

NOVEMBER 23, 2021

**BEHAVIORAL HEALTH AND SOCIAL SERVICE CRISIS
RESPONSE PLANNING SERVICES IN PROVIDENCE:
PROJECT REPORT AND
RECOMMENDATIONS**

The Providence Center and Family Service of Rhode Island

GOALS OF THIS PROJECT

In May 2021, the City of Providence, through its Healthy Communities Office, contracted with The Providence Center to conduct a six-month planning project to work with community stakeholders to craft recommendations for improvements to the city's system of behavioral health and social service crisis response. This contract resulted from a Request for Proposals review process conducted by the Healthy Communities Office. The project proposed to the City was a collaborative effort of The Providence Center and Family Service of Rhode Island. All activities of the project were conducted by staff and consultants of the two organizations.

The primary aim of the project was to make recommendations to increase the capacity of the Providence Public Safety Department to identify behavioral health and social service crisis calls and assign the appropriate level of response, minimizing law enforcement involvement when possible.

The project's recommendations are meant to guide the development of programs and services that:

1. Direct persons served to appropriate behavioral health service and social services and resources to reduce hospitalizations and/or justice involvement.
2. Provide clinically-appropriate interventions that utilize an anti-racist, anti-stigma lens.
3. Improve the crisis response system and create effective crisis interventions and solutions in order to reduce the need for repeated crisis interventions.
4. Provide training and education for public safety staff to improve their understanding of mental health, trauma, and substance use disorder.
5. Improve information sharing as appropriate across the system and service providers through formalized communication and processes.
6. Reinforce, foster, and create effective, collaborative partnerships between public safety, behavioral health providers, social service providers, harm reduction organizations, and other community stakeholders.
7. Regularly evaluate program implementation and outcomes.

The goals of the planning process are – and the project team recommends also of the resulting services and programs should be:

1. Ensure that behavioral health and social service crises that connect to the Providence Public Safety Department receive an appropriate response by behavioral health or social service providers.
2. Reduce justice involvement in behavioral health and social service issues.

3. Reduce inequities in justice involvement by members of the BIPOC communities and those in need of mental health, behavioral health, and social service assistance, and
4. Reduce the likelihood of recurring issues and produce better physical and behavioral health outcomes for people in Providence.

PROJECT ACTIVITIES

In July 2021, the Project Team initially focused on assembling the infrastructure for the project and established a schedule of bi-weekly meetings with Healthy Communities Office staff, alternating with internal Project Team meetings. The Team recruited a 17-member, multi-disciplinary Steering Committee to guide all aspects of the project. The Committee included individuals with lived experience of behavioral health and/or social service issues and public safety involvement, community activists, behavioral health and social service providers, and representatives of public safety agencies. A schedule and format for five Steering Committee meetings was developed. The Team also established a format and schedule for four community meetings, and developed a date request for the city, as well as a plan for call data analysis, dispatch process mapping, and researching established and emerging best practices in crisis response across the nation. On July 29, 2021 The Project Team met with Councilwoman Nirva LaFortune during which time she presented her proposed model for a Providence Crisis Intervention Program.

In August 2021, Project staff toured the Providence dispatch center and the statewide 911 call center. Project staff also presented to the Mayor's Coalition on Behavioral Health. The project website was launched, along with opportunities for the public to offer feedback via an online feedback form and a dedicated voice mailbox.

A series of focus groups and individual interviews with interested Steering Committee members were conducted throughout September and October 2021.

Community Meetings were held August, September, October, and November, 2021 (one each month).

An online community survey was conducted October and November, 2021.

Final recommendations were presented to Mayor Elorza on November 30, 2021.

PROJECT TEAM

Contracted through the City of Providence Healthy Communities Office, The Providence Center and Family Service of Rhode Island partnered to lead the project with the following Project:

For The Providence Center

Jacqueline Mancini-Geer, MA, LMHC, QMHP, CRC, Director of Acute Care

For Family Service of Rhode Island

Sarah Kelly-Palmer, LISCW, Vice President, Healing Division

Candace Johndrow, MPA, Victim Services Director

Kinzel Thomas, MSW, LCSW, LCDP, CCHW, Community Health Team Supervisor

Rachel Small, PhD, Director of Quality Improvement and Evaluation

Lauren Santos, MBA, Program Coordinator/Administrative Support

William Tregaskis, Marketing and Communications

Project Consultants

Owen Heleen, MA - Planning process

Sean Varano, PhD, Roger Williams University School of Justice Studies - Process mapping and data analysis

Matt Perkins, PhD and James Stark, MPA, Local Initiative Support Corporation - Identification and assessment of emerging best practice response approaches

City of Providence Healthy Communities Office Liaisons

Laurie Moise Sears, Director

Rachel Newman-Greene, Deputy Director

STEERING COMMITTEE

- Douglas Buonanno, Deputy Director of Communications, Providence Telecommunications Department
- Yanine Castedo, Community Organizer, Rhode Island Coalition to End Homelessness
- Dr. Akila Dulin, PhD, Associate Professor of Behavioral and Social Sciences, Brown University
- Colleen Daly Ndoye, Executive Director, Project Weber/Renew
- Laurie Moise Sears, MPH, Director, Healthy Communities Office, City of Providence
- Ryan Duxbury, Outreach Team Manager, Anchor Recovery Community Center
- Jennifer Etue, LICSW, Integrated Behavioral Health Manager, Providence Community Health Centers
- Zachariah Kenyon, Emergency Medical Services Chief, Providence Fire Department
- John MacDonald, MSW, LCSW, Chief Program Officer, Housing and Support Services, Crossroads Rhode Island
- Maryann Mathews, Chief Executive Officer, Multicultural Innovation Center and Business Collaborative, Mayor's African American Ambassadors Group, Police Advisory Group
- Charlotte Raine, MSW, LCSW, QMHP, Mobile Crisis Clinician, BH Link
- Jeremiah Rainville, CCHW, CPRS, CCSP, CAMHFA, Peer Programs Manager, NAMI-RI
- Machiste Rankin, Outreach Specialist, RICARES
- Major Henry Remolina, Uniform Division, Providence Police Department
- Lucy Rios, Deputy Director, Rhode Island Coalition Against Domestic Violence
- Tahon Ross, M.Ed., Principal, Providence Public School District
- Corinna Roy, Director of Program Planning and Implementation Unit, Division of Behavioral Health Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals
- Harrison Tuttle, Executive Director, Black Lives Matter RI PAC

The Steering Committee met on July 28, August 25, September 22, October 20, and October 27, 2021. Across these meetings, the Committee discussed and advised on current elements of behavioral health and social service crisis response, service gaps, racial inequity, dispatch processes, the project website, focus group implementation, community survey design, community meeting marketing and facilitation, project community outreach materials, emergency response, staffing and funding resources, and training and professional development needs.

Project consultant James Stark did a presentation for the Committee outlining various models for crisis response employed by other communities across the country.

Committee members provided their feedback as to how they thought the models might inform a Providence-specific response model. The Committee also reviewed related system enhancement initiatives currently in development locally, including the statewide 988 roll out.

The last two meetings were focused on development and review of the project recommendations.

FOCUS GROUPS

Four focus groups were facilitated by project staff. Focus group questions and overviews of alternative response models from across the nation (see #5 below) were shared with all participants in advance of their respective focus group.

