

DEFUND THE POLICE - INVEST IN COMMUNITY CARE

A Guide to Alternative Mental Health Responses



Defund the Police - Invest in Community Care: A Guide to Alternative Mental Health Responses

IC INTERRUPTING CRIMINALIZATION

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INTRODUCTION

Background

Ignited by the murders of George Floyd, Breonna Taylor, Tony McDade, and hundreds more killed by police over the past year, the summer uprisings of 2020 marked a critical historical juncture in the movement for racial justice and protest against police violence. Amidst a global pandemic during the last term of the Trump administration, the movement to defund the police¹ gained new ground, resulting in the largest social movement in U.S. history. Further fueled by the Minneapolis City Council's announcement of a decision to dissolve their local police department to create a new department of Community Safety and Violence Prevention, people power pushed federal, state, and local governments to redefine and resource safety as community systems of care, and not the police.

For the first time, broad national attention to police killings turned not toward more reforms like body cameras and more training, but toward divesting from police altogether and investing in the things communities need to actually be safe. Social movements directed attention to the ways in which bloated police budgets preclude municipalities from meeting community needs, demanding significant cuts to policing and investments in community safety.

Over the past year, the question of where can we invest dollars in place of police responses has increasingly taken center stage: how do our demands to invest in community care -- housing, health, mental health, education, jobs, culture, climate -- translate into programs, policies, and frameworks for the future? Envisioning and implementing non-police responses to mental health crises and traffic enforcement² are two areas in which the most concrete proposals have emerged.

The Focus on Mental Health

Since 2015, over 6,000 people have been shot and killed by the police, averaging around 1,000 per year. Of those 6,000, close to 1,500 or almost 1 in 4 (23%) were people who were - or were perceived to be - experiencing a mental health crisis, with that figure rising to 39% in small or mid-size metropolitan areas.³

¹ Efforts to divest from policing and invest in community safety are not new. For instance, Oakland's Anti-Police Terror Project named their campaign DefundOPD in 2015. See <https://www.defundopd.org/>. For more information on campaigns across the country to defund police, please see Interrupting Criminalization's report *The Demand is Still Defund the Police*. January 2020, available at bit.ly/DefundPoliceUpdate, and visit defundpolice.org.

² For more information on non-police models of traffic enforcement, see O'Connor, M. (2021, Jan 13). "What traffic enforcement without police could look like," *The Appeal*. (<https://theappeal.org/traffic-enforcement-without-police/>).

³ See Kindy, K., Tate, J., Jenkins, J., & Mellnik, T. (2020, Oct 17). "Fatal police shootings of mentally ill people are 39% more likely to take place in small and midsize areas," *The Washington Post*. (https://www.washingtonpost.com/national/police-mentally-ill-deaths/2020/10/17/8dd5bcf6-0245-11eb-b7ed-141dd88560ea_story.html).

Of these killings, over 42% were of Black and Latinx people.⁴ A person with unmet mental health needs is 16 times more likely to be killed by the police.⁵ These alarming figures do not reflect the mass incarceration of people with mental and cognitive disabilities and unmet mental health needs locked up in jails in prisons, conservatively estimated at bookings numbering 2 million every year,⁶ in psychiatric institutions, in emergency rooms, homeless/houseless in the streets, and dying by suicide or overdose every day.

Efforts to defund the police and invest in community care are far from new. However, in the midst of the summer uprisings of 2020, a growing number of cities and counties across the U.S. began to consider and implement new policies and programs that limit or change police contact with the public in both an effort to stop the killings and to create systems of care that effectively address the crises. In this context, considerable attention has been paid to mental health and non-police mental health crisis responses. While the strength of organizing already on the ground has been key to the success of community-driven strategies, the widespread and rapid mobilization and engagement of city and county elected officials and institutions, legislators, police and sheriff departments, fire departments, dispatch units, and private and non-profit mental health providers in these conversations elevates the speed and scope necessary for community-led efforts to remain at the center.

In drafting this guide, we asked ourselves the following questions:

- ▶ ***What proposals for alternative mental health crisis response are gaining traction? What do they involve?***

- ▶ ***Have they moved beyond talk to reality?***

- ▶ ***Do they really provide non-police responses – or are they simply a cover for continued police control?***

Additionally, new legislation at the federal and state levels such as the federal CAHOOTS Act and a new emergency 9-8-8 telephone system (see section on legislation for more on these proposals) are poised to bring potential dollars and mandates to what are now mostly local measures.

⁴ For an up-to-date count, see the Washington Post Police Shootings Database available at <https://www.washingtonpost.com/graphics/investigations/police-shootings-database/>. See also Mapping Police Violence for 2020 statistics: https://policeviolencereport.org/?gclid=CjwKCAjwm7mEBhBsEiwA_of-TANlZ8ehrZ5ugfwgZYQhUPBrAHHs8TMsvOB1Rsk_InQpuVUFsAmdfhoClpAQAvD_BwE.

⁵ Darrach, A. (2021, Jun 19). "Imperfect Victims: Mental Illness and Police Brutality," Columbia Journalism Review. Podcast. (<https://www.cjr.org/podcast/mental-illness-police-brutality-racism.php>).

⁶ National Alliance on Mental Illness (NAMI). (2021, Mar 10). "Help Not Handcuffs: Legislation and Community Models." (<https://www.nami.org/Blogs/NAMI-s-Ask-the-Expert/2021/Help-Not-Handcuffs-Legislation-Community-Models>).

With respect to these initiatives, we asked ourselves:

- ▶ *What legislation related to mental health crisis response is likely to pass or has already passed?*
- ▶ *What impact will it have on what alternative mental health crisis responses, and which models are actually funded and implemented?*

Purpose

Given the urgency of these current proposals, the primary purpose of this guide is to serve as a pragmatic tool for individuals and communities organizing and advocating for non-police mental health crisis responses, and to offer key considerations for what can be a complex, costly, and long-term intervention strategy.

This guide highlights considerations for real, meaningful shifts away from law enforcement and towards autonomous, self-determined community-based resources and responses to unmet mental health needs. It also takes into account a range of knowledge and expertise among the intended audience: community members, advocates, organizers, activists, mental health professionals, policymakers, and other change agents working towards the selection and implementation of mental health crisis responses.

This guide aims to:

- Clarify distinctions between current and proposed mental health crisis responses;
- Identify key organizing points that can make a difference between alternatives still controlled by, reliant upon, and driving resources to law enforcement -- and community led and driven options;
- Provide case examples from current organizing struggles to inform strategies determining future models for implementation;
- Build and strengthen multiple non-police mental health options and resources available and accountable to impacted communities -- Black, Indigenous, and communities of color (BIPOC), lesbian, gay, bisexual, trans, queer, intersex, asexual (LGBTQIA+), immigrant (including undocumented), disabled (taking into account the full spectrum of disabilities), youth, criminalized, homeless/houseless and other people and communities who may be likely to experience unmet mental health needs or be subjected to law enforcement-based or coercive mental health crisis responses.

What This Guide Does Not Do

Our goal is to offer an initial and overarching overview of the current landscape of non-police mental health responses. However, it does not and cannot serve every purpose necessary for the selection and implementation of alternative mental health responses. For example:

- This is not a guide that can dictate what is necessary for every location or person. Specific local needs and demographics, local relationships and networks, options already available, political and economic conditions, local laws and lawmakers, and unique organizing histories and capacities differ in each locale. It is necessary for each community to make the assessment regarding local conditions -- and organize strategies and tactics that best fit these conditions. Again, this guide helps to organize key considerations in what can be a complex, costly, and long-term intervention strategy.
- This guide reviews and builds around some key mental health response models and local strategies currently at the forefront of policy and legislative efforts across the country, but it is not a complete compendium of all current or possible models.
- This guide does not address the entire array of mental health interventions available or needed to collectively and accessibly meet our communities' mental health needs. It remains focused on currently proposed non-police mental health crisis responses, with an emphasis on mobile responses.

This guide does, however, highlight peer-led, mutual aid, harm-reduction, and self-determined options (e.g., CAT-911 and Fireweed Collective) to emphasize how critical and central these are to the overarching eco-system of non-police mental health responses.

New Opportunities

Organizing and initiatives to divest from policing and invest in non-police community-based safety strategies around the country are creating new openings and opportunities to advance new models for mental health prevention and intervention. Today, references to alternative response systems, particularly CAHOOTS, proliferate in reports, legislation, recommendations and pronouncements. However, seemingly overarching support for alternatives to police-only mental health crisis response obscures the complex factors and distinctions that underlie current and potential options. It has also led to new areas of struggle, as navigating mental health crisis response at a city, state or national scale requires engagement with and by elected officials, governmental agencies, and community organizers, activists, and advocates -- some with little prior experience of interaction with each other or mental health crisis response.

In this context, proponents of reduced police, non-police, and, in some cases, abolitionist, practices and policies to respond to unmet mental health needs may struggle to define:

- **Relationships to law enforcement** (and other authorities such as fire departments, departments of health and/or mental health, offices of violence prevention, and other governmental agencies);
- **Relationships to complex institutions that make up mental health and health systems** -- including city and county mental health departments, emerging departments of community safety and violence prevention, psychiatric institutions, hospitals, mental health clinics, homeless/houseless crisis response, and the array of for-profit and non-profit mental health organizations;
- **Accountability to and direction by people and communities most impacted by mental health crises and police violence** including BIPOC, poor, mentally and physically disabled, neuro-divergent, LGBTQIA+, immigrant (including undocumented), criminalized, and homeless/houseless people and communities;
- **Relationships to autonomous community-led and controlled institutions** including radical peer and self-determined mental health, healing justice spaces.

A Note on the Terms “Alternative” & “Mental Health Crisis”

This report uses the term “alternative” to refer to an array of reduced, non-policing and, in some cases, anti-policing mental health crisis responses. This language was chosen to take advantage of the high public usage of the term “alternative” (in the arenas of both campaigns to defund police and mental health crisis response) to refer to a significant move away from police-only and police-involved mental health responses. As Interrupting Criminalization has pointed out in the past, not every police activity or function requires an “alternative,” nor can a single “alternative” response meet the multiplicity of community needs. Use of the term “alternative” in this guide does not imply the promotion of or preference for the term “alternative,” but serves as an entry point based on currently used terms to the more nuanced aims of this report.

In addition, in this guide, the term, “alternative,” points more narrowly to “alternative to police-only” mental health crisis responses -- and not necessarily alternatives to responses that involve policing or social control, such as reliance on regulated mental health professionals, social workers, and/or clinical, hospital, psychological, and psychiatric responses to people experiencing unmet mental health needs or mental health crises. Many medicalized responses to mental health needs are

coercive and experienced as policing or social control. These professionalized responses are implicated and referred to in our discussions of implementation of all three primary models reviewed here. Closer attention to critiques of the expansive array of coercive or punitive medical responses to disabled people and people with unmet mental health needs is necessary.⁷ For more information on reforms to avoid from the Abolition and Disability Justice Coalition, please see Appendix C.

This guide also uses the term “mental health crisis response” in a field in which many different terms may be used to refer to these types of responses. The report authors understand that there is contention over even more fundamental terms such as “mental health,” “mental illness,” and “mental health crisis.” Our choices for the purpose of this report are not intended to dismiss these critical contentions, distinctions, and contexts in which they take place. Again, these terms are used as an entry point to the current discussion within the limited aims of this guide.

Mapping Mental Health Crisis Responses

While police-only responses to mental health crisis still dominate, other alternative mental health crisis responses under consideration (or, in some cases, already implemented) include:

- **Co-Response or “police-mental health collaboration” (PMHC)** (the most common option which involves police accompanied by a mental health professional - part of a broader set of police strategies known as crisis intervention teams (CIT))
- **CAHOOTS**-type models (diversion at the point of 911 dispatch to non-police mental health response; these programs are coordinated with police, enabling the police to maintain a role in situations involving higher level threats of violence, including use of weapons) -- includes more recent STAR (Denver) and MACRO (Oakland) adaptations (see section on Implementation Cautions and Challenges for more information)
- **Mental Health First-type models** (completely non-police dispatch and implementation - centralized and coordinated community-based mental health crisis response model - created by and accountable to most impacted communities)

⁷ For more information on critiques of coercive medical and social worker based interventions, please see the Abolition and Disability Justice Coalition’s “Reforms to Avoid” (<https://abolitionanddisabilityjustice.com/reforms-to-oppose/>); The “Medical Industrial Complex Visual” (<https://leavingevidence.wordpress.com/2015/02/06/medical-industrial-complex-visual/>); and Lewis, T. L. (2020, Oct 7), “Disability justice is an essential part of abolishing police and prisons,” Abolition for the People. (<https://level.medium.com/disability-justice-is-an-essential-part-of-abolishing-police-and-prisons-2b4a019b5730>).

These models are primarily focused on mental health crisis response - answering calls for assistance when unmet mental health needs reach a crisis point, or at least when someone - a family member, neighbor, business owner, or bystander feels they have. Some, including Mental Health First, are also focused on mental health crisis prevention - reaching people and offering support before a crisis point is reached. Disability justice advocates, including members of the Harriet Tubman Collective,⁸ point to the need to focus on crisis prevention - and that meeting basic needs for food, housing, income support, and caregiving, ending criminalization, and widely available, non-coercive, non-judgmental, affirming and accessible mental health care in communities, including respite centers, are all essential components of mental health crisis prevention.

In addition, completely non-police community-based efforts to provide peer-led, mutual aid support, including mental health crisis response, without specific foundation funding or state support have always existed and are expanding. Many of our communities have always provided “actual, valuable, life-saving practices, as ‘that’s just what we do.’”⁹ These generally fall under the categories of disability justice, healing justice, and harm reduction. Some models include:

- **CAT 911**-type models (informal, decentralized community-based mutual aid networks providing crisis mental health responses and resources);
- **Fireweed Collective**-type models (peer-led community-based organization providing mental health-related harm-reduction, peer-support, and mutual aid through a healing justice lens led by and for most directly impacted individuals and communities).

What is Crisis Intervention Training (CIT)

The acronym CIT is used to refer to Crisis Intervention Training or Crisis Intervention Teams. Crisis Intervention Teams are discussed in greater detail in this guide under the “co-response” model.

Crisis Intervention Training refers to specialized training received by a select number of officers focused on “understanding behavioral health, developing empathy, navigating community resources, de-escalation skills, and practical application.”¹⁰ While proponents of CIT training recommend that officers receive at least 40 hours of training, many jurisdictions certify officers as CIT trained with as little as 10 hours of additional training. Crisis intervention training can take place as part of a crisis intervention team model or separately.

⁸ For more information on the Harriet Tubman Collective, please visit: <https://www.facebook.com/HTCollective/>

⁹ Quote by Monique Noel organizer with the Los Angeles Community Action Network (LA CAN).

¹⁰ CIT International, Inc., Crisis Intervention Team Program. (https://citinternational.org/resources/Pictures/CIT_Broad_Overview.pdf).

Officers trained in CIT have been responsible for a number of killings of people who were or were perceived to be in a mental health crisis, including Michelle Cusseaux, David Felix, Charleena Lyles, and Decynthia Clements, among others. The American Rescue Plan Act has set aside \$80 million for training which will not only go toward training health care providers but also CIT training for the police.¹¹

Analysis

Co-response can reduce police-only response, but it is not a real alternative to police or law-enforcement based responses. Look out for and beware of co-response as a police-controlled and government-preferred alternative – used to divert from other non-police options.

