Health, Housing & Community Services
Mental Health Commission

To: Mental Health Commissioners
From: Jamie Works-Wright, Commission Secretary
Date: December 9, 2021

Documents Pertaining to 12/16/21 Agenda items:

Health, Housing & Community Service Department
Mental Health Commission

Berkeley/ Albany Mental Health Commission

Regular Meeting
Thursday, December 16, 2021

Time: 7:00 p.m. - 9:00 p.m. **Zoom meeting** https://zoom.us/j/96361748103

Public Advisory: Pursuant to Government Code Section 54953(e) and the state declared emergency, this meeting of the City Council will be conducted exclusively through teleconference and Zoom videoconference. The COVID-19 state of emergency continues to directly impact the ability of the members to meet safely in person and presents imminent risks to the health of attendees. Therefore, no physical meeting location will be available.

To access the meeting remotely: Join from a PC, Mac, and IPad, IPhone or Android device: Please use the URL: https://zoom.us/j/96361748103. If you do not wish for your name to appear on the screen, then use the drop-down menu and click on "rename" to rename yourself to be anonymous. To request to speak, use the "raise hand" icon by rolling over the bottom of the screen.

To Join by phone: Dial 1-669-900-9128 and enter the meeting ID 963 6174 8103. If you wish to comment during the public comment portion of the agenda, Press *9 and wait to be recognized by the Chair.

Please be mindful that the teleconference will be recorded, and all other rules of procedure and decorum will apply for Council meetings conducted by teleconference or videoconference.

All agenda items are for discussion and possible action

Public Comment Policy: *Members of the public may speak on any items on the Agenda and items not on the Agenda during the initial Public Comment period. Members of the public may also comment on any item listed on the agenda as the item is taken up. Members of the public may not speak more than once on any given item. The Chair may limit public comment to 3 minutes or less.*

AGENDA

7:00pm

1. **Roll Call**
2. **Preliminary Matters**
    a. Action Item: December 16, 2021 Agenda Approval
    b. Public Comment
    c. Action Item: Approval of the October 28, 2021 minutes

Health, Housing & Community Service Department
Mental Health Commission

3. **Behavioral Health Crisis Systems & 24 Hour Crisis Stabilization Programs Presentation & Q&A**
    - **Maggie Shapiro, BACS Program Manager, Amber House 24 Hour Crisis Stabilization, Oakland, CA**
    - **Jovan Yglecias, BACS Chief Program Officer, Oakland, CA**
    - **Holly Harris, Crisis Services Program Manager, Deschutes County, OR**

4. **Discussion re: Next Steps on Behavioral Health Crisis Services and Possible Action**

5. **Discussion and vote to establish the Mental Health Commission 2022 calendar for regular meetings**

    a. Meeting Dates Form
    b. City Calendar
    c. Religious Holidays

6. **Specialized Care Unit Steering Committee Update & Discussion re: RDA Report**

7. **Re-Imagining Public Safety Task Force Update - Ned Opton (MHC appointee), boona cheema (Vice-Chair, RPSTF)**

8. **Santa Rita Jail Subcommittee Report - Andrea Pritchett**

9. **Mental Health Manager's Report and Caseload Statistics - Steve Grolnic-McClurg**

    a. MH report
    b. Berkeley Mental Health Caseload Statistics December
    c. Berkeley SU Current State Report Final

10. **MHSA INN Homeless Encampment Wellness Project Update – Draft proposal is currently available for public comment**

11. **Whole Person Care - Community Health Records Update and Implementation Plan Update**

12. **Substance Use/Harm Reduction - Services, Supports, Diversion from Criminal Legal System**

13. **Policing Complaint - Kim Nemirow**

14. **Prioritize Agenda and Topics for January Meeting**

Health, Housing & Community Service Department
Mental Health Commission

15. Adjournment

Communications to Berkeley boards, commissions or committees are public record and will become part of the City's electronic records, which are accessible through the City's website. **Please note: Email addresses, names, addresses, and other contact information are not required, but if included in any communication to a City board, commission or committee, will become part of the public record.** If you do not want your e-mail address or any other contact information to be made public, you may deliver communications via U.S. Postal Service or in person to the secretary of the relevant board, commission or committee. If you do not want your contact information included in the public record, please do not include that information in your communication. Please contact the secretary to the relevant board, commission or committee for further information. The Health, Housing and Community Services Department does not take a position as to the content.

Contact person: Jamie Works-Wright, Mental Health Commission Secretary (510) 981-7721 or Jworks-wright@cityofberkeley.info

Communication Access Information: This meeting is being held in a wheelchair accessible location. To request a disability-related accommodation(s) to participate in the meeting, including auxiliary aids or services, please contact the Disability Services specialist at 981-6418 (V) or 981-6347 (TDD) at least three business days before the meeting date. ***Please refrain from wearing scented products to this meeting. Attendees at trainings are reminded that other attendees may be sensitive to various scents, whether natural or manufactured, in products and materials. Please help the City respect these needs.*** *Thank you.*

SB 343 Disclaimer

Any writings or documents provided to a majority of the Commission regarding any item on this agenda will be made available for public inspection in the SB 343 Communications Binder located at the Adult Clinic at 1521 University Ave, Berkeley, CA 94703

Department of Health,
Housing & Community Services
Mental Health Commission

Berkeley/Albany Mental Health Commission
Draft Minutes

7:00pm
Zoom Webinar

Regular Meeting
October 28, 2021

Members of the Public Present: Gigi Crowder, Judy Appel, Carole Marasovic, Elana Auerbach, Paul Kealoha-Blake, Barb Atwell
Staff Present: Fawn Downs, Lisa Warhuus, Steven Grolnic-McClurg Jamie Works-Wright

1) **Call to Order at 7:03pm**
   Commissioners Present: boona cheema, Tommy Escarcega, Margaret Fine, Monica Jones, Edward Opton **Absent:** Maria Moore, Andrea Prichett, Terry Taplin, Javonna Blanton

2) **Preliminary Matters**
   a) **Approval of the October 28, 2021 Agenda**
   M/S/C (Fine, Opton) Motion to adopt the October 28, 2021 agenda
   PASSED
   Ayes: cheema, Escarcega, Fine, Jones, Opton **Noes:** None; **Abstentions:** None; **Absent:** Blanton, Moore, Prichett, Taplin

   b) **Public Comment** – 1 Public Comment

   c) **Approval of the June 24, 2021 Minutes**
   M/S/C (Fine, Opton) Motion to approve the July minutes
   PASSED
   Ayes: cheema, Escarcega, Fine, Jones, Opton **Noes:** None; **Abstentions:** None; **Absent:** Blanton, Moore, Prichett, Taplin

3) **Presentation by Ms. Gigi Crowder, Executive Director, NAMI**
   No Motion Made
   .

4) **Mental Health Manager's Report and Caseload Statistics - Steve Grolnic-McClurg**
   a) **MH report**
   b) **Berkeley Mental Health Caseload Statistics September**
   - **No Motion Made**

5) **Narrative report on qualification for future BMH staff- boona cheema and Kim Nemirow**
No Motion Made

6) **Specialized Care Unit Steering Update & Discussion re: RDA Reports – Dr. Lisa Warhuus**
No Motion Made

7) **Reimagining Public Safety Task Force Update**
No Motion Made

8:57*Motion to extend the meeting by 15 minutes
M/S/C (cheema, Fine)
PASSED
Ayes: cheema, Escarcega, Fine, Jones, Opton **Noes:** None; **Abstentions:** None;
Absent: Blanton, Moore, Prichett, Taplin

8) **Santa Rita Jail Subcommittee Report –**
No Motion Made

9) **Whole Person Care – Community Health Records**
No Motion Made

10) **MHSA INN Homeless Encampment Wellness Project Update**
No Motion Made

11) **Prioritize Agenda items for December Meeting**
No Motion Made

12) **Adjournment – 9:15**
M/S/C (cheema, Fine) Motion to adjourn the meeting
PASSED
Ayes: cheema, Escarcega, Fine, Jones, Opton **Noes:** None; **Abstentions:** None;
Absent: Blanton, Moore, Prichett, Taplin

Minutes submitted by: _____
Jamie Works-Wright, Commission Secretary

Works-Wright, Jamie

From: Berkeley/Albany Mental Health Commission
Sent: Monday, December 6, 2021 2:25 PM
To: Works-Wright, Jamie
Subject: FW: 2022 Commission Meeting Schedule Reminder
Attachments: 2021-11-18 Memo - Religious Holidays.pdf; 2022 City Holiday - VTO Calendar.pdf; Resolution 69,127-NS.pdf; Meeting Date Form 2022.docx

Importance: High

From: Works-Wright, Jamie
Sent: Monday, November 22, 2021 1:07 PM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: FW: 2022 Commission Meeting Schedule Reminder
Importance: High

Thank you for your time.

Jamie Works-Wright
Consumer Liaison & Mental Health Commission Secretary
City of Berkeley
2640 MLK Jr. Way
Berkeley, CA 94704
Jworks-wright@cityofberkeley.info
Office: 510-981-7721 ext. 7721
Cell #: 510-423-8365

From: Commission
Sent: Friday, November 19, 2021 2:26 PM

Subject: 2022 Commission Meeting Schedule Reminder
Importance: High

Dear Commission Secretaries:

It is time to work with your respective commissions to establish a schedule of regular meetings for 2022. The meeting schedule should be agendized and adopted by formal action of your commission. Please see the attached memo and List of Significant Religious Holidays and the City-observed holiday calendar for your commission's consideration while planning its schedule.

Once your commission has established its meeting schedule for 2022, please complete the attached template and return it to the Commission Inbox as soon as possible after you have set your meeting schedule, but no later than **Friday, January 7, 2022**.

Some additional administrative details to consider:

- As most commissions have resumed meeting regularly, albeit virtually, the most recently adopted Commission Meeting Frequency Schedule is still in effect. Resolution No. 69,127–N.S. is attached for your reference and designates how many times your commission should meet in the coming year. Please note that meetings beyond the number specified in the frequency schedule must be approved by the City Council.
- The resolution also directs commission secretaries to prepare an information report to Council whenever two consecutive meetings are cancelled due to lack of quorum.
- This is a good time to remind commissioners to request a leave of absence from their appointing Councilmember or body should they need to miss a meeting. Commissioners may also request, in writing, an excused absence for cultural or religious holidays, using the form found in Groupware. All leaves must be requested prior to an absence.

Please contact us with any questions.

Thank you

Leslie S. Rome
Assistant Management Analyst
City Clerk Department
(510) 981-6908
commission@cityofberkeley.info

RESOLUTION NO. 69,127–N.S.

2020 COMMISSION MEETING FREQUENCY SCHEDULE

WHEREAS, on June 13, 2005, the City Council adopted a plan which created three categories of meeting schedules and a process for requesting Council or Agenda Committee approval of any extra meetings; and

WHEREAS, Council also directed commission secretaries to submit an information report whenever a commission cancels two consecutive meetings for lack of quorum and an annual attendance report; and

WHEREAS, on January 15, 2008, the City Council adopted a plan which created a fourth category of meeting frequency; and

WHEREAS, adopting a commission meeting schedule will provide commissions with direction to set their respective regular meeting schedules for subsequent years.

NOW THEREFORE, BE IT RESOLVED that the Council of the City of Berkeley directs that commission secretaries shall submit an information report to Council whenever a commission cancels two consecutive meetings for lack of quorum.

BE IT FURTHER RESOLVED that commissions may request that the Council approve extra meetings by placing a report on the City Council agenda for consideration.

BE IT FURTHER RESOLVED that commissions will meet according to the following categories:

Category A. These commissions will meet on their own schedule.

Board of Library Trustees
Design Review Committee
Fair Campaign Practices Commission
Housing Advisory Commission
Joint Subcommittee on the Implementation of State Housing Laws
Landmarks Preservation Commission
Open Government Commission
Personnel Board
Planning Commission
Police Review Commission
Zoning Adjustments Board

Category B. These commissions will have a maximum of ten meetings per year.

Cannabis Commission
Civic Arts Commission
Children, Youth, and Recreation Commission
Commission on Aging
Commission on Disability
Commission on Labor
Commission on the Status of Women
Community Environmental Advisory Commission
Community Health Commission
Disaster and Fire Safety Commission
Energy Commission
Homeless Commission
Homeless Services Panel of Experts
Human Welfare and Community Action Commission
Measure O Bond Oversight Committee
Mental Health Commission
Parks and Waterfront Commission
Peace and Justice Commission
Public Works Commission
Sugar-Sweetened Beverage Product Panel of Experts
Transportation Commission
Youth Commission
Zero Waste Commission

Category C. These commissions will meet as necessary to fulfill their legal requirements as determined by the board chair and/or staff.

Elmwood Business Improvement District Advisory Board
Loan Administration Board
Solano Avenue Business Improvement District Advisory Board

Category D. These commissions will have a maximum of six meetings per year.

Animal Care Commission

BE IT FURTHER RESOLVED that commission secretaries will submit a commission attendance and meeting frequency report for the period September 1st through August 31st to the City Clerk in September of each year.

BE IT FURTHER RESOLVED that a report presenting commission attendance and meeting frequency will be submitted to the City Council for review in October of each year.

BE IT FURTHER RESOLVED that the meeting frequency schedule contained herein shall remain in effect until superseded by Council Resolution.

The foregoing Resolution was adopted by the Berkeley City Council on October 15, 2019 by the following vote:

Ayes: Bartlett, Davila, Droste, Hahn, Harrison, Kesarwani, Robinson, Wengraf, and Arreguin.

Noes: None.

Absent: None.

Jesse Arreguin, Mayor

Attest:
Mark Numainville, City Clerk

2022 Commission Meeting Dates

Please complete this form and email it to the
Commission Inbox by: **Friday, January 7, 2022**

Name of Commission: _Mental Health Commission

Commission Secretary: Jamie Works-Wright

Please Note the Commission Meeting Dates for 2022 Below

Please fill in meeting date below. If no meeting for the month is scheduled please note as "No Meeting."

Example

Month	Meeting Day and Date	Time
February 2022	**Wednesday 2/10/2022**	**7:00 pm**

Month	Meeting Day and Date	Time
July 2022	**No Meeting**	

2022 Meeting Dates

Month	Meeting Day and Date	Time
January 2022	Thursday 1/27/22	7:00 PM
February 2022	Thursday 2/24/22	7:00 PM
March 2022	Thursday 2/24/22	7:00 PM
April 2022	Thursday 4/28/22	7:00 PM
Jewish	Yom HaShoah	
May 2022	Thursday 5/26/22	7:00 PM
June 2022	Thursday 6/23/22	7:00 PM

Month	Meeting Day and Date	Time
July 2022	Thursday 7/28/22	7:00 PM
August 2022	**No Meeting**	
September 2022	Thursday 9/22/22	7:00 PM
October 2022	Thursday 10/27/22	7:00 PM
November 2022	**No Meeting**	
December 2022	Thursday 12/8/22	7:00 PM
	12/15/22 or 12/22/22	

commission@cityofberkeley.info
City Clerk Department
Please contact our office at (510) 981-6908 with any questions.

