 Mental Health Crisis Response Model					
Fully staff a comprehensive model to ensure the success of the SCU mobile team, including supervisory and administrative support roles for SCU					
11					
12 Operate one SCU mobile team per shift for three 10-hour shifts					
13 SCU staff and Dispatch personnel should travel to alternative crisis programs for in-person observation and training	<p>incorporate into training itineraries to allow for these periods of travel and training. <i>Note: City of Berkeley and/or the contracted CBO may need to reach out to the other cities and programs to solidify travel and training plans prior to the hiring of any individual personnel.</i></p> <p>Allot time after the site visit(s) for debriefing, reflecting on lessons learned, and discussing how to integrate key takeaways into the SCU model.</p> <p>Include in debrief and planning conversations personnel that traveled for site observations, HHCS staff, additional Dispatch leadership, and Steering Committee members as needed.</p>				
14 Prepare the SCU mobile team with training, informed by community needs		Plan the training schedule based on community needs, ongoing assessment and planning, and prerequisite skills and experiences of hired personnel			

Phased Implementation Approach

	Phase 0 Nov 2021 - Aug 2022	Phase 1		Phase 2 Feb 2024+	Future, Beyond Phase 2
		Implementation Sept 2022 - Aug 2023	Planning for Phase 2 Sept 2023 - Feb 2024		
Administration and Evaluation					
15 Contract the SCU Model to a CBO			Extend contract and provide funding for Phase 2, as applicable		Determine if the SCU can be administered through the City of Berkeley, elevating it to the status of Police and Fire as an essential citywide emergency service and ensuring long-term sustainability
16 Integrate SCU into existing data systems	Assess feasibility of data integration across various systems and sources: assess system capacity needs to realize integration, seek consultation on legal issues surrounding patient protections and sharing health data across providers Evaluate implications for Recommendation 18 (care coordination case management meetings) based on feasibility and adaptations from this recommendation (Recommendation 16) Maintain and strengthen data privacy before SCU is integrated with Dispatch (given that Dispatch is situated within Berkeley Police and that many health conditions can be criminalized and prosecuted)		Continue: Assess feasibility of data integration across various systems and sources: assess system capacity needs to realize integration, seek consultation on legal issues surrounding patient protections and sharing health data across providers Coordinate with Alameda County Care Connect to plan for bi-directional data feeds with the Community Health Record (CHR) Plan for access to EHRs and other relevant data systems		
17 Collect and publish mental health crisis response data publicly on Berkeley's Open Data Portal	Coordinate with City of Berkeley to add new data to Portal Plan for how regularly data will be refreshed/updated on Portal	Publish data regularly			
18 Implement care coordination case management meetings for crisis service providers	Involve all relevant agencies in planning to define, align, and adjust data definitions, variables, and collection practices. (e.g., 911-Dispatch, MCT, BPD, BFD, Falck, HHCS, SCU, etc.) Engage potential participants to plan for Phase 1 implementation of care coordination case management meetings (identify and confirm participants, confirm meeting intervals, set meeting times, etc.)	Convene and implement care coordination meetings			
19 Implement centralized coordination and leadership across city agencies to support the success of mental health crisis response	Engage potential participants to plan for Phase 1 implementation of centralized coordination and leadership meetings (identify and confirm participants, confirm meeting intervals, set meeting times, etc.)	Convene and implement centralized coordination and leadership meetings			

Phased Implementation Approach

	Phase 0 Nov 2021 - Aug 2022	Phase 1		Phase 2 Feb 2024+	Future, Beyond Phase 2
		Implementation Sept 2022 - Aug 2023	Planning for Phase 2 Sept 2023 - Feb 2024		
<i>Administration and Evaluation (continued)</i>					
20 Continue the existing SCU Steering Committee as an advisory body	Identify additional Steering Committee members Invite and engage new members Adapt processes, group norms and agreements, and/or meeting schedules, as relevant Decide on methods and intervals for collecting community input and feedback during Phase 1	Hold regular meetings of SCU Steering Committee; incorporate decision-making processes across other Recommendations			
21 Solicit ongoing community input and feedback	Develop a plan to communicate the opportunities for community and feedback; incorporate into public awareness campaign	Solicit ongoing community input and feedback; incorporate decision-making processes across other Recommendations			
22 Adopt a rapid monitoring, assessment, and learning process	Plan for the evaluation and rapid assessment processes to use overlapping data and be mutually-supportive and streamlined Plan for all data definitions and collection processes to be aligned across rapid assessment and evaluation aims.	Ensure that the evaluation findings are available for the latter six-months of Phase 1 to support planning for Phase 2	Review evaluation findings Plan for Phase 2		
24 Launch a public awareness campaign to promote community awareness and education about the SCU	Plan for public awareness campaign, including targeted modalities, targeted audiences, and/or phased timing Launch public awareness campaign	Continue public awareness campaign, as necessary			
25 The SCU mobile team should conduct outreach and build relationships with potential service utilizers	Conduct targeted outreach and establish trusting relationships between SCU and community members, promoting utilization of SCU	Continue targeted outreach and build relationships as necessary			