- **Police, sheriffs, and other systems** (many times, including Department of Health/Mental Health, Department of Public Health, Department of Public Safety or Violence Prevention, Fire Department), will push for **reforms that will not jeopardize police legitimacy, role, control, and funds.**
- **Co-response is not a real alternative to a police response** -- co-response still relies upon police involvement and control of mental health response, even if in collaboration with mental health providers. In fact, mental health providers are often responsible for retaining ties to and calling in the police in the context of mental health crisis responses, and for participating in or facilitating coercive and punitive “treatment,” including incarceration, whether in a “mental health jail” or locked psychiatric ward.
- **Co-response often involves a police-only response first**, followed by a discretionary or mandatory (although mandates are frequently violated) determination to call in mental health professionals once police have already have first engagement. For instance, in the case of David Felix, a Black queer youth killed by police in a New York City housing facility for people receiving mental health treatment, officers were trained to call in mental health professionals, but did not do so. The officers who killed Charleena Lyles and Decynthia Clements similarly failed to call in mental health professionals.
- **Co-response also prioritizes the central role for law enforcement in mental health response**, even if mediated by specialized training and collaboration with mental health professionals -- law enforcement remains the overarching decision-maker in co-response models. Health care providers and first responders report that officers on the scene will often forcefully advocate for or order use of chemical or physical restraints over time and de-escalation techniques.

¹¹ Sec. 2703 (a) and (b), H.R. 1319, 117th Congress. (<https://www.congress.gov/bill/117th-congress/house-bill/1319/text#HB-6589B580E1E483AAE96521C14D42BB5>).

- **Because mental health systems and programs have been defunded and deprioritized as police budgets have skyrocketed, there are often not enough mental health workers to respond to all mental health calls received by police** - as a result, mental health professionals often only respond to the most “severe” mental health calls, leaving the remainder to be handled by cops alone. For instance, in Chicago, seven community based mental health clinics were closed and only one remains, while the city continues to spend 40% of its budget on the police department.
- **Changes proposed by police, sheriffs, and reformers invested in the continued involvement in police will tend towards co-response implementation** (or expansion, if co-response already exists) - which requires funds to go through law enforcement agencies - at the expense of any new or existing systems based in the community. For instance, NAMI, the Leadership Conference for Civil Rights, and the Center for Policing Equity promote co-response models.¹²
- **Departments of Health/Mental Health, Department of Public Health, Department of Public Safety or Violence Prevention, Fire Department – are, with rare exceptions, tied to and/or beholden to the police/sheriffs.** Even well-intentioned individuals, including directors who may want to advocate for non-police responses, may not have the power to make these changes -- at least not without community pressure. And even then, they will, in most cases, opt in favor of co-response on the belief that mental health crisis equates to “danger” and that safety can only be provided by police.

CAHOOTS-type models can significantly reduce the role and scope of the police – but they still involve some level of police collaboration.

If adopting a CAHOOTS-type model, it is critical to be aware of the principles guiding any program being proposed, and control the details of implementation, including:

- Non-police control of dispatch
- Qualifications for and make-up of response team
- Ties to harm-reduction resources, including non-coercive mental health resources
- Quality of training
- Criteria for police involvement, if any, and
- Accountability to most impacted individuals and communities

¹² NAMI, Crisis Intervention Team Programs ([https://nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-\(CIT\)-Programs](https://nami.org/Advocacy/Crisis-Intervention/Crisis-Intervention-Team-(CIT)-Programs)); Leadership Conference for Civil and Human Rights, A New Era of Public Safety (2019) (https://civilrights.org/wp-content/uploads/Policing_Full_Report.pdf).

- **Is 911 dispatch outside of police control?** In Eugene, Oakland, and other jurisdictions where CAHOOTS originated and is being implemented, **911 dispatch is not within the control of the police**, although calls can be routed to police. At the point of dispatch, operators can choose where to route calls, and receive training on protocols setting out which mental health crises are not sent to the police but should be routed directly to the mental health crisis response.

Dispatch autonomy in selecting which calls are routed to police and clear protocols defaulting to routing to mental health crisis response are critical to significantly reducing the control of the police. It is also essential that police not be able to “listen in” on 911 calls and show up anyway even if not dispatched.

Experience has shown that 911 autonomy is necessary, but not sufficient, to successfully separate mental health crisis response from police response - in many cases 911 operators maintain close ties to police and default to diverting mental health calls to them. Denver’s implementation of the CAHOOTS-inspired STAR program demonstrates that the police can still control dispatch even if dispatch operates separately from the police department (see section on Implementation Cautions and Challenges).

- **Who constitutes the response team?** CAHOOTS in Eugene has developed a team model that creates central roles for people who do not necessarily have a college degree, licenses, etc. At the same time, they select for individuals who have work and/or life experience in crisis de-escalation and public-friendly skills, such as people who have been and/or worked with homeless/houseless individuals, baristas, and bartenders.

The medic component of the team includes EMTs, paramedics, and nurses. Expansion to include EMTs rather than relying exclusively on more highly trained, licensed, and higher paid paramedics creates a pathway for more available and less costly medics. This has allowed for a larger, relatively easy-to-recruit, and more diverse pool of employees -- potentially including people who can be trained and recruited from most impacted communities. This has also lowered the personnel cost of the program, which allows for a more expansive crisis response system. Because staff receive 500+ hours of field training, the program is still able to provide on-the-job skills training, resulting in not only a large but also a highly trained pool of personnel.

- **How and when are police involved?** CAHOOTS operates as an unarmed, non-police response to mental health crises. However, the program does follow a protocol in which certain types of crises that are deemed violent or potentially violent are handled by the police or, in some cases, police accompanied by CAHOOTS. According to CAHOOTS, in 2020, with over 18,000 calls to CAHOOTS (17% of all calls to 911), CAHOOTS staff called in the police in only 311 situations. The high volume of response and low number of responses referred to

the police highlight the potential of CAHOOTS to serve as a mental health crisis response in which the vast majority of cases never reach the police.

- **How do most impacted individuals and communities remain at the center of these responses?** CAHOOTS remains a white-led and -dominated response within a predominantly white (83%) community, raising the question of how implementation of CAHOOTS-type models in other largely BIPOC communities can structurally ensure the centrality of impacted individuals and communities, particularly given every pressure to keep our communities marginalized or tokenized, at best.

For example, although Denver's STAR program began with collaboration between a diverse community and government, those who have emerged as STAR program decision-makers (government officials and large white-led mental health non-profits) did not adopt a charter¹³ that would have established an advisory committee centering most impacted communities (see section on Implementation Cautions and Challenges). Conversely, Oakland organizers implementing MACRO (alongside the Mental Health First model) have fought for and maintained community control thus far through a historic city council resolution¹⁴ and other efforts (see section on Implementation Cautions and Challenges).

MENTAL HEALTH FIRST-type models offer promise in autonomous, non-police mental health crisis and overall response centering most impacted communities.

How do we fight for legitimacy, support for, and ample multi-year funding for these programs?

These are still emerging programs which do not have the resources nor the 30-year track record of CAHOOTS. They are also actively opposed by the police and other city and county systems trying to keep control over selection and implementation of alternatives. These realities raise the question of how local forces can organize and strategize to make sure that these programs are supported and funded in a context which fights to exclude them? How do we keep these programs alive and thriving -- even in jurisdictions which might also have co-responder and/or CAHOOTS-type programs?

¹³ Denver Alliance for Street Health Response (DASHR). STAR Expansion Committee. Charter. (<http://dashrco.org/star charter>).

¹⁴ See the March 16, 2021 Oakland City Council Resolution. (<https://cao-94612.s3.amazonaws.com/documents/View-Legislation-2.pdf>).

What makes real mental health crisis response alternatives possible?

Community-based and accountable mental health crisis responses require adequate multi-year funding - and remain more cost-effective than high-cost programs that require police, fire departments and/or the most highly licensed personnel. Alternatives which are only available during limited hours or that have so little capacity that they take too long to respond can be essentially equivalent to police-only response. For instance, although the city of Berkeley, CA had an alternative crisis response program, it wasn't operational when Kayla Moore's roommate called for assistance during what was perceived to be a mental health crisis. As a result, police responded, and killed Kayla, a Black trans woman, in her own home.¹⁵

Real mental health crisis response alternatives require:

- ▶ Autonomy from the police/sheriffs;
- ▶ Widely publicized, available, and accessible (to d/Deaf and hard of hearing, blind/visually impaired, multilingual people, among others) low or no-cost system of dispatch (autonomous of police);
- ▶ Orientation towards harm reduction, peer support, de-escalation, and agency, self-determination/choice for people needing assistance;
- ▶ Orientation towards/central role for impacted communities, including BIPOC, poor, mentally, cognitively, and physically disabled, neuro-divergent, LGBTQIA+, immigrant (including undocumented), criminalized, and homeless/houseless people and communities;
- ▶ Adequate infrastructure;
- ▶ Ample personnel (representing impacted communities);
- ▶ Sufficient training;
- ▶ Adequate number and quality of vehicles for transportation;

¹⁵ Ruggiero, A. (2020, Aug 18). "They didn't refer to her as a human: Remembering Kayla Moore," East Bay Times. (<https://kpfa.org/blog/remembering-kayla-moore/>).

- ▶ Robust accessibility of services for visually impaired, D/deaf and hard of hearing people, monolingual and multilingual people, and people with mental, cognitive, and physical disabilities;
- ▶ Meaningful peer decision-making, direction and involvement (among those with direct experience with mental health crisis -- and representing most impacted communities);
- ▶ Harm-reduction, trauma-informed, peer-led or involved community-based mental health resources;
- ▶ Protection/freedom from control, harm, threat, or influence by police/sheriff and other governmental systems;
- ▶ Sufficient, sustained sources of funding and other resources to be able to run 24/7 -- and provide rapid response across regions.

Real mental health crisis response alternatives must also support an ecosystem of diverse, autonomous, self-determined mental health resources, especially those created specifically by and for people vulnerable to mental health crises (and including people from BI-POC, LGBTQIA+ and other impacted communities).

Alternatives cannot ignore, oppose, take resources from or otherwise diminish other mental health options (such as CAT-911 and Fireweed Collective featured in this report) – but must work in collaboration with them or in such a way that they do not diminish their capacities

Federal, state and local legislation related to mental health crisis response can strongly influence resources and options.

- The existence of and interplay between city, county, state, and federal laws and agencies can determine the future path of mental health crisis response. Keeping track of and delving deeply into bills and laws which fund new programs, expand existing programs, or create new mandates is essential to making real alternatives to police-based responses possible. (See section on The Legislative Landscape for legislation to look out for key legislation including the CAHOOTS Act and The National Suicide Hotline Designation Act which promotes a non-police emergency 9-8-8 line).

KEY MENTAL HEALTH CRISIS RESPONSE MODELS

	Co-Response	CAHOOTS	Mental Health	CAT-911	Fireweed Collective
Brief Description	Police & mental health professional (most common “alternative” model) -- co-response is part of overall police-led crisis intervention teams (CITs)	Community-based mental health mobile crisis program with relationship with police (since 1989)	Community-based mobile crisis program with no relationship to police; Since Jan 2020, Sacramento Since August 2020, Oakland	Southern California decentralized, community-based skills-building and response network - addressing multiple community needs including mental health crisis	Mental health education and mutual aid through disability justice and healing justice lens
Where	Many jurisdictions	Eugene, OR & Springfield, OR - Replication or similar efforts in many jurisdictions including MACRO in Oakland and STAR in Denver	Sacramento & Oakland	Southern California	Richmond, California and online
Demographic	Diverse	Predominantly white (Eugene was 83.3% white in 2019)	Predominantly BIPOC	Diverse demographics that include BIPOC	Predominantly impacted communities including BIPOC & LGBTQIA+
Ties to Law Enforcement	Police response modified to include mental health professional	Run by White Bird Clinic in collaboration with police/systems	None	None	None
Ties to Mental Health Resources	Different models have relationships with different mental health providers/context-specific	Program of White Bird Clinic, a long-time harm-reduction oriented, trauma informed mental health clinic	Building collaborations with local mental health providers; many volunteers with mental health background	Some members are mental health professionals operating on a peer, volunteer basis	Autonomous
Types of Responses to Mental Health Crises	Armed assessment & de-escalation; crisis counseling; suicide prevention; resources connection; transportation to involuntary commitment for a period of “observation” or services -- hospital or service provider.	Unarmed de-escalation; crisis counseling; suicide prevention; conflict mediation; grief & loss; welfare checks; substance abuse; housing crisis; harm reduction; first aid & non-emergency medical care; resources connection; free transportation to services -- hospital, service provider or shelter	Unarmed de-escalation; crisis counseling; suicide prevention; conflict mediation; harm reduction; resource connection; free transport to safe space and services on a case-by-case basis; distribution of survival packages including food, socks, blanket, narcon, etc.	Building community skills and infrastructure for decentralized, localized responses	Hold multiple, accessible, diverse support groups to build peer-led crisis prevention & systems of support and care

	Co-Response	CAHOOTS	Mental Health	CAT-911	Fireweed Collective
Hours	Varies	24-7; 60 service hours/day between 3 vans	7pm - 7pm Friday through Sunday (Sacramento); 8pm - 8am Friday through Sunday (Oakland)	NA	Support groups and FB communication available at multiple hours
Response Team	Various models, but basic model is police officer (uniformed or non-uniformed) with licensed mental health professional. Staffing is usually driven by who is licensed to carry out involuntary hospitalization.	Crisis intervention worker and medic (EMT, paramedic, or nurse)	Crisis responder, medic (EMT or nurse), and security liaison	Decentralized - organized by neighborhood and/or city and/or specialized type of response - e.g., mental health crisis, community conflict, etc.	NA
Approach	Armed but approach claims to focus on de-escalation and assessment; many co-response programs claim to prioritize community resources but will conduct non-consensual transport to services including involuntary hospitalization	Unarmed; verbal de-escalation; emphasis on support & stabilization in the field -- least intervention necessary; prioritize informed decision-making by "client" or the person in crisis	"Self-determined crisis management" -- unarmed; focus on de-escalation and identifying and delivering responses as determined by the "participant" or person in crisis	Decentralized mass-scale skills-based training; building of complementary locally-based networks; disability justice lens	Peer support; disability justice and healing justice lens
Security or safety	Police role is to provide security, enforce involuntary hospitalization, and call for additional police back-up if deemed necessary	De-escalation model is safety approach; in addition, assess for 3 levels of danger -- leaving most dangerous level for police response or police and CAHOOTS response; in 2020, out of 18,000 calls to CAHOOTS, only 311 referred to the police	Security liaison, a response team member, is primarily there to defuse the situation including potential harm from law enforcement	Key aspects of skills training include de-escalation and community security	Aspects approximating safety checks and planning embedded into self-determined peer support
Training & Licensing	Specialized police training on mental health de-escalation is central to model - but could be as little as 2 hours; mental health professionals are usually licensed LCSW or psychologists; psychiatrists are rarely part of the response team but are often tied to a response model	Community intervention workers do not need formal college degree but do need to have related personal and/or work experience; EMT are licenced; over 500 hours of field training and over 30 hours in the classroom	Currently 6-8 hours of training which includes first aid and differentiation between health and mental health crises	Focus is on community-based and accessible training on many aspects of mental health and other response -- substance use, de-escalation, responding to domestic and sexual violence	Non-licensed, peer support; trainings are peer-led

	Co-Response	CAHOOTS	Mental Health	CAT-911	Fireweed Collective
Dispatch	911	911; call centers are trained to triage calls directly to CAHOOTS; can intervene in police calls; majority of calls through non-emergency number or vans driving through city	Independent phone number/ Facebook/ twitter	Currently no centralized crisis number; relies upon decentralized, localized response	NA
Involuntary Hospitalization	Yes; for some co-response models,, involuntary hospitalization is the key role	CAHOOTS will not involuntarily hospitalize someone, but police may be called in rare instances which could result in involuntary hospitalization	No	No	No
Domestic Violence (DV)	Police DV response separate from mental health crisis response	Will deal with family members in dispute, but not DV	Incorporating DV into response model	Forming regional DV & sexual assault response networks & training	Not explicitly working on DV
Funding	City, county, and state funding Medicaid; private grant funding; sales taxes	\$2.2 million/year; \$1 million from city for Eugene; grant from County Health & Human Services for Springfield; fund raise \$500K & more recently, partnership with Medicaid insurer (\$46,000) + \$250,000 - \$300,000 for fleet	Current funding from individual funders, limited county funding, and grants	Volunteer/member run with limited individual donor and grant support	Grants and donors

Information on the co-response model from Gahert, K., & Moore, A. (2020). Responding to Individuals in Behavioral Health Crisis via Co-Responder Models: The Roles of Cities, Counties, Law Enforcement, and Providers. Policy Research, Inc. and National League of Cities. (<https://www.theiacp.org/sites/default/files/SJCResponding%20to%20Individuals.pdf>).