2022 CITY CALENDAR

JANUARY						
Sun	Mon	Tues	Weds	Thurs	Fri	Sat
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

FEBRUARY						
Sun	Mon	Tues	Weds	Thurs	Fri	Sat
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28					

MARCH						
Sun	Mon	Tues	Weds	Thurs	Fri	Sat
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

APRIL						
Sun	Mon	Tues	Weds	Thurs	Fri	Sat
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

MAY						
Sun	Mon	Tues	Weds	Thurs	Fri	Sat
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

JUNE						
Sun	Mon	Tues	Weds	Thurs	Fri	Sat
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

JULY						
Sun	Mon	Tues	Weds	Thurs	Fri	Sat
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

AUGUST						
Sun	Mon	Tues	Weds	Thurs	Fri	Sat
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

SEPTEMBER						
Sun	Mon	Tues	Weds	Thurs	Fri	Sat
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

OCTOBER						
Sun	Mon	Tues	Weds	Thurs	Fri	Sat
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

NOVEMBER						
Sun	Mon	Tues	Weds	Thurs	Fri	Sat
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

DECEMBER						
Sun	Mon	Tues	Weds	Thurs	Fri	Sat
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

2022 CITY OF BERKELEY RECOGNIZED HOLIDAYS

Jan. 1	New Year's Day - Obs. 12/31	May. 19	Malcolm X's Birthday	Sept. 5	Labor Day
Jan. 17	Martin Luther King Jr.'s Birthday	May. 30	Memorial Day	Oct. 10	Indigenous Peoples' Day
Feb. 12	Lincoln's Birthday- OBS. Feb. 11	June. 19	Juneteenth - Obs. 6/20	Nov. 11	Veteran's Day
Feb. 21	Washington's Birthday	July. 4	Independence Day	Nov. 24/25	Thanksgiving Day/Day After

Dec. 25 Christmas Day - OBS. Dec. 26

Pay Day

Observed Holiday

Observed VTO Day

12

City Clerk Department

November 19, 2021

To: Commission Secretaries

From: Mark Numainville, City Clerk

Subject: City Policy Regarding Scheduling of Meetings on Significant Religious Holidays

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On October 12, 2021, the City Council adopted Resolution No. 70,066-N.S., creating a policy to avoid scheduling meetings of City Legislative Bodies on religious holidays with work restrictions. The Legislative Bodies impacted by this policy include the City Council, Commissions and Boards, Task Forces, and Council Policy Committees.

The City Clerk Department has compiled a list of religious holidays and dates for 2022. Commissions, Boards and task Forces should avoid scheduling meetings on any of the dates in the attached list.

Attachments:
1. List of Religious/Cultural Observances
2. Resolution No. 70,066-N.S.

City Policy Regarding the Scheduling of City Meetings on All Significant Religious Holidays

Pursuant to Resolution No. 70,066-N.S., it is the policy of the City to avoid scheduling meetings of City Legislative Bodies (City Council, Commissions and Boards, Council Policy Committees, Task Forces) on religious holidays that incorporate significant work restrictions.

City legislative bodies must avoid scheduling meetings on the religious holidays listed below.

Religion	Holiday	Date	2022 Date
Christian	Good Friday	Varies (March or April)	4/15/22
Christian	Easter Sunday	Varies (March or April)	4/17/22
Christian	Christmas	December 25	12/25/22
Jewish	Rosh Hashanah	Varies (Sept. or Oct.)	9/25/22-9/27/22
Jewish	Yom Kippur	Varies (Sept. or Oct.)	10/4/22-10/5/22
Jewish	Sukkot - first and last day	Varies (Sept. or Oct.)	10/9/22, 10/16/22
Jewish	Shmini Atzeret	Varies (Sept. or Oct.)	10/16/22-10/18/22
Jewish	Simchat Torah	Varies (Sept. or Oct.)	10/17/22-10/18/22
Jewish	Chanukah (1st night)	Varies (Nov. or Dec.)	12/18/22
Jewish	Passover (Nights 1, 2, 7, 8)	Varies (March or April)	4/15,4/16,4/22,4/23
Jewish	Shavuot	Varies (May or June)	6/4/22-6/6/22
Jewish	Shabbat	Weekly	Friday sunset to Saturday sunset
Jewish*	Purim	Varies (February or March)	3/16/22-3/17/22
Jewish*	Tish'a B'Av	Varies (July or August)	8/5/22-8/6/22
Jewish*	Yom HaShoah	Varies (April or May)	4/27/22-4/28/22
Buddhist	Vesak	Varies (April or May)	5/6/22
Hindu	Diwali	Varies (Oct. or Nov.)	10/24/22
Hindu	Dussera	Varies (Oct.)	10/5/2022
Hindu	Holi	Varies (March)	3/17-3/18
Hindu	Makar Sankranti	Varies (January or February)	1/14/2022
Islam	Eid al-Fitr	Varies	5/2/22-5/3/22
Islam	Eid al-Adha	Varies	7/9/22-7/10/22
Shinto	New Year	January 1-3	1/1/22-1/3/22
Shinto	Obon Ceremony	August 13-15	8/13/22-8/15/22
Baha'i Faith	Birth of Baja'u'llah	Varies	10/26/22-10/27/22
Baha'i Faith	Birth of Bab	Varies	10/25/22-10/26/22
Cultural	Chinese New Year (Day 1-7)	Varies (Jan. 21 – Feb. 20)	2/1/22-2/15/22
Cultural	Kwanzaa	Dec. 26 – Dec. 31	12/26/22-1/1/23

* *No work restriction, but avoid scheduling meetings if possible*

RESOLUTION NO. 70,066-N.S.

ESTABLISHING A PRACTICE TO AVOID SCHEDULING CITY MEETINGS ON ALL SIGNIFICANT RELIGIOUS HOLIDAYS

WHEREAS, The City of Berkeley traditionally does not schedule any City related meetings on Christian religious holidays such as Christmas, Easter, and Good Friday where such meetings would conflict with religious services and celebration; and

WHEREAS, there is no formal policy that addresses the scheduling of meetings on other religious holidays that incorporate significant work restrictions such as Rosh Hashana, Yom Kippur, Passover (1st night), Diwali, Chinese New Year, Birth of Baja'u'llah, Kwanzaa, Gantan-sai, Eid al-Fitr and Eid al-Adha; and

WHEREAS, while consideration has been taken to avoid scheduling meetings on such dates, it is not a consistent practice and, as such, conflicts have occurred; and

WHEREAS, ensuring that a policy is in place to avoid scheduling on religious holidays that incorporate significant work restrictions will ensure that all beliefs and people are treated equally.

NOW THEREFORE, BE IT RESOLVED by the Council of the City of Berkeley that it will be the policy of the City to avoid scheduling meetings of City Legislative Bodies (City Council, Commissions and Boards, Council Policy Committees, Task Forces) on religious holidays that incorporate significant work restrictions and such days shall be identified through consultation with community religious leaders.

The foregoing Resolution was adopted by the Berkeley City Council on October 12, 2021 by the following vote:

Ayes: Bartlett, Droste, Hahn, Harrison, Kesarwani, Robinson, Taplin, Wengraf, and Arreguin.

Noes: None.

Absent: None.

Jesse Arreguin, Mayor

Attest: Mark Numainville, City Clerk

Health Housing and
Community Services Department
Mental Health Division

MEMORANDUM

To: Mental Health Commission
From: Steven Grolnic-McClurg, Mental Health Division Manager
Date: December 6th, 2021
Subject: Mental Health Manager Report

Mental Health Services Report

Please find the attached report on Mental Health Services for October, 2021.

Mental Health Apps

The Mental Health Division is excited to make available mental health apps to the Berkeley community. Anyone 13 and over who works, lives or attends school in Berkeley can access these free mental health resources (we have purchased 5000 subscriptions for each of these apps). We began our promotional campaign for the apps in Mid-November, and by the date of this report around 850 individuals in Berkeley had enrolled in HeadSpace – the initial response has been very exciting!

You can email MHApps@CityofBerkeley.info to receive a toolkit that provides materials for helping get the word out about this opportunity or if you have any questions. Please consider spreading the word and utilizing the toolkit to promote this opportunity. Below is the community message we are promoting, that explains the apps and the opportunity:

Anyone at least 13-years-old who lives, works or attends school in Berkeley can now use one of two apps for free to help navigate issues ranging from depression and substance abuse to a more general support around mindfulness and meditation. These two widely-used apps can help develop daily practices and habits that have the potential to provide a space of solace, address a long-standing struggle or simply lower stress.

No one tool can address all of a person's individual needs. But the goal is that these two differing apps – myStrength and HeadSpace – can provide stepping stones on a path toward greater emotional well-being.

The state provides almost all of the funding for Berkeley Mental Health with a mandate to help those with the most serious needs in our community. The division – one of only two operating at the City level in California – joined this state-funded, multi-county

initiative to help address mental health issues that are even more pronounced during the pandemic. This initiative allows for providing support to a much larger population than the Mental Health Division usually serves. Sign up for one or both apps. And spread the word – we never know who may be struggling and could use some support.

myStrength app: Access proven mental health interventions
The MyStrength app provides personalized and interactive activities that address depression, anxiety, stress, substance use, chronic pain and sleep challenges. The individually tailored program is designed to empower users and also supports the physical and spiritual aspects of whole-person health
.
The myStrength experience is based on clinical models like cognitive behavioral therapy, acceptance and commitment therapy, positive psychology, mindfulness, and motivational interviewing – proven interventions that have helped millions improve and sustain health and wellbeing.

Headspace app: Access meditation, sleep and movement exercises
The Headspace app is a popular online meditation and mindfulness resource. The app's library of exercises can help manage anxiety, encourage stress relief, increase focus, enhance sleep and improve mood
.
Additional features include meditation reminders, tracking your practice statistics, and inviting a buddy to join and meditate together. Meditations for children are also available, though only those at least 13-years-old can sign up.

Sign up for one or both apps
For either app, you must be at least 13-years-old. Start by visiting the Help@Hand website: https://helpathandca.org/berkeley/

1. For myStrength subscription (active until Oct. 31, 2022)
   a. Scroll down and select the myStrength button
   b. Complete the myStrength sign-up process, use access code: cityofberkeley and set up your profile.

2. For Headspace subscription (active until Sept. 30, 2023)
   a. Scroll down and select Headspace button
   b. Complete the Headspace sign-up process, enter "Berkeley" and your zip code where you work, live or go to school, and set up your profile.
   c.

Improving mental health in Berkeley
Help@Hand, a multi-County collaborative, originated the project. The total cost for this state-funded project is $462,916, which covers the development, coordination, licenses for the apps, and evaluation of the project.

The COVID-19 epidemic has increased isolation and limited access to mental health services for many Berkeley residents. The partnership with myStrength and Headspace is an exciting expansion of benefits available to the community. This platform, open to all Berkeley community members, builds upon our existing effort to provide access to mental health information and resources. Improving your mental health will make you, the people you care about, and our community stronger. Sign up and spread the word about these free online mental health resources.

Resource Development Associates (RDA) Report on Crisis System and Stakeholder Perspectives

This RDA report on the current crisis system in Berkeley and stakeholder perspectives is attached in the packet. From the executive summary in the report:

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

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

Changes

I'm retiring from the City of Berkeley on Monday, May 9th, 2022. It's been an honor to work for the City of Berkeley for the last eight years, and I deeply appreciate the partnership of all of you in this work. Supporting mental health recovery is both an amazing privilege and incredibly difficult – we are partnering with some of the most oppressed individuals in society and getting to share in their lives in a very intimate way. I'm very proud of the way the mental health division responds to this challenge every day, and the commitment and dedication it shows towards this mission. I've given the City about six months' notice of my retirement to support the needed time to hire a new division director.

As a division, we are in a strong place – we've just about doubled in size over the last eight years, we've vastly upgraded our facilities, we've added new teams and expanded

our programs, and we've greatly increased the amount of funding we are providing to community providers. We have diversified our staffing at all levels, and are working together around issues of health equity and racial justice. Our fiscal situation is strong, we are moving forward towards implementing RBA outcome measure across our programs, and we are working with stakeholders to develop a Specialized Care Unit that will provide 24/7 crisis services without the use of law enforcement. We are also part of a department that is committed to health equity and providing excellent services, and led by a department director who exemplifies those values.

During my time at Berkeley, I've learned from the knowledge and diverse perspectives of the Mental Health Commissioners. I'll miss working with you, and appreciate the opportunities I've had to grow in my time at Berkeley.

Information Requested by MHC
The following topics were requested by the MHC Chair.

Mobile Crisis Response Request for disposition of incidents for mobile crisis response, including by phone or in the field

Were linkages or referrals made to any providers, including to Amber House 24 hour crisis stabilization center, during the past 2 years and what types of linkages and referrals?
The community members in crisis that the Mobile Crisis Team (MCT) serves are provided the relevant crisis intervention for their needs, which may include referrals/linkages. After the crisis intervention, the details of the intervention are logged in the Mobile Crisis Log – this record keeping system is not able to report on the numbers or types of referrals.

The Transitional Outreach Team (TOT) will follow up with community members who have interfaced with MCT in order to offer support in linking to longer term mental health services, if desired. These referrals/linkages by TOT also do not have a quantitative mechanism to track this data. Amber house and other appropriate resources are used by both MCT and TOT for standard referral options. These linkages would be described qualitatively in the clinical notes, but again, there is no process at this time to pull out and track this data.

Were transports, other than for 5150 transports, made during the past 2 years from the MCT in the community; who made the transports (e.g. police, Fire/EMT, Falck); and what were the destinations, including to Amber House 24 hour crisis stabilization center?

The MCT has not been directly providing transport to residents whom they encounter during crisis situations. Transportation is usually provided by Fire/EMT, Falk, BPD, and

Mental Health does not track the dispositions (nor does it have the current ability). MCT is exploring direct transport options in addition to bus/taxi vouchers. Anecdotal reports from staff indicate that BPD rarely transports to Amber House, though we do not have data on these transports, nor the ones by Berkeley Fire or EMS.

What were the destinations for the 5150 transports for the last 2 years, and who transported the individual (e.g. police, Fire/EMT, Falck)?

The Mental Health Division does not have data regarding 5150 transports. This data would be held by Falck, which provides these transports. Berkeley Police and Berkeley Fire do not transport to receiving stations, typically, since that role is held by the contractor, Falck.

The standard receiving facility to receive transports of 18+ clients on a 5150 hold would be John George unless there is a medical clearance needed first. Medical clearances would have a standard disposition of Alta Bates. For clients 12-17, Willow Rock is the standard transport destination for youth 12 and older, and Children's Hospital Oakland for clients under 12. The standard medical clearance for clients under 18 would be to at Children's Hospital. Some clients have Kaiser insurance and they may be taken to Kaiser instead. Even if mental health staff were told the planned destination of the transport, there is not a way for Mental Health to know if this was the actual destination (there may be a medical issue in the ambulance and they may reroute to a medical facility, or some other change may happen that shifts the disposition).

<u>Status Update on Demographic Data Collection for the Division of Mental Heatlh</u>

Mental Health Equity Committee - housing status for clients

The Mental Health Equity Committee is examining data on the housing status of clients that entered services. The data will be sorted by a variety of demographic categories, including race, ethnicity, and gender. This data will be included in the MHC report after it has been considered by the equity committee.

Data Collection by race, ethnicity, gender, sexual orientation, disability, age, other demographic categories, including for MHSA CSS, PEI, INN, WET programs, as required by Alameda County (including on new client registration form) and Medi-Cal

As has been reported previously, the mental health division is collecting data as required.

Staff Trainings and training for outside subcontractors to ensure accurate, complete demographic data collection, including to comply with new client registration forms for Alameda County

The Mental Health Division is a contract provider for the Alameda County Behavioral Healthcare Plan. As a contractor, it cannot subcontract medi-cal services, and so no

contract agencies bill medi-cal or complete the client registration forms utilized by Alameda County. However, all MHSA contractors are required to collect any required demographic information for MHSA funding, and all MHSA contractors are currently reporting this data. Given the success of the training on Sexual and Gender Orientation trainings for mental health division staff, we are exploring if the vendor can provide training to contractors.