Questions included:

1. *What aspects of behavioral health and substance use crisis response are working well in Providence?*
2. *What aspects of behavioral health and substance use crisis response are not working well in Providence?*
3. *What could make it better?*
4. *Do you have any suggestions for reducing negative interactions when police respond to minority individuals (individuals of color, LGBTQ* individuals, etc.) in behavioral health/substance use crisis?*
5. *Please share your thoughts on alternative response models, such as mobile crisis response teams, peer-run crisis respite, psychiatric urgent care clinics, police specialized response crisis intervention teams, co-responder model, etc. (See page 2 for overviews of these models)*
6. *Is there anything you want us to know that we haven't talked about yet?*

** Law Enforcement were also asked: How much time and resources would you say the PPD spends on engaging with people experiencing behavioral health and substance use crisis as compared to responding to criminal activity or other community emergencies?*

Focus Group Schedule and Participant Demographics:

September 17, 2021 Law Enforcement. 45 minutes. 5 Participants with 3 to 12 years' experience: 2 white male Lieutenants, 1 Hispanic/Latino/Spanish Origin male Sergeant, 1 white Patrolwoman

September 24, 2021 Individuals With Lived Experience. 90 minutes. 4 Participants: 1 Black/African American female NAMI peer program coordinator, professional experience working with police; 1 White male Oasis Wellness and Recovery Center staff, in schizophrenia recovery; 1 Black/African American Non-Hispanic Biracial activist in recovery community, former sex worker; and, 1 Biracial Black/African American/white female foster parent of child with serious mental illness. *Each individual received a \$50 Visa gift card for their participation.

September 28, 2021 Behavioral Health Responders. 90 minutes. 3 Participants with 3 to 16 years' experience: 1 Bolivian female FSRI Providence Police Victim Service Co-Responder; 1 white female TPC Emergency Services Manager; and, 1 white female TPC Emergency Services Clinician

October 6, 2021 Mayor's Coalition on Behavioral Health. 90 minutes. 27 Participants: Diverse group of substance misuse treatment and prevention, mental health, social service, education, advocacy, medical, education, and minority-focused providers, professionals, and volunteers. Included 1 non-binary individual, 1 Middle Eastern/North African individual, 1 Asian individual, 4 Black/African American individuals, and 3 Hispanic/Latino/Spanish Origin individual, as well as 1 white male youth with lived experience of mental health disorder and public safety involvement.

Focus group discussion was summarized, noting common responses/themes and noteworthy individual responses and ideas.

The state Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals also shared a transcript of a listening session it conducted with people with lived experience of behavioral health and social service crises.

KEY INFORMANT INTERVIEWS

Steering Committee members were offered the opportunity to be interviewed to share their thoughts and experiences outside of a time-limited group meeting. Interviews were scheduled late September through early October 2021. Interview questions mirrored those of the focus groups with two additional questions specific to funding – What funding trends do you perceive related to behavioral health crisis response in Providence that might positively or negatively impact individuals in crisis and the providers serving them? Do you have any advice around funding sustainability for alternative approaches?

Both the interview questions and overviews of alternative response models from across the nation were shared with all Committee members in advance of their respective interviews. Interviews were virtual and lasted 30 to 60 minutes depending on interviewee availability.

Steering Committee members who elected to be interviewed:

- Ryan Duxbury, Outreach Team Manager, Anchor Recovery Community Center
- Zachariah Kenyon, Emergency Medical Services Chief, Providence Fire Department
- Charlotte Raine, MSW, LCSW, QMHP Mobile Crisis Clinician, BH Link
- Major Henry Remolina, Uniform Division, Providence Police Department
- Lucy Rios, Deputy Director, Rhode Island Coalition Against Domestic Violence
- Corinna Roy, Director of Program Planning and Implementation Unit, Division of Behavioral Health Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals
- Harrison Tuttle, Executive Director, Black Lives Matter RI PAC

Laurie Moise Sears, Director, Healthy Communities Office, City of Providence was also interviewed.

Common responses/themes and noteworthy individual responses and ideas were documented.

COMMUNITY MEETINGS

Four in-person Community Conversations were co-facilitated by Project staff to examine aspects of a “re-imagined” behavioral health/social service response system and hear directly from people with lived experience and other members of the Providence community. The conversations were held August 11, September 15, October 16, and November 10, 2021, inclusive of three late afternoon sessions (3:30pm to 5pm) and one Saturday afternoon session (1pm to 2:30pm). The conversations were held at Anchor Recovery Community Center, 310 Reservoir Avenue, Providence 02907; twice at the Southside Cultural Center, 393 Broad Street, Providence, RI 02907; and, lastly, at the Joseph A. Doorley, Jr. Municipal Building, 10 Greene Street, Providence, RI 02903. The last meeting included a discussion of draft final recommendations.

Community Conversation outreach and marketing materials were developed in multiple languages (i.e., English, Laotian, Spanish, Portuguese, Creole, and Khmer), and broadly distributed through FSRI, TPC, City of Providence, and Steering Committee member distribution lists and networks. Community Conversations were also promoted through

the Project website and the FSRI Facebook page. Spanish interpretation was made available and COVID-19 PPE and social distancing protocols were followed. Seventeen community members attended these conversations combined. Minutes were taken and common themes and noteworthy individual feedback was highlighted.

WEBSITE AND ONLINE PUBLIC INPUT OPPORTUNITIES

Early in the project, a “PVD Behavioral Health Crisis Response Planning Project” website (www.pvdbhcr.info) was created to disseminate project information to the public and allow for virtual opportunities for people to get involved. The landing page was available in English, Spanish, Khmer, and Portuguese. Much care was taken to ensure website language was accessible for varied levels of proficiency, and the website was inclusive and engaging. Landing page language included:

There has never been a more important time to raise awareness of the needs of people in crisis in Providence. Help us understand how the city should respond to people who need emergency help for mental health, homelessness, immigration, drug or alcohol misuse, and other issues. These are often called “behavioral health crises.”

And

We want to hear from you! In Providence, when someone is having a mental health, homelessness, immigration, substance misuse, or other “crises”, they or someone close to them usually calls 9-1-1, and law enforcement or other public safety staff respond. This can result in unnecessary arrests and trips to hospital emergency rooms. The city would like to hear the stories and ideas of Providence residents for how we can do a better job getting people in crisis the immediate care and support they need.

Website visitors were then offered three opportunities to share their input:

1. Join one of four in-person community conversations. Dates, times, details, and COVID transmission risk reduction protocols for each meeting were listed and people could register for one or more meetings, though registration was not mandatory to attend.
2. Share your story using our online feedback form. This was a great option for residents who were unable to attend or uncomfortable attending a public meeting or would prefer to share their thoughts and experiences in writing. People could provide their name or remain anonymous.
3. Share feedback by voice message. People were able to call a dedicated voice mail box at (401) 519-2281 to share their thoughts and experiences. There was no time limit for a message and people could provide their name or remain anonymous.

Later in the project, a pop-up box and link appeared on the landing page inviting people to take a brief online survey about their experience with mental health, substance use, or social service crisis response in Providence and their ideas to make the system better.

The website also offered information on behavioral health crises from the National Alliance on Mental Illness (NAMI) and a link to the NAMI website; allowed people to download and share project flyers with community meeting details; read the latest news about the project; and, see a list of project steering committee members.

The website was broadly promoted through FSRI, TPC, City of Providence, and Steering Committee member distribution lists and networks. However, only six community conversation registrations and two completed feedback forms were completed. No voice messages were received.

POSTCARD AND COMMUNITY SURVEY

In a further attempt to maximize opportunities for community input, the project team developed a dual language (English/Spanish) postcard for mass mailing to 1,000 random Providence households. The postcard directed residents to the project website where they would have the opportunity to complete a brief survey (also available in English and Spanish). Residents were encouraged to complete the survey by November 15, 2021 to be entered to win one of two \$50 Visa gift cards. The postcard included a QR scan code for quick access to the survey via mobile phone, and the following language:

Have a minute? We would love to hear about your experience with mental health, substance use, or social service crisis response in Providence and your ideas to make the system better.

We need your voice? The lived experience of our residents can truly transform how we respond to those in need. Please take 10 minutes to help inform our efforts!

Take our survey for a chance to win a \$50 gift card.

The survey asked the following:

Are you a resident of Providence?

- Yes
- No

Who are you most likely to call when you have a mental health, substance use, or social service emergency?