IMPLEMENTATION CAUTIONS & CHALLENGES

THERE IS NO ONE SIZE FITS ALL SOLUTION, NO SINGLE MODEL THAT CAN BE SCALED UP AROUND THE COUNTRY.

This section points to specific implementation cautions and challenges based on on-the-ground reports from Eugene and Springfield (CAHOOTS), and from struggles for selection and mobile crisis response implementation in Denver (STAR), Oakland (MACRO and Mental Health First).

Local conditions are critical to determining selection, implementation and other strategies. The choice of appropriate and feasible models depends largely upon the local context within which they are built. What are the demographics within that locality? What is the strength and longevity of community-based organizing -- particularly with regard to challenging the police and building autonomous, self-determined community services? What mental health resources are available -- particularly those oriented towards self-determination and peer-response rather than top-down paternalism and/or pathologization? What local laws are relevant (mandatory reporting and other laws influencing who and how people can intervene in mental health crises) and/or how are state-wide or federal laws implemented locally? Who are local lawmakers and elected officials?

Selection and implementation are important sites of struggle. Across the country, local jurisdictions are researching, selecting, funding, and figuring out the details of implementation for mental health crisis response. In each of these jurisdictions, these decisions are made through struggles by the people most impacted, activists, organizers, mental health and homeless/houseless providers and others pushing and pressuring (or conceding to) elected officials, Departments of Mental Health/Health, Departments of Community Security/Violence Prevention, and, of course, police and sheriffs to determine which mental health crisis responses will be implemented. In some cases, community-based organizers and providers may support the involvement of the police or be vulnerable to concessions to the police and other more powerful governmental stakeholders.

Governmental systems (even if well meaning) will try to or be pressured to maintain police control and/or maintain control within governmental entities (Department of Health/Mental Health/Public Health and/or newly emerging Departments of Community Safety/Violence Prevention and others). The police department and/or sheriff's department, along with the multiple associations and unions (depending upon city and/or county jurisdiction), have considerable power. These entities will push for ways to undermine, reduce or rid themselves of mental health crisis responses which threaten police monopoly on

mental health crisis response, particularly where there is resistance to divestment from policing, and advocate for “alternative” responses that do not diminish police control, overall role, and funding. This can translate to police/governmental:

- Maintenance of control over agendas and implementation through overt tactics and behind-the-scenes negotiations out of the purview of community members;
- Distraction so that nothing is changed at all including delaying tactics and studies that result in nothing; and/or
- Advocacy for co-response models that maintain police control (and police jobs and funding); expansion of existing co-response funding and scope; and/or efforts to justify and maintain existing co-response options even as other alternatives such as CAHOOTS-style and/or Mental Health First models are being built.
- Substitution of other government agencies like health/mental health/public health as substitutes for community control or alternatives but these entities function like police.
- Contract negotiations and collective bargaining to maintain control over particular areas of work, existence of particular units, or transfers that can preclude disbanding existing co-response units or removal of mental health crisis response from police jurisdiction.

A variety of models are being introduced and referred to as “CAHOOTS” – many lacking the critical factors that reduce CAHOOTS reliance on the police.

Beware of:

- Implementation that will result in the minimal reduction of police control and role, such as:
 - * police retention of control over dispatch;
 - * police response to mental health calls at discretion of the police;
 - * maintenance of, or expansion of co-response models.
- Staffing by the most licensed and regulated health and mental health professionals, such as Department of Mental Health clinicians, licensed psychologists and/or licensed clinical social workers, Fire Department, and paramedics -- rather than non-licensed, but highly skilled and trained, crisis responders and EMTs. NOTE: co-response models aim for staffing that will be licensed to perform involuntary hospitalization such as police and licensed psychologists/psychiatrists -- this then becomes the baseline staffing for co-response -- this reasoning may be imposed on CAHOOTS-type models even though CAHOOTS does not use this staffing approach (see section on CAHOOTS).

- Implementation of mental health crisis response that maintains police presence - even if they leave or arrive separately from EMT/paramedic transport response -- resulting in multiple uniformed personnel confronting a single person in mental health crisis.
- Significantly higher per person cost -- meaning lower capacity per given amount of funding -- e.g., CAHOOTS estimates that Los Angeles co-response model (MET) cost per call is \$3,750 (\$800 per call response if only the MET team responded to a call vs. initial police response, additional EMT or paramedic response, etc.). This compares to an estimated \$150 per call for CAHOOTS, based on their staffing structure -- cost skyrockets with higher licensing requirements for staff, Fire Department involvement, and, of course, if the team includes police.

Retention of control by BIPOC and other impacted communities might be given lip service but be thwarted in implementation through:

- Excluding community groups that may have been engaged in long-term decarceral (dismantling from police control) strategies for people experiencing mental health crises;
- Bringing diverse community stakeholders to the table but making all key decisions behind closed doors;
- Equating "community" with large, mainstream non-profit mental health providers that are invested in police involvement and with little commitment to most impacted communities;
- Assuming that there are no BIPOC (LGBTQIA+, criminalized, poor, immigrant, disabled) people qualified to be part of the response team or decision-makers -- and lacking will and/or capacity for selection, hiring and/or specific training programs that do include or center most impacted individuals and communities;
- Assuming BIPOC (LGBTQIA+, criminalized, poor, immigrant, disabled) can only play a role as current or former "users" of mental health resources -- named as peer navigators who then are given an imaginary, undefined future role that is never actually put into place (except perhaps as negligible, free labor).

Track, oppose, and circumvent federal, state, and local legislation that favors and resources police training or co-response models, or creates new infrastructure for mental health response that is tied to police. Keep an eye out for:

- Funding for police training, co-response models, or police involvement in mental health, substance abuse, suicide crisis intervention that is often buried in seemingly non-related federal, state, and local legislation;
- Direct funding to police agencies to carry out mental health or substance abuse functions or to create grant programs that are controlled and monitored by police bodies;
- Adoption of 9-8-8 alternative crisis line networks which appear better than 9-1-1, but can end up being another system that defers easily to police; and
- Large scale systems consolidation that offers significant funding for mental health crisis response, but contains mandates that weaken the non-police approach of your program.

Case Examples

Early implementation - that is, start-up of mental health crisis responses within the last two years (since 2019) - offers insights into opportunities and implementation challenges that other jurisdictions may face. While many jurisdictions are in the planning stages for the expansion or start up of a new alternative mental health crisis response model, very few are currently in the implementation stage.

These brief case studies of Denver's Support Team Assistance Response (STAR) model and APTP's Mental Health First model in Sacramento and Oakland demonstrate the opportunities and challenges in the actual selection and implementation of these models. The distinctions between implementation of community-based, non-police mental health crisis responses, and police-involved, systems-based models may be blurred in early rhetorical stages.

There may initially be agreement on the need for “alternatives,” shifting budgets away from the police, and care rather than a criminalizing response to mental health crises among a wide range of stakeholders, including the police. However, experiences on the ground show that distinctions between community-led strategies accountable to most impacted communities and those that serve the status quo become clearer in the details of implementation.

What are some lessons for communities striving to implement meaningful non-police and community-based mental health crisis response options?

Denver Support Team Assistance Response (STAR)

Denver's mental health crisis response program, Support Team Assistance Response (STAR) was launched on June 1, 2020 as the result of a collaboration between the city of Denver (including the Police Department under a "progressive" Chief of Police), the Department of Safety, local community based organizations, and a local funder following a visit to Eugene, Oregon in 2019, with a view to establishing a similar program to CAHOOTS in Denver. The pilot program launched with a \$200,000 investment from the Caring for Denver Foundation. In 2020, the city of Denver approved \$1.4 million of general fund dollars for STAR expansion in 2021, with more fundraising in the works,¹⁶ and with hopes for the passage of the federal CAHOOTS Act (see section on legislation) to offer an additional infusion of dollars. However, the CAHOOTS Act in its current form would not fund programs like STAR because the legislation specifically requires that programs operate 24/7 and that participation be entirely voluntary, and STAR currently utilizes involuntary mental health holds.

Denver Alliance for Street Health Response (DASHR) is a key party to the collaboration, and serves as a facilitator for the development and expansion of STAR and implementation of similar programs across 10 Colorado cities. DASHR, which has its own street medic program, has focused on centering BIPOC and other most impacted communities as response team staff, program advisors, and decision-makers in the development of STAR. During STAR's infancy, a six-month evaluation was completed highlighting the initial challenges and cautions. It is important to note that this program is new and conditions are changing rapidly.

Denver (STAR): Cautions and Challenges

Impact on police calls. During the initial six-month period, police received 95,000 calls, 2,500 of which fell into the STAR's scope of operation. However, only 743 calls were actually routed to STAR - representing just under 3% of all police calls.¹⁷ Oregon's CAHOOTS, on the other hand, responds to 17% of all calls. While STAR is just beginning, the low percentage of calls diverted to STAR indicates structural barriers which leave 97% of call responses to the police. Possible points of intervention include dispatch and Denver's refusal to reduce or eliminate co-response, as well as building political will and funding resources for the program.

¹⁶ Hauck, G. (2021, Feb 6). "Denver successfully sent mental health professionals, not police, to hundreds of calls," USA Today. (<https://www.usatoday.com/story/news/nation/2021/02/06/denver-sent-mental-health-help-not-police-hundreds-calls/4421364001/>).

¹⁷ Ibid.

Denver's 911 dispatch is in a separate department from the Denver Police Department. Prior to the creation of STAR, 911 calls were either diverted to the police or hospitals. STAR then created a "third path" for "non-violent" calls relating to mental health crises, substance use, and/or homelessness/houselessness.¹⁸ While the police do not directly operate the dispatch system, they designed the protocol that sets out the decision tree, in effect keeping police in control of how calls are dispatched.

The question of which calls are deemed "violent" versus "non-violent" may also be limiting the number of calls dispatched to STAR. The race of the person in crisis and/or race and class make up of the neighborhood a crisis call comes from plays a significant role in determining which calls are labeled as "violent" or "non-violent." There is not yet enough evidence of how this distinction is playing out in the context of STAR - but it may be contributing to the low number of calls diverted to STAR. The determination of whether a call is deemed "violent" or "non-violent" controls which calls go to police versus community - eliminating this distinction may be critical to building successful mental health alternatives to police as first responders.

In addition, Denver had a co-response model in place before the establishment of STAR. As Vinnie Cervantes of DASHR reports, "Denver really loves its co-responder program. The police love the co-responder program. The mayor loves the co-responder program. The community has a complicated and dissatisfied relationship with it." How is dispatch defining which cases not only go to the police -- but which go to co-response, rather than STAR? This evaluation data is not publicly available, but the co-response model persists, and the political will is for co-response to stay in place.

Notably, the Chief of Police, while praising STAR has also made it clear that he does not believe its existence should result in a reduction of the need for the police nor for reduced police funding.¹⁹ This statement clearly illustrates a strong motivation for not ceding mental health crisis calls to community-based responses.

Involvement and decision-making by impacted communities. Despite early commitments to significant community involvement (with an emphasis on BIPOC and other impacted communities), they have not come to fruition. Response teams consist of a paramedic and a licensed mental health professional, who remain primarily white, and racial demographics for STAR users are incomplete (about 30% of people they came into contact with were "unidentified" with regards to racial or ethnic identity).

¹⁸ STAR Program Evaluation. (2021, Jan 8). (https://wp-denverite.s3.amazonaws.com/wp-content/uploads/sites/4/2021/02/STAR_Pilot_6_Month_Evaluation_FINAL-REPORT.pdf).

¹⁹ Sachs, D. (2021, Feb 2). "In the first six months of health care professionals replacing police officers, no one they encountered was arrested," Denverite. (<https://denverite.com/2021/02/02/in-the-first-six-months-of-health-care-professionals-replacing-police-officers-no-one-they-encountered-was-arrested/>).

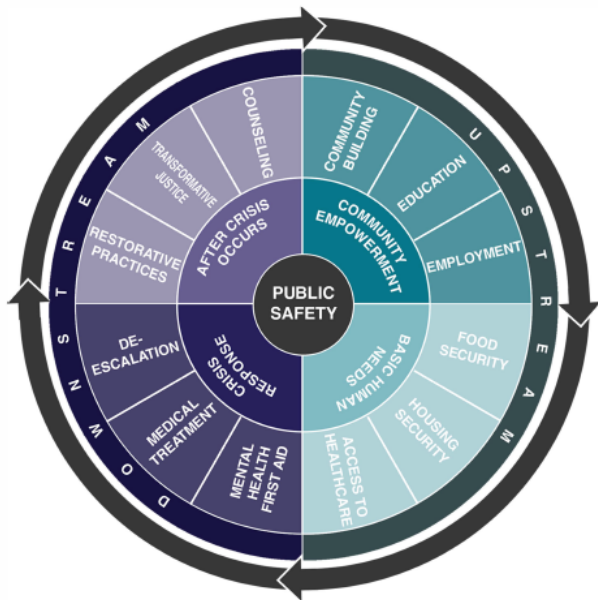


Figure represents DASHR's elements of a reimagined public safety.

A new funding expansion for STAR places the program under the purview of Denver Department of Public Health and Environment (DDPHE). Originally not involved during the pilot project formation, DDPHE is now the gatekeeper to community access and control. DDPHE has been resistant to incorporating community demands critical to the success of the program. This only reinforces law enforcement's already significant influence over the program, despite the shift from a public safety program to a public health program.