Community Health Record Implementation (CHR)

The CHR is has been approved internally by all stakeholders, and the agreement for participation has been signed. We are currently routing a payment for the CHR, and once that is received by Alameda County they will schedule a meeting to begin implementation.

Options Recovery Substance Use & Harm Reduction Contract & Implementation

We are planning on going to City Council on January 18th, 2022 to ask for permission for the City Manager to enter into a contract with Options Recovery Services (Options) for co-located substance used disorder and harm reduction services at the adult clinic. If City Council approves the resolution, we will work with Options to complete a contract and begin these services.

Berkeley Mental Health Caseload Statistics
for October 2021

Adult Services	Intended Ratio of staff to clients	Clinical Staff Positions Filled	# of clients open this month	Average Monthly System Cost Previous 12 Months	Fiscal Year 2022 (July '21-June '22) Demographics as of October 2021
Adult, Older Adult and TAY Full Service Partnership (AFSP) (Highest level outpatient clinical case management and treatment)	1-10 for clinical staff.	4 Clinicians .5 Team Lead	64	$5,138	67 Clients API: 1 Black or African-American: 30 Hispanic or Latino:2 Other/Unknown: 3 White: 31 Male: 42 Female: 25
Adult FSP Psychiatry	1-100	.75 FTE	57		
AFSP FY21 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)			$2,037,600		
Homeless Full Service Partnership (HFSP) (Highest level outpatient clinical case management and treatment)	1-8 for clinical staff	3 Clinicians, 1 Team Lead	16	$4,487	18 Clients API: 2 Black or African-American: 9 Hispanic or Latino:1 Other/Unknown: 1 White: 5 Male: 13 Female: 5
HFPS Psychiatry	1-100	.2 FTE	16		
HFSP FY22 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)			TBD		
Comprehensive Community Treatment (CCT) (High level outpatient clinical case management and treatment)	1-20	8 Clinicians 1 Manager	171	$2,266	177 Clients American Indian: 1 API: 12 Black or African-American: 66 Hispanic or Latino:10 Other/Unknown: 13 White: 73 Male: 90 Female: 87
CCT Psychiatry	1-200	1 FTE	136		

CCT FY21 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)			$2,617,010		
Focus on Independence Team (FIT) **(Lower level of care, only for individuals previously on FSP or CCT)**	1-20 Team Lead, 1-50 Post Masters Clinical 1-30 Non-Degreed Clinical	1 Clinical Supervisor, I Licensed Clinician, 1 CHW Sp./ Non-Degreed Clinical	97	$996	100 Clients API: 6 Black or African American: 42 Hispanic or Latino: 1 Other/Unknown: 1 White: 49 Male: 59 Female: 41
FIT Psychiatry	1-200	.5	87		
FIT FY21 Mental Health Division Estimated Budgeted Personnel Costs, including Psychiatry and Medical Staff (FY22 not yet available)			$900,451		

Family, Youth and Children's Services	Intended Ratio of staff to clients	Clinical Staff Positions Filled	# of clients open this month	Average Monthly System Cost Last 12 months	Fiscal Year 2022 2022 (July '21-June '22) Demographics as of October 2021
Children's Full Service Partnership (CFSP)	1-8	1.5 Clinical	7	$3,652	11 Clients American Indian: 1 API: 2 Black or African-American:4 Hispanic or Latino: 1 Other/Unknown: 1 White: 2 Male: 6 Female: 5
CFSP Psychiatry	1-100	0	1		
CFSP FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$489,235		
Early and Periodic Screening, Diagnostic and Treatment Prevention (EPSDT) /Educationally Related Mental Health Services (ERMHS)	1-20	2.5 Clinical	61	$2,007	64 Clients American Indian: 1 API: 4 Black or African-American: 26 Hispanic or Latino: 16 Other/Unknown: 1 White: 16 Male: 34 Female: 30
ERMHS/EPSDT Psychiatry	1-100	0	3		
EPSDT/ERMHS FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$1,062,409		
High School Health Center and Berkeley Technological Academy (HSHC)	1-6 Clinician (majority of time spent on crisis counseling)	2.5 Clinical	Drop-in: 23 Externally referred: 25 Ongoing tx: 37 Groups: 0		N/A
HSHC FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$396,106		

Crisis and ACCESS Services	Staff Ratio	Clinical Staff Positions Filled	Total # of Clients/Incidents	MCT Incidents Detail	Calendar Year 2021 (Jan '21-Dec '21) Demographics – From Mobile Crisis Incident Log (through October 2021)
Mobile Crisis (MCT)	N/A	2 Clinician filled at this time	• 75 Incidents • 21 5150 Evals • 7 5150 Evals leading to involuntary transport	• 46 Incidents: Location - Phone • 24 Incidents: Location - Field • 0 Incidents: Location - Home	635 Clients API: 34 Black or African-American: 136 Hispanic or Latino: 26 Other/Unknown: 285 White: 154 Male: 298 Female: 289 Transgender: 7 Unknown: 41
MCT FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available)			$771,623		
Transitional Outreach Team (TOT)	N/A	1 Licensed Clinician, 1 Case Manager (both sometimes reassigned due to staffing needs in other units)	8 Incidents	N/A	273 Clients API: 22 Black or African-American: 60 Hispanic or Latino: 14 Other/Unknown: 104 White: 73 Male: 128 Female: 131 Transgender: 4 Unknown: 10
TOT FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available))			$272,323		
Community Assessment Team (CAT)	N/A	1 Team Lead, 1 Clinician, 1 Non-Degreed Clinical	92 Incidents	N/A	461 Clients API: 16 Black or African-American: 117 Hispanic or Latino: 26 Other/Unknown: 183 White: 119 Male: 215 Female: 217 Transgender: 2 Unknown: 27
CAT FY21 Mental Health Division Estimated Budgeted Personnel Costs (FY22 not yet available))			$735,075		

Not reflected in above chart is Early Childhood Consultation, Wellness and Recovery Programming, or Family Support.
In demographics, other/unknown is used both when a client indicates that they are multi-racial and when demographic info is not known.

*Average System Costs come from YellowFin, and per ACBH include all costs to mental health programs, sub-acute residential programs, hospitals, and jail mental health costs.

City of Berkeley

Mental Health Crisis Response Services and Stakeholder Perspectives Report

RDA CONSULTING

CITY OF BERKELEY

City of Berkeley
Specialized Care Unit Model Recommendations

City of Berkeley Mental Health Crisis Response and Stakeholder Perspectives Report

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

Resource Development Associates, October 2021

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Table of Contents

Executive Summary

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

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

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

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

Key Themes from Stakeholder Feedback

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

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

Perceptions of insufficient crisis services for substance use emergencies

Perceptions of a need for a variety of crisis transport options

Perceptions of a lack of sites for non-emergency care

Perceptions around supporting the full spectrum of mental health crisis needs

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

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

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

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

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

Community Aspirations

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

Stakeholder-identified opportunities for centering BIPOC communities in crisis response

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

Introduction

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

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

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

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

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

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

Communitywide Data Collection

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

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

Community Engagement Planning Process

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

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

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

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

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

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

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

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

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

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

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

Data Sources

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

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

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

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

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

Demographics of Participants of RDA's Data Collection Efforts

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

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

Impacts of COVID-19 Pandemic on Data Collection

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

Overview of Berkeley Crisis Response

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

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

Process of Response to a Mental Health Call[4]

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

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

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

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

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

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

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

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

City and County Teams that Respond During a Crisis

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

Berkeley Mental Health Crisis Programs:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Crisis Services Eligible to Berkeley Residents

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

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

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

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

Crisis Services Not Eligible to Berkeley Residents

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Crisis Stabilization Units and Psychiatric Facilities

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

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

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

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

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

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

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

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

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

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

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

Drop-In Centers

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

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

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

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

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

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

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

Medical Service Providers

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

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

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

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

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

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

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

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

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

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

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

Key Mental Health Call Volume Trends

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

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

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

Stakeholder Feedback

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

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

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

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

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

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

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

Key Themes from Stakeholder Feedback

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

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

Perceptions of insufficient crisis services for substance use emergencies

Perceptions of a need for a variety of crisis transport options

Perceptions of a lack of sites for non-emergency care

Perceptions around supporting the full spectrum of mental health crisis needs

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

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

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

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

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

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

- SCU Survey Respondent

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

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

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

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

- SCU Survey Respondent

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

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

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

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

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

- SCU Survey Respondent

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

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

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

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

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

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

- SCU Survey Respondent

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

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

Additional Perspectives from the SCU Survey

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

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

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

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

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

Perceived Strengths

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

Perceived Challenges

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

Stakeholder Ideas

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

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

- SCU Survey Respondent

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

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

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

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

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

- SCU Survey Respondent

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

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

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

- SCU Survey Respondent

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

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

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

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

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

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

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

- SCU Survey Respondent

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

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

Additional Perspectives from the SCU Survey

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

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

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

Stakeholder perceptions of insufficient crisis services for substance use emergencies

Perceived Strengths

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

Perceived Challenges

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

Stakeholder Ideas

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

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

- SCU Survey Respondent

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

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

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

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

- SCU Survey Respondent

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

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

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

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

Additional Perspectives from the SCU Survey

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

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

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

Perceived Strengths

- Transport is provided to emergency sites during medical emergencies

Perceived Challenges

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

Stakeholder Ideas

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

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

- SCU Survey Respondent

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

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

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

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

Additional Perspectives from the SCU Survey

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

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

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

Perceived Strengths

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

Perceived Challenges

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

Stakeholder Ideas

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

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

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

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

Additional Perspectives from the SCU Survey

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

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

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

Perceived Strengths

- Relationship building is important in crisis response

Perceived Challenges

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

Stakeholder Ideas

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

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

- SCU Survey Respondent

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

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

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

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

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

- SCU Survey Respondent

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

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

Additional Perspectives from the SCU Survey

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

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

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

Perceived Strengths

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

Perceived Challenges

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

Stakeholder Ideas

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

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

- SCU Survey Respondent

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

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

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

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

- SCU Survey Respondent

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

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

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

Additional Perspectives from the SCU Survey

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

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

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

Perceived Strengths

- Providers know the referral options available for their clients

Perceived Challenges

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

Stakeholder Ideas

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

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

- SCU Survey Respondent

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

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

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

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

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

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

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

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

Additional Perspectives from the SCU Survey

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

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

Perceived Strengths

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

Perceived Challenges

- Limited data integration across providers inhibits care coordination

Stakeholder Ideas

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

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

- SCU Survey Respondent

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

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

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

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

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

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

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

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

- SCU Survey Respondent

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

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

Additional Perspectives from the SCU Survey

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

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

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

Perceived Strengths

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

Perceived Challenges

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

Stakeholder Ideas

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

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

- SCU Survey Respondent

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

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

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

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

- SCU Survey Respondent

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

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

Additional Perspectives from the SCU Survey

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

Community Aspirations

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

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

Community Aspirations

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

Stakeholder-identified opportunities for centering BIPOC communities in crisis response

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

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

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

- SCU Survey Respondent

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

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

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

Additional Perspectives from the SCU Survey

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

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

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

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

Stakeholder-identified opportunities for centering BIPOC communities in crisis response

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

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

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

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

Additional Perspectives from the SCU Survey

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

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

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

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

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

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

Additional Perspectives from the SCU Survey

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

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

Appendices

Appendix A. Sample Interview Guide

CBO Staff Focus Group Guide

Focus Group Details

Date	
Facilitator	
Community groups in attendance	

Overview

[Introduce facilitator and notetaker]

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

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

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

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

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

Does anyone have any questions before we begin?

Questions

Warm-up

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

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

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

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

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

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

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

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

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

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

Ideas for alternative model

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

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

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

Wrap up

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

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

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

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

Closing

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

Appendix B. Demographics of Community Engagement Participants

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

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

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

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

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

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

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

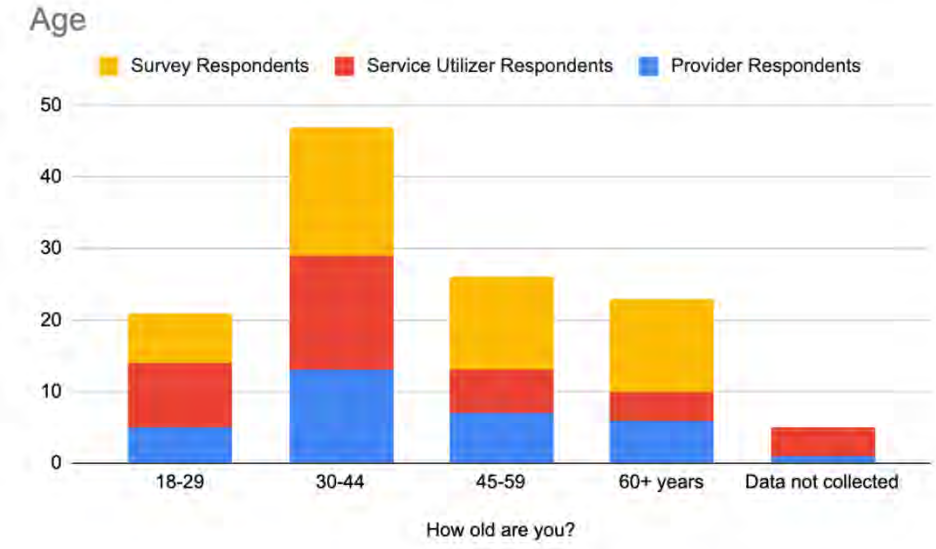


Figure 2 below shows the racial and ethnic distribution of participants in RDA's data collection.[30] Participants were asked to note all races/ethnicities that they identified with, so these are duplicated counts; for this reason, specific percentages should not be interpreted from this data. A large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

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

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

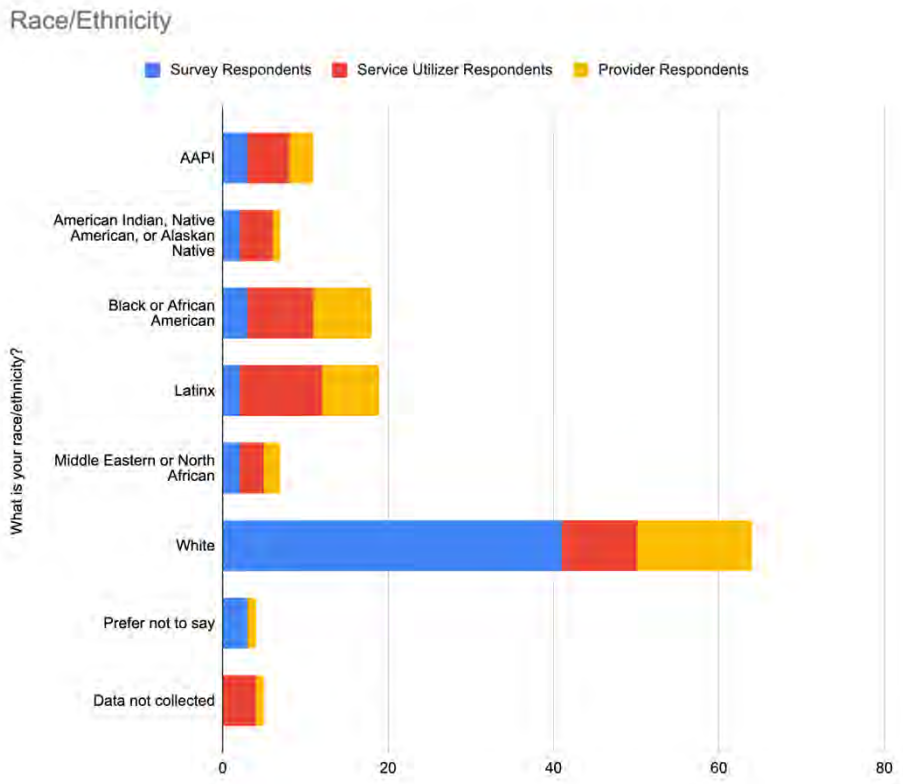


Figure 3 below shows the number of transgender and cisgender participants of RDA's data collection. Overall, there were far more cisgender participants than transgender participants. However, a higher proportion of service utilizer respondents (13%) were transgender, while less than 4% of survey respondents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