- A family member or spouse
- A friend
- Police
- Mental Health Crisis Hotline (211)
- Someone else (please describe)

Please read each statement below, and how rate how much you agree or disagree with each.(Answer options: Strongly Disagree, Disagree, Agree, Strongly Agree, Unsure)

- If I (or someone I knew) was struggling with issues like mental health or substance use, I would know where to seek help in my community
- Police officers make an effort to get to know the people that live in my neighborhood
- If there was a way to get help in a crisis without police being involved, I would be more likely to call for help
- If I was having an emergency, I would like help from a person with the same experience as mine. instead of from a professional
- If I was having an emergency, I would prefer assistance from an Ambulance/EMS professional.
- If I was having an emergency, I would refer assistance from a social service professional.
- If I was having an emergency, I would refer assistance from a police officer.

How often do you feel a social worker should be present when responding to emergencies related to mental health or substance use?

- Never
- Occasionally
- Often
- Always
- Unsure

What would be the most helpful way to support people going through a mental health or substance use crisis?

Is there any other feedback you would like to share about how to make Providence a safe and supportive community for people in mental health or substance use crisis?

What is your age?

- Under 18
- 18-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65+

How do you identify with regards to gender?

- Man
- Woman
- Gender Non-binary
- Another Gender

Do you identify as Hispanic or Latinx?

- Yes
- No

How do you identify your race?

- American Indian or Alaska Native
- Asian or Asian American
- Black or African American
- Native Hawaiian or other Pacific Islander

- White or Caucasian
- More than one race
- Another race (please describe)

The survey was also broadly promoted through FSRI, TPC, City of Providence, and Steering Committee member distribution lists and networks, as well as across all Providence Neighborhood Associations. However, only six completed surveys were received.

WHAT WE HEARD FROM THE COMMUNITY – THEMES

Our project team took an eclectic approach to capturing the voices and opinions of a variety of stakeholders while also process mapping the current system of response. Through our efforts, we heard several major themes to inform our recommendations on a new approach to behavioral health crisis response in the city of Providence.

First, and most broadly we heard from community representatives as well as service providers that effective behavioral health response should be thought of as a coordinated system of diverse services and interventions rather than a single one-size-fits all approach. While there is some overlap in the services provided and populations served from one provider to another, there are some providers with specialized service offerings or focused client populations. A new crisis response model will need to leverage the expertise of various providers to meet the diverse needs of a diverse population of Providence consumers. Additionally, this new system will need to create a menu of treatment providers and their offerings that is accessible to the community and to other providers so that individuals can be matched most appropriately with services in an efficient way.

We also heard repeatedly that consumers and in many cases, providers are not well versed in what currently exists for residents of the city who may experience some type of behavioral health need. Furthermore, many people may not be knowledgeable about the ways mental health, substance use, or social problems may manifest, how to recognize these issues, intervene in a sensitive and appropriate way and where to access help. For these reasons, a new system will need to include an education campaign aimed at increasing awareness surrounding behavioral health topics, encouraging early intervention, and decreasing stigma around seeking help and around those affected by these human conditions. This education campaign will also need to involve the marketing of new approaches or options for intervention and treatment. Throughout this planning

project we were reminded to consider the necessity of persistence and longevity in developing any public education campaign. The campaign to promote 911 nationally in the 1970s and the campaign to promote seat belt use were examples provided to us and seem to be edifying models for effectively influencing public knowledge and behavior.

Another theme heard throughout the project from various sources is the notion that crises can be conceptualized as existing along a continuum of acuity. Most stakeholders agreed that some high acuity crises will require some type of police involvement. If the nature of the situation is clearly violent, there are weapons in play, or if a person is actively causing harm to themselves or others police will likely need to be dispatched immediately. On the other end of the spectrum, there are calls that are clearly non-violent, and do not involve weapons but get called into police/fire simply because people do not know who else to call. For these low acuity calls, an appropriate service provider should step in for police. But between these two extremes is a category of crisis calls representing moderate or unknown risk. Several stakeholders postulate this last category represents the vast majority of calls and will be the biggest challenge for a new system as it begins the work of identifying which calls to dispatch without police presence. For this reason, collecting and analyzing data will be central to the success of any new system. Additionally, the role of the dispatcher is of critical importance to gather the most accurate information possible and send the most appropriate team of responders.

Throughout the planning process, we consistently heard that the data is crucial but currently scarce. Although police, fire and dispatch data exists, the way calls are coded and categorized is largely dependent upon the individual dispatcher taking the call. Dispatchers have little to no specialized training in recognizing behavioral health issues or how best to respond to them. The training they receive is on the job and as taught by a small group of very dedicated Communications Division leaders who have many years of experience behind them. Dispatchers are also dependent upon the accuracy of the reporting party. Many times a person calling about an emergency is not actually on scene where the emergency is happening, is not calling with first-hand information, or may not be able to accurately articulate what is going on. All of these factors and more leave margin for error in accurately categorizing the acuity of a crisis call. If the first responder gets to the scene and discovers the true nature of the situation is different than originally understood, re-categorization may not always occur unless the first responder requests the dispatcher adjust the call coding. The way a situation is resolved is not always captured by the City's current system. Police and EMS reports do not feed back into the same system from which calls are dispatched. Therefore, data from all three systems will need to be available to inform the new system and mechanisms need to be installed to

move toward more precisely categorizing and coding calls if we are to build a system which is able to learn how best to deal with behavioral health calls in which the acuity is ambiguous. Not only will data be important to the professionals working within the system but transparency of data or data reports will be vital for quality improvement and accountability to the public.

A major theme and catalyst for this project has been public mistrust for the police and desire to remove police officers from responding to any behavioral health related call for service particularly if that call involves persons from marginalized communities. On the other hand, we have heard first responders and services providers concerned for safety in general. We anticipate that keeping data driven decisions central in program design will help begin to bridge this gap. Training for all first responders and services providers on topics such as cultural sensitivity, trauma-informed responses and verbal de-escalation are also highly encouraged in this effort while alternative responses are being assembled. A new system might also aim to dispel racial tension through employment of community health workers to respond to the neighborhoods they represent. Community stakeholders and people with lived experience felt that they might be better served by such a service particularly in providing pre and postvention resources to those at risk for behavioral health crises. Treatment providers and first responders all agreed that prevention services and follow up service connection are important components to a broad approach to crisis management. There was also consensus that intervention at these intercept points do not require police presence as standard protocol.

Many stakeholders, particularly those from BIPOC communities, urged the creation of a mechanism to hold the City accountable and stressed that any committee representing the community should not include politicians or City employees. They also stressed the need to provide any committee with the resources needed to analyze disaggregated data.

Finally, in our effort to reimagine a system of behavioral health crisis response we researched several models from cities around the country. What we found is that no one model seems to fit perfectly for adoption in Providence. Given our, size, demographic, and resources, Providence will need to build its own model. However, there are components of other sites' response programs which could be useful to inform best practice approaches here in Providence. The models we found most promising are outlined in the next section.

PROMISING PROGRAMS AND MODELS

Over the past few years, communities across the United States are exploring how they can improve responses to persons in behavioral/mental health and substance abuse crisis. Reviewing the current spectrum of responses, we see that responses vary widely; require coordination between mental health providers, law enforcement and dispatch centers; and that they are rarely supported by dedicated funding streams.

Below is a review of the current spectrum of responses:

Crisis Intervention Teams (CIT) – Created in [Memphis, TN](#) as a partnership between Memphis Police Department, the Memphis Chapter of the Alliance for the Mentally Ill, mental health providers and two local universities, the collaboration sought to provide a more intelligent, understandable, and safe approaches for police response to mental crisis events. CIT is a 40-hour training for police officers involving scenario-based exercises and participation of community stakeholders including Behavioral Health Clinicians, treatment agencies, people with lived experiences, families, and advocacy groups.¹ Training topics include mental health diagnoses, psychiatric medications, and issues of drug abuse and dependence. Outcomes of CIT officer response area higher likelihood of referral to treatment, lower likelihood of arrest and responses are likely to use verbal redirection as the highest intensity level of force.²

- For more information on CIT in action, listen to a TED Talk from former [San Antonio Police Officer Joseph Smarro](#).