Although community members were involved early in the planning for and implementation of STAR, their role was limited to superficial decisions largely confined to logo, name,

and colors -- not the critical design, protocols, and implementation decisions of the program. Such key decisions were made behind closed doors without the involvement of community partners. In August of 2020, this led to a community push to hire a facilitator. DASHR was chosen as the group that would provide that community-driven facilitation. However, even with this hire, the city applied significant barriers to decision-making and creating a vision for the expansion of the program. While DASHR waited for updates from the city regarding the advisory committee and the RFP process, the city council excluded all the community groups and went ahead with only government partners (i.e. the Denver Police, Department of Safety, Department of Public Health and Environment, Denver 911, and the contracted clinicians from MHCD) to present on STAR expansion.²⁰

A charter²¹ written by community members, including DASHR, when STAR was first established included in its proposed structure and bylaws an "advisory committee" that would "include and prioritize BIPOC membership and members of the LGBTQ and disability community and people with lived experience." This proposal, initially supported by the police department and governmental agencies, was ultimately not approved. There remains no supportive structure for the inclusion

²⁰ Sachs, D. (2021, Apr 1). "People who have been demanding police alternatives for years want the city to yield some control of its young program," Denverite (<https://denverite.com/2021/04/01/people-who-have-been-demanding-police-alternatives-for-years-want-the-city-to-yield-some-control-of-its-young-program/>).

²¹ Denver Alliance for Street Health Response (DASHR). STAR Expansion Committee. Charter. (<http://dashrco.org/star charter/>).

of impacted community members in the program. The city continues to insist that the charter will inform their request for proposal (RFP) process, but that has not been reflected thus far.²²

Mention of BIPOC involvement often elicits responses that reveal assumptions that BIPOC participation is equivalent to the inclusion of peer navigators, as if BIPOC and other impacted community members are not policymakers, mental health providers, medics, or capable of filling regular decision maker and staff positions within STAR.

This loss of control has DASHR and others still working with STAR wondering if an autonomous system of mental health crisis response which offers a real community-based option is still needed.

Interventions by state entities. Local city and county efforts can either be derailed or supported by state actors like the state governor, legislature or state agencies. In Denver's case, lawmakers proposed a state bill in 2021, HB 21-1030,²³ to expand an existing fund for peace officer mental health responses to include funding for co-responder programs and community responder programs. The bill's sponsors claimed that the legislative intent was to support programs like STAR and CAHOOTS.

However, the language of the bill would neither support programs like STAR nor CAHOOTS, nor the other alternatives in development in different cities throughout Colorado state.

Initially, the bill required that any funds go directly to law enforcement agencies (which meant Aurora, Denver's STAR, and other cities working to implement mental health crisis response alternatives would be left out). Additionally, it required that \$2 million of the fund be earmarked for peace officer mental health, which left virtually nothing for co-responder or community responder programs. Groups like DASHR opposed the legislation. Eventually the bill passed out of committee with amendments pushed by groups including DASHR, Black Lives Matter 5280 and the ACLU. Even with these amendments, the bill remains problematic because, while it expands the types of grantees that can receive funds beyond law enforcement to include public health agencies and behavioral health organizations, the funding is still controlled by law enforcement, who decides how it should be spent and whether the model should be based on co-response.²⁴ Bill sponsors insisted STAR was at the table; however, none of the community groups currently working on these efforts, including DASHR which is working with multiple cities, were included to any degree in drafting the legislation until after the bill was presented and legislators had already adopted the amendments. (For more on DASHR's position, see opposition statement in footnote.)²⁵

²² Sachs, D. (2021, Mar 26). "Some Denver groups credited with helping create and expand STAR aren't thrilled with the expansion or the narrative," Denverite (<https://denverite.com/2021/03/26/some-denver-groups-credited-with-helping-create-and-expand-star-arent-thrilled-with-the-expansion-or-the-narrative/>) and Sachs. (2021, Apr 1). op cit.

²³ <https://leg.colorado.gov/bills/hb21-1030>.

²⁴ Clark, M. (2021, Mar 8). "Power of public testimony: Bill that would expand law enforcement grant programs amended in response to community concerns," Colorado Newswire. (<https://coloradonewswire.com/2021/03/08/power-of-public-testimony-bill-that-would-expand-law-enforcement-grant-program-amended-in-response-to-community-concerns/?fbclid=IwAR1IQG5Yey-p8J-q4ZXsOgcs-W-r-L-phauCz4AShMXwK1xX069xHJJKkQgM>).

²⁵ Statement by Community in opposition to bill; see post here in <https://www.facebook.com/coloradodashr/>

Sacramento & Oakland Mental Health First

Sacramento police receive 500,000 to 600,000 service calls annually. In 2020, 34,121 of those calls were related to homelessness; 13,374 were related to mental illness; 4,395 calls involved a clinical mental health evaluation; and 13,416 were family disturbance calls.²⁶ Public pressure for alternatives to police response increased when on July 11, 2016, the Sacramento police shot and killed Joseph Mann, a 51-year old Black man who was experiencing a mental health crisis. By January 2020, Sacramento's Asantewaa Boykin was focusing on the need for mental health response that built upon the hundreds of years of self-determined mutual aid within Black communities which is an organic part of community -- non-police, non-systems based, located directly within neighborhoods, and responsive to the immediate needs of the community.²⁷ She asked herself how this form of support could be replicated at a larger level and still retain the essential characteristics of these traditions of community care. The group organized by Boykin examined other mental health response models such as CAHOOTS, and then created the Mental Health First model.

Sacramento & Oakland Mental Health First: Cautions and Challenges

Sacramento: Mental Health First versus the Office of Community Response. In the midst of the summer of 2020 uprisings, the Sacramento City Council voted 8-0 on July 1st to establish an Office of Community Response to train social workers to respond to mental health crises, homelessness, and other non-violent situations. While APTP and Mental Health First had already started their community-based crisis support in January 2020, the City Council measure was used to promote other non-police mental health responses that would operate within city agencies.

The Office of Community Response is led by an Interim Director who is a licensed clinical social worker with experience heading the social service unit of a neighboring police department, on mental health and hospital units, and on the homeless outreach Impact Team of the Sacramento police department.²⁸ The city has now given the Interim Director the responsibility of creating an alternative mental health crisis response with no community input, and with no plans for the involvement of Mental Health First.

In other words, the 2020 uprisings prompted the Sacramento City Council to take a more aggressive approach to enacting "alternatives" to the police. However, selection and implementation of that alternative is happening under the control of leadership and a newly created Office of Community Response that is beholden to the police and city managers.

[posts/4011268892256999](https://www.sacbee.com/news/investigations/the-public-eye/article249677048.html)

²⁶ Ahumada. op cit.

²⁷ Katayama. op cit.

²⁸ Ahumada, R. (2021, Mar 25). "'We don't need police, period.' Who should handle mental health 911 calls in Sacramento?" Sacramento Bee. (<https://www.sacbee.com/news/investigations/the-public-eye/article249677048.html>).

Oakland: Mental Health First and MACRO

Meanwhile, in Oakland, long-time community organizing among a collaborative of community partners has led to a multi-pronged effort to defund the police and funnel resources into non-police community-based alternatives and other forms of community care. The allyship of two city council members has been key to the passage of city ordinances that battle efforts by the mayor and her allies to keep police funding and police-controlled alternatives intact.

Maintaining Community Control. Mental Health First launched in Oakland in August 2020 based on the model started in Sacramento in January 2020. Additionally, community organizers have also been closely involved in another mental health crisis response modeled after CAHOOTS called Mobile Assistance Community Responders of Oakland (MACRO). At the urging of the Coalition for Police Accountability, the Oakland City Council funded a report by the Urban Strategies Council in 2019 to look into the feasibility of the CAHOOTS model in Oakland.²⁹ Coordinated by the Department of Violence Prevention established in 2017 in response to high murder rates in Oakland, and currently headed by a former deputy mayor of Los Angeles and social worker with experience in gang intervention in Los Angeles and Central America,³⁰ the MACRO model is being launched with \$1.35 million,³¹ which is much less than the \$3.08 million proposed by the report. The Oakland Police Department was funded in 2020 at \$380 million and has a proposed budget of \$330 million for 2021.

After an unsuccessful and contentious bid to house MACRO within an existing community agency, MACRO will be housed in the Fire Department, which will hire new staff, purchase vehicles, and start a newly branded program to offer a CAHOOTS style response featuring a team consisting of an EMT and a mental health worker.³² In Oakland, both MACRO and Mental Health First are being pursued by coordinated sets of community groups.

On March 16, 2021, the City Council passed a historic city council resolution³³ following intensive organizing and advocacy by APTP that made the establishment of MACRO (which is still in planning stages) contingent upon community control. While struggles between the city, other community organizations vying for control of MACRO, and BIPOC-led community organizations such as APTP continue, passage of this resolution, which structures BIPOC leadership and community

²⁹ Urban Strategies Council. (2020, Aug 10). Report on Feasibility and Implementation of a Pilot of Mobile Assistance Community Responders of Oakland (MACRO). (https://urbanstrategies.org/wp-content/uploads/2020/06/USC-MACRO-REPORT-6_10_20.pdf).

³⁰ Dubrovsky, A. (2021, Apr 13). "Can Oakland's Department of Violence Prevention succeed?" Oaklandside. (<https://oaklandside.org/2021/04/13/caoakland-department-violence-prevention-guillermo-cespedes-gun-violence/>).

³¹ City of Oakland. (2021, Apr 29). Oakland Reimagining Public Safety Task Force: Report and Recommendations. (<https://cao-94612.s3.amazonaws.com/documents/Oakland-RPSTF-Report-Final-4-29-21.pdf>).

³² Orenstein, N. (2021, Mar 3). "It's decided: the Oakland Fire Department will run MACRO, a new non-police emergency response program," The Oaklandside. (<https://oaklandside.org/2021/03/03/its-decided-the-oakland-fire-department-will-run-macro-a-new-non-police-emergency-response-program/>).

³³ See the March 16, 2021 Oakland City Council Resolution (<https://cao-94612.s3.amazonaws.com/documents/View-Legislation-2.pdf>).

control pre-implementation, is an example of critical steps that community groups can and must take to ensure control.

Unlike Sacramento, where the city sponsored mental health crisis response is in opposition to the Mental Health First program already underway, Oakland's local conditions and strong organizing coalitions have managed to keep non-police alternatives front and center, whether within the Fire Department, as one strategy to reduce contact with the police or through the support of Mental Health First, which offers BIPOC-led non-police and non-system alternatives to Oakland's most impacted communities. These community-control measures also stand in contrast to Denver's STAR project, in which grassroots BIPOC communities remain committed to their control over STAR, but remain subject to continued efforts to undermine their decision-making power and involvement.

KEY MENTAL HEALTH MODELS IN DETAIL

Co-response

Brief Description. Co-response or "police-mental health collaboration" (PMHC) remains the predominant form of mental health crisis response besides police-only response. Generally seen as alternative to police-only response, co-response generally: (1) provides mental health and de-escalation training to police officers in that unit; (2) collaborates with a mental health professional who either rides with the police officer, is called in to join the police after response to an incident, or arrives at approximately the same time but in a separate vehicle.³⁴



Figure from Krider, A., Huerter, R., Gahert, K., & Moore, A. (2020).

³⁴ Krider et al. op cit.

Co-response falls under a broader category of crisis intervention teams (CIT) or police training and licensing for law enforcement as mental health first responders.³⁵ There are an estimated 2,700 CIT programs nationwide which creates connections between law enforcement, mental health providers, hospital emergency services and individuals with mental illness and their families.³⁶ Although co-response comes in many different forms, Los Angeles County's Mental Evaluation Team (MET) is often used as a model example of a co-response or PMHC program. LA County covers over 4,700 square miles and had 34 deployment teams or MET units in 2018-2019.³⁷

Response Team. Co-response always includes at least one police officer or, for county-level programs, a sheriff or deputy sheriff. Mental health partnerships vary -- usually including a licensed mental health professional who can be a licensed clinical social worker (LCSW) or a psychologist. For MET, the team consists of a deputy sheriff and a Department of Mental Health licensed mental health clinician. In MET's case, the clinician must be qualified to initiate involuntary acute psychiatric hospitalization (a common requirement driving staffing in co-response models). According to the MET Annual Report FY 2018-2019, the "MET provides mental health support, field crisis intervention, and appropriate psychiatric placement in situations involving patrol deputy contacts with citizens suffering from mental illness" (p. 10).

Cost. Los Angeles MET 2019-2020, \$3.4 million^{38 39}

Cost savings. Los Angeles MET 2018-19, estimated savings of \$4,122,539⁴⁰

CAHOOTS (Crisis Assistance Helping Out on the Streets) (Eugene, OR and Springfield, OR)

Brief description. CAHOOTS was started in 1989 by the White Bird Clinic in Eugene, OR, a mental health center,⁴¹ based upon harm reduction, trauma-informed care and run as a consensus-based collective. Because of its longevity, CAHOOTS offers a rare example of a robust community-based mental health response system operating 24-7, with well-established statistics backing up its effectiveness and cost savings. It serves as evidence that other programs can provide these benefits.

³⁵ Ibid.

³⁶ Ibid.

³⁷ Mental Evaluation Team Progress Report. Fiscal Year 2018-19. Los Angeles County Sheriff's Department and Department of Mental Health, Emergency Outreach & Triage Division. (<https://lasd.org/pdfs/web/FY2018-19%20Annual%20Report%20on%20MET.PDF>)

³⁸ Note that this \$3.4 million figure mostly covers mental health providers but does not include the cost for the deputies.

³⁹ LAist Staff. (2019, Apr 15). "LA County Released Its New \$32.5 Billion Budget. Here's Where the Money is Going," LAist. (<https://laist.com/news/la-county-budget-release-billions>).

⁴⁰ Los Angeles Sheriff's Department and Department of Mental Health. op cit.

⁴¹ Beyond a mental health center alone, CAHOOTS is a "federally qualified health center" which includes dental care, primary health care, a drop-in center, outpatient drug treatment, and other programs.

CAHOOTS offers an unarmed mobile response team serving the Eugene and Springfield areas, predominantly white (over 80%) communities with a large homeless/houseless population. They have three vans that operate 24-7, or 60 service hours/day (3 vans from 11 pm to 11 am and 2 vans from 11 am to 11 pm). CAHOOTS provides a range of services or interventions including: unarmed de-escalation; crisis counseling; suicide prevention; conflict mediation; grief and loss support; welfare checks; substance abuse; housing crisis; harm reduction; first aid and non-emergency medical care; resources connection; free transportation to services -- hospital, service provider or shelter.⁴²

Response Team. The CAHOOTS response team consists of two people: (1) crisis intervention worker; and (2) medic (EMT or nurse). The crisis intervention worker is the primary person providing de-escalation intervention; for CAHOOTS, this position requires an undergraduate degree and life or work experience that makes them particularly suited to de-escalation in crisis situations, including people with experience working in homeless shelters or people or as bartenders or baristas. The medic for the CAHOOTS team is an EMT or, in some cases, a nurse.

CAHOOTS has specifically chosen staff people they consider to be less conventional (not requiring a specific education or license), but particularly suitable for de-escalation crisis support work, and uses EMTs, who are entry level emergency medical service workers, as opposed to more highly trained paramedics or other licensed medical staff. It is also known for offering an exceptional paid training program with over 500 field hours and over 30 hours in the classroom.