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

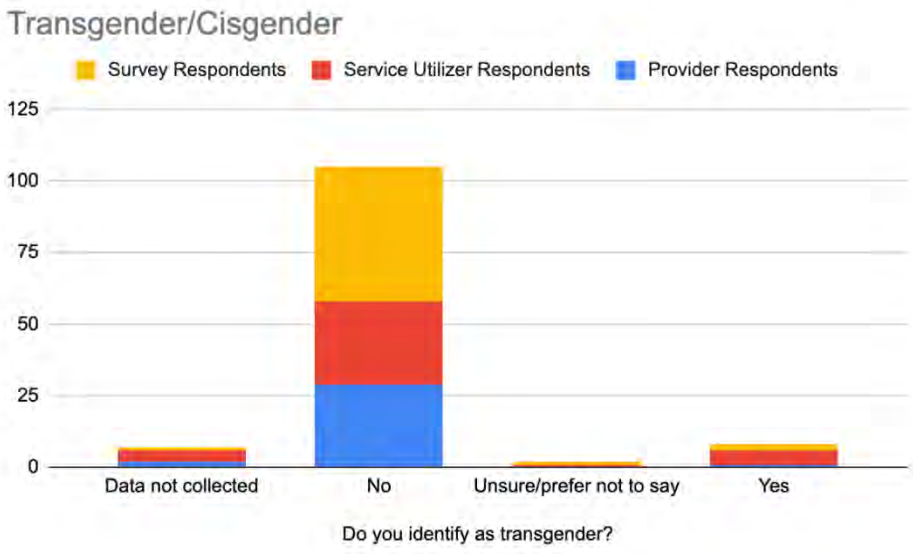


Figure 4 below shows the gender identity distribution of participants to RDA's data collection. RDA collected feedback from more than double the number of female-identifying participants (72) than male identifying participants (31). There was an even distribution among service utilizer respondents (41%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

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

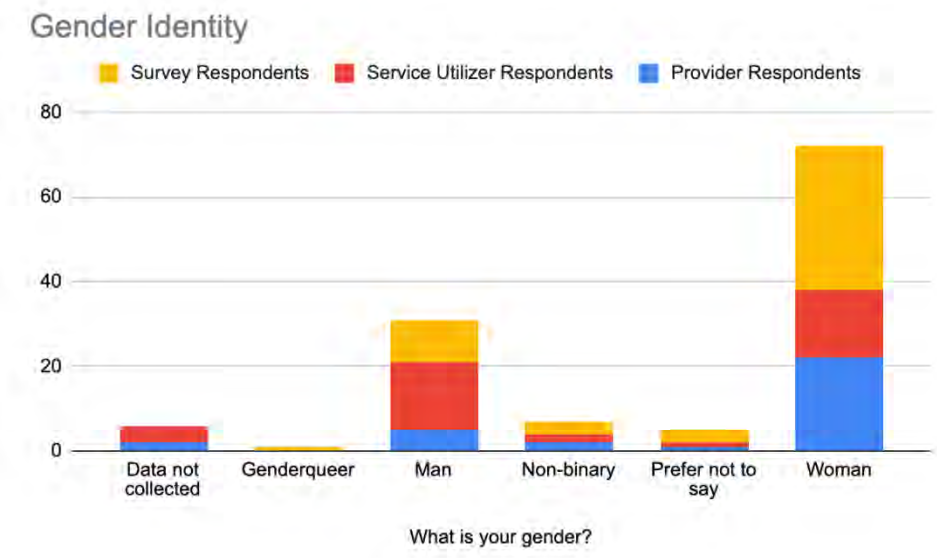


Figure 5 below shows the sexual orientation of participants of RDA's collection. Over one third (35%) of participants identified as heterosexual or straight, while over one fourth (28%) identified as LGBTQ+. The remaining participants did not share their sexual orientation or it was not asked of them.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

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

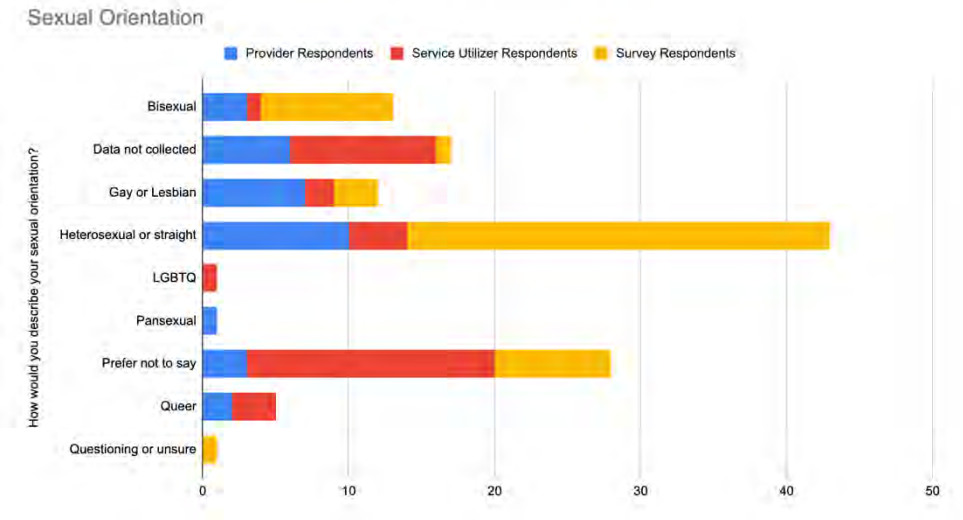
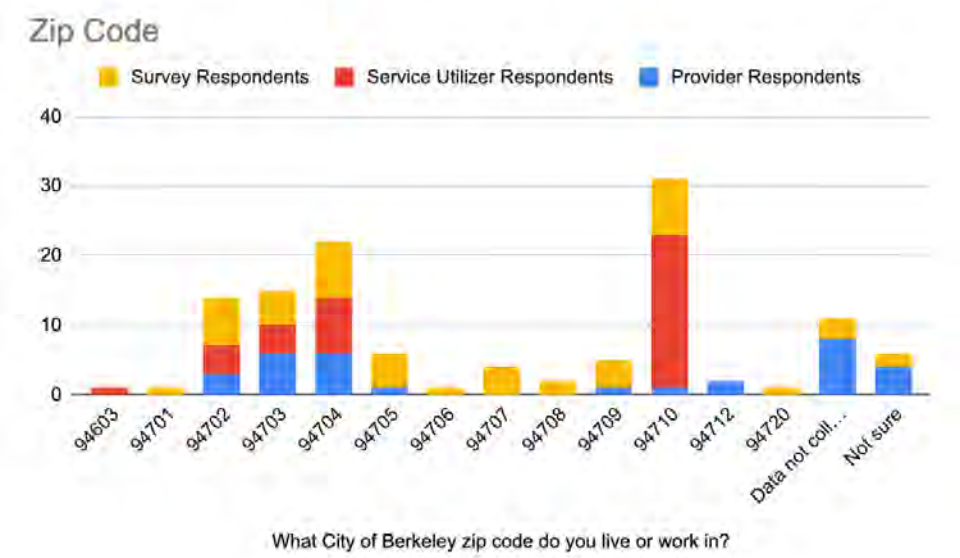
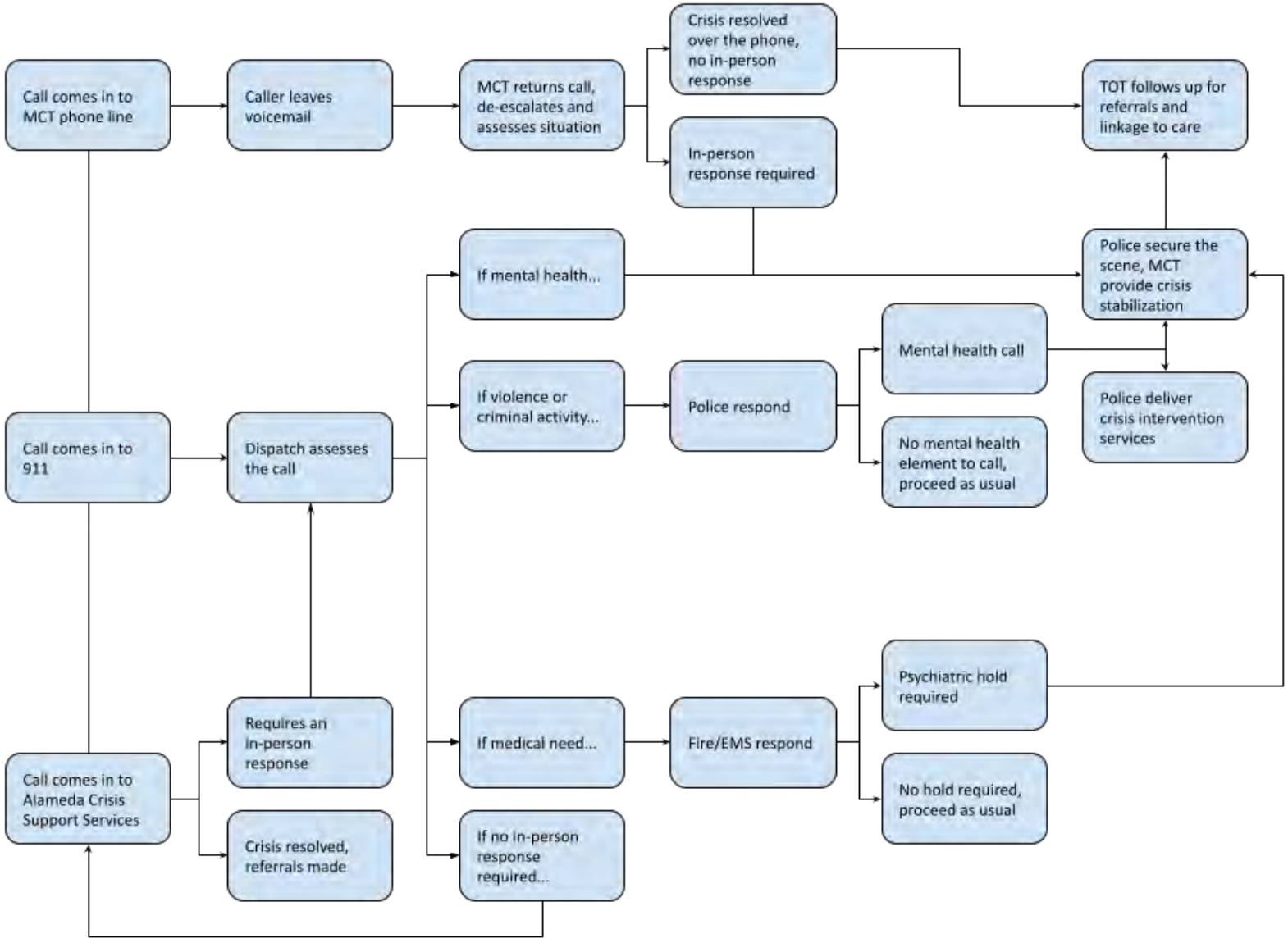


Figure 6 below shows the geographical distribution of participants of RDA's data collection. The most common zip code of participants was 94710 (25%), in large part due to the number of Seabreeze encampment residents that participated in this process. Closely following were the Berkeley ZIP codes of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

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



Appendix C. Process of a Mental Health Call



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

Data Collection Methods and Challenges

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

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

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

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

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

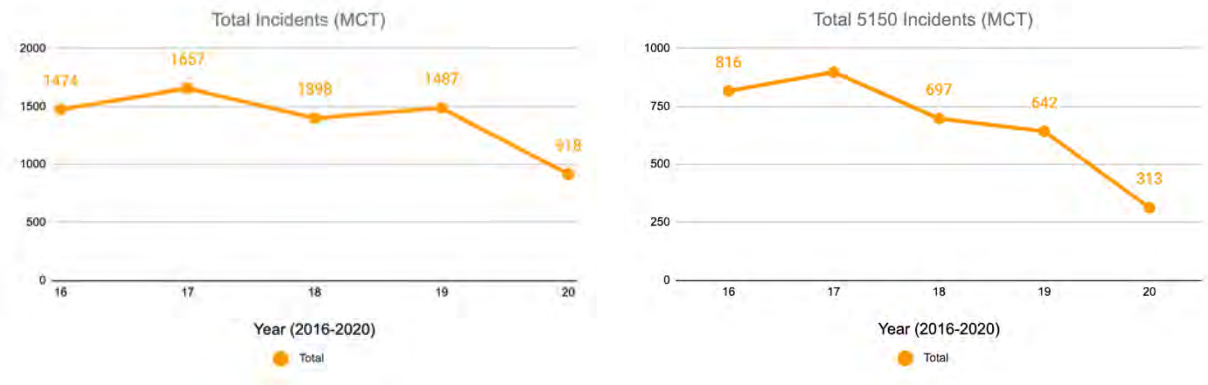
The data challenges that RDA encountered were very similar to those faced by the Berkeley City Auditor; please refer to the Berkeley City Auditor's report of its findings of Berkeley's Police Response for a thorough description of their data challenges.[32]

Mental Health Call Volume

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

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

Total Incidents | **5150s Only**

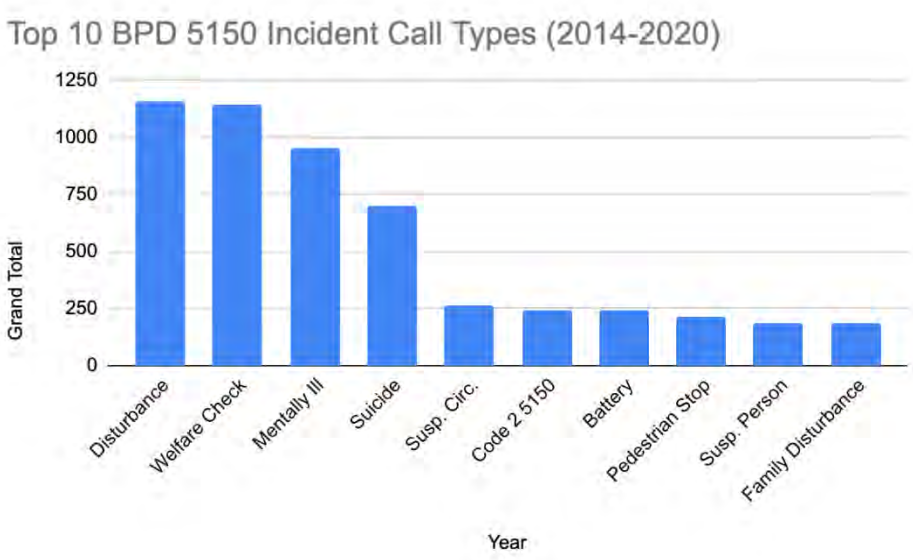


Since 2015, there has been a gradual decline in the number of total and 5150 incidents that MCT responded to in Berkeley due to staff vacancies as well as the COVID-19 pandemic.