Co-Response – Co-response models pair police with trained behavioral health professionals to respond to all levels of crisis response calls. The theory underlying co-response is that police are specialists in handling situations that involve violence and potential injury while mental health professionals are specialists in providing mental health consultation to officers and mental health care to individuals in crisis. In some cases, co-response may also include offering case-management support to persons that have had significant history of involvement in the criminal justice system and/or calls for service where the teams help those individuals from cycling back into that system. An

¹ Mental Health First Aid is also a less resource intensive option as well. It includes 8 hours of training to build mental health literacy and helps officers identify, understand, and respond to signs of mental illness. Officers learn how to assess risk, listen to and support the person in crisis, and more. Trained officers can learn from, and work with, trained victim advocates to help someone through a panic attack, engage with someone who may be suicidal, or assist an individual who has overdosed.

² National Association of State Mental Health Program Directors - [Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies](#), August 2020

October 2019 Vera Institute of Justice study found that police appreciate clinician response as it improves community-police relationships, and that it helps them learn about the impacts of mental health and trauma. Often, having a clinician in the vehicle helps them process traumatic events they have witnessed; though some police departments did indicate challenges such as that having clinicians during responses resulted in them “having another person to protect”.

Mobile Crisis Teams (MCT) – Typically composed of one or two providers including a masters-level clinician and persons trained in emergency medical response, MCTs meets persons in crisis where they are, at the home, emergency room, on the street with the goal of addressing the crisis and reducing the need for transport to a more restrictive environment. MCTs are most frequently dispatched to lower acuity 9-1-1 calls related to mental health, addiction and homelessness such and calls currently classified as wellness checks, intoxicated persons, or mental crisis³. Behavioral health teams work with police and dispatch to determine the calls eligible for MCT response and also create clear clinical criteria to request assistance from law enforcement to reduce potential for implicit bias.

- For more information about MCT, see CAHOOTs model below.

Community Responder – Borrowing from the co-response and MCT models, community responders include persons trained to provide behavioral health supports and mediation skills (and frequently neighborhood experience), but may not necessarily be a professionally trained clinician. Community responders identify persons and locations with high utilization of emergency services to develop specific solutions and reduce repeat interactions. They may also respond to dispatch calls unrelated to behavioral health needs such disturbances, suspicious persons, noise complaints, quality of life concerns and low-risk neighborhood conflicts.

- [Olympia Crisis Response & Peer Navigators](#) utilizes a budget of \$550,000 (funded through a public safety levy), these teams are most frequently are contacted by social service providers, or sent by police who recognize a situation is better suited for the alternative response. They provide free, confidential, voluntary crisis response assistance including conflict resolution, housing support, harm reduction, resource connection and referrals, and transportation.
- [Chelsea HUB](#) – Coordinated through the Chelsea Police Department, a team of 25 community and government providers meet weekly to address specific persons and places facing elevated levels of risk, and develop immediate, coordinated, and

³ Center for American Progress - [The Community Responder Model How Cities Can Send the Right Responder to Every 911 Call](#), October 2020

integrated responses through mobilization of resources to address specific situations before an emergency occurs.

- Also, see below Albuquerque Community Safety Department model.

Crisis Response Center – Crisis Response Centers offer a wide range of modalities including suicide prevention lines and will, in mid-2022, include a national 9-8-8 national health crisis line to receive and respond to crisis calls. Crisis Response Centers may also include facilities for intake to reduce the likelihood of persons being removed from the street to jail or the emergency room. Challenges to crisis response centers primarily focus around communication and staffing resources. Residents must know about alternative options and partners must have resources to handle referrals.

- [The Boston Emergency Services Team](#), coordinated by the Boston Medical Center, uses a dedicated toll-free number to provide support, information, referral, or arrange an in-person evaluation. The call center will dispatch mobile clinicians to intervene at the site of the crisis unless a different setting is requested by a family or if the containment of a more secure setting is required.
- Also, see the [Tucson Crisis Response Center](#) and below information describing the Southern Arizona Crisis Line.

Eugene, Oregon

CAHOOTS – Crisis Assistance Helping Out on the Streets⁴

Created over thirty years ago as a partnership between the city of Eugene, Oregon and the White Bird Clinic, [CAHOOTS](#) provides support for Eugene Police Department (EPD) personnel by taking on a broad range of non-criminal crises, including homelessness, intoxication, disorientation, substance abuse and mental illness problems, and dispute resolution. Non-emergency medical care, first aid, and voluntary transportation services (to a clinic or hospital) are also provided. CAHOOTS is not designed to respond to violent situations where there is an indication of violence or weapons, or in life-threatening medical emergencies. If the situation involves a crime in progress, violence, or life-threatening emergencies, police will be dispatched to arrive as primary or co-responders.

Funded by the city through EPD, CAHOOTS has an annual budget just shy of \$1.1 million, which accounts for about 2% of the EPD budget. This allows CAHOOTS team, made of a medic and crisis worker making \$18/hour, to offer 36 hours of service/day for 7 days a week. Two teams (each with a City of Eugene van) for 12 hours/day and one team (with a CAHOOTS van) 12 hours/day. Calls originate both from the city emergency 911 system

⁴ Data provided on CAHOOTS generally comes from a study conducted by the Vera Institute (<https://www.vera.org/behavioral-health-crisis-alternatives/cahoots>) as well as the EPD and White Bird Clinic websites.

and the police non-emergency line. CAHOOTS teams are dispatched, free to the public, via the same system as EPD and Eugene Springfield Fire (ESF). CAHOOTS respond to a variety of calls, diverting some from EPD and other emergency services, as well as handling a subset of unique calls that wouldn't normally be responded to by law enforcement. Average response time for CAHOOTS is 116 minutes, compared to 71 minutes for police, which is the most common complaint about the program. To address issues of equity and increase usage and trust, the city is exploring creating a new, separate line for CAHOOTS that would not be connected with the police department.

CAHOOTS recruitment and training is critical to the program success. Most staff have EMT certifications, have experience working in the human services field, and are becoming more multilingual. All CAHOOTS team members complete at least 40 hours of class time and 500-600 hours of field training. This training includes a focus on responding to crisis incidents and de-escalation. CAHOOTS indicated that no staff has been seriously injured as part of their responses.

An EPD analysis found that CAHOOTS response⁵ diverts between 5%-8% of EPD calls for service, saving the city an estimated \$8.5M in tax dollars yearly. EPD and CAHOOTS staff collaboratively developed criteria for calls that might prompt a CAHOOTS team to respond, and continues to revise these criteria based on experience. The official protocol, however, is used as a guide rather than a rule. The three highest call responses for CAHOOTS staff are "welfare checks" (30%)⁶, "assist public" calls (29%)⁷, and "transport" calls (24%)⁸. CAHOOTS staff responded with EPD to approximately 13% of total calls, with the three highest joint response calls being for suicidal suspect, check welfare and disorderly subject. Only 2.2% of CAHOOTS only initial responses required EPD backup response.

⁵ Diverts criteria require each of these elements: 1) the call is received by dispatch; 2) Police are normally dispatched to the call; 3) The call is dispatched to, an arrived at by, an outside agency, and; 4) No EPD resources are dispatched to the call.

⁶ The CAHOOTS Welfare Check nature is generally separate from the EPD Welfare Check. Dispatch makes the determination at the time of the call that the caller does not appear to require a law enforcement response, or the caller specifically requests CAHOOTS.

⁷ The CAHOOTS assist public call is not considered a traditional police call. It generally involves non-emergency service requests from the public. Calls may include requests for counseling, to injury evaluation after a person declined to be evaluated by a medic, to providing general services.

⁸ CAHOOTS transport call generally involves moving an individual, often unhoused and in need or dealing with mental health issues, from one location to another for non-emergency services.

Other city programs modeling after CAHOOTS include [Denver Support Team Assisted Response](#) program in [Colorado](#), [Mobile Assistance Community Responders in Oakland, CA](#), [Portland Street Response in Oregon](#) and the [Olympia Crisis Response Unit in Washington](#).

Pima County, Arizona

Southern Arizona Crisis Line

The Southern Arizona Crisis Line (ACL), managed by Arizona Complete Health (ACH), a private health care partner, provides 24/7 assistance for persons in crisis that does not involve criminal activity. Responses include a mental health screening and/or on-site support from a Crisis Mobile Team trained to evaluate, counsel, and provide stabilization to persons in the field.