Appendix B: Sample Shift Structure & Redundancy Needs

Model Component	Phase	Staffing Needs	Shift Type	M	T	W	Th	F	Sa	Su	No. of shifts (week 1)	No. of shifts (week 2)	No. of staff per unit	No. of units	No. of FTE needed	Notes	
SCU	Phase 1	Shift 1	10-hour shift	mobile unit A	mobile unit A	mobile unit A	mobile unit B	mobile unit E	mobile unit E	mobile unit E	mobile unit a	3	4	3	6	18	Assumes one mobile unit per shift
		Shift 2	10-hour shift	mobile unit B	mobile unit B	mobile unit B	mobile unit C	mobile unit F	mobile unit F	mobile unit F	mobile unit b	4	3	3			Assumes a three-person mobile unit
		Shift 3	10-hour shift	mobile unit C	mobile unit C	mobile unit C	mobile unit D	mobile unit D	mobile unit D	mobile unit D	mobile unit c	4	3	3			Six clinicians, six peers, six therapists
											mobile unit d	4	3	3			
											mobile unit e	3	4	3			
											mobile unit f	3	4	3			
SCU	Phase 1	Shift 1	10-hour shift	clinical supervisor A	clinical supervisor A	clinical supervisor A	clinical supervisor B	clinical supervisor E	clinical supervisor E	clinical supervisor E	clinical supervisor A	3	4	1	6	6	
		Shift 2	10-hour shift	clinical supervisor B	clinical supervisor B	clinical supervisor B	clinical supervisor C	clinical supervisor F	clinical supervisor F	clinical supervisor F	clinical supervisor B	4	3	1			
		Shift 3	10-hour shift	clinical supervisor C	clinical supervisor C	clinical supervisor C	clinical supervisor D	clinical supervisor D	clinical supervisor D	clinical supervisor D	clinical supervisor C	4	3	1			
											clinical supervisor D	4	3	1			
											clinical supervisor E	3	4	1			
											clinical supervisor F	3	4	1			

SCU	Phase 1	shift business	8-hour shift	program manager	program manager	program manager	program manager	program manager	-	-	program manager	5	n/a	1	1	1	Assumes mobile unit peers are supervised by clinical supervisor during shift; this specialist is for other professional supports for Peer Specialists
		shift business	8-hour shift	peer supervisor	peer supervisor	peer supervisor	peer supervisor	peer supervisor	-	-	peer supervisor	5	n/a	1	1	1	
Alternative Phone Line	Phase 1	Shift 1	12-hour shift	call team A	call team A	call team A	call team B	call team D	call team D	call team D	call team a	3	4	2	4	8	Assumes two call receptionists per shift
		Shift 2	12-hour shift	call team B	call team B	call team B	call team C	call team C	call team C	call team C	call team b	4	3	2			
											call team c	4	3	2			
											call team d	3	3	2			
Dispatch	Phase 0	shift business	8-hour shift	BH/MH triage clinician	BH/MH triage clinician	BH/MH triage clinician	BH/MH triage clinician	BH/MH triage clinician	-	-	BH/MH triage clinician	5	n/a	1	1	1	
	Phase 1	Shift 1	12-hour shift	BH/MH triage clinician A	BH/MH triage clinician A	BH/MH triage clinician A	BH/MH triage clinician A	BH/MH triage clinician C	BH/MH triage clinician C	BH/MH triage clinician C	BH/MH triage clinician A	4	3	1	4		Assumes one clinician per dispatch shift

	Shift 2	12-hour shift	BH/MH triage clinic n B	BH/MH triage clinic n B	BH/MH triage clinic n B	BH/MH triage clinic n B	BH/MH triage clinic n D	BH/MH triage clinic n D	BH/MH triage clinic n D	BH/MH triage clinic n B	4	3	1				
										BH/MH triage clinic n C	3	4	1				
										BH/MH triage clinic n D	3	4	1				

Appendix C: Budget

Salaries, wages, benefits	FTE	Salary	Cost/Year	Notes	Source
BH Licensed Clinician / Psych-NP	6	\$ 178,000.00	\$ 1,068,000.00	JobsEQ "Nurse Practitioner"	JobsEQ Mean Annual Wages for San Francisco-Oakland-Bay Area
Mental Health Peer Specialist	6	\$ 77,500.00	\$ 465,000.00	JobsEQ "Health Education Specialists"	JobsEQ Mean Annual Wages for San Francisco-Oakland-Bay Area
BH Licensed Therapist / LCSW	6	\$ 85,800.00	\$ 514,800.00	JobsEQ "Mental Health and Substance Abuse Social Worker"	JobsEQ Mean Annual Wages for San Francisco-Oakland-Bay Area
Clinical Supervisor	6	\$ 178,000.00	\$ 1,068,000.00	JobsEQ "Nurse Practitioner"; unable to find accurate salaries for a supervisory position	
Peer Specialist Supervisor	1	\$ 85,800.00	\$ 85,800.00	unable to find accurate salary range; using LCSW range	
Program Manager	1	\$ 105,000.00	\$ 105,000.00		
Phase 0 Dispatch MH/BH Clinician	1	\$ 105,782.00	\$ 105,782.00	"SUPERV PUBLIC SFTY DISP"	https://www.cityofberkeley.info/uploadedFiles/Human_Resources/Level_3_-_General/ClassificationAndSalaryListingByTitle.pdf
Subtotal			\$ 3,412,382.00	Total FTE Salary	
Subtotal			\$ 853,095.50	Fringe Benefits, 25%	
Total Salary + Benefits			\$ 4,265,477.50		
Ongoing materials and services			Cost/Year	Notes	
Evaluation			\$ 185,000.00	Used cost of RDA feasibility study as estimate	
Vehicle maintenance	4	\$ 20,000.00	\$ 80,000.00	Estimate provided by Berkeley Fire	
Advertisement & PR	12	\$ 2,000.00	\$ 24,000.00	Includes community education workshops, advertising, outreach and engagement	
Small equipment & supplies	1200	\$ 20.00	\$ 24,000.00	Wound care, hygiene, harm reduction, meals, transportation vouchers,	

