THE BOSTON COMMUNITY LED **MENTAL HEALTH RESPONSE MODEL**

FALL 2022

THE CITY SCHOOL & BOSTON LIBERATION HEALTH

The Boston Community Led Mental Health Response Model

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BACKGROUND

In 2020, as Robin D.G. Kelley writes in Freedom Dreams, “the world caught fire . . . Some twenty-six million people around the world took to the streets to protest the public execution of George Floyd in Minneapolis; the vigilante murder of Ahmaud Arbery in Brunswick, Georgia; the killing of Breonna Taylor, a twenty-six-year-old EMT worker gunned down in her bed by Louisville police during a ‘no-knock’ raid. . . An unprecedented number of people risked their health and safety to face down riot police, tear gas, rubber bullets, and the COVID-19 pandemic, to demand justice and a radically different approach to public safety.” (Kelley, 2020, pg xvi).

The history of Black organizers calling for alternative mental health crisis response predates spring 2020, however, and is situated within a long multi-racial working class movement history of calling for community-based mental health care as part of Black liberation and racial justice. Seeing “proper medical attention and care” as vital for “our future survival,” the Black Panther Party provided a People’s Free Ambulance Service which provided “free, rapid transportation for sick or injured people without time-consuming checks into the patient’s financial status and means,” which had hotlines that operated 24 hours a day (Women in Black Panther Party, 1974). The Young Lords in New York City worked with the Health Revolutionary Unity Movement to provide free door-to-door medical care in collaboration with progressive nurses, medical technicians, and doctors. These are just a few examples of community-led assessments and interventions around health and medical care.

In Boston, in spring 2020, thousands of constituents took to the streets, engaged in direct actions in neighborhoods and at City Hall, and organized virtual and in-person gatherings with

candidates and elected officials. Community members called for a defunding of police and other carceral entities and a reinvestment in Black communities and communities of color. Spending on policing in Boston is already over one million dollars a day, and the Boston Police department annually overspends beyond its allocated millions in overtime (WGBH, 2022; Defund BosCops website, 2022).

Many organizers, community members and organizations played critical roles in this movement effort, not all of which can be credited completely here. The Movement for Black Lives nationally, Defund BosCops locally, and Black organizers and community members from Boston and Greater Boston, were central to this movement. This effort is indebted to the Defund BosCops coalition, which includes local grassroots organizing groups such as Youth Justice and Power Union, For The People Boston, Muslim Justice League, Asian American Resource Workshop, Boston Liberation Health, Boston Immigration Justice Accompaniment Network, Material Aid and Advocacy Program, and more.

Most of these organizations are Black and/or people of color-led groups, with member bases that represent community members most impacted by the violence of policing. All of them advance a vision of community safety that includes: a community (non-police) mental health response, community-led safety programming and initiatives, increased youth jobs funding, and affordable housing, healthcare, and education.

These groups organize with Black communities and communities of color, working class communities, young people, queer and trans people, Muslim communities, immigrant and undocumented communities and communities most impacted by deportation and detention, community members who are substance users, community members who are unhoused, and

community members impacted by criminalization and policing. These organizations also represent social workers and mental health service users who have seen firsthand the devastating consequences of police involvement, particularly in mental health crises.

All of these communities have spoken to a variety of urgent needs, including: 1) the development of a mental health crisis response program that operates completely outside of the Boston police department; 2) responders including residents with strong community relationships and who get the training they need, with an appropriate role for clinicians; 3) standards for best practices determined by participating organizations and community members (defundboscop, 2021).

Because of these organizing groups' efforts, in 2021, Mayor Kim Janey's administration earmarked $1.75 million for the development of a community proposal for what a non-police mental health crisis response for Boston could look like. This context highlights the values that our proposal is anchored in, such as **"being non-carceral and consent-based," and "not involving the police in any way."** These values represent the needs of community members who are most impacted and their clearly stated expectations for the project, themes our team heard over and over again from CLDG members and community members surveyed (See values in Table 1).