This employment model opens up job opportunities and, hence, emergency medical trajectories to a broader pool of people. It also means that staff are hired at what CAHOOTS describes as “non-profit” wages,⁴³ allowing for more staff at a lower cost. This has lent the program cost-effectiveness and the ability to more easily cover highly trained staffing for 24-7 hours. However, a critique has been that it offers low wage employment.

Ties to police. While CAHOOTS is officially a project of the White Bird Clinic, it has developed as a program tied to the police. These ties remain in a number of ways:

- Dispatch -- uses 911 although the Eugene, OR dispatch is not held within the police department;
- Coordination with the police on mental health calls deemed to be potentially violent (e.g., use of weapons, some forms of active violence, including domestic violence);
- Acceptance of police role in handling other forms of “crime”;
- General legitimization of police roles in areas outside of mental health related or homeless/houseless related calls.

⁴² NAMI, op cit.

⁴³ NAMI Finger Lakes Family Forum Presents CAHOOTS-Crisis Assistance Helping Out On the Streets. (2021, Jan 30). Webinar. (https://www.youtube.com/watch?v=9Xwp8BiYq94&ab_channel=NAMIFingerLakes)

Reduced reach of police. The existence of CAHOOTS does ensure that a preponderance of mental health crisis-related calls never go to the police. Although Eugene and Springfield operate differently, Eugene's dispatch system is not within the police department. Dispatchers are trained to triage calls so that those deemed to be in a mental health crisis (and that do not involve direct physical assault or weapons) will not reach the police -- but, rather, go directly to CAHOOTS. In addition, CAHOOTS staff monitor police calls and can intervene to directly divert those calls from the police - or send in CAHOOTS to the scene. CAHOOTS has been able to divert a number of "disorderly conduct" incidents that would otherwise result in jail time through de-escalation, meeting basic needs, and transport to sobering and detox centers for public drinking and substance use.

In 2020, there were 105,000 public safety calls in Eugene. CAHOOTS responded to 18,000, or approximately 17%, of all calls. Out of calls CAHOOTS responded to, the police were called to assist on only 311.⁴⁴ A study conducted by the Eugene Police Department found that only 5-8% of calls were diverted to CAHOOTS even though CAHOOTS is taking 20% of total calls that come to the central dispatch center. CAHOOTS interprets this discrepancy to mean that in the absence of CAHOOTS, 12% of calls would have had no response. Another interpretation is that the police department is actively underestimating CAHOOTS' impact in an effort to undermine its effectiveness.

According to CAHOOTS, no staff person has ever experienced an injury in all their years of operation.

Cost. CAHOOTS costs \$2.2 million per year. The cost is covered in different ways depending upon the jurisdiction. Overall, CAHOOTS is funded by:

- \$1 million from city funding (Eugene);
- a grant from County Health & Human Services (Springfield);
- over \$500K raised annually through individual donors; and
- a recent partnership with a Medicaid insurer (\$46,000).

CAHOOTS' fleet of three vans costs between \$250,000 - \$300,000 per year and is owned and managed through the police department.⁴⁵

Cost savings. CAHOOTS has calculated that it saves the Eugene and Springfield communities an estimated \$14,000,000 per year. For example, their response costs are \$70/hour compared to \$200-\$300/hour for police and more for the fire department. In addition, their support services

⁴⁴ Ibid.

⁴⁵ Ibid.

divert emergency room (ER) visits, thereby saving money for hospital health care and potential expenses to those who would be charged for hospital services. For people using CAHOOTS services, they receive free transport to the hospital or other staffed services, as opposed to being charged a very high bill for emergency medical transport/ambulance. The program also calculates savings in terms of reduced Medicare costs.⁴⁶

Mental Health First (MH First) (Sacramento, CA and Oakland, CA)

Brief Description. Mental Health First is a mobile mental health response developed by the Anti Police-Terror Project (APTP) based in APTP's Sacramento Chapter. APTP was initiated in the midst of protests following the murder of Oscar Grant in Oakland by Bay Area Rapid Transit (BART) police on January 1, 2009. While APTP is committed to building replicable models to challenge, interrupt and eliminate police violence, APTP's Sacramento branch also focused more closely on mental health response or what they call "self-determined crisis management," particularly through the leadership of emergency room RN and co-founder of APTP, Asantewaa Boykin. Mental Health First has been in operation in Sacramento since January 2020.⁴⁷ Mental Health First launched in Oakland in August 2020.

Mental Health First Sacramento currently runs from 7pm to 7am Friday through Sunday. The crisis response team responds to direct phone calls to its local number (non-911), the MH First Facebook page, or Twitter. During those hours, the response team attends to any calls or other social media outreach seeking crisis assistance. They will drive to the site and work with the participant to determine what they want and need -- whether it be de-escalation, transportation to supportive services, or a package with survival supplies including easily consumed foods, socks, a blanket, naran if needed, and other items. Mental Health First team members regularly conduct what they call "canvassing" or outreach to particularly vulnerable community members, in order to distribute survival supplies and to build trusted relationships, creating the self-determined communities of care that are central to the ultimate goals of the Anti Police-Terror Project and other abolitionists.

Mental Health First Oakland launched in August 2020 and is currently operating from Thursday to Sunday, 8pm to 8am. The mental health crisis response delivery model is based upon Mental Health First Sacramento.⁴⁸

Response Team. The Mental Health First Sacramento response team is made up of three people, a "medic," who is ideally an EMT or a nurse whose primary focus is to tend to the health and/

⁴⁶ Ibid.

⁴⁷ Katayama, D., Cruz Guevarra, E., & Montecillo, A. (2020, Jun 17). "What one alternative to policing looks like," KQED. (<https://www.kqed.org/news/11824698/what-one-alternative-to-policing-looks-like>).

⁴⁸ Darden, J. (2021, Mar 8). "Oakland groups work to replace police responses to mental health crises," KQED. (<https://www.kalw.org/news/2021-03-08/oakland-groups-work-to-replace-police-responses-to-mental-health-crises>).

or mental health needs of the person in crisis, who they refer to as the “participant.” The second person is what they refer to as the “crisis responder” who is a trained volunteer whose primary role is to engage the person in crisis, support de-escalation if needed, and determine the appropriate support strategies that meet the needs of the participant as determined by that person. The team also includes a “security liaison” whose role is to minimize or interrupt threats by law enforcement and whose role is separate from those providing direct mental health or medical care.

Currently, the crisis responders are made up of a volunteer pool of community members, many of whom have training in social work or mental health care. They receive 6-8 hours of training that includes first aid and mental health de-escalation.

For more information on Mental Health First, please check out Interrupting Criminalization’s ‘zine, part of the One Million Experiments Website at millionexperiments.com.

The mental health crisis response ecosystem must include critical community-based alternative spaces initiated and directed by impacted people and communities. CAT-911 and the Fireweed Collective are two organizations which offer peer-led, mutual aid organizing models embedded within the framework of disability justice.

DISABILITY JUSTICE & PEER-LED ALTERNATIVES

CAT-911

Community Action Teams-911 (CAT-911) is a Southern-California network of CAT teams that serve as local skills-building and response networks to collectively identify and solve problems without turning to the police. In their own words, CAT-911⁴⁹ is committed to an approach that “lets us take control of our lives and our communities into our own hands and nurtures each other’s growth and human possibility.”

Offering network-wide and city or neighborhood-specific trainings and discussion forums, CAT-911 is building de-centralized, community-based alternatives.

⁴⁹ CAT-911. Home. Website. (<https://cat-911.org/>).

CAT-911's model addresses:

- Peace building and conflict resolution,
- Police violence,
- Domestic violence,
- Sexual violence,
- Mental health crises, and
- Acute first aid when paramedics are not responding or there is a concern about police involvement.

While CAT-911 remains a flexible, non-institutional organizing space for the development of organic response networks, they also organize mental health professionals and others who want to use their knowledge and skills to support local, non-institutional, community-based resources.

Fireweed Collective

In their words⁵⁰, “Fireweed Collective is a sanctuary for people creating their own definitions of health and wellness.” This Bay Area-based organization operates through regular community-led support groups by and for impacted people and communities, including BIPOC, LGBTQIA+ people. Deeply embedded within a healing justice, harm reduction and self-determination framework, Fireweed Collective does not use medicalizing language such as “mental illness,” diagnostic categories, nor does it advocate for use of psychiatric drugs. Choice and self-determination are fundamental principles and the means through which health and wellness are honored and promoted.

While Fireweed Collective does not explicitly offer mental health crisis response, they are a critical and central part of the local mental health/wellness ecosystem⁵¹ in which regular, low-cost or free supportive spaces are offered primarily in the form of time limited peer-led support groups, party spaces, member only social media, and other forums offering multiple and creative spaces for wellness.

While Fireweed Collective does not explicitly offer mental health crisis response, they are a critical and central part of the local mental health/wellness ecosystem⁵² in which regular, low-cost or free supportive spaces are offered primarily in the form of time limited peer-led support groups, party spaces, member only social media, and other forums offering multiple and creative spaces for wellness.

⁵⁰ Fireweed Collective's Facebook General Guidelines, para. 9. (https://docs.google.com/document/d/e/2PACX-1vQrK2n-VNc7VSCPTWSUD0Y7c4P5wYcZKJl4kKGsPDGMFkv1sZwro_aGOJ19WkTWy-F6DWMYZ5HTk9c/pub).

⁵¹ Nationwide, other groups provide peer-led support or supportive resources for disability justice oriented resources and support for peer-led, self-determined support for people experiencing mental health needs and/or facing harmful systems responses to mental illness, neuro-divergence, or mental health crises. These include Frontline Wellness United (<https://www.frontlinewellness.org/>) which offers no-cost equipment, training, and direct medical and mental health care to social justice organizations and communities.

⁵²Ibid.

THE LEGISLATIVE LANDSCAPE

The following section highlights key legislative efforts on the federal and state levels that impact approaches to mental health crisis responses at the local level. It also discusses some of the challenges and opportunities this new landscape poses for efforts to defund the police and invest in community care.

Federal Legislation

Crisis Assistance Helping Out on The Streets (CAHOOTS) Act.⁵³ Introduced in August 2020 by Senator Ron Wyden, D-Ore. The bill's co-sponsors include Sens. Jeff Merkley, Dianne Feinstein (CA), Bernie Sanders (VT), Sheldon Whitehouse (RI), Tina Smith (MN) and Bob Casey (PA). Representative Peter DeFazio introduced the U.S. House companion bill.⁵⁴

- This act is promoted as supporting alternatives to police response for mental health crises modeled after CAHOOTS through federal Medicaid dollars. The bill's co-sponsor hopes to build CAHOOTS into the future DNA⁵⁵ of Medicaid as part of the wraparound services provision. The legislation would provide states with enhanced federal Medicaid funding at a 95% federal match for three years to provide qualifying community-based mobile crisis services to individuals experiencing a mental health or SUD crisis.⁵⁶
- Additional Medicaid funding would support state implementation and administration of multidisciplinary mobile crisis teams that are available 24/7, every day of the year, and trained in trauma-informed care, de-escalation, and harm reduction to provide voluntary assessment and stabilization services for individuals in crisis, as well as coordination and referrals to follow-up care and wraparound services, including housing assistance.

Teams must be able to provide or coordinate transportation to help individuals reach their next step in care.⁵⁷

- The legislation requires mobile crisis teams to partner with key community resources to facilitate referrals and coordinated delivery of care. For example, teams must have relation-

⁵³ CAHOOTS Act H.R. 7961, 116th Congress (2020) (<https://www.congress.gov/bill/116th-congress/house-bill/7961>).

⁵⁴ Houston, H. (2021, Feb 19). "CAHOOTS Bill in House COVID-19 Relief Package," Eugene Weekly. (<https://www.eugeneweekly.com/2021/02/19/cahoots-bill-in-covid-19s-house-relief-bill/>).

⁵⁵ Jordyn B. (2020, Aug 5). "Wyden embeds CAHOOTS DNA into Medicaid legislation," The Register-Guard. (<https://www.msn.com/en-us/news/politics/wyden-embeds-cahoots-dna-into-medicaid-legislation/ar-BB17C4Jh>).

⁵⁶ 117th Congress CAHOOTS Act Factsheet, February 2021. (<https://www.finance.senate.gov/imo/media/doc/021721%20CAHOOTS%20One-Page%2017th%20Congress.pdf>).

⁵⁷ Ibid.

ships with behavioral health providers, crisis respite centers, housing assistance providers such as public housing authorities, and other organizations and agencies that provide social services.⁵⁸

- The bill directs mobile crisis teams to be connected to regional hotlines and emergency medical service systems. Mobile crisis teams under this option must not be operated by or affiliated with state or local law enforcement agencies, though teams may coordinate with law enforcement if appropriate.⁵⁹
- The bill requires states that provide mobile crisis services under the new state option to conduct a robust evaluation of the impact of mobile crisis services on emergency room visits, the involvement of law enforcement in mental health or SUD events, diversion from jails, and other outcomes. States must also report on the models and programs they design, including how people are connected to care following the delivery of mobile crisis services. States must also report on the demographic information of the individuals their teams help in order to identify and help address health disparities.⁶⁰
- The U.S. Department of Health and Human Services (DHHS) is required to summarize states' results and identify best practices for delivering effective mobile crisis intervention services.⁶¹

Currently, the bill is in the Senate Finance Committee which oversees Medicare and after to Congress for a vote.

H.R. 1319 American Rescue Plan Act of 2021 (ARPA). Inserted into this federal legislation are specific provisions of the CAHOOTS Act under Section 9813 "State Option to Provide Qualifying Community-Based Mobile Crisis Intervention Services."

The American Rescue Plan Act of 2021⁶² ("COVID-19 Stimulus Package" or "American Rescue Plan") is a \$1.9 trillion economic stimulus bill passed on March 11, 2021, to accelerate the recovery from the economic and health effects of the COVID-19. ARPA establishes a "down payment" for states to set up CAHOOTS-like programs,⁶³ providing an estimated \$1 billion over 10 years that provides an 85% match in Medicaid funds⁶⁴ for states that set up mobile crisis teams.⁶⁵

⁵⁸ Ibid.

⁵⁹ Ibid.

⁶⁰ 117th Congress CAHOOTS Act Factsheet, February 2021. (<https://www.finance.senate.gov/imo/media/doc/021721%20CAHOOTS%20One-Pager%20117th%20Congress.pdf>).

⁶¹ Ibid.

⁶² The American Rescue Plan Act of 2021, H.R. 1319, 117th Cong. (2021). (<https://www.congress.gov/bill/117th-congress/house-bill/1319>).

⁶³ Young, O. (2021, Mar 17). "\$1 billion for CAHOOTS Act included in American Rescue Plan," NBC16. (<https://nbc16.com/news/local/1-billion-for-cahoots-act-included-in-american-rescue-plan-03-18-2021>).

⁶⁴ Section 9813(c). The American Rescue Plan Act of 2021, H.R. 1319, 117th Cong. (2021). (<https://www.congress.gov/bill/117th-congress/house-bill/1319/text#H3E69A99FFA594041A6541246A7B8D5B8>).