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

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

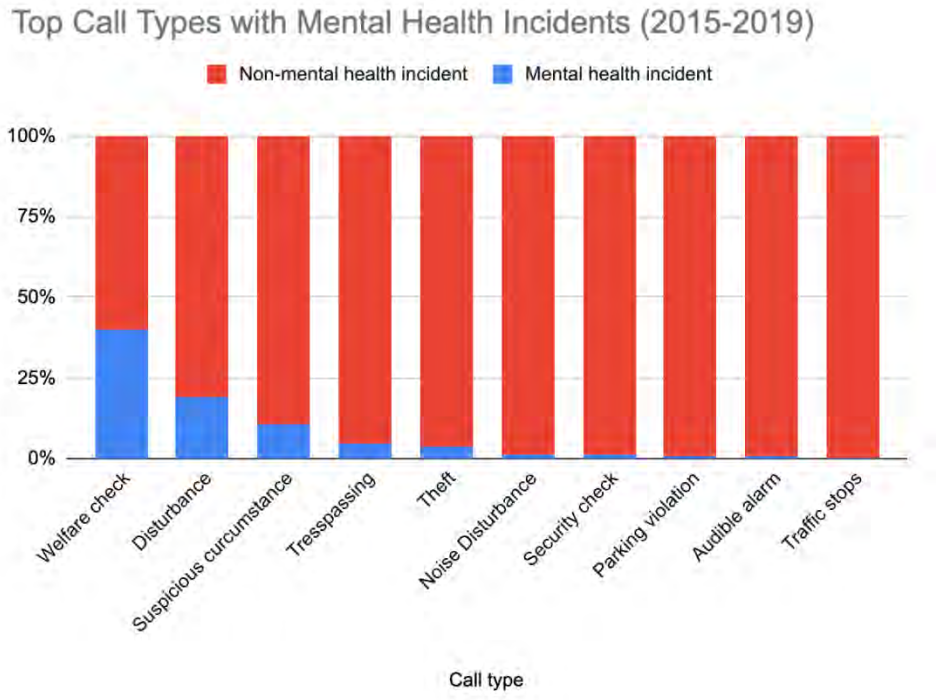
[32] Berkeley City Auditor. (2021, July 2). *Data Analysis of the City of Berkeley's Police Response*. https://www.cityofberkeley.info/uploadedFiles/Auditor/Level_3_-_General/Data%20Analysis%20of%20the%20City%20of%20Berkeley's%20Police%20Response.pdf



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

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

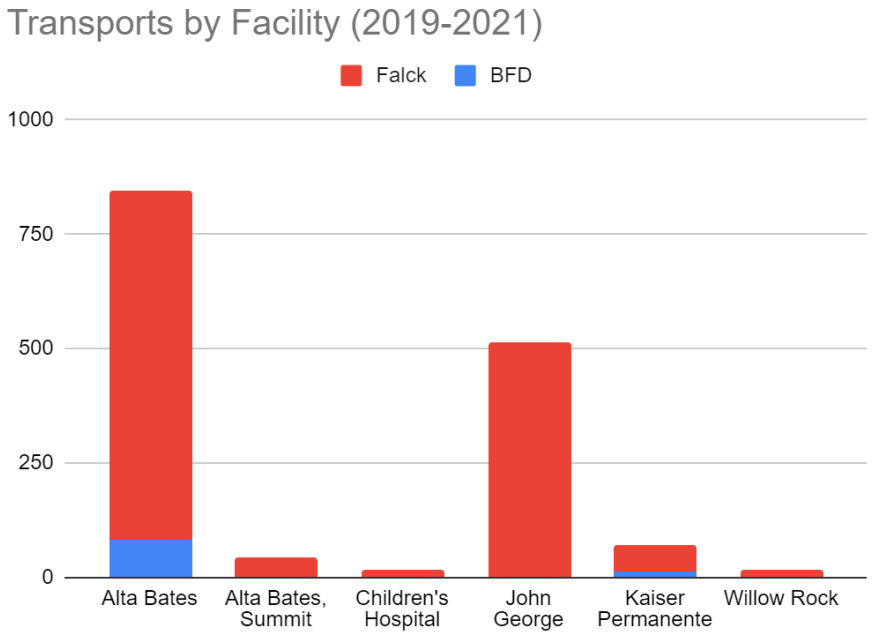
Figure 9. Berkeley Police Department (BPD) Call Types, 2015-2019



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

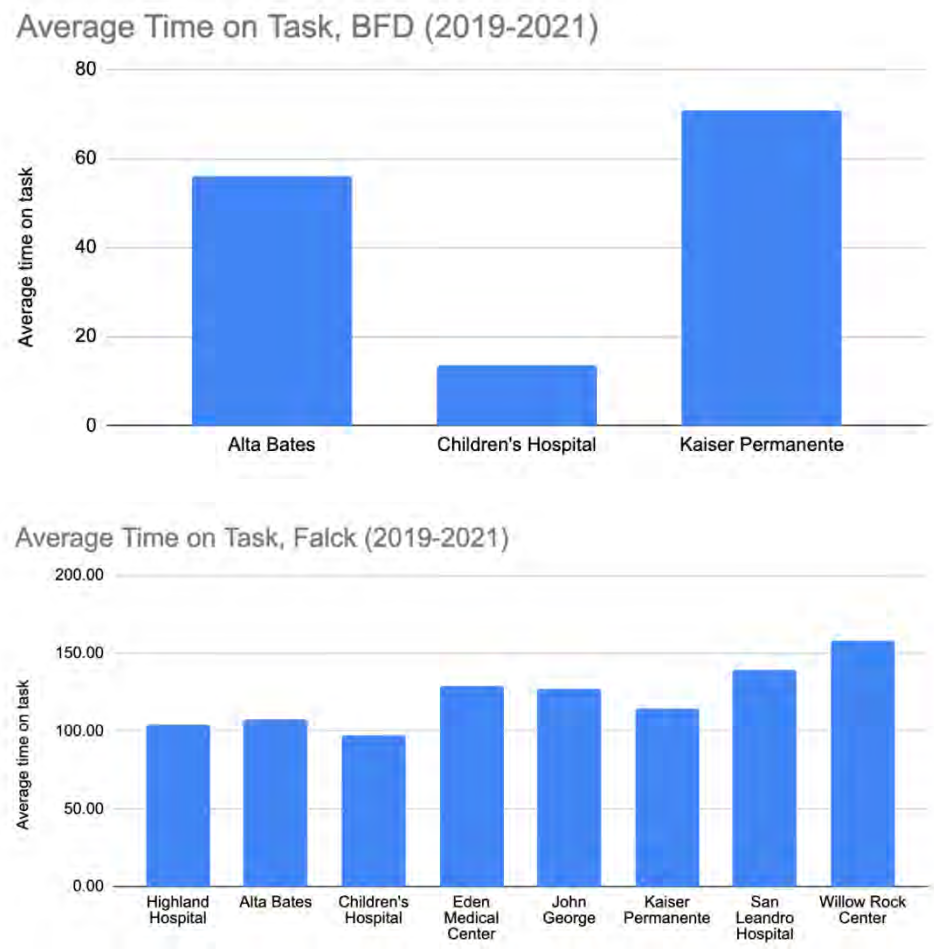
Berkeley Fire Department: The data that BFD shared with RDA (which included data from BFD and Falck) included information on the facilities that BFD and Falck transported 5150 cases to between 2019-2021. Falck conducted the large majority of 5150 transports in Berkeley. Most 5150 transports were to Alta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

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



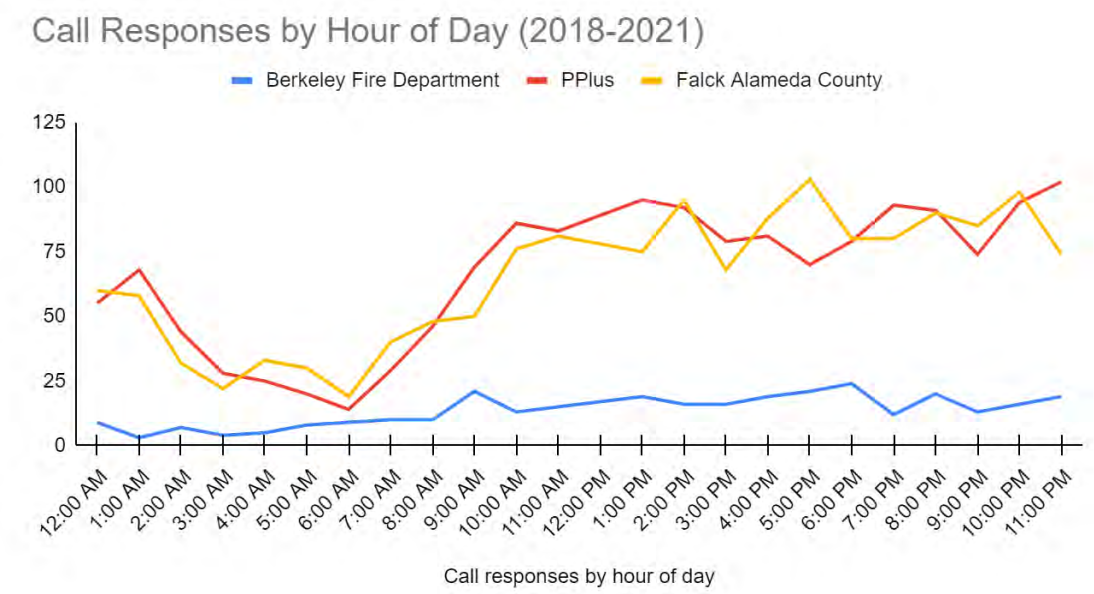
BFD also shared data regarding their and Falck's time on task for each 5150 response and transport. Time on task represents the time from which BFD or Falck arrive at the scene to the point in which they complete the transport of the patient to the destination. Of the 95 5150 transports that BFD conducted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

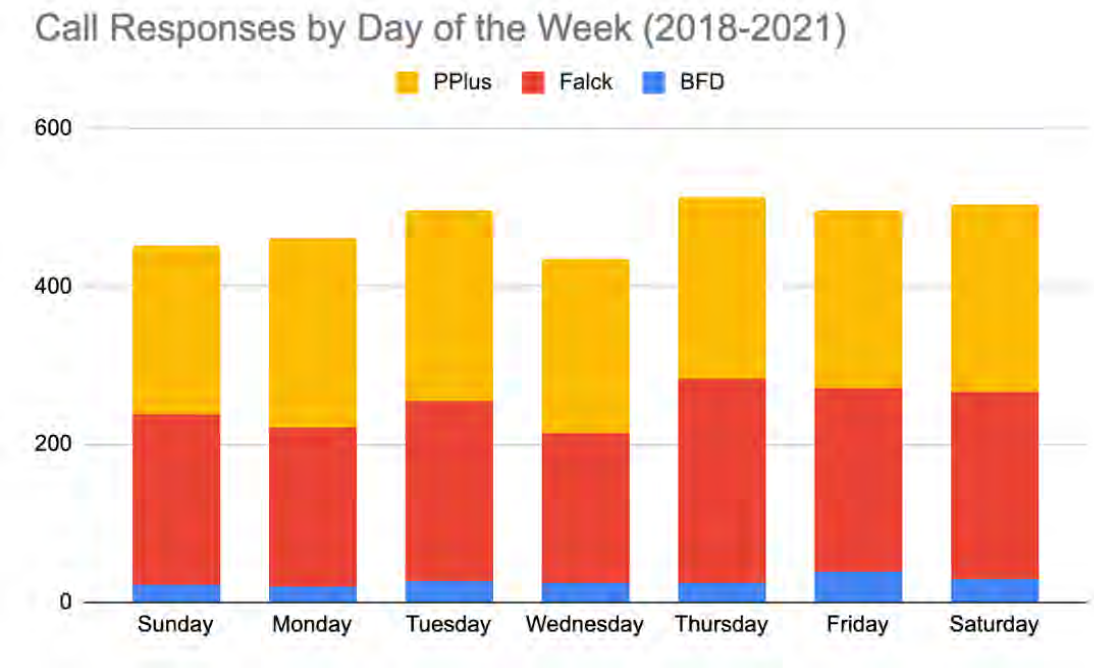
Figure 11. BFD and Falck Time on Task for 5150 Transports, 2019-2021



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

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



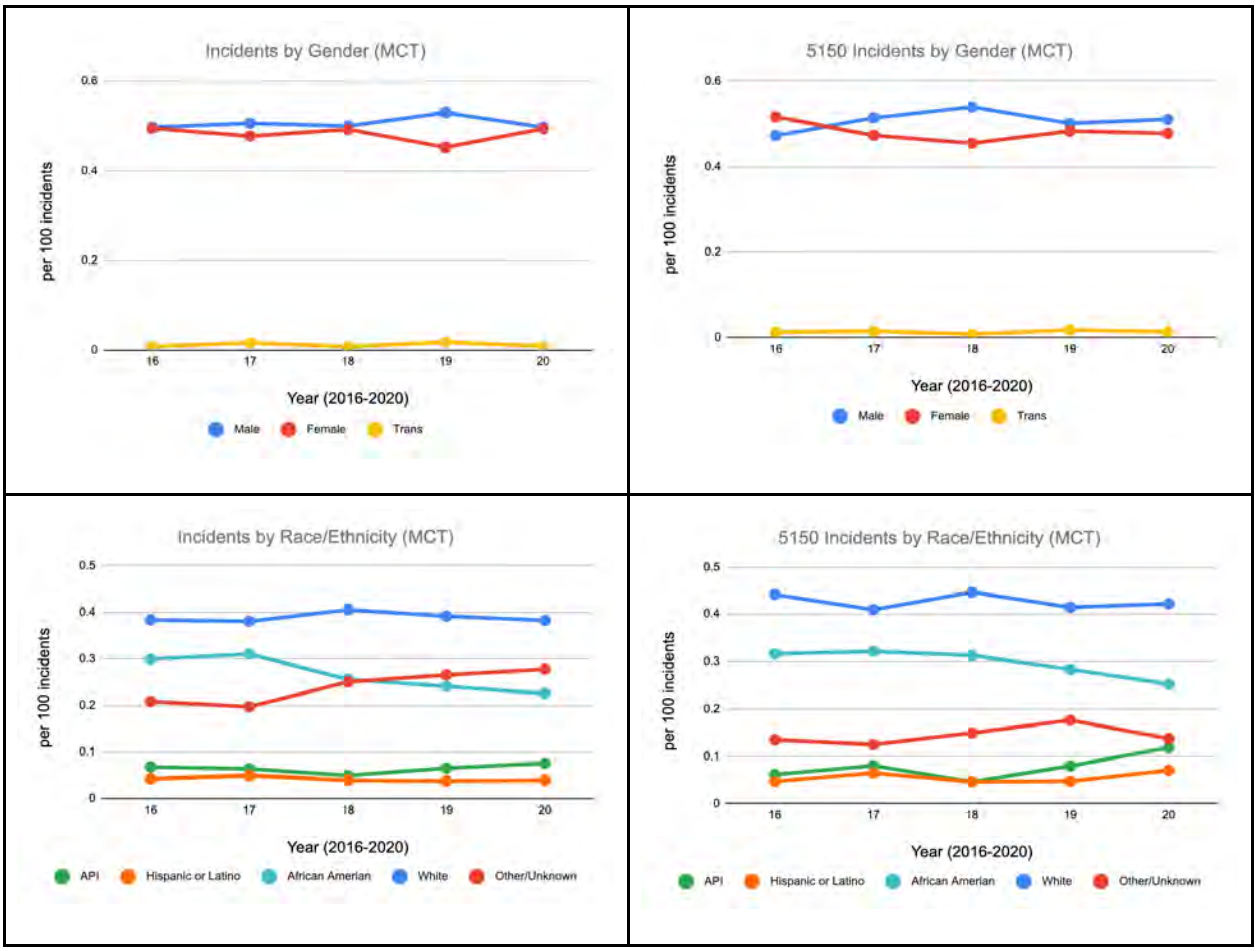


Demographics of Mental Health Call Responses

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

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

Total Incidents	5150s Only



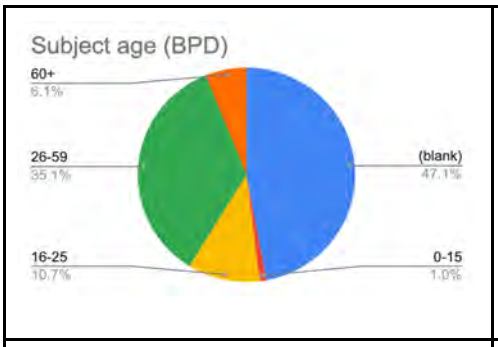
MCT incidents were with slightly more males than females, and very few trans individuals. And, regarding race/ethnicity, MCT cases were most often White, followed by African American, other/unknown, Asian Pacific Islander, and Hispanic or Latino. Given that African Americans comprise only 7.9% of Berkeley's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