In April 2021, City of Boston put out a call for organizations to facilitate a community-led design process to propose a new model for Mental Health Crisis Response for the city of Boston that does not involve the police. This effort started with Mayor Kim Janey's leadership and continued under Mayor Michelle Wu's leadership. This request for proposals was part of a three-pronged initiative approach to revamping the mental health crisis response in the City of Boston.

The other two approaches include expanding the BPD's co-response with mental health providers from the BEST Team and establishing a joint response of EMTs and social workers.

COMMUNITY-LED DESIGN TEAM ORGANIZATIONS AND APPROACH

In January 2022, The City School and Boston Liberation Health were selected as organizational leads to facilitate the city of Boston's process to design a community-based mental health response.

The City School. The City School's mission is to develop and strengthen young people to become effective leaders for racial and social justice. Since 1987, The City School has been running racial and social justice education and leadership development for young people in Boston. Now rooted in Uphams Corner in Dorchester, The City School continues to bring together young Black people and young people of color for political education, leadership development and community organizing training on racial, gender, economic and queer justice. The City School has been based in Boston for close to three decades, and in Dorchester for over 15 years; in that time, TCS has built both a wide and deep network of partnerships within Dorchester, Roxbury, Jamaica Plain and Mattapan, as well as with other community and grassroots youth and adult organizations from across the city.

Boston Liberation Health. For the past two decades, the Boston Liberation Health Group has organized social workers, health care workers and users, community members and all advocates of social justice and human liberation in the struggle for a healthy society. The Boston Liberation Health Group's mission is to build, disseminate, advocate for, and practice Liberation

Health theory via bi-directional clinical practice, direct action, and community building in order to support liberation, dismantle all forms of oppression, and promote the healing of ourselves and our communities.

Community-Led Design Team. In spring 2022, the City of Boston selected 14 members of the Community-Led Design Group based on their applications, and their lived and professional experiences of mental health challenges. Made up of all Boston residents, the Community-Led Design group was majority BIPOC and included community members with lived experiences of substance use, homelessness, criminalization, and major mental illness, as well as professional experiences as social workers, community facilitators, peer responders and therapists. The group represented a range of languages, levels of ability, experiences with immigration, and different neighborhoods of Boston.

THE DESIGN PROCESS

The City School and Boston Liberation Health took a popular education approach rooted in the values of racial and social justice, equity, and accessibility for community members. Our

approach for this scope of work was guided by the lived experiences of community members who are part of the Design Group and the broader group of community members engaged throughout the process. Our facilitation team drew on principles of popular education as best practices to move forward an agenda while being accessible to a range of ages, educational experiences, and familiarity with mental health systems. Our Facilitation Team also prioritized accessibility by ensuring CLDG members' needs -- including food, stipends for travel costs, ASL interpretation, electronic and translated materials and childcare -- were met.

Logistics. We facilitated seven data driven planning sessions with the community design team, which was followed by an intensive retreat, a set of 6 community listening sessions with over 200 community members total in English, Spanish and ASL, and 2 final design team sessions to incorporate feedback from the broader community. In this section we describe the content for each section as well as the types of data used to inform the group's planning. More information about our approach to facilitation and pedagogy can be found in our overview of sessions (see Appendix 5).

As noted, design team members were selected by the city through a competitive application process; group members were new to one another and new to facilitators and had not previously worked together. As such, strategies to support the stages of group development (forming, storming, norming, performing), were embedded in the facilitation process across sessions (Tuckman, 1965). For example, during sessions one and two as the cohort was forming, group members were introduced to the overall work plan and the arch of the initiative. Facilitators focused on establishing a shared language around racism, anti-Black racism and other systems of oppression, as well as on "optimal mental health" and "crisis response," among the

team. In sharing a clear set of goals and program overview, as well as taking the time to develop a shared language and framework, the facilitation team was able to provide design team members with a set of expectations for the work they would engage in.

An overview of each planning session can be seen in Appendix 5. Sessions were iterative, each informing the next. Participants were introduced to data, frameworks, and models during sessions, which were interrogated through dynamic planning activities which involved thinking through the information in the context of their own lived experiences, both personal and professional. After each session, the facilitation team met to synthesize outputs from group discussions as well as to assess the effectiveness of session facilitation. Synthesized data was used to inform the following session and to determine the research needed to further inform the process. Assessments were used to adjust the facilitation approach and types of task-oriented group activities employed (see Appendix 5).