In the spring of 2019, ACL expanded by co-locating ACH staff in the 911 dispatch to triage calls in an effort to create more effective responses to persons in crisis including non-law enforcement responses. During phase 1 of this partnership, a two-month risk assessment determination process took place as mental health professionals and 911 dispatch paired up reviewing all calls to determine which types of calls ought to be triaged by the ACH team. After creating “call cards” to determine triage, 911 dispatchers used these cards to deploy law enforcement or ACH response. Moving into phase two, mental health professionals and 911 dispatchers held bi-monthly crosswalk conversations to determine if calls ought to be triaged differently. Unfortunately, during phase two, due to the COVID-19 pandemic, ACH pulled its staff from the dispatch and managed calls that only came into the ACL call line. At the time, ACH was pulled from dispatch, approximately 5% of calls were being transferred to ACH teams.

Reflecting on the partnership, Tucson Police Department (TPD) found they learned several critical lessons. They wished they worked more closely with ACH to determine appropriate measures of success. While more calls were being transferred, response times from traditional responses were often much shorter than calls transferred to ACH, which was the public’s one frustration with ACH. TPD also wished there was a higher level of commitment to the work, as there is a frustration that ACH staff has not returned to dispatch to continue the partnership. This was exacerbated in a June incident where a mobile response team responded to an ACL call and was kidnapped during a mental health welfare check. While ACH has access to behavioral health histories, they do not have access to law enforcement history as they would if they were co-located in dispatch.

Similar call diversion programs exist in Charlotte, NC, Wichita, KS, Madison, WI and Mesa, AZ.

Albuquerque, New Mexico

Albuquerque Community Safety Department

In an effort to re-imagine 911 response, and as a result of strong mayoral support, leadership from the now director, and community support, the city of Albuquerque created a third branch of the city's public safety system, the [Albuquerque Community Safety \(ACS\) Department](#). ACS staff and field responders, all city employees to ensure staff would be compensated adequately and reduce turnover, began deployments August 2021. Budgeted as a stand-alone department for its population of 560,000 residents, ACS is designed to complement the city's police and fire departments. As operations ramp up, ACS seeks to increase its budget to \$7.5M to deploy over 200 trained professionals to non-violent and non-medical 911 calls for service involving issues such as mental/behavioral health, homelessness, and addiction as well as non-behavioral issues such as abandoned vehicles and needle pick-ups.

All ACS staff receive 120 hours of training heavily focused on crisis intervention and providing exposure to various types of encounters they will likely experience in the field. Most employees are recent hires and respond to a limited set of lower acuity calls, without police, ranging from supporting unsheltered individuals and intoxicated persons, to needle pickups. ACS staff responding without police include three teams, community responders, behavioral health responders and street outreach and resource coordinators. These employees work 8am-5pm, but as staffing increases, they expect to have 24/7 coverage. ACS staff also include mobile crisis teams, where independently licensed mental health professionals work in a team with law enforcement officers to co-respond to higher acuity mental and behavioral health emergency where de-escalation may be needed.

ACS was intentional about not creating a new 911 response center and instead worked with dispatch to identify lower acuity calls for response. ACS teams are dispatched after the 911 operators determine the call qualifies with an ACS code, moves through fire dispatch for a second review, and then to the ACS team. While only currently responding to 10 types of emergency calls, these calls account for about 20% of the calls the city's 911 department takes over the course of the year. As ACS is in its early stages, it currently responds to approximately 400 calls/month with the vast majority focused on unsheltered persons, but expects that to increase to 3,000/month when ACS becomes fully staffed. As the program expands, city officials hope that ACS will provide a tool for

the city to address root causes of systemic issues like substance abuse and chronic homelessness that drive a substantial volume of repeat 911 calls.

RECOMMENDATIONS

We present our recommendations to the City of Providence in seven sections:

- Framing of the Initiative
- Training and Community Education
- Structure in City Government
- Data
- Dispatch
- Program Development
- Future Funding

Additionally, we indicate the timeframe for each recommendation:

Phase 1: December 2021 to June 2022

Phase 2: July 2022 to June 2023

Phase 3: July 2023 to June 2024

A timeline for activities in all three phases is included in Appendix 1.

Where possible, we provide a cost estimate for implementation of the recommendation. In many cases, services will be procured through a request for proposals process including competitive bidding. In these cases, actual cost will vary considerably and it is not possible to make an accurate estimate.

Because this project was not able to access data on the City's current crisis response, it is not possible to provide cost estimates for recommendations concerning data.

FRAMING OF THE INITIATIVE

1. Phases 1-3: The City should promote the understanding that implementing a new program or department cannot by itself achieve the goals of improving behavioral health and social service crisis response, reducing stigma and racism, and focusing municipal resources on activities that truly produce community safety. Achieving these goals will require an approach that understands programs operate in an "ecology" of other systems, ingrained behaviors, and well-established beliefs. Key informants and members of the community reminded us how many years it took to establish seat belt use as a safety norm, to create the existing 911 system, or to

promote the use of concussion protocols in youth sports. Achieving these goals may take a decade or more.

2. Phases 1-3: The work of the City and its partners in this initiative must be deliberately based in an anti-racist, anti-stigma framework. Each step in the initiative must be examined to ensure that it:
 - Includes a workable strategy to examine differential outcomes for racial/ethnic groups, genders, and LGBTQ+ individuals;
 - Includes strategies to provide services in the languages spoken by Providence's diverse communities;
 - Takes concrete steps to provide a crisis response workforce that reflects Providence's diversity;
 - Provides recipients of services with a voice concerning the quality and outcomes of the services they receive;
 - Reduces the stigma associated with mental illness, substance use, and homelessness through conscious use of anti-stigma language, the inclusion of people with lived experience in the workforce, and the incorporation of anti-stigma training activities into their operations.

All activities funded by the City or directly undertaken must delineate strategies that meet all of these criteria. Requests for Proposals issued by the Healthy Communities Office or the new Office of Community Safety (see below) should include scoring criteria that reward programs that include specific plans that address all of the above points.

TRAINING AND COMMUNITY EDUCATION

3. Phases 1-3: The City should fund and conduct training on behavioral health and social service issues to promote more widespread public awareness and knowledge. The Office should support the Police Department's ongoing Crisis Intervention Training (CIT), offer training for EMTs and other Fire Department staff, and promote Mental Health First Aid training for the general public. Mental Health First Aid training materials are available in both Spanish and English.

Crisis Intervention Training is a 40 hour training program aimed at creating connections between law enforcement, mental health providers, hospital emergency services and individuals with mental illness and their families. Through collaborative community partnerships and intensive training, CIT improves communication, identifies mental health resources for those in crisis and ensures officer and community safety. The National Alliance on Mental Illness supports CIT programming in that it aims for every person in crisis, and their families, to receive a humane

response that treats them with dignity and connects them to appropriate and timely care. Cost of both training programs estimated at approximately \$25,000 per year.

4. Phases 1-3: Develop a trauma-informed approach that is infused throughout the behavioral health crisis response program. A trauma-informed approach acknowledges that many individuals who are struggling with mental health and substance use disorder have been impacted by traumatic experiences. This approach is rooted in principles and practices that promote safety, trustworthiness, choice, collaboration, and empowerment. In addition, a trauma-informed approach acknowledges cultural, historical and gender issues. An emphasis on the importance of an understanding of historical trauma is essential to promote an anti-racist approach to crisis response. Training on the impact of trauma and how to apply a trauma-informed lens is important to ensure a compassionate response to those in crisis.

Organizations that may serve as resources include Family Service of Rhode Island (Providence), the Center for Trauma and Embodiment at the Justice Resource Institute, Health Resources in Action, and Futures Without Violence (all have offices in Boston). The Substance Abuse Mental Health Service Administration (SAMHSA) has resources that can guide trauma-informed practice and program design. Training should be customized to meet the needs of the community and program design.

Training should be offered across the public safety continuum to include law enforcement, EMTs and staff from the new Office of Community Safety (see below).