⁶⁵ Associated Press (2021, Apr 24). "US Government funds mental health crisis teams to stand in for police." (<https://www.voanews.com/usa/us-government-funds-mental-health-crisis-teams-stand-police>).

Under ARPA, \$15 million has been allocated for state planning grants.⁶⁶

Notably, unlike the CAHOOTS Act, funding for mental health crisis response under ARPA does not bar coordination with police and it does not directly fund police departments. Also embedded in the coronavirus care package is \$80 million for crisis intervention training for public safety officers and health care providers (CIT).⁶⁷

National Suicide Hotline Designation Act.⁶⁸ This legislation is an effort to consolidate hundreds of suicide crisis hotline calls into a 9-8-8 crisis line that will offer assistance to people contemplating suicide or in a mental health or substance use related crisis. The creation of this three-digit number separate from 911 was recommended and formally established in 2020 by the Federal Communications Commission (FCC) and enacted into law through the National Suicide Hotline Designation Act⁶⁹ (passed in October 2020). It will go live in July of 2022.

The designation of 988 as a nation-wide crisis number by the FCC came alongside the uptick in suicide crisis calls across the country in the midst of the global pandemic.⁷⁰ Supporters of this effort, including NAMI, hope to create a network of call centers that forms the foundation for a re-imagined crisis system that can provide mental health response to crises rather than relying on 9-1-1, which in the vast majority of jurisdictions involves police intervention.

The 9-8-8 legislation allows states to impose a user fee on callers to fund crisis services. This is a steadier and more consistent source of funding rather than reliance on a yearly state budget allotment which must be approved every year or every other year, and are subject to economic downturns which place them under threat, resulting in cuts to crisis services. However, user fees will likely serve as a barrier to use by people who most need crisis support.

The question of which entities will qualify to serve as a legitimized crisis service remains unclear and will be subject to state and local rulings.

For example, places like Orange County are considering “a single point of entry” into crisis assistance because they have 21 different crisis hotlines. Their hope is to develop a standardized,

⁶⁶ Section 9813(e). The American Rescue Plan Act of 2021, H.R. 1319, 117th Cong. (2021). (<https://www.congress.gov/bill/117th-congress/house-bill/1319/text#HDA7B907C553943B28B88BE8684697304>): “There is appropriated, out of any funds in the Treasury not otherwise appropriated, \$15,000,000 to the Secretary for purposes of implementing, administering, and making planning grants to States as soon as practicable for purposes of developing a State plan amendment or section 1115, 1915(b), or 1915(c) waiver request (or an amendment to such a waiver) to provide qualifying community-based mobile crisis intervention services under this section, to remain available until expended.”

⁶⁷ Sec. 2703 (a) and (b), H.R. 1319, 117th Congress. (<https://www.congress.gov/bill/117th-congress/house-bill/1319/text#HB-6589B580E1E483AAE96521C14D42BB5>).

⁶⁸ National Suicide Hotline Designation Act of 2020, S.2661, 116th Cong. (2020). (<https://www.congress.gov/bill/116th-congress/senate-bill/2661/text>).

⁶⁹ Ibid.

⁷⁰ Chatterjee, R, (2020, Oct 29). “New law creates 988 hotline for mental health emergencies,” NPR. (<https://www.npr.org/sections/health-shots/2020/10/19/925447354/new-law-creates-988-hotline-for-mental-health-emergencies>).

CAHOOTS model response system that orbits around their crisis campuses. They are considering developing 9-8-8 as an actual 9-1-1 alternative with both crisis phone triage and intervention, along with dispatch capabilities. They hope that police 9-1-1 crews would send any calls they get to 9-8-8 the same way they send them to EMS, but the bulk of crisis intervention calls would skip those dispatchers entirely.

What infrastructure already exists? The existing 9-8-8 system is funded by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), and offers free confidential support 24/7 through a network of 170 low price call centers across the country. When a person calls the 10 digit lifeline number, pressing one will route the caller to the National Veteran's Crisis Line. Pressing two will route to a Spanish call center network. All other calls get routed by the lifeline to a local crisis center. If that local crisis call center is unable to answer in time, the call is rerouted to the lifeline's national backup network. The same system will be used to route and respond to calls to 9-8-8.

What local crisis call centers look like and their relationship to law enforcement is determined locally. For example, suicide hotlines routinely call police as the only recourse for an in-person intervention – which all too often leads to police killing the caller. Each region's dispatch will decide which calls get diverted to police and which are diverted out. While this allows mental health professionals and trained peers to answer the call, it does not guarantee that they will be able to do so. And if a state or jurisdiction does not have an alternative mental health crisis intervention infrastructure or response in place, then callers will not get access to alternative care, treatment, support, as dispatch or whoever answers the 9-8-8 call would likely default to diverting people in crisis to police.

Getting ready for the infrastructure to go live. Once this 9-8-8 system goes live, it is expected that more people will be making calls, pushing call centers to handle a larger volume and wider range of mental health, substance abuse and suicidal crises. Because of this, groups like NAMI are advocating that local jurisdictions must have 24/7 crisis center hubs, mobile crisis teams, and crisis stabilization programs established. They also are pushing state and local 983w28 call centers to have well trained staff available through phone, text and chat in English and other languages. These local call centers should serve as hubs that have strong connections with other emergency systems and with local mental health and substance use provider networks. While diversion from police-only response is a goal, mental health provider ties to the police are standard.

How is this different from 2-1-1? 2-1-1 is a three digit number reserved in Canada and the United States that provides information and referrals to health, human, and social service organizations. It does not provide a direct connection to services.

State Legislation

Below are some highlights of alternative mental health crisis response related state legislation being pushed across the country. This does not represent an exhaustive overview of the legislative landscape. Some bills address meeting the requirements of the new 9-8-8 crisis call line, while some would directly fund mental health programs that respond to community crisis without police.

States with Active 9-8-8 Legislation – Highlights

As of May 1, 2021, legislation related to implementation of 988 has been introduced in 17 states. Each bill is different since each state's crisis care terrain varies. In 2020, the National Associations of State Mental Health Care Program Directors created model legislation for states outlining what they should consider and legislate in anticipation of 988 going live, influenced by NAMI and SAMHSA proposals documented in SAMHSA's National Guidelines for Behavioral Health: Best Practice Toolkit.⁷¹ NAMI is promoting a Crisis Now Campaign⁷² to create a national uniform system of crisis intervention that does not involve police. We encourage communities to monitor and engage in state's planning discussions, as most states currently have a planning committee for 9-8-8 implementation, whether on the county or state levels.

Georgia. Georgia's 9-8-8 system is favored by NAMI as a model state program,⁷³ mainly because they have had time to consolidate a state-wide infrastructure. Georgia's crisis and access lines have the ability to schedule urgent outpatient appointments while people are on the phone. They also have electronic bed inventories, so they can monitor where there are open crises and detox beds.⁷⁴ Their system predates the federal 988 legislation, and emerged as a result of a 2009 lawsuit in which the United States Department of Justice sued the state of Georgia for violating the Americans with Disabilities Act (ADA), and the 1999 Supreme Court's decision in *Olmstead v. L.C.* The plaintiffs Lois Curtis and Elaine Wilson cycled in and out of hospitalization because the state lacked support for people with mental or developmental disabilities outside of an institutional setting. The settlement agreement was enforced like a consent decree, resulting in five years of planning to create what they hoped was a robust system outside of institutional settings. That then laid the groundwork for Georgia's 9-8-8 system.⁷⁵

⁷¹ Substance Abuse and Mental Health Services Administration (SAMSHA). (2020). National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit. (<https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>).

⁷² Crisis Now: Transforming Crisis Services. Website. (<https://crisisnow.com/>)

⁷³ See "Help Not Handcuffs: Legislation & Community Models." (<https://www.nami.org/Blogs/NAMI-s-Ask-the-Expert/2021/Help-Not-Handcuffs-Legislation-Community-Models>).

⁷⁴ Hepburn, S. (2021, Mar 23) "Georgia's crisis system Transformation and lessons learned in anticipation of 988," #CrisisTalk. (<https://talk.crisisnow.com/georgias-crisis-system-transformation-and-lessons-learned-in-anticipation-of-988/>).

⁷⁵ See *United States v. Georgia* Civil No. 1:10-CV-249-CAP Settlement Agreement Fact Sheet (October 2010). (https://www.ada.gov/olmstead/documents/georgia_fact_sheet.pdf).

California. California is considering legislation, AB 988,⁷⁶ to prepare for state-wide implementation of the federal 9-8-8 legislation. The legislative intent is to remove law enforcement as first responders to mental health crises. The bill is named in honor of Miles Hall, who was a 23-year-old Black man living in Walnut Creek in the San Francisco Bay Area, and was in the midst of a schizophrenic mental health crisis when his family called 9-1-1 for help in 2019. Despite being familiar with Miles' condition, police officers shot and killed Miles. Like all states, California has historically underfunded mental health services.⁷⁷ As a result, the criminal system serves as the state's default mental health provider, filling jails and prisons with people with unmet mental health needs and exacerbating their conditions.

Community-Based Organizing for Mental Health Crisis Funding

Community groups and family survivors of violence are also advocating for legislation to fund mental health crisis response alternatives, including the following legislative initiatives.

Community Response Initiative to Strengthen Emergency Systems (C.R.I.S.E.S.) Act in California. Community organizations like APTP co-sponsored the C.R.I.S.E.S. Act,⁷⁸ which, in addition to building the 988 system, creates pathways for funding pilot projects designed to serve as non-police alternatives to police in mental health crisis situations. The bill was first introduced by California Assembly member Sydney Kamlager (AB 2054)⁷⁹ in February of 2020, but was vetoed by Governor Newsom because he wanted the grant program to be housed under an essentially law enforcement controlled body, the Board of State and Community Corrections (BSCC),⁸⁰ rather than the Office of Emergency Services (OES). The Board of State and Community Corrections is a state agency that oversees and provides guidance and funding to California's courts, prisons, and jails. This body has 13 members, the majority of whom are required to be sheriffs, chief probation officers, judges, police chiefs, and Department of Corrections officials; only two seats are designated for community service providers or advocates. The legislation was reintroduced in 2021 as AB 118, and creates a new body to oversee a pilot program run out of the Office of Emergency Services under the governor's office. The bill mandates that the oversight body be made up of community organizations, and is currently pending before the state legislature.⁸¹

⁷⁶ AB 988, 2021 Biennium, 2021 Reg. Sess. (CA 2021). (https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB988).

⁷⁷ Ibid.

⁷⁸ French, P. (2021, Feb 17). "California bill that promotes alternatives to policing is back despite Governor's veto," The Appeal. (<https://theappeal.org/politicalreport/california-crises-act-2021/>).

⁷⁹ AB 2054, 2020 Biennium, 2020 Reg. Sess., (CA 2020). (https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB2054).

⁸⁰ See website for the Board of State and Community Corrections (BSCC). (<https://www.bscc.ca.gov/>).

⁸¹ AB 118, 2021 Biennium, 2021 Reg. Sess. (CA 2021) (https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB118).

C.E.S.S.A. Act. In Illinois, a group of disability advocates and the family of Stephon Watts, a young Black man was shot by police, have proposed the Community Emergency Services and Support Act (C.E.S.S.A.), designated as HB 2784⁸² and SB 2117.⁸³ C.E.S.S.A. would create an emergency response alternative for mental health crises that does not involve any police or law enforcement.

This act would require each of the state of Illinois' EMS Regions to coordinate a mobile mental and behavioral health service through its 9-1-1 provider so that such service is available wherever the region provides ambulance service. Subject to certain minimum service levels, each EMS Region would decide the extent to which it will rely on existing service options or encourage additional providers to offer services. Other features of the legislation include:

- The bill does not train police and does not support a co-responder model where police accompany social workers. The intent of the bill is to avoid any police intervention.⁸⁴
- Creates a 9-1-1 response option apart from law enforcement for mental and behavioral health emergencies everywhere an ambulance service exists.⁸⁵
- Requires responders to use appropriate de-escalation techniques and then connect callers to their existing care providers or to available community services and supports.⁸⁶
- Saves state and local dollars by supporting people in the community rather than in emergency rooms and jails.

The bill just passed the Illinois state House.⁸⁷

Considerations on Mental Health Alternative-Related Legislation

As local efforts to select, implement, and fund alternative mental health crisis responses demonstrate, the interplay between city, county, state, and federal policymaking can determine implementation and resourcing of mental health crisis responses. It is only more recently that federal bills like the CAHOOTS Act and the National Suicide Hotline Designation Act (9-8-8) have gained prominence, potentially bringing sweeping changes to the legitimacy and, most importantly, the resources available to local implementation efforts. But those resources come with conditions and limitations which have yet to be negotiated or transparent.

⁸² HB 2784, 2021 Biennium, 2021 Reg. Sess. (IL 2021) (<https://www.ilga.gov/legislation/BillStatus.aspx?DocNum=2784&GAID=16&DocTypeID=HB&SessionID=110&GA=102>).

⁸³ SB 2117, 2021 Biennium, 2021 Reg. Sess. (IL 2021) (<https://www.ilga.gov/legislation/billstatus.aspx?DocNum=2117&GAID=16&GA=102&DocTypeID=SB&LegID=134768&SessionID=110>).

⁸⁴ See website for Access Living, Action Alert: Support Illinois CESSA Bill. (<https://www.accessliving.org/defending-our-rights/racial-justice/community-emergency-services-and-support-act-cessa/>).

⁸⁵ Ibid.

⁸⁶ Ibid.

⁸⁷ Ibid.

For example, government grants like Medicaid require programs to abide by certain restrictions. Existing programs that are not 24/7 and lack the resources to scale up to that level immediately would not qualify for funding. On a positive note, nor would programs that impose involuntary treatment.

It will take federal funding, state general funds, and services that can be built within Medicaid, private insurance, and local city and county resources together to make a robust crisis care system possible. It will also take the entire ecosystem of mental health crisis responses from city-wide or county-wide CAHOOTS-style or Mental Health First programs to a rich flora of self-determined, peer support networks to offer multiple access points for individuals and communities to get the prevention and intervention responses needed.

While legislative efforts to shift the role of police can reduce police contact with people in crisis, centralization and overregulation can limit access to and growth of autonomous community-based care networks and formations. It is unclear how funds will be distributed to community groups, and what limitations will be placed on such funds. It is also unclear how surveillance and data collection will be implicated in a centralized 9-8-8 system and government led mental health intervention models. It is still too early to tell -- all we have are countless lessons from the patterns and ways criminalization reproduces and legitimizes itself to prepare and organize accordingly.



The Breathe Act (breatheact.org) developed by the Movement for Black Lives calls for a federal overhaul of national spending based on a redefinition of public safety by divesting federal resources from incarceration and policing and investing in non-punitive, non-carceral approaches to community safety that lead states to shrink their criminal-legal systems and build healthy, sustainable, and equitable communities.

By getting at the root causes of mental health crises, legislation like The Breathe Act can redirect billions of dollars away from law enforcement agencies toward providing for housing, health and mental health care, education, and decent jobs.

"Intelligent Mischief" from Aisha Shillingford and Terry Marshall from the We Breathe Art collection available at: <https://breatheact.org/art/>.