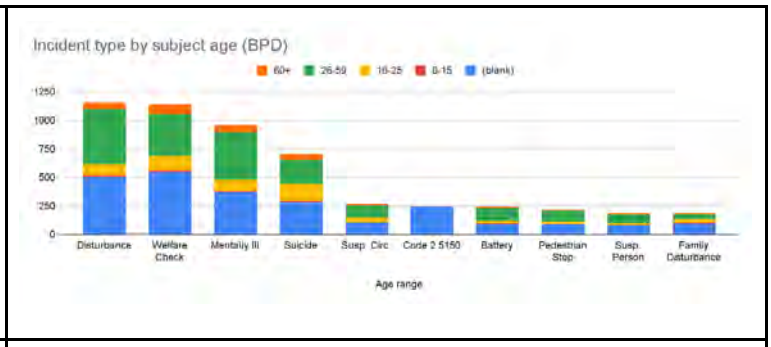
Berkeley Police Department: For the six-year period of CY 2014 through CY 2020, the Berkeley Police Department (BPD) shared data regarding demographics (age, race, and sex) for each of its calls that were originated as designated 5150 responses. Since 2019, the majority of 5150 responses were conducted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

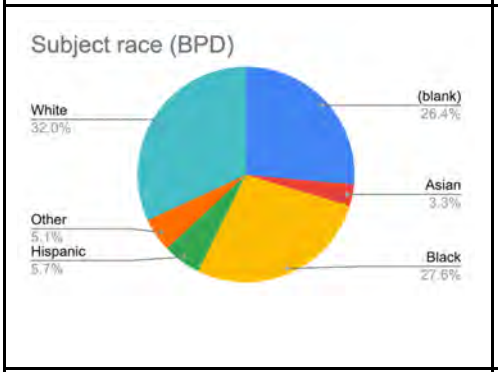
Figure 14. Berkeley Police Department (BPD) 5150 Subjects in 2014-2020 - Demographics and Incident Types[33]

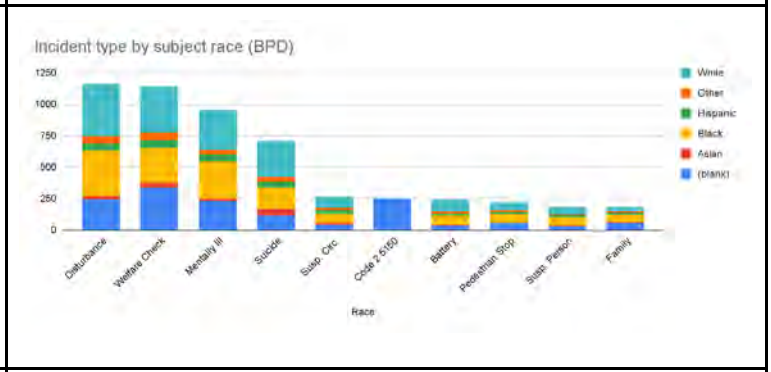
Subjects by Demographics	Incident Types by Demographics

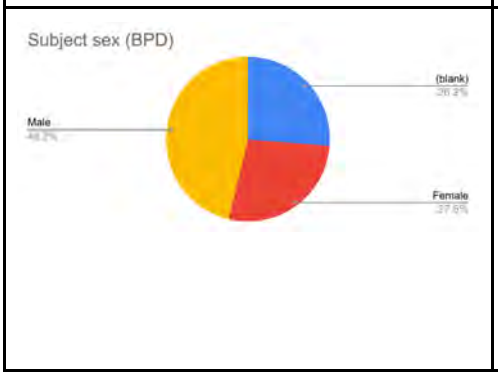
[33] Data noted as (blank) represent data points where data were missing.

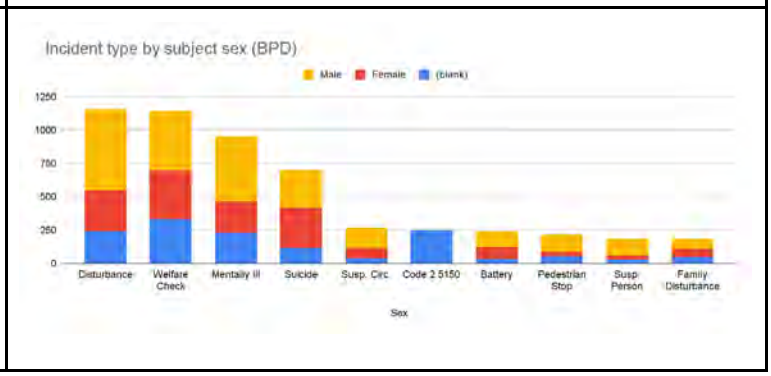










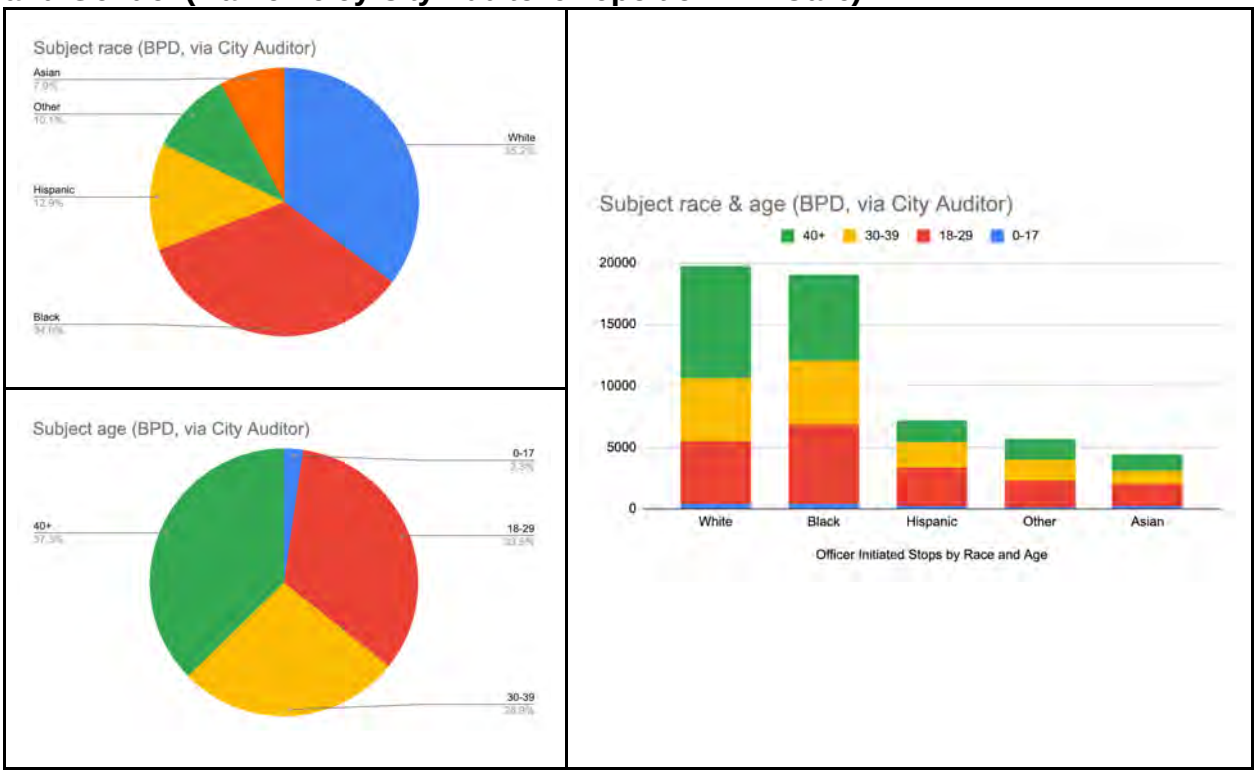


Of the BPD 5150 calls that had demographic variables coded, most responses were with individuals between ages 26-59, White, or male. Liked noted above with MCT's service utilizer population, given that African Americans comprise only 7.9% of Berkeley's population (see Table 1), they are also very overrepresented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

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

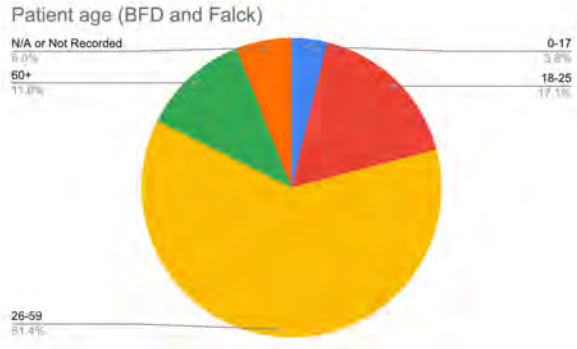
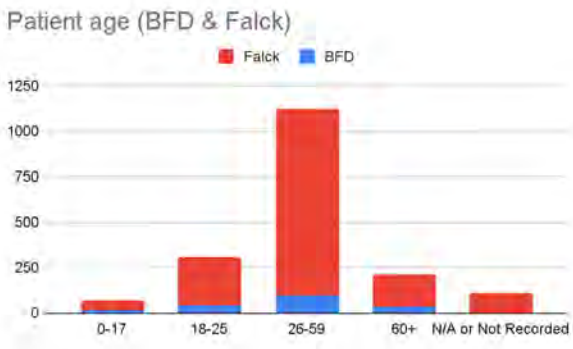
[34] Berkeley City Auditor. (2021, July 2). *Data Analysis of the City of Berkeley's Police Response*. https://www.cityofberkeley.info/uploadedFiles/Auditor/Level_3_-_General/Data%20Analysis%20of%20the%20City%20of%20Berkeley's%20Police%20Response.pdf

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



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

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

Patients by Demographics	Transport Agency by Demographics
	

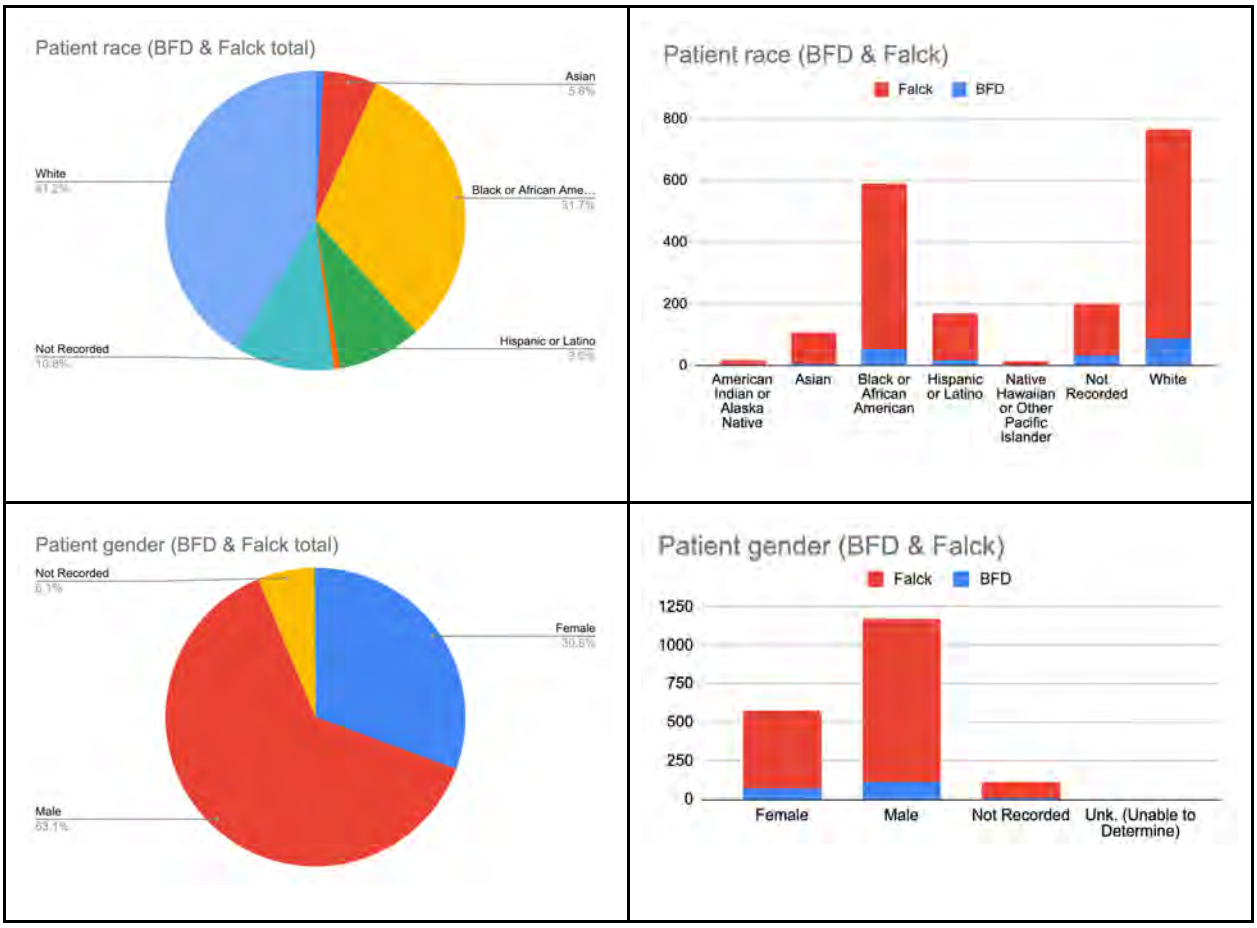
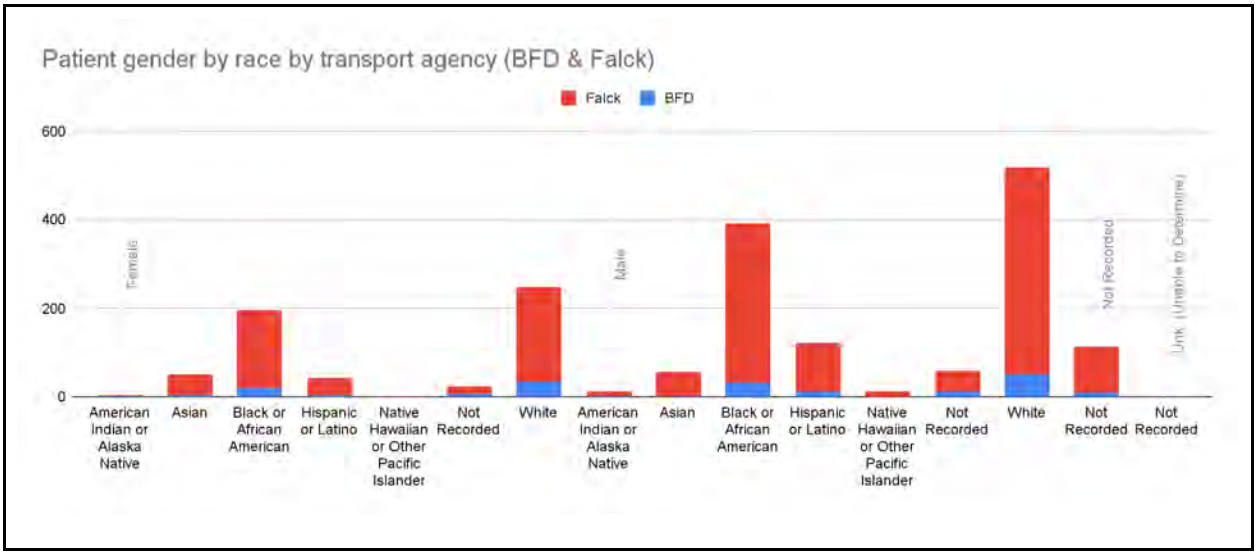
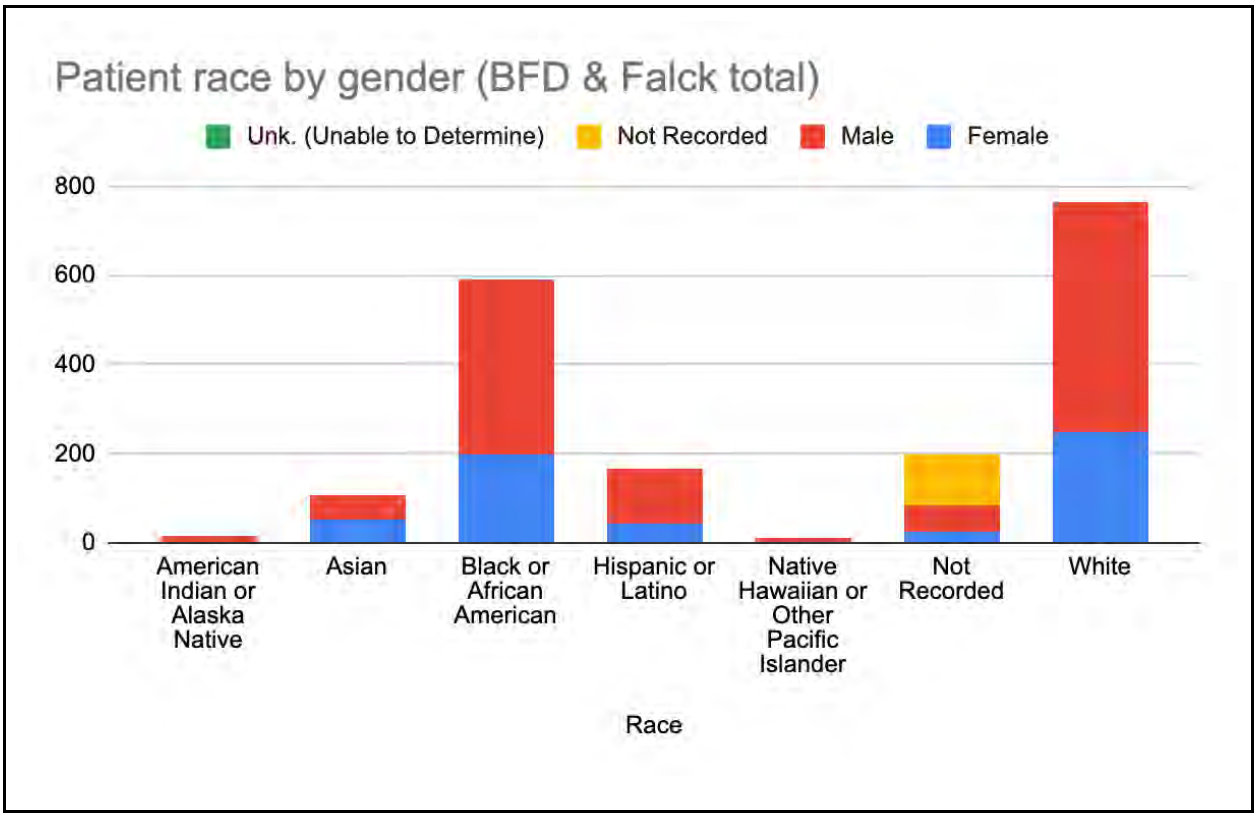