5. Phases 1-3. Collaborate with the Rhode Island Coalition of Domestic Violence to coordinate training in best practices in responding to domestic violence incidents and formalize connections to encourage referrals and connection to law enforcement advocates and other various programs for victims.

STRUCTURE IN CITY GOVERNMENT

6. Phases 2-3: Implement a new Office of Community Safety within the Providence Public Safety Department. This office will have the explicit charge to coordinate public safety response and reduce officer involvement in non-crisis response. The Office will have a budget with which to contract with outside agencies to launch new programs.

In a subsequent phase, the Office of Community Safety should develop new approaches to reducing law enforcement involvement in other areas of public safety. This plan should consider replacing school resource officers with contracted social workers employed by outside agencies. Social workers should have background and training in trauma-informed care.

The Office should be provided with an annual budget of approximately \$2.6 million, beginning in the next fiscal year. While there are many cities beginning to implement programs aimed at non-police crisis response, the best example we have found that corresponds to Providence's goals is Albuquerque, New Mexico. In December 2020, Albuquerque launched its new Community Safety Department with a Council-approved budget of \$2.5 million and 13 positions. That budgeted was subsequently increased to \$7.7 million with the addition of federal American Rescue Act funding. Albuquerque has a population of 564,559. If Providence funding was proportionate to its population, the Providence budget amount would be \$2.6 million.

The staff leading the Office should have experience in behavioral health crisis response knowledge of the impact of trauma, an understanding of public safety systems, extensive experience in project management, and have the appropriate credentials to provide clinical supervision.

Beginning in Phase 2, \$2.6 million per year.

7. Phases 1-3: While the Office of Community Safety should lead the operational and data collection and analysis aspects of this work, it should collaborate intensively with the Healthy Communities Office. The Healthy Communities Office should lead the planning and evaluation of new community safety projects.

In the first quarter of calendar year 2022, the Healthy Communities Office should use funding in the City budget to support contracts to launch three programs – one each focused on mental health crises, substance use crises, and unhoused persons in

crisis. The Healthy Communities Office should issue Requests for Proposals (RFP) for each project and select vendors based on technical quality and cost. Projects should launch by April 2022. These new programs should be considered pilot programs with outcomes reported to the Community Steering Committee (see below). Initially, they should provide crisis response during daytime hours. By June 2022, they should develop plans to ramp up to expanded hours after the pilot phase.

The Healthy Communities Office should coordinate with the state Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) regarding its plans to issue an RFP for a program based on the CAHOOTS model.

Total funding, for three programs, in phase 1, \$600,000. In Phases 2 and 3, costs are included in \$2.6 million discussed in Recommendation 4. If funding is secured from BHDDH for the CAHOOTS model in Providence, funds could be redeployed to other program development efforts.

8. Phases 2-3. Convene a Community Steering Committee comprised of Providence residents, with an emphasis on individuals with lived experience. Working with Healthy Communities Office assistance, this Steering Committee should be charged with evaluating the effectiveness of behavioral health and social service crisis response programs in:
 - Improving outcomes for individuals
 - Reducing the number of repeated crises an individual experiences
 - Reducing public safety – police and fire – involvement in crisis response, and
 - Reducing stigma and racism.

As the limitations of privacy laws will make sharing information across agencies difficult, developing ways to gauge effectiveness on these measures will require technical assistance, perhaps from experts from communities around the country.

The Community Steering Committee should consider utilizing components of the Justice Audit as developed by the Aspen Institute’s Criminal Justice Reform Program. The Justice Audit is designed to report and track the forms of governance, training, and oversight in criminal justice and related agencies in a community, including but not limited to policing. The tool is designed to promote community-engaged development, transparency, and accountability.

Members of the Steering Committee will be appointed to two-year terms by the Director of the City of Providence Healthy Communities Office. Two-thirds of the committee shall be comprised of residents of Providence with no more than two individuals residing in a single Providence ward. Other members of the committee may be staff of social service or youth-serving organizations serving the city of Providence. No members should be elected or appointed City officials. No member of the committee shall be an employee or board member of an organization contracting with the Office of Community Safety. The committee shall have 9-13 members.

With the assistance of staff from the Healthy Communities Office, the committee will develop and issue an annual report outlining progress toward the goals of the Office of Community Safety.

DATA

To design a perfect system robust data would be collected at several points in the crisis response system, including when a call comes in through dispatch, when response personnel is on scene, at the conclusion of the event, and at follow up points after some time has passed. However there are many barriers preventing this data collection and its reporting which need to be acknowledged.

Ideally, when an incident is called into dispatch data will be collected such as: who the subject is, is there one subject or multiple actors, what relation is the caller to that subject, where in the city is the incident occurring, does the subject live at that location, history of prior emergencies, true nature of the emergency, does the person have a weapon, are they acting violently toward themselves or others. While dispatchers do their best to gather this information, the accuracy of it is degraded by many factors. For example, many times the person that reports the emergency is calling on behalf of someone else or is not on scene at the crisis to report first-hand information. Other times, a period of time has passed before the information is called in at all. The caller's knowledge of mental health or substance use issues might help or hinder their ability to accurately describe related behaviors leading to inadvertent misrepresentation of events, or the situation may evolve after it is called into dispatch. Finally, the urgency of the call and need to make a quick judgment about who to send to the scene might mean additional details cannot be solicited before sending that response.

When first responders arrive on scene, they can access more data that would be ideal to analyze for program design and review. The demographic information, diagnoses, and

social needs of the person or persons in need of help would be useful to analyze from a program perspective. However, it is challenging, and in many cases inappropriate, for a police officer or EMT to solicit a person's gender identity or race during a crisis situation. Asking these types of questions in these types of situations could be intrusive and potentially traumatizing. It would also be problematic to ask first responders to make assumptions about a person's demographic information. Information about diagnoses, specific symptoms, or social determinates of health might be better gathered and accurately reported by a healthcare professional or behavioral health worker. In the event such a person were dispatched directly or in conjunction with first responders, some of this data might be better captured but would again depend of the acuity of the situation and time allowed for such questioning. However, in many cases laws designed to protect health information precluded sure behavioral health professions from feeding this data back into the same system dispatch or first responders might use. The data would need to be de-identified and aggregated in order to be shared. Depending on the data collection and reporting practices of the organization responsible to provide this service, the quality of that data would be more or less useful.

At the conclusion of an incident, outcome data should be collected. This might be arrest data, data representing a transport to a hospital or other treatment site, or data relating to follow up service referrals. In the event the person was not arrested, information about the nature of the call, the needs of the individual, cultural and linguistic implications for care should be relayed to the next level of response. The ability to hand this information off accurately will depend on the operating hours of service referred to as compared to the time of the event. If the person is hospitalized, information can be relayed in real time but if the person is diverted from unnecessary hospitalization, referral information may not be relayed until the next business day in some cases. This delay is known to contribute to the degradation of information and can impact its accuracy.

In either case, obtaining data after the event to monitor the effectiveness of the crisis intervention is challenging. In most cases privacy laws prevent the receiving agency from reporting on a person's level of participation in treatment, symptom improvement or subsequent treatment. This fact would require the person to give consent and participate in providing follow up data. There are many grant funded behavioral healthcare programs that require this type of follow up participation from service recipients. Typically, response rates for completing follow up questionnaires is low even when incentives are offered. Factors such as housing insecurity, not having access to a phone, attrition, or unwillingness to participate can interfere with follow up data collection. Such data would be ideal for program evaluation, quality assurance, and to analyze who is utilizing the

crisis response system, what are their diverse backgrounds, how do the demographics of the treatment community match up with the demographics of the client community, and does the response system offer the right services at the right time.

We estimate that some of these data points are being collected at various points in the current system. The aim of a new reimagined system will need to identify what data is being collected at which points, how that data can be streamlined to be useful, what data might be missing and how to build it in to the system in a way that respects peoples' right to confidentiality.

The following recommendations aim to build a framework for this more ideal data system.