MOVING FORWARD: CLOSING RECOMMENDATIONS

This guide emphasizes the unique local conditions and factors that influence and shape feasible mental health crisis response options and strategies. Based upon the creation and implementation of existing programs reviewed here, some common themes and lessons have emerged to provide insight for effective organizing. Based on a review of programs during the early stages of implementation (with the exception of the 30 year history of CAHOOTS), we recommend the following:

Support Healing Justice/Disability Justice/Transformative Justice

- ▶ While this guide narrowly focuses on mental health crisis response, this is a single intervention within a broader context of ensuring community mental health needs are met through frameworks of self-determination, healing justice,⁸⁸ disability justice,⁸⁹ transformative justice, and liberation.
- ▶ Mental health crisis response focuses on reactive responses to people in crisis - we need to orient towards creating the conditions in which mental health crises are prevented by addressing the root causes created by racism, ableism, sexism, homophobia, transphobia, xenophobia, etc. - and by providing universal access to quality, accessible, affordable, sustainable and long-term housing, health and mental health care and resources, human-centered education, living wage and respectful employment; rich access to culture; and a sustainable climate.

Center Impacted Communities in Organizing and Planning

- ▶ Commit to and create structures for leadership by and accountability to impacted communities, including BIPOC, low- and no-income, disabled (recognizing the broad spectrum of disabilities), neuro-divergent, LGBTQIA+, immigrant (including undocumented), criminalized, and homeless/houseless communities.
- ▶ Include local peer-led, mutual aid, disability justice, and healing justice organizations and formations in the planning process in the earliest stages.

⁸⁸ For more information on healing justice, a concept originated by the Kindred collective, please visit: <http://kindredsouthernhjcollective.org/what-is-healing-justice/>.

⁸⁹ Please see the principles of disability justice outlined by Sins Invalid at <https://www.sinsinvalid.org/blog/10-principles-of-disability-justice>.

- ▶ Include mental health providers and/or organizations committed to envisioning and implementing non-police options who are not tied to police collaboration -- and act upon this commitment
 - This might require organizing and training mental health providers in non-police, anti-carceral, and abolitionist social work, psychology, public health, and psychiatry.⁹⁰
 - This might mean working around mental health providers towards peer-response.
- ▶ Thoroughly study mental health crisis response models (advantages and disadvantages) -- this guide serves as an initial tool to make your way through identification and assessment.
- ▶ Study and be aware of cautions and challenges at the front end of your organizing.
- ▶ Line up, meet with, pressure, and strategize with allies among elected officials and governmental non-police decision-makers (if there are any).

Initiate and Intervene in Local and State Legislation

- ▶ Track, monitor, and investigate local laws, state laws, and federal laws (as well as their relationship to each other), and organize policy interventions to ensure that mental health crisis response selection and implementation plans are not thwarted by or made ineligible for funding resources through legislation -- including the local operationalization and implementation of policy.
- ▶ Support and create legislation that does not cut off future creative openings for meaningful community interventions, experiments, and projects.
- ▶ Create legislation that will prioritize and support community-led mental health crisis responses.
- ▶ Create and/or intervene in local plans to implement upcoming federal CAHOOTS legislation and/or 9-8-8 legislation.
 - This federal legislation could have enormous negative impacts for the feasibility and funding of community-based and accountable mental health programs, or for local mental health crisis legislation.
 - Local governmental jurisdictions may already have plans on how these will translate at the local level -- possibly leaving your strategies out or creating priorities that leave your strategies unlikely to gain traction.

⁹⁰ Documentation from Interrupting Criminalization's Beyond Do No Harm webinar (<https://www.interruptingcriminalization.com/do-no-harm>) highlights what mental health practitioners can do to center non-criminalization mental health and health care. See facebook page of Abolitionist Social Work (<https://www.facebook.com/groups/abolitionistsocialwork/>) and website of Network for the Advancement of Abolition Social Work (NAASW) (<https://www.naasw.com/>) for other resources.

Consider Multiple Options and Entry Points

- ▶ Understand mental health crisis responses as an “ecosystem.”
- ▶ Plan support for and implementation of non-police mental health responses.
- ▶ Consider support for more than one system of mental health crisis response -- e.g., community organizers support Oakland’s CAHOOTS-style MACRO (implemented through the Fire Department) and Mental Health First (autonomous BIPOC-led community-based mental health crisis response).

Create Policy Changes and Formations that Facilitate Impacted Community Leadership

- ▶ Ensure that community organizing centers community members impacted by mental health crisis response.
- ▶ Institutionalize community leadership and ownership throughout the process of planning and implementation. See examples such as Denver STAR’s charter (not passed) and Oakland’s City Council Resolution (passed) that aim to institutionalize the leadership of BIPOC people and communities, and of people affected by mental health crisis response.

Create Policy Changes that Reduce or Eliminate Police Response

- ▶ **Dismantle police control of dispatch**
 - Move dispatch from police to non-police/autonomous control and/or adopt non-police community dispatch.
 - Investigate and change dispatch protocols and perhaps personnel to remove police control and reduce or eliminate prioritization of police response or co-response.
- ▶ **Reduce/eliminate police-only or co-response**
 - Do not include co-response into your mental health crisis response strategy -- co-response is not a real alternative.
 - Significantly reduce or eliminate existing police-only and/or co-response.
- ▶ **Embed safety into response strategies – not police security strategies**
 - Safety strategies should be embedded within de-escalation, self-determination, and harm reduction strategies within your mental health crisis response.
 - Do not orient towards danger assessment and involvement of police or other armed response.

Create Crisis Response Teams that Include Unlicensed and Low-Level Licensed (but Trained) Experts

▶ Crisis Intervention Workers or Crisis Responders

- Both CAHOOTS and Mental Health First adopt personnel strategies that prioritize people as crisis responders who are oriented towards supportive, harm reduction crisis response -- not towards degrees and licenses
 - * Mental Health First prioritizes members of BIPOC or other most impacted communities

▶ Medics

- Both CAHOOTS and Mental Health First models include “medics” -- and include EMTs who are trained medics but with less licensing than paramedics, doctors, psychiatrists, etc.

▶ Do not set involuntary hospitalization as a personnel bottomline or operational standard

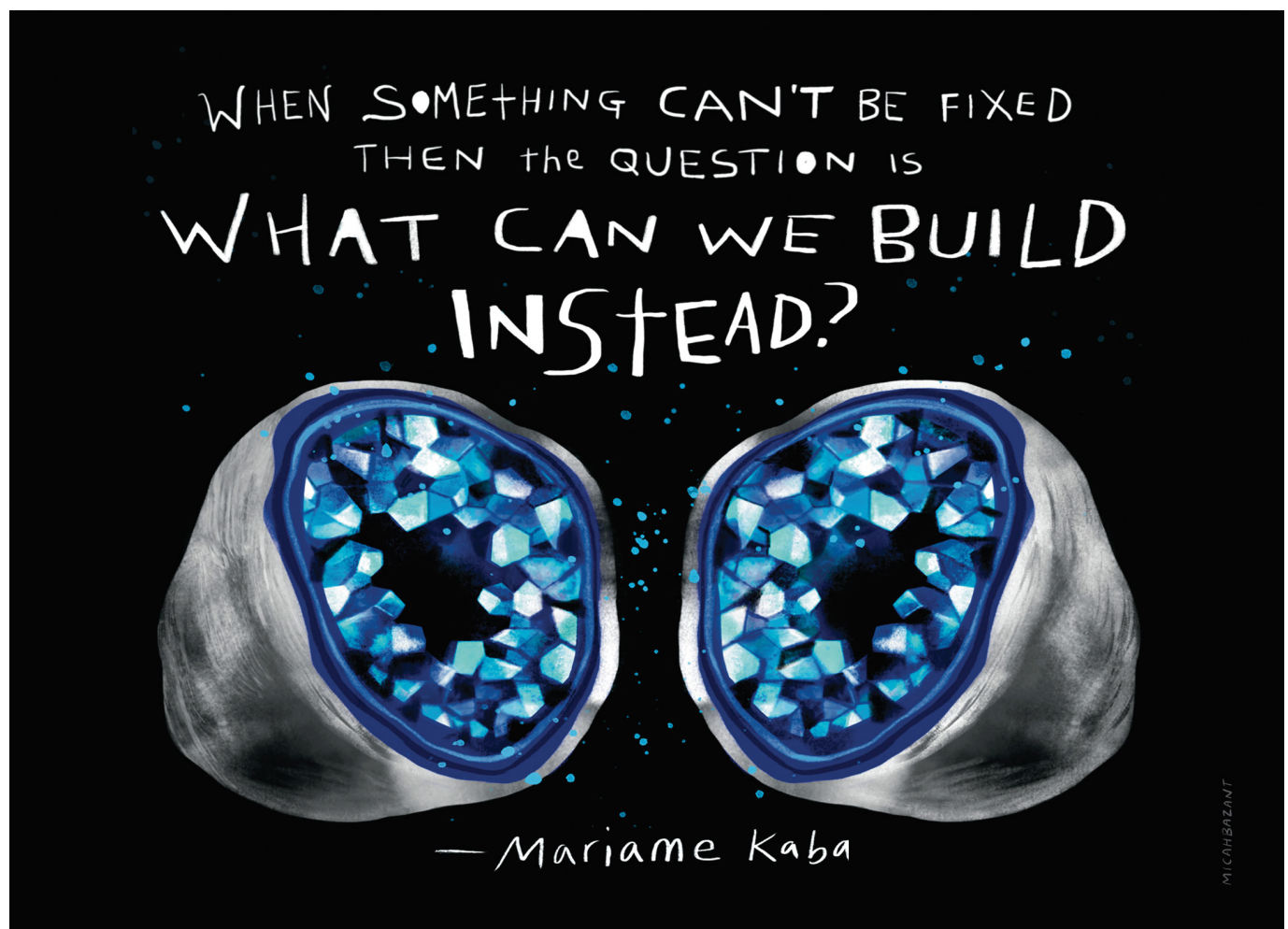
- Many programs set their licensing threshold so that all response teams can perform involuntary hospitalization
 - * First of all, question involuntary hospitalization
 - * Second, do not use this as a standard for your response teams -- this orients you towards involuntary hospitalization and sets your licensing requirements so that response teams must include highly trained and licensed (and, most likely, police-oriented) responders

Training

- ▶ For over 30 years, CAHOOTS has developed a systematic and extensive 500+ hour paid training program for its responders -- this has provided for an effective, available set of trained crisis response personnel, which is not always the case for programs that only use licensed individuals as responders.
- ▶ The training protocols and content of CAHOOTS can be adopted into programs more responsive to BIPOC communities -- thereby, centering most impacted community members as responders and providing a mechanism for potentially widespread mental health response training within and among most impacted communities
- ▶ In addition to the number of hours, continuation of training, and the content of training, we must be vigilant in interrupting policing or carceral approaches among EMTs, nurses, social workers, peer counselors etc.

Imagine, Dream, Seed, Grow

And finally, imagine, dream, seed, grow. The call by Project Nia and Interrupting Criminalization to expand our ideas about what keeps us safe through #1MExperiments⁹¹ is an invitation to imagine, dream, and grow things not yet in existence or to re-member what has been severed. A central question for our organizing must be how can we live in a way that builds the kind of ecosystem that does not produce crises and extreme forms of violence, neglect, and harm, whether on ourselves or each other.



Art by [Micah Bazant](#) (Instagram: [@micahbazant](#)) for the Abolition Imagination Cards collection available at: <https://www.interruptingcriminalization.com/imagination>

⁹¹ One Million Experiments (<https://millionexperiments.com/>).

APPENDIX A - Important Definitions and Concepts

- ◇ **Abolition or Prison Abolition** refers to a commitment to the complete dismantling and elimination of all systems of punishment and surveillance -- centered on the elimination of the criminal legal or carceral system, including police, prosecutors, courts, jails, prisons, child and family regulation systems, ICE and Border Patrol, and probation, and parole, but also extending to practices of coercion, punishment and surveillance in the medical and educational systems (see the definition for carceral systems).
- ◇ **Anti-carceral** refers to opposition to society's reliance upon the criminal legal system or carceral systems (see definition for carceral systems). People who are anti-carceral may subscribe to abolitionist beliefs (see abolition), but being anti-carceral, in and of itself, does not necessarily extend to the belief in or commitment to the elimination of all carceral systems.
- ◇ **BIPOC** refers to Black, Indigenous and other people of color.
- ◇ **Carceral systems** refers to systems that rely on surveillance, policing, punishment and exclusion, including, but not limited to, the criminal legal system or the system of police, prosecutors, courts, jails, prisons, probation and parole. Carceral systems, in the case of mental health may extend to fire departments, departments of health and mental health, family regulation systems, education, immigration control, paramedics, emergency medical technicians (EMT), hospitals, clinics, psychiatrists, psychologists, social workers and others who collaborate with or report to law enforcement and rely upon policing as one way to deal with people experiencing mental health crises.
- ◇ **Community safety** or **real safety** are terms used to redefine the meaning of safety -- primarily by questioning law-enforcement driven definitions of safety and pointing towards notions of safety rooted in prioritizing community needs -- housing, healthcare, mental health care, childcare, education, employment in living wage jobs, adequate transportation, parks and recreation, arts and culture, and sustainable climate -- which will establish the conditions for safety. It also refers to safety strategies that look towards community care such as transformative justice rather than law enforcement.
- ◇ **Cooptation** refers to tactics by power elites such as government officials, law enforcement, departments of mental health and health, mainstream mental health institutions, psychiatrists, and social workers -- to use the language and concepts of alternative mental health crisis responses to actually maintain the status quo or minimize changes to the existing systems and power structures.
- ◇ **Co-response** refers to police-involved mental health crisis response in which police officers are trained to respond to mental health crises, and linked in some way to social workers or other licensed mental health workers to respond to what would be considered non-violent mental health crises that may include substance abuse, suicide, and issues related to homelessness/houselessness.

- ◇ **Crisis Intervention Teams (CIT)** is a broad term for law enforcement programs training police in mental health response and connecting them to mental health service providers. Co-response is one of the most common categories which fall under the category of CITs.
- ◇ **Crisis Intervention Training (CIT)** refers to training programs focused on first responder mental health crisis response. These are geared for the police -- but can also be broadened to include other crisis responders and mental health workers. Often presented as a panacea against police violence targeting people experiencing mental health crises, federal funding and other mental health crisis proposals center on training police as opposed to a shift to non-police mental health crisis response.
- ◇ **Crisis intervention workers** are non-licensed professionals trained to respond to mental health crises who are skilled in counseling and de-escalation. CAHOOTS includes crisis intervention workers as a key member of their mobile response team.
- ◇ **Crisis responders** are trained mental health responders. Mental Health First teams include a crisis responder, who are currently unpaid volunteers who may or may not have professional training or licensing in some aspect of mental health care, but who have gone through a Mental Health First mental health crisis response training. Mental Health First includes a crisis responder as a key member of their mobile response team.
- ◇ **Disability justice** is a framework and practices based upon the perspectives, needs, and self-determination of people impacted by ableism. Disability justice requires initiatives that center consent, non-coercion, creation by and for disabled people and/or people impacted by ableism, peer-led and initiated support and resources, proactive rather than reactive approaches, and accessibility to all regardless of language, culture, identities, and disability/ability.
- ◇ **EMS or emergency medical services** is the overarching system of emergency response for people experiencing physical and/or mental health crises requiring emergency medical response. EMS providers include EMTs and paramedics (see definitions for EMT and paramedics).
- ◇ **EMT or emergency medical technicians** are entry-level members of emergency medical services (EMS) trained to provide basic-level life support. EMTs are key members of the mobile response team in some crisis mental health response models.
- ◇ **Harm reduction** is a framework originally associated with drug use that centers the rights and self-determination of people who use drugs -- including their control over the use or non-use of drugs -- and focuses on safer use, in distinct opposition to forced abstinence or terms of use and non-use determined by authorities. It has been expanded to include other types of experiences and behaviors that might be considered "criminal," "immoral," or unsafe -- such involvement in the sex trades, sex work, and street economies, engaging in self injury, or detoxing from psychiatric medication.
- ◇ **Healing justice** is a framework first articulated by Southern Healers in the Kindred collective that centers individual and collective healing from present-day and generational/historical

legacies of physical, psychological, cultural, sexual, ecological, spiritual, and other forms of harm based upon systems of oppression such as racism, ableism, homophobia, etc.