Figure 17. Berkeley Fire Department (BFD) and Falck 5150 Patients in 2019-2021 - By Gender and Race





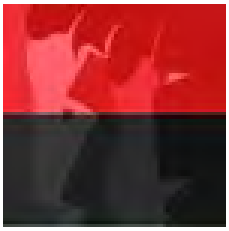
Similar to the incidents that MCT responded to, the 5150 patients that BFD and Falck responded to are mostly between ages 26-59, White, or male. Falck also conducted a large majority of the 5150 transports in Berkeley, as compared to BFD.

Works-Wright, Jamie

From: Works-Wright, Jamie
Sent: Monday, December 6, 2021 12:45 PM
To: Works-Wright, Jamie
Subject: FW: Crisis Stabilization Materials
Attachments: Crisis Stabilization Materials.zip

Please see the email below and attachments from Margaret Fine

Jamie Works-Wright
Consumer Liaison
Jworks-wright@cityofberkeley.info
510-423-8365 cl
510-981-7721 office



From: Margaret Fine <margaretcarolfine@gmail.com>
Sent: Monday, December 6, 2021 11:57 AM
To: Works-Wright, Jamie <JWorks-Wright@cityofberkeley.info>
Subject: Crisis Stabilization Materials

Hi Jamie,

I hope you're well.

Would you please be so kind and send this email and the attachments to the Mental Health Commissioners?

It contains comprehensive materials on alternatives to emergency rooms and jails from many local jurisdictions, including for crisis stabilization units.

It is noted that these materials will be part of the Agenda Packet.

Best wishes,
Margaret

Margaret Fine
Cell: 510-919-4309

Arnold Ventures

HMA
Health Management Associates

A Community Guide for Development of a Crisis Diversion Facility

A Model for Effective Community Response to Behavioral Health Crisis

Prepared for Arnold Ventures
By Bren Manaugh, Amanda Ternan, Michelle Janssen

FEBRUARY 2020

Table of Contents

Acknowledgements

We would like to express the deepest appreciation to the multiple leaders, champions, and stakeholders, and observed programs and facilities in four communities that informed this report. We would also like to thank Arnold Ventures for their commitment to issues outlined in the report, and work to support the development of a product that aims to accelerate work in communities across the country who are pushing to improve outcomes for their most vulnerable populations.

This is an independent report commissioned by Arnold Ventures. The opinions expressed in this publication are not necessarily those of Health Management Associates or the funders.

About Health Management Associates (HMA)

Health Management Associates (HMA) is an independent national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. HMA provides technical assistance, resources, decision support and expertise and works across disciplines to put our knowledge to work supporting clients in addressing healthcare's challenges.

About Arnold Ventures (AV)

Arnold Ventures is a philanthropy dedicated to tackling some of the most pressing problems in the United States. AV invests in sustainable change, building it from the ground up based on research, deep thinking, and a strong foundation of evidence. AV drives public conversation, crafts policy, and inspires action through education and advocacy.

AV is headquartered in Houston with offices in New York and Washington, D.C. The philanthropy's work focuses on four key issue areas: Criminal Justice, Education, Health, and Public Finance. Their work is guided by Evidence-Based Policy, Research, and Advocacy.

Effective Response to Individuals in Crisis: An Opportunity for Communities and States

Communities across the country are increasingly challenged by pressures on their healthcare and criminal justice systems from high volumes of persons experiencing behavioral health (BH) crises arising from mental health, addiction, and related unresolved needs.[4] People suffering from substance use and mental health challenges, or both, often have limited access to health care and face other barriers, contributing to increased utilization of emergency criminal justice and health services.[5]

Mental illness and substance use drive a disproportionate number of avoidable emergency department (ED) and, at the same time, are recognized as contributing to repeated involvement with the criminal justice system, 911/ emergency response, and other safety net systems.[6, 7]

While the number of people presenting at the ED with mental health emergencies has increased, the number of psychiatric inpatient beds has dropped, with the result that EDs often serve as a holding facility for transition to inpatient psychiatric care; a practice known as psychiatric boarding.[8] EDs are intended for acute medical care and typically are not equipped to effectively respond to psychiatric emergencies. A recent survey of emergency physicians indicated that only about 17% of EDs had an on-call psychiatrist.[9] A significant number of people who are currently admitted could have their treatment needs addressed with more appropriate interventions and in a more appropriate setting.[10]

In addition to high rates of mental health conditions, as many as two-thirds of people in correctional settings have a diagnosable substance use disorder.[11] And, increasingly, homelessness and other social determinants of health are recognized as contributing to criminal justice system and ED encounters.[12] People in jails with mental health and/or substance use conditions are most likely to be there due to low-level offenses like jaywalking, disorderly conduct, or trespassing.[13] Concerns about these trends, and mounting pressures on jail capacity, have led to efforts to generate solutions that are both more cost effective and more conducive to effective treatment.

Involvement in the criminal justice system compounds the challenges faced by people with behavioral health issues, interrupting their access to benefits, treatment relationships, and routines and other sources of support and stability, and making them vulnerable to trauma.[14] At the same time, EDs, which provide screening and triage for acute medical conditions, are not the best treatment option for individuals whose crisis state is driven by mental illness and or substance use that could be more effectively addressed in a specialized setting.

To address this reality, the criminal justice system has developed alternatives to booking and incarceration for people whose primary reason for law enforcement encounters is their mental illness or addiction. Programs such as specialized law enforcement training, screening in the field by officers with

From 2006 to 2014 the overall number of ED visits for all reasons in the US increased 14.8% while the increase in the rate for mental health/ substance abuse-related ED encounters was over three times that at 44.1% during this same period.[1]

A 2017 study found that almost half of inmates were diagnosed with a mental illness (48%), of whom 29% had a serious mental illness and 26% had a history of a substance use disorder.[2]

As many as two-thirds of people in correctional settings have a diagnosable substance use disorder.[3]

diversion to assessment, and specialty courts that connect individuals to treatment for their mental health or substance use condition are growing in number across the country and demonstrating positive results. Communities have fostered these alternatives to address concerns about jail capacity and to better serve individuals who are in the criminal justice system because of their circumstances, not because they pose a risk to public safety.

Lack of coordination across the multiple points of community response to BH crisis leads to fragmentation and gaps despite best efforts of providers and responders and considerable investment of safety net dollars. These system gaps ultimately contribute to potentially avoidable ED and criminal justice system encounters. The development of a crisis services model with timely interventions at the least restrictive level of care is increasingly recognized as the emerging standard. This approach not only results in better outcomes for persons served but also contributes to reduced costs. Community-based crisis services offer an alternative to costly acute care at hospitals and emergency safety net services, i.e. Emergency Medical Services (EMS), which too often are the response system to behavioral health crisis.[15]

A Promising Model: The Crisis Diversion Facility

The ***crisis diversion facility*** is among emerging community-based strategies to engage and better serve this population. The crisis diversion facility model can be a core component of a coordinated, systemic response, bringing health and service sectors together with law enforcement and first responders in a central facility, providing comprehensive care, reducing reliance on the public safety net and emergency and acute care, and better supporting and stabilizing vulnerable community members.

The crisis diversion facility is a physical hub for a community's crisis continuum of care. This model effectively prevents and responds to BH crises and supports engagement in ongoing mental health and substance use disorder treatment and support services for long term stability. Coordinated BH crisis services are:

- ***24-hour Crisis Lines*** with assessment, screening, triage, preliminary counseling, and information and referral services;
- ***Walk-in Crisis Services*** that offer immediate attention and services to the community on a walk-in basis and drop-off centers for law enforcement to reduce unnecessary arrests;
- ***Mobile Crisis Teams***, available to provide 24/7 community-based screening and assessment in conjunction with law enforcement, crisis hotlines, and hospital emergency personnel;
- ***Crisis Stabilization Units (CSUs)***, sometimes referred to as Extended Observation Units for stays less than 24 hours, are inpatient facilities of less than 16 beds for people in a mental health crisis that serve as a hospital alternative for those whose needs cannot be met safely in residential service settings.

Each of the multiple stakeholders involved in community crisis response and jail diversion, including law enforcement, the judiciary, crisis and community-based providers, and city and county officials, has a specific role within the response system. The crisis diversion facility is based on a common mission and culture of stakeholder collaboration that supersedes individual roles and agendas to inform comprehensive efforts that help people in crisis gain recovery and stability in the community.

Crisis diversion facilities build upon community assets to improve the health and wellbeing of individuals with behavioral health and other challenges, with the result being better outcomes and cost reductions for communities.

A Guide to Crisis Diversion Facilities: What is a Crisis Diversion Facility?

The model crisis diversion facility ...

- ✔ Improves the health and wellbeing of individuals experiencing BH crisis and those with repeated criminal justice system encounters by integrating supports and health care, and law enforcement, criminal justice, and emergency agencies, to improve access to services that reduce reliance on emergency health and public safety response;
- ✔ Is a coordinated community approach by stakeholders with key roles and responsibilities in the system of care that leverages multiple funding streams and community investment;
- ✔ Is developed in alignment with best practices and evidence-based models for driving a service delivery system that is trauma-informed, person-centered, and recovery-oriented.

Arnold Ventures commissioned a study to provide a profile of current promising practices in crisis diversion facilities in the U.S. This report offers a model for BH crisis diversion facilities based on a literature review of strategies for BH crisis and criminal justice diversion in the United States and case studies of four established crisis diversion facilities with promising results. Criteria for the model include:

- Development driven by collaboration and stakeholder input;
- A structure for community governance that includes systematic data sharing and analysis;
- A business case for initial capital expenses and sustainability; and
- A collaborative integrated service delivery system leveraging partnerships and evidence-based practices (see *Detailed Model Framework* included as **Appendix A** of this document).

This Guide is intended to help those who are considering developing a crisis diversion facility with information compiled and lessons learned from successful implementations of such facilities.

Key Elements of Success

The following factors are key elements in developing and sustaining an effective BH crisis diversion facility:

The crisis diversion facility model intentionally addresses and overcomes fragmentation and gaps in the service delivery system with alignment and integration. The model crisis diversion facility does not exist in a vacuum. It serves as the hub for the crisis continuum of care and structured care coordination with community-based services to support recovery and stability. Historically in the American BH service delivery system, mental health and substance use services are separated by funding streams, regulations, and divergent treatment cultures. As conventional wisdom and the evidence base grow to support integrated whole-person care, the crisis diversion facility presents not only the opportunity, but the imperative to integrate mental health and substance use disorder services.

The model crisis diversion facility incorporates standardized screening, assessment, and provision of evidence-based substance use treatment to address the high number of co-occurring mental illness and substance use conditions among the population relying on the safety net, as well as rampant instance of opioid and other substance use disorders leading to crisis. Model facilities have the capacity to provide a full continuum of Medication Assisted Treatment and other evidence-based SUD services on site or have a robust referral partnership that includes warm hand offs and transportation to assure persons served are effectively linked with SUD services.

Making the Case • The visions and goals of the community form the foundation for investment in the crisis diversion facility. Questions like *Why is it important we do this? How will it benefit persons served; key partners; the public? How will we know we are being successful?* are the basis for developing measures and outcomes that tell the story of the facility's progress to generate initial, and continued, investment and support.

Leverage Existing Efforts • Building on iterative efforts and scaling up strategically is an effective way to build both key relationships and the case for larger scale investment. Leaders use their experience in, and results from, other initiatives to develop relationships, foster a culture supporting community response to mental health and addiction, and to inform the business case for a comprehensive crisis diversion facility.