				clothing, blankets, etc. Based on SF SCRT data, assumes 100 contacts with clients per month, \$20 per client contact; SF SCRT budgeted 10k and said they needed more	
Office supplies and postage	12	\$ 200.00	\$ 2,400.00		
Communications	12	\$ 600.00	\$ 7,200.00		
Printing and copying	12	\$ 100.00	\$ 1,200.00		
Travel and transportation	12	\$ 100.00	\$ 1,200.00	Local travel for care coordination & meetings	
Training and meetings	12	\$ 1,000.00	\$ 12,000.00	Equity, team dynamics, and other ongoing training	
Licenses/fees/subscriptions	12	\$ 50.00	\$ 600.00		
Insurance			\$ -		
Contract services			\$ -		
Legal services			\$ -		
Audit and consulting			\$ -		
Utilities			\$ -		
Facilities			\$ -		
Subtotal			\$ 337,600.00	ongoing materials and services	
Subtotal: Personnel and non-personnel recurring subtotal			\$ 4,603,077.50		
Administrative overhead			\$ 276,184.65	6% for all recurring costs	
Total recurring cost			\$ 4,879,262.15		
One time cost			Cost/Year	Notes	
Vehicle	5	\$ 60,000.00	\$ 300,000.00	Assume 60k per van with wheelchair capacity	
Recruitment	27	\$ 4,000.00	\$ 108,000.00	Median national average of recruiting new employee	

Training (SCU staff and Dispatch)			\$ 75,000.00	Assume training for all Dispatch, BPD, Fire, MCT, & SCU staff; both program onboarding and emerging best practices related to crisis response
Technology (computers, phones, etc.)			\$ 25,000.00	Laptop/tablets, cell phones for all staff, MiFi, portable chargers
Rapid assessment			\$ 40,000.00	Evaluation planning meetings, data request development, community-input meetings
Community outreach and education (including materials development)			\$ 25,000.00	Curriculum development, materials, advertisement, outreach (SF SCRT hired consultant to do this work)
Subtotal			\$ 573,000.00	
Administrative overhead			\$ 34,380.00	6% for all one-time costs
Total one-time cost			\$ 607,380.00	
Recommendations			Cost/Year	Notes
Signing bonus	7	\$ 5,000.00	\$ 35,000.00	Signing bonus recommended for licensed clinical staff
Technical Assistance			\$ 15,000.00	Consultation from existing similar alternative models
Total additional recommendations			\$ 50,000.00	
Total cost with recommendations			\$ 5,536,642.15	Estimated cost for program and recommendations

Appendix D: Anticipated Incident Volume

		Potential Daily Incidents for SCU (Average)	Potential Incidents per shift for SCU (Average)
Average daily BMH-Crisis incidents (FY15-19) <i>MCT, TOT, CAT</i>	10.73 incidents	19.82	6.61
Average daily BPD MH Incidents (FY14-20)	28.91 incidents		
Average time on task for transports BFD & Falck	101.48 minutes		

	Denver ³¹ 6 months, 1 team, not citywide, not 24/7	Portland ³² 6 months, 1 team, not citywide, not 24/7	CAHOOTS ³³ Annual, 1-2 teams, 24/7
Average incidents per shift	5.75	3	(Per hour) 1.81
% incidents that resulted in a transport	14.30%	6.27%	23.38%
% transports that were to the hospital	16.82%	58.33%	
Average minutes on task	24.65	19.33	
Reduction of BPD calls	2.75%	4.60%	5-8%

³¹ STAR Program Evaluation (2021, January 08). https://wp-denverite.s3.amazonaws.com/wp-content/uploads/sites/4/2021/02/STAR_Pilot_6_Month_Evaluation_FINAL-REPORT.pdf

³² City of Portland

Bureau of Fire and Rescue (2021, October). Portland street response: Six-month evaluation. <https://www.portland.gov/sites/default/files/2021/psu-portland-street-response-six-month-evaluation-final.pdf>

³³ Eugene Police Department Crim Analysis Unit (2020, August 21). CAHOOTS program analysis. <https://www.eugene-or.gov/DocumentCenter/View/56717/CAHOOTS-Program-Analysis>