- ◇ **Law Enforcement/Police:** When we reference law enforcement or police, we include sheriffs, prosecutors/district attorneys, school police, resource officers, probation officers, city police, city attorneys who act as prosecutors, ICE, Border Patrol, private police, corrections officers, and jail and prison wardens.
- ◇ **LGBTQIA+ or lesbian-gay-bisexual-transgender-queer/questioning-intersex-asexual** people; the + indicates the expansiveness and fluidity of this overarching category.
- ◇ **Medics** are medical professionals. Both CAHOOTS and Mental Health First response teams include a medic, usually either an EMT or a nurse, as a key member of their mobile response team.
- ◇ **Mental health crisis response** is the umbrella term being used in this report to describe rapid response to more immediate and critical needs of an individual experiencing a mental health crisis. Other similar terms include: alternative emergency response, crisis mental health response, mobile crisis intervention team, mental health mobile response, mental health emergency response.
- ◇ **Non-reformist reforms** refer to tactics and strategies that might reduce the scope of law enforcement, significantly reduce the harm of law enforcement, or build pathways from current systems responses to an eventual if not immediate end to current reliance on systems of law enforcement. With regard to law enforcement, our notion of non-reformist reforms ask critical questions regarding whether or not our proposed reforms further: (a) legitimize law enforcement, (b) preserve or increase funding to law enforcement; (c) institutionalize or codify alternatives that maintain a lasting role for law enforcement; or (d) constrain, control, or diminish options autonomous from law enforcement.
- ◇ **Nurses** are licensed medical professionals trained to provide a broad level of healthcare services. There are several types of nursing licenses, but the majority of nurses are licensed as a licensed practical nurse (LPN) or registered nurse (RN). Those nurses reaching the level of advanced practice registered nurse (APRN) include nurse practitioners. Nurses may be specialized in mental health care with a psychiatric mental health nurse practitioner (LMHNP) serving at the level of highest training, skill, and pay structure. While nurses cannot prescribe medication, they often work in conjunction with doctors including psychiatrists who are licensed to prescribe medication. A nurse is a key member of the mobile response team under some crisis mental health response models.
- ◇ **Paramedics** are licensed medical professionals at the highest level of training, skill and pay structure among those performing emergency medical services (EMS). Paramedics can provide emergency health care services at the level of a hospital emergency room, and are licensed to perform advanced life support. Paramedics are key members of mobile crisis response teams under some crisis mental health response models.

- ◇ **Peer navigators** is a term used to refer to people brought into mental health crisis response teams or other programming specifically as people who have experienced mental health crisis or involvement in mental health systems and/or who may be formerly incarcerated, formerly homeless/houseless, people with a history of substance abuse. People designated for peer navigator roles are often BIPOC. While many references are made to peer navigators, they tend to have a voluntary, limited and/or an anticipated but unclear future role in programming.
- ◇ **Psychiatrists** are licensed medical doctors trained in psychological conditions and licensed to prescribe medication. A psychiatrist holds the highest level of training, skill, and pay structure in a mental health medical team. Crisis mental health responses often include a psychiatrist at some level of crisis response, although they are rarely part of the regular mobile crisis response team.
- ◇ **Psychologists** are licensed professionals with an advanced degree such as a Ph.D., PsyD, or doctorate in psychology who are trained in various aspects of behavioral and mental health conditions. Psychologists can provide assessment, evaluation, diagnosis and treatment. While psychologists in most states cannot prescribe medication, they often work in conjunction with psychiatrists who are licensed to prescribe medication. A psychologist may play a role at some level of crisis response, although they are rarely part of the regular mobile crisis response team.
- ◇ **Security liaisons** are individuals trained to provide non-law enforcement security -- including reduction and interruption of violence from law enforcement. Mental Health First includes a security liaison as a key member of their mobile response team. Their role is to remain focused on security so that the medic and crisis responder can be free to focus on mental health needs.
- ◇ **Social workers** are informally or formally trained professionals who provide services to improve the social welfare of individuals, groups or communities. While the breadth of social work is wide, social workers who participate in crisis mental health response generally have experience and/or specialized training in mental health services. Social workers may have a bachelor's degree (BSW), master's degree (MSW) or an advanced degree (Ph.D. or DSW, Doctorate of Social Work). In addition, most states have a category of licensed clinical social worker (LCSW) who has an MSW and additional training and examination required for a license in clinical social work. Social workers (with an MSW or LCSW) have been proposed under some crisis mental health response models as a member of the mobile response team.
- ◇ **Transformative justice** refers to anti-carceral and abolitionist frameworks and practices that prevent and intervene in violence, abuse and harm committed by using methods and processes of survivor-centeredness, accountability, collective dialogue, compassion and connection rather than punishment and systems responses.

APPENDIX B - RESOURCES

Alternatives to Policing Based in Disability Justice

<https://abolitionanddisabilityjustice.com/main/>

CAHOOTS

<https://whitebirdclinic.org/cahoots/>

CAT-911

<https://cat-911.org/trainings-and-resources/resources-produced-by-cat911/>

Denver Alliance for Street Health Response (DASHR)

<http://dashrco.org/>

Fireweed Collective

<https://fireweedcollective.org/>

Frontline Wellness United

<https://www.frontlinewellness.org/>

Healing Justice

<https://transformharm.org/healing-justice/>

Interrupting Criminalization

<https://www.interruptingcriminalization.com>

Mad Queer Organizing Strategies by Elliott Fukui

<https://madqueer.org/>

Mental Health First/Oakland

<https://www.antipoliceterrorproject.org/mh-first-oakland>

Mental Health First/Sacramento

<https://www.antipoliceterrorproject.org/mh-first-sac>

Network to Advance Abolitionist Social Work

<https://www.naasw.com>

One Million Experiments

<https://millionexperiments.com>

APPENDIX C - REFORMS TO AVOID BY THE ABOLITION & DISABILITY JUSTICE COALITION

1. Reforms that replace policing and criminalization with mandatory social or health services.

- Including those that replace imprisonment with other forms of incarceration, such as in a group home, nursing home, drug treatment facility, or hospital.
- Including seemingly benign ones like check-ups that are used to surveil and gate-keep people from getting other services (like education and housing).

Mandatory social and health services are no less damaging than our systems of policing and cages. In these contexts, people who are Neurodivergent and/or living with disabilities are systematically abused and prevented from making decisions about our own lives.

2. Reforms that require compliance with medication or any kind of forced drugging to avoid incarceration/hospitalization or in order to get other services (like housing or Social Security benefits).

People who are Neurodivergent and/or Disabled are just as entitled to make decisions about what we eat and wear, where we live, and the medications and treatment we receive as anyone else. Forcing people to stay on medication or in treatment in order to access their survival needs is abusive and coercive.

3. Reforms that expand funding for mandatory services like psych hospitals or psychiatrization more broadly, or mandatory check-ups (by medical professionals, Child Protective Services, etc.).

These systems operate with the same level of power over and lack of accountability as policing. People who are targeted by these systems have few paths to justice or equity. All systems must be accountable to the people they serve.

4. Reforms that rely upon the usage of forced restraint or corporal punishment, such as tasers.

Ableism enforces the idea that people who are Neurodivergent and/or Disabled are inherently dangerous and should be subject to forced treatment, institutionalization, restraint and control. This is violent and coercive. In fact, people with disabilities are much more likely to suffer violence, and these practices only add to the violence they already endure.

5. Reforms that require registries, monitoring, or surveillance.

These systems position people who are Neurodivergent and/or Disabled as a crisis to be managed rather than as people who, like all people, best thrive with supportive care systems. Surveillance and monitoring are seen as care; however, they provide the foundation by which people with disabilities are often criminalized later. For example, Disabled people are often penalized (including with monetary fines) for not keeping appointments or complying with treatment plans. Tracking systems enable carceral systems to more easily criminalize people with disabilities.

6. Reforms that rely upon the use of Mandatory Reporting

Mandatory reporting in the case of domestic violence has actually increased the amount of retaliation and violence against survivors. It also takes away survivors' agency to determine if they want to go through a criminal legal system and entraps immigrant survivors into cooperating with ICE and the state. Similarly, mandatory and voluntary reporting and wellness checks on individuals experiencing suicidal ideation or non-normative behavior can result in additional harm through the medical and carceral systems they thereby become subject to.

7. Reforms that rely upon the expansion of Adult Protective Services and Child Protective Services.

These agencies have basically no check on their powers and often target families with children or caregivers with disabilities. We know that Black and Indigenous families and other Families of Color; families with Queer and Trans caregivers; Immigrant, Migrant and Refugee families; and Poor Families have been specifically targeted for removal of children from the home. Mandatory reporting for Black and brown child sexual abuse survivors is a pipeline into the foster care system that rips communities and families apart and exposes children to equally abusive conditions as "wards of the state."

8. Reforms that base eligibility for housing or other services on sobriety, medication compliance, not engaging in self-harm, or other restrictive criteria.

These kinds of eligibility criteria keep out the people who are most in need of care and life-sustaining resources. We need to respect people's autonomy, coping mechanisms and survival strategies.

9. Reforms that further isolate and segregate people.

Peoples with disabilities are often seen as a social problem to be isolated from society. Separating and isolating people as a way of "treating" them or addressing crises is a common approach that endangers vulnerable people and worsens the harms they face.

A CHECKLIST FOR ASSESSING MENTAL HEALTH RESPONSE MODELS

This tool offers a set of questions organizers should ask when assessing proposals for mental health crisis response. It is intended to be used in conjunction with the Interrupting Criminalization, Creative Interventions and Justice Practice report *Defund the Police, Invest in Community Care: A Guide to Alternative Mental Health Responses*.

- 1** Is the proposed mental health crisis response completely separate from and out of the control of the police? Or is it a "co-response" or CIT model?
- 2** Will a police response or "co-response" model remain in place in addition to a non-police response?
- 3** Will mental health crisis calls be routed through 911 or a separate number?

If 911

- ? If 911, is it under police control? Can you move dispatch away from police control?
- ? What is the relationship between 911 operators and police - are they represented by the same union? Do they share other interests?
- ? Who trains 911 operators in implementing the mental health crisis response protocol? How can you build in training protocols and trainers that can minimize police response and/or maximize community response?

If a separate number (like 211, 311, 988, or regular line)

- ? If a separate number, how is that number being promoted? Through the police department?
- ? If a separate number, who runs the response program?
- ? If a separate number, will callers be routed directly to non-police mental health response?
- ? If a separate number, will callers who call 911 be re-routed to the separate number?
- ? If a separate number, will law enforcement have the ability to listen in on calls and decide whether to respond?
- ? How is the separate number being resourced?

4

Who is driving and controlling identification, selection, implementation, and evaluation of alternative mental health crisis responses?

- Are the police involved? If so, how can their control be significantly diminished, checked, or removed?
- Is control within other government agencies such as a Department of Public Health, Department of Health/Mental Health, Office of Prevention, Fire Department, etc.?
 - ? How are these departments still tied to the police or other carceral responses, e.g., diagnoses, psychiatric institutionalization, involuntary hospitalization, mandatory reporting, child welfare, etc.?

A CHECKLIST FOR ASSESSING MENTAL HEALTH RESPONSE MODELS

4 Who is driving and controlling identification, selection, implementation, and evaluation of alternative mental health crisis responses? (continued)

○ Is control within large non-profit organizations?

? How are these organizations tied to police or other carceral responses?

? How are communities impacted by mental health crisis response represented?

○ Who is involved in/consulted in developing the protocol for mental health crisis response?

? People impacted by mental health crisis response?

? Harm reduction service providers?

? Organizations engaged in outreach and advocacy around homelessness?

○ Who decides what a “non-police” or “unarmed” response is? The police? Government agencies? Communities?

○ Is there authentic community participation and control by communities impacted by mental health crisis response in:

○ program design

○ oversight

○ crisis response teams

○ evaluation

○ implementation

○ Is community participation and control by communities impacted by mental health crisis response institutionalized by mechanisms such as charters, city or county resolutions, etc.?

5

Who is responding to mental health crisis calls?

- **Who makes up the crisis response team?**
 - ? Does it include people directly impacted by mental health crisis response?
 - ? Does it include skilled community de-escalators?
 - ? Does it include nurses, paramedics, or EMTs?
 - ? Does it include social workers? What licensing level do they require?
 - ? Are police ever part of the crisis response team? When? How? Why?
- **Will the police department have the ability to listen in on 911 calls and decide whether to respond to mental health crisis calls on a case by case basis?**
- **Will the crisis response team have the power to involuntarily commit people?**
 - ? Will that be their primary option?
 - ? Is the makeup of the team determined by making sure that someone with that power is on the team?
- **Who employs the crisis response team?**
- **Who trains the crisis response team?**
 - ? How much training do they receive?
 - ? What will the content of the training be for the crisis response team?

A CHECKLIST FOR ASSESSING MENTAL HEALTH RESPONSE MODELS

5 Who is responding to mental health crisis calls? (continued)

○ Is the response team tied to community-based mental health options that are accountable to communities directly impacted by mental health crisis response, harm-reduction principles, and self-determined models of care?

? If not or if there are few, how can you expand or build new options?

○ Will the crisis response team be able to meet immediate needs for housing, basic needs such as food, harm reduction services and resources, voluntary medical care?

6 Criteria for Non-Police Mental Health Crisis Response

○ Does the protocol exclude calls involving people who are “dangerous” or people who have “weapons” from the non-police mental health crisis response?

? What criteria determine whether a person is deemed “dangerous”?

? What constitutes a “weapon”?

7 How will the program be evaluated?

○ Who will collect data on the calls received and call outcomes?

○ How is the program evaluated?

○ Who evaluates the program?

○ What are the evaluation measures? How are they related to community values and priorities?

A CHECKLIST FOR ASSESSING MENTAL HEALTH RESPONSE MODELS

8

How will the program be funded?

- How will mental health crisis response be funded?
 - Federal, state, county, city funds?
 - Private foundations?
- Will the police department continue to be funded to respond to mental health crises?
- Does funding directly reduce police budgets (or do they leave them intact or even expanded)?
- Is funding for community-based non-police response
 - adequate
 - multi-year?

9

Does the police contract contain any provisions relating to mental health crisis response?