Relationships • Champions for developing a crisis diversion facility build on existing relationships to engage partners and unite the community. These champions share a common vision and commitment to improve their community's ability to respond effectively and compassionately to individuals with mental illness and addiction. They occupy formal roles such as Sheriff, Mayor, District Attorney, Judge, Chief of Police, Chief Executive Officer or Executive Director of primary behavioral health or community agency, County Commissioner or Supervisor, and County Manager, that positions them to have the credibility and authority to drive positive change.

Vision and Goals: • A common vision and goals among the champions and leaders is essential. A vision for serving community members with mental illness and substance use disorders drives establishment of goals aligned with the community's priorities. Priorities vary by community, but common themes are a recognition of the high volume of individuals with mental

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illness and substance use disorders in the jail and on the streets, and the correlation between these behavioral health conditions and frequent contact with 911/emergency response, law enforcement, EDs, and jails. Communities have a common goal to develop a system that better serves their vulnerable residents who experience BH crisis.

Culture: • The organizational culture, perspectives, and agendas of each of the key partners in the coalition is incorporated to create and build a crisis diversion facility. The facility plan is built from the partners' shared vision to provide effective, efficient response and services to community members. The facility's infrastructure supports processes that align with and maximize the roles, responsibilities, and positive impact of each partner.

Person-Centered Care • A commitment to ***person-centered care that is respectful, compassionate, and based on evidence-based and emerging best practice*** is central to planning. Sites use evidence-based models for criminal justice system diversion and deflection and behavioral health community response such as CIT and assisted outpatient treatment; adopt a crisis model based on provision of care in the least restrictive setting possible; and commit to data driven decision-making and continuous quality improvement.

Criminal Justice System Engagement: • Alignment and collaboration with law enforcement and the criminal justice system is critical to effective community response centered in a crisis diversion facility. The Sequential Intercept Model (SIM) is a framework of the SAMHSA GAINS Center that "provides a conceptual framework for communities to organize targeted strategies for justice-involved individuals with behavioral health disorders.[16] Within the criminal justice system there are numerous intercept points — opportunities for linkage to services and for prevention of further penetration into the criminal justice system" and the SIM can be used by communities and states "to assess available resources, determine gaps in services, and plan for community change." [17]

The six intercept points in the Sequential Intercept Model can be examined alongside the movement of people with BH conditions to understand how people come into contact with the criminal justice system and various services within the care continuum. This supports planning for strategic partnerships and allocation of resources to develop effective responses. Crisis diversion facilities are especially well-positioned to support responses at:

- **Intercept 0:** Community Services – In the field, mobile crisis outreach teams, emergency departments, and law enforcement divert to community-based interventions and treatment.
- **Intercept 1:** Law Enforcement – Specialized training for dispatchers and law enforcement officers and specialized police response teams can support diversion to community-based interventions and treatment.
- **Intercept 2:** Initial Detention / Initial Court Hearings - Creating a site to support screening, assessment, and provision of care as a diversion to booking and incarceration and with mental health warrants.
- **Intercept 3:** Jails / Courts - Crisis diversion facilities can play a role in partnering with the judicial system to provide treatment and support to individuals in therapeutic court programs.
- **Intercept 4 and 5:** Reentry and Community Corrections - Support post-incarceration re-entry to the community by improving access to treatment and support services.

Knoxville, Tennessee's Behavioral Health Urgent Care Center (*Figure 1*) and Salt Lake City, Utah's Receiving Center (*Figure 2*) provide examples of the strategic alignment of crisis diversion centers with those communities' sequential intercept systems.

Partnerships, Roles, and Relationships

The crisis diversion facility leverages the roles and strengths of each collaborative partner. Key partners for effective behavioral health crisis diversion are:

- Policy makers and public entities that develop, fund, and contract for services;
- Law enforcement and first responders;
- The courts and judiciary;
- Behavioral health and other community-based providers;
- Hospitals; and
- Community members and stakeholders of the partners listed.

Culture has been described as "how we do things around here." The organizational culture of a behavioral health agency is different from a police department, for example. Project champions develop the crisis diversion facility plan from a common vision incorporating the culture, capabilities, and contributions of each key partner. Essentially, the "people" part of the plan must be in place before the technical and infrastructure development occurs. This shared vision is critical to create an efficient and effective model facility

Key Partners and Roles

Law Enforcement

The primary role of law enforcement is public safety. The crisis diversion facility supports the critical role of law enforcement as first responders to BH crisis, with services that facilitate officers' rapid disposition of individuals in BH crisis. The warm handoff lets officers return to the street in a matter of minutes and provides an alternative to time spent transporting individuals in BH crisis to an emergency department or inpatient facility and waiting for screening and disposition.

Having a "customer centric" perspective for law enforcement officers is essential when planning a facility. As "customers" of the crisis diversion facility, law enforcement officers and deputies benefit from several features of a model facility:

- **Timeliness:** Model facilities have a standard of no more than 15 minutes for an officer to complete a warm handoff of an escorted individual.
- **Convenience:** A dedicated law enforcement entrance and access to a dedicated kiosk for completing paperwork, restrooms, and snack machines: all without the officer being required to disarm.
- **"No Wrong Door":** A common concern of law enforcement is being told upon arrival that an admission is not eligible. If officers are turned away from a facility for eligibility restrictions, they are less likely to use the facility and to go instead where they can count on getting a disposition, in most cases an ED. Model crisis diversion facilities have a "no wrong door" policy to maximize the use of the facility by officers to meet the community's goal of easing the pressure on both the criminal justice system and ED.s.

In Knoxville, Tennessee, the D.A. and law enforcement leaders have established nine charges that are eligible for law enforcement officer disposition to Knoxville's crisis diversion facility, the Behavioral Health Urgent Care Center.

Other First Responders

Emergency Medical Services (EMS) is also on the "front line" with BH crises. Like police officers and sheriff's deputies, EMS has a responsibility to support public safety with the specific charge to provide urgent and emergent health care response whenever and wherever there is a need in the community. EMS uses algorithms and protocols based on prevailing medical standards to identify and respond to all health conditions presenting among the populace. However, mental health and substance use conditions are often co-occurring with medical conditions – acute or chronic – and at the same time mental health and substance use disorder conditions themselves can be co-occurring. The complexity of this presentation combined with the primary role of EMS to perform acute health care triage and transportation has historically resulted in all such cases being transported to an ED, even when the EMS technician suspects that the primary presenting concern is due to mental illness or substance use. Crisis diversion facilities offer a viable alternative for EMS where the patient is determined by established algorithms to not be medically urgent or emergent but requires specialized mental health and/or intoxication assessment that can be effectively provided at the crisis diversion facility instead of an ED. An example of an EMS protocol integrated with a crisis diversion facility can be found in Rhode Island's BH Link Policy Manual.

Criminal Justice and Judicial System

Individuals with a history of BH crisis often also have legal involvement with the criminal justice and judicial system. They may have multiple citations or charges for offenses resulting in outstanding warrants, repeat detentions or incarcerations, or other legal involvement that results from — and contributes to — their instability in the community while also creating a burden on the enforcement system. Specialty courts, District Attorneys, and Public Defenders can partner with law enforcement, providers, and other system stakeholders to develop treatment alternatives for individuals with behavioral health crises that address their core mental illness and/or substance use in lieu of criminal justice actions. Crisis diversion facilities contribute to diversion models by enhancing access of specialty courts to timely assessment and mental health and substance use treatment, and provide an effective institutional link between the criminal justice system and care for individuals impacted by BH challenges.

Community-Based Behavioral Health and Social Services Providers

Agencies offering mental health and substance use disorder services, and those who meet the need for housing, employment, transportation, food, and other social determinants of health, have a critical role in the safety net. Community members in need often also struggle to access routine medical care, leading to chronic conditions that limit their ability to be stable in the community. The model crisis diversion facility views each person through a multidimensional lens that incorporates all these needs. Individuals who frequently encounter safety net services, law enforcement, and first responders may have developed a mistrust of the system due to previous experiences where they felt that they were not treated respectfully or where response failed to resolve their needs. Crisis diversion facilities incorporate the following elements to effectively engage and serve persons in crisis:

- Trauma-informed: Focus on the needs of the individual in an approach and environment that promotes a feeling of safety and security.
- Recovery-oriented: Support individuals experiencing mental disorders and substance use disorders in a process of change through which they improve their health and wellness, live a self-directed life, and can reach their full potential.
- Person-centered: See and deliver services through the eyes and experience of the person served to align services and resources to best meet the individual's goals for recovery.
- Integrated: Coordinate mental health, addiction, health, and social services, resources, and supports in a seamless approach that provides effective individualized response.

BH and social services providers in the crisis diversion facility engage community members to conduct screening and assessment, and follow up services, in a crisis stabilization unit or with outpatient care that support resolution of crisis without relying on acute care facilities.

City, County and State Administrators and Elected Officials

City, county, and state governments and elected officials are stewards of dollars for critical infrastructure and safety net services and have a responsibility to implement policy that meets the needs of constituents and preserves the public trust. The crisis diversion facility offers public officials and leaders an opportunity to invest in a model that transcends the traditional silos of safety net services and delivers improved outcomes and reduced costs. Policy makers and funders can play a strong role in driving and supporting alignment across the system's variety of agencies and entities that must work together to provide coordinated BH crisis response.

- Through the leadership of the governor's office, Rhode Island developed a crisis diversion facility, BH Link. Sustainability of ongoing operations is supported by implementation of a Medicaid case rate for individuals served at BH Link. This rate "bundles" services offered at BH Link into a payment model alternative to the traditional fee for service model. Such case rates are developed to reflect the value driven by better coordinating care in a defined service model that improves outcomes and reduces costs.
- In Tennessee, state funding for jail diversion initiatives funded the development of and will support ongoing operations at the Behavioral Health Urgent Care Center in Knoxville.

State policy can play a critical role in incentivizing cross system coordination through rewards, penalties, and contract standards. See the "Funding" section for additional details on these initiatives.

Hospitals

Hospitals and other acute health care facilities provide assessment and treatment of individuals experiencing acute medical conditions, including those co-occurring with or caused by BH conditions. The crisis diversion facility model offers an alternative to ED and other hospital encounters. Model crisis diversion facilities offer mental health and substance use disorder screening and assessments, immediate stabilization services, including those for psychiatric crisis stabilization and substance use withdrawal, and can triage and stabilize minor medical conditions. Law enforcement officers and EMS technicians can divert from EDs and inpatient care to an appropriate lower level of care. Hospitals can save resources for acute care that can only be provided in a hospital to better meet community emergency health needs.

Data and Analysis

The stories told by communities about how and why they want to better respond to community members with mental health and substance use conditions give rise to the crisis diversion facility that fulfills the community's vision.

Data that reflect the community's issues and challenges help make the case for the imperative to support a model facility to better serve people with BH conditions. The data paint the picture of the need which in turn ignites community members' compassion and commitment to developing solutions. Some data points communities have used to make the case for a crisis diversion facility include:

- Jail bed census compared to jail capacity
- Numbers of persons in jail with a diagnosed BH condition
- Recidivism rate of individuals with a diagnosed BH condition
- Number of MH warrants served and where individuals under warrant receive crisis intervention
- Law enforcement officer/deputy response to BH crisis
  - Number of responses
  - Average time spent until disposition of BH crisis
- Costs associated with
  - Jail bed days, including for one:one – or – individual observation for detainees with high risk BH conditions
  - Booking costs for individuals with BH conditions
  - Law enforcement officer BH crisis response time

The Data-Driven Justice Playbook outlines a multi-step strategy for the use of data to engage and inform a community effort to develop a criminal justice diversion system: [18]

- Use data to tell the story of challenges your community faces;
- Use data to show that change is needed;
- Establish agreements for sharing data; and
- Integrate data across systems to understand the magnitude of cross-system utilization and key characteristics of cross-system utilizers.

> To further tell the story, community members developing a crisis diversion facility must ask the question, "Who will be served at the crisis diversion facility?"

This question is best answered by considering the community's pain points where people in BH crisis intersect with the criminal justice and emergency response systems. The population of focus is typically people with BH conditions with multiple police encounters for low-level offenses (criminal trespass, failure to appear on citations for jaywalking, panhandling) or due to community complaints requiring law enforcement response; those who frequent the ED with issues due to their BH condition but not requiring acute-level care; and frequent 911 utilizers with, again, issues that could be resolved without the involvement of emergency response services.

As community leaders develop their data story, the following elements are important in planning:

- Include experts in information technology and data analytics such as the CIO, Privacy Officer, Finance/CFO, and Database Administrators from participating agencies in the planning process for data collection. These subject matter experts can assist with identifying data sources and plan how to systematically collect information to make the case for the facility and to profile the population to be served. They can also resolve concerns regarding privacy and other aspects of data sharing. The Data-Driven Justice Playbook outlines key steps to build consensus and document the specific uses for sharing data, identifying the minimum types and amounts of data needed to achieve the established purpose, while offering ongoing opportunities to inform individuals and the public about how their data are being used to gain trust, and building privacy, security, and civil liberty protections into the design of the data sharing systems.[19] To guide development efforts, the U.S. Department of Health and Human Services (HHS) provides answers to many of the common questions and misperceptions regarding HIPAA. [20]
- Develop the framework for ongoing data collection to support clear actionable milestones, data-sharing, and data-driven process improvement. Communities and organizations often fail to do this initial work to determine what data is needed to prove the positive impact of their facility and how the data will be collected and monitored. Not doing this work upfront means a lost opportunity to build a strong "business case" for the facility that attracts investment from varied partners and supports sustainability through continued funding support. Funders of all types and at all levels — private and public; individual, city, county, state, and federal – are most likely to financially support facility development efforts and ongoing operations that are represented by a data-based proof of concept and evaluation model. This guide's companion report profiles four crisis diversion facilities and includes examples of community data "stories", with examples from these, and other sites, summarized below.

Rapid City, Pennington County, South Dakota

Rapid City in Pennington County South Dakota is the site of The Care Campus, a facility that opened in September 2018 offering a single point of entry to the community for, and law enforcement disposition of, behavioral health crisis with co-located programs in one location. The Care Campus is a partnership of the Pennington County Sheriff's Office; Pennington County Health and Human Services; the City of Rapid City; and the Crisis Care Center operated by Behavior Management Systems, a private provider under the oversight of the Pennington County Sheriff's Office. The Care Campus includes a full continuum of co-located services addressing the crisis stage of mental health and substance use disorders and support services to assist Care Campus clients with attaining recovery and maintaining stability in the community. Services at the Care Campus are documented in the same electronic record that is used for the Rapid City Police Department, Pennington County Sheriff, Pennington County Jail and Juvenile Detention Center. This creates a coordinated view of individuals served in the Care Campus with their history in the criminal justice system, while also supporting the ability to analyze and report on a shift in costs from jail to services provided at the Care Campus.

Knoxville, Knox County, Tennessee

The Behavioral Health Urgent Care Center (BHUCC) in Knoxville, Tennessee, is a collaborative effort of leaders from county and city government, the District Attorney, Knoxville Police Department, Sheriff, and the Helen Ross McNabb Center, a private behavioral health agency. The BHUCC, which opened in March 2018, provides a full continuum of crisis services and drop off disposition for law enforcement. Nine misdemeanor charges have been standardized for which law enforcement can automatically divert individuals who appear to have behavioral health issues to the BHUCC unless deemed violent, or for other exclusions based on risk. They are assessed and offered voluntary admission in lieu of charges being filed. The BHUCC staff, law enforcement, and DA's office track the following measures to support ongoing quality and utilization monitoring of the BHUCC. See Table 1 for more detail.