9. Phase 1. The Healthy Communities Office should work with the Police Department and EMS to produce a comprehensive report on 2020 and 2021 behavioral health and social service crisis calls. This report should include the number of calls, neighborhoods, type of incident and outcome, if known (arrest, crisis resolved without arrest, referral to services, transport to hospital, transport to other services), and co-responder involved in response. These compilations of annual data will allow the community to understand how crisis needs have changed during the COVID-19 pandemic. The compilation will require a simplification of EMS diagnosis coding and the development of a comparable categorization of police incident types. Several stakeholders noted how variable police coding of incident type can be. Once comparable coding methods are established, the Police Department and EMS should provide staff training to promote more consistent coding. These annual reports should be compared with reports from co-responder agencies (The Providence Center, Family Service of Rhode Island, BH Link). The 2020 and 2021 reports should be provided to the Community Steering Committee as a baseline.
10. Phase 1. The Healthy Communities Office should work collaboratively to develop methods to track the race and ethnicity of persons assisted. The departments should also work collaboratively to develop common methods to track repeat services to an individual or address.
11. Phase 2. If these common methods can be developed, the Office of Community Safety should add one full-time staff person to manage and report data. \$82,500 per year in Phases 2 and 3.

12. Phases 1-3. Crisis response programs funded by the City should be required to submit de-identified data on individuals served (including race and ethnicity), response time, and the outcomes of crisis services to the City quarterly.
13. Phase 1. The Healthy Communities Office analysis of 2020 and 2021 data reports should seek to identify “peak” times of the day or days of the week with the highest needs for crisis response. “Peak” times may be different for different types of crisis (mental health versus substance use, for example).

DISPATCH

14. Phases 2 and 3. The Office of Community Safety should employ two clinicians with experience in behavioral health to work with staff in Dispatch. These clinicians will collaborate with existing staff to identify situations that do not require a police response and to identify strategies to reduce response time for all behavioral health calls. This combined staff should develop regular communication with State 911 to provide feedback on 911’s new screening protocol designed to better identify behavioral health calls and those that do not require crisis response. One clinician should hold licensing appropriate to provision of clinical supervision and serve as the lead. \$210,000 per year.
15. Phase 2. This expanded dispatch staff should work with organizations contracted with the City to provide behavioral health and socials service response to develop a real-time system to show when they are available for response. The City should coordinate with the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, examining possible adaptation of the “bed board” system it had developed for substance use disorder treatment availability.
16. Phases 2 and 3. Develop ways to increase the “content expertise” of dispatch staff in order to better understand what calls can be safely diverted to community responders. Launch needed training and professional development programs for dispatch. This training may begin with the CIT training discussed in Recommendation 2 above. Cost estimate for training dispatch staff \$25,000 per year.

PROGRAM DEVELOPMENT

17. Phases 1-3. While some services provided by programs discussed in these recommendations may be reimbursed by private insurance or Medicaid, the majority of funding for these programs must come through performance-based contracts. These contracts should be structured like grants, providing agencies with funding “up

front” to invest in staff, training, and facilities. Cost-reimbursement contracts that provide agencies with funding only after they have incurred the expenditure would limit the organizations that could participate to those that are large and well-resourced and limit opportunities for smaller, grassroots organizations to participate. Contracts should include provisions that encourage organizations to bill Medicaid and private insurance when possible. The total contract amount should be reduced by half of the amount collected to provide the organization with incentive to bill third-party insurance and with additional funding to develop staff and infrastructure.

18. Phases 1-3. Strengthen and expand programs that currently provide crisis response in conjunction with police and EMS to provide round-the clock response capacity. These existing programs include the collaborations between the Providence Police Department and The Providence Center and Family Service of Rhode Island and between the Providence Fire Department and BH Link. This is to recognize that, for a number of years, the majority of crises will receive a response that involves police officers. While Providence implements new programs aimed at reducing police involvement, it should strengthen and expand co-response models. Stakeholder input received throughout this project advocated for social workers and/or individuals with lived experience responding with police when police must respond.

Full implementation of the model with The Providence Center would include two clinicians and two case managers. The total annual cost of this component is estimated to be \$332,800. Federal State Opioid Response funding flowing through the state Department of Behavioral Healthcare will fund one additional clinician beginning in January 2022. If the full model was implemented in July 2022, this annual costs would be reduced by \$45,700 due to the overlap of the funding periods.

Full implementation of the Family Services of Rhode Island program would require adding two clinicians to the existing staffing for an annual cost of \$224,167.

19. Phases 2 and 3. Develop a sobering center in Providence. Individuals who are chronically inebriated or who chronically use other substances are not well served at hospital emergency departments. They are often released without treatment and are transported back to the hospital. Many individuals repeat this process several times per week. This center should be modeled after the center operated by The Providence Center at Emmanuel House from 2016 to 2019. The new center should be larger and should be funded through a contract rather than through Medicaid reimbursement. In its previous iteration, the sobering center at Emmanuel House saw many individuals

who were undocumented and ineligible for Medicaid coverage. Cost dependent on location.

20. Phases 2 and 3. Collaborate with BH Link, the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH), and The Providence Center to explore the development of a Providence crisis center where people experiencing mental health or substance use crises can be stabilized and connected with needed treatment. Providence Police and EMS report that transport times to BH Link's East Providence location are unacceptably long, taking vehicles off Providence streets while both forces are under-manned. Annual cost dependent on location, scope, and provider. Cost dependent on location and scale of program.
21. Phases 2 and 3. Collaborate with Rhode Island Department of Children, Youth, and Families and other child-serving organizations to strengthen existing and develop new crisis response programs for children and families to reduce the need to hospitalize children for mental health crises and expand the capacity for children's behavioral healthcare.
22. Phases 2 and 3. Convene a collaborative project with BHDDH and service-providing agencies to plan other elements of a behavioral health crisis response system. These might include a peer-run respite center.
23. Phases 2 and 3. Continue funding for Safe Stations Providence, including funding to promote the availability of the program. The City should join others in advocating for increased substance use disorder treatment capacity convenient to the city. Safe Stations Providence is currently funded by the Healthy Communities Office through October 2022. Beyond that date, annual funding is \$111,000. This supports the costs of peer recovery specialist response and transport of individuals to needed treatment or other services.
24. Phase 2 and 3. Increase the capacity of Providence EMS units to include a dedicated behavioral health clinician "riding along" with EMTs. A grant from SAMHSA to Family Service of Rhode Island will fund a subcontract to The Providence Center that will provide one clinician to EMS beginning in January 2022. The approximate cost of adding behavioral health clinicians from contracted agencies is \$105,300 per clinician per year.

25. Phase 2. Collaborate with BHDDH and BH Link in the development and implementation of Rhode Island's 988 Crisis Mental Health Line so that the collaborative programs supported by this project can respond to Providence behavioral health crises. 988 is scheduled to "go live" In June 2022. This coordination would require the Office of Community Safety to develop a system to allow its staff to "see" when staff from contracted projects are available to respond. This system could also reduce duplicative responses to a single crisis such as when multiple police officers, EMTs, and clinicians from multiple agencies respond to the same call.
26. Phase 2. Collaborate with the Rhode Island Department of Public Safety as it implements new call screening protocols in the statewide Enhanced 9-1-1 Uniform Emergency Telephone System. These protocols will introduce new options besides "Police, Fire, or Medical" emergencies. The new protocols are scheduled for implementation in June 2022. Through these new protocols behavioral health crises in Providence may be routed to the new Office of Community Safety.
27. Phase 2 and 3. Collaborate with United Way 211 to explore ways to provide telephone consultation to individuals experiencing non-crisis behavioral health issues, perhaps utilizing responders from the Providence network of programs during times when they are not "out on a call." This program would focus on serving Providence residents. The rationale for such a program would be that providing a brief intervention such as Motivational Interviewing and a connection to needed treatment might intervene before issues reach the crisis point.
28. Phase 1 and 2. Collaborate with statewide efforts such as the Rhode Island Sequential Intercept Model and BHDDH's efforts to develop a statewide crisis response system to ensure that the collaborative project described here become the major elements of Providence crisis response.
29. Phase 2 and 3. Develop neighborhood crisis teams staffed with community health workers who live in the neighborhood. These teams might be based in Police Department sub-stations or Health Equity Zones. These neighborhood teams would receive clinical support by the clinical staff of the Office of Community Safety and other collaborating agencies. They could intervene in a range of issues before they escalate to a crisis. Cost estimate \$970,000 per year, based on three teams of four community health workers each plus one project coordinator to coordinate citywide project and organizational overhead.

30. Phase 2. Explore the development of a video consultation that would allow police officers to improve their service to individuals experiencing a behavioral health crisis during times when community responders are not available. Such a program would need to overcome the challenges presented by HIPAA and 42 CFR confidentiality laws. Examine models from other communities.
31. Phase 2. Explore the development of a voluntary registry of individuals with serious behavioral health issues. This would allow responders to know if a registered individual had special health care needs or would benefit from special handling. This may be an expansion of the existing Rhode Island Special Needs Emergency Registry (RISNER) which currently includes those with disabilities, chronic conditions, and special healthcare needs to include those with mental health issues. RISNER is administered by the Rhode Island Department of Health. It interfaces with 911 by transmitting a RISNER enrollee's top three health conditions across the 911 operator's screen. This information is relayed to local dispatch.
32. Phase 2. Dispatch staff have expressed concern about liability should crisis calls be routed to community responders instead of public safety staff and an adverse incident occur. Similarly, some service providers have expressed concern about risk as clinical and other staff respond without police accompaniment. Convene stakeholder meetings to include public safety leadership, dispatch, and community providers and those responsible for risk management in their organizations to discuss best practice in risk management. The meetings should include staff from programs around the country who have experience addressing the issues of liability and risk in these types of programs.

FUNDING

33. Phases 2 and 3. The organizations collaborating with the City in this initiative should collaborate with the Healthy Communities Office to coordinate the pursuit of competitive funding opportunities. When allowed by competitive bidding regulations, the Healthy Communities Office should coordinate with the state Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) to apply for funding from Federal programs passing through BHDDH. As an example, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) mental health block grant provided to the State contains a required 5% set-aside for crisis response.
34. Phase 1. The Rhode Island Foundation's recent report Make It Happen: Investing for Rhode Island's Future made recommendations to Governor McKee and the General

Assembly as they consider potential uses for the \$1.1 billion in American Rescue Plan Act funding provided to the state. The Foundation’s report recommended “one-time investments” (workforce training and vehicle purchases) in mobile response and stabilization services that are aimed at ensuring the safety and well-being of children, youth and their families who may be experiencing emotional or behavioral stress to avert a psychiatric admission or other out-of-home placement.” City leadership should coordinate with Governor and General Assembly leadership to investigate the possibility that some of this funding could be directed to Providence.

35. Phase 1. Several Substance and Mental Health Service Administration (SAMHSA) competitive grant programs may provide significant funding for program components recommended here. Mental Health Awareness Training (MHAT) grants are awarded annually. The next notice of funding availability is projected to be issued in February 2022. FSRI currently delivers MHAT-supported Project Support Ocean State training statewide for law enforcement and others. This training focuses on children up to age 18 who are struggling with mental health challenges and have disproportionate contact with law enforcement and child welfare. Certified Community Behavioral Health Clinic (CCBHC) Expansion grant availability is forecast to be issued in December 2021. FSRI is currently launching a CCBHC program serving Providence (in collaboration with TPC).
36. Phase 1. The Health Resources and Services Administration (HRSA) Community Health Worker and Paraprofessional Training Program may offer grant support to the aspects of these recommendations that involve community health workers. A request for proposals is preliminarily scheduled to be released in February 2022.
37. Additional funding for co-responder models connected with police may be available through the Rhode Island Public Safety Grants Office, Victims of Crime Act program (applications due in August) and the U.S. Department of Justice, Bureau of Justice Assistance grants programs (no grant opportunities projected at this date.)
38. Phase 3. Rhode Island is one of only two states in the nation with a statewide 911 system (the other is New Hampshire) in which calls are answered centrally and then transferred to local dispatch. Rhode Island charges wireless phone consumers a 15.39% tax on wireless bills. Currently, the majority of this amount goes to the State general fund, despite a 2018 law change that seems to direct funding to “first responder and emergency services agencies.” City and project leadership should

consultant with General Assembly and Executive leaders to determine if this is a possible funding source for local crisis response.

Timeline for Implementation Activities

	PHASE 1 1-Dec-21	PHASE 2 1-Jul-22	PHASE 3 1-Jul-23
Rec. 1. Framing. Long-term initiative.			
Rec. 2. Framing. Anti-racist, anti-stigma.			
Rec. 3. Training. Mental Health First Aid, Other.			
Rec. 4. Training. Trauma-informed.			
Rec. 5. Training. Domestic violence.			
Rec. 6. Structure in City Government. New Office of Community Safety.			
Rec. 7. Structure in City Government. Healthy Communities Office planning, evaluation, funding activity, partner to pursue CAHOOTS funding.			
Rec. 8. Structure in City Government. Convene Community Steering Committee.			
Rec. 9. Data. Healthy Communities Office develops baseline report on 2020 and 2021 crisis calls.			
Rec. 10. Data. Healthy Communities Office develops methods to track race, ethnicity.			
Rec. 11. Data Manager added to Office of Community Safety.			
Rec. 12. Data. All funded programs required to submit data.			
Rec. 13. Data. Healthy Communities Office identifies "peak" times.			
Rec. 14. Dispatch. Two behavioral health clinicians added to Dispatch.			
Rec. 15. Dispatch, Healthy Communities Office, and Office of Community Safety develop availability monitoring system for crisis response.			

Timeline for Implementation Activities

	PHASE 1 1-Dec-21	PHASE 2 1-Jul-22	PHASE 3 1-Jul-23
Rec. 16. Dispatch. Training for Dispatch staff.			
Rec. 17. Program Development. Healthy Communities Office and Office of Community Safety provide "up-front" contract funding with incentive to access Medicaid reimbursement.			
Rec. 18. Program Development. Fund existing "co-responder" models.			
Rec. 19. Program Development. Develop sobering center.			
Rec. 20. Program Development. Collaborate with BH Link and BHDDH to create new Providence crisis center.			
Rec. 21. Program Development. Collaborate to strengthen children's crisis system.			
Rec. 22. Program Development. Collaborate with BHDDH to explore development of peer-run respite programs.			
Rec. 23. Program Development. Continue Safe Stations funding after October 2022.			
Rec. 24. Program Development. Add ride-along clinicians to EMS.			
Rec. 25. Program Development. Collaborate with development of 988 system.			
Rec. 26. Program Development. Collaborate with Rhode Island Public Safety as it implements new protocols for statewide 911.			
Rec. 27. Program Development. Collaborate with United Way Rhode Island regarding use of 211 system.			
Rec. 28. Program Development. Rec. 28. Collaborate with BHDDH as it develops statewide Sequential Intercept model.			

Timeline for Implementation Activities

	PHASE 1 1-Dec-21	PHASE 2 1-Jul-22	PHASE 3 1-Jul-23
Rec. 29. Program Development. Develop community health worker crisis response team.			
Rec. 30. Program Development. Explore development of video consultation for police.			
Rec. 31. Program Development. Explore development of voluntary registry of individuals with serious behavioral health concerns.			
Rec. 32. Program Development. Convene stakeholder meetings re: liability.			
Rec. 33. Funding. Healthy Communities Office and Office of Community Safety collaborate to pursue competitive funding directly or through partner organizations.			
Rec. 34. Funding. Explore State funding for crisis response infrastructure.			
Rec. 35. Funding. Coordinate with partner organizations to pursue SAMSAH funding.			
Rec. 36. Funding. Coordinate with partner organizations to pursue HRSA funding.			
Rec. 37. Funding. Investigate state VOCA program and USDOJ programs as possible funding sources for co-responder programs.			
Rec. 38. Funding. Explore use of 911 tax for crisis response with State leaders.			

Structure Within City Government



Proposed Structure of the Office of Community Safety