Session one focused on group development and creating a safe environment in which designers were able to take risks and dream big about the future of mental health crisis response in Boston. Participants shared with one another, and developed group agreements, in addition to reviewing the overall initiative work plan. During this session, participants focused on racial, economic, gender, and queer justice and equity frameworks to guide their work. CLDG members

engaged in small group planning as they interrogated frameworks in the context of their own lived experience. These discussions informed session two which was focused on developing shared definitions of mental health and crisis response. Like in session one, participants engaged with definitions within the context of their own experiences. Session two also covered the history of policing and mental health institutions, as well as the carceral aspects of the mental health care system. Design team members employed the Liberation Health model to analyze the factors influencing why people call the police in mental health crises and critically assessed the limitations of Boston's current model. Themes from their discussion were extracted from session two to develop a set of Core Values for Community Mental Health Crisis Response (see Table 1: Core Values). Design team members engaged with the Core Values through gallery walks and group discussions to further hone and revise them during sessions three and four.

During session three, design team members examined mental health response models. This process involved focusing on distinctions between co-response and community-based response models, the historical context in which models emerged, and models implemented nationally as well as those operating in the greater Boston area. Team members mapped the Boston landscape using information compiled by the research team, exploring assets and gaps in services. In addition, they grappled with the disproportionate impacts of harm on minoritized examined the data compiled by the research team on local and national models for alternative mental health crisis response. Also during session four, CLDG members developed the values by answering the question: "what is most important to the group in designing a model?." Additionally CLDG members developed criteria and needs for the Boston-based model. Session 5 starts the second phase of the process: "Researching and Developing the Proposal." During

session five, the CLDG members closely examined response models. This involved reading about models, reviewing information compiled through interviews with sites and hearing directly from sites.

Exploring Models from Across the Country. During these sessions, the Design team critically examined six models: Crisis Assistance Helping Out On The Streets (CAHOOTS) in Eugene, Oregon; Community Action Teams-911 (CAT-911) in Southern California; Mental Health First (M.H. First) in Sacramento and Oakland, California; Support Team Assistance Response (STAR) in Denver, Colorado; Behavioral Health Emergency Assistance Response Division (B-HEARD) in New York City; Cambridge Holistic Emergency Alternative Response Team (HEART) in

Table 1: Core Values

- Mental health crisis response that doesn't involve the police in any way and is rooted in community
- Accessible across the city of Boston / citywide
- Accessible 24/7
- FREE (fully funded, so there is no cost/charge to community members)
- Centering needs of communities most impacted by policing: Black and Indigenous people and people of color, undocumented people, disabled people, unhoused people, people who use drugs, survivors, young people, and young adults, and trans, non-binary, and queer people
- Responders reflect these communities and include peers who have similar lived experiences to those they are responding to
- A response that is non-carceral and consent-based.

Cambridge, MA. The Steering Committee and Facilitation Team also consulted with members connected to two additional models: the Portland Street Response Team in Portland, Oregon, and Coalition for Police Accountability's work around Mobile Assistance Community Responders of Oakland in Oakland, California. These models had some similarities and some differences as each one adapted its approach based on the local community, funding, leadership team, and

more. The design team paid close attention to scope of response and dispatch; staffing and training; and operations and cost associated with each model as well as reach. A brief discussion of the models is provided.

CAHOOTS in Eugene, OR: Crisis Assistance Helping Out on the Streets, better known as CAHOOTS, in Eugene, Oregon is one of the oldest documented alternative response models in the country, having been launched in 1989. This particular model has served as a blueprint for over 20 cities across the country and has provided trainings and shared information to help others design their programs. CAHOOTS is staffed and co-founded by the White Bird Clinic, an agency founded by activists, medics, and social workers looking for alternatives to policing back in 1969. Over time, the non-profit began building a relationship with emergency responders to establish the programs and services available today. The team uses City of Eugene vehicles (white vans) to arrive on the scene and provide services.. The program dispatches program responders - a medic and a crisis responder - through either the emergency (911) or non-emergency line. CAHOOTS program responders are sent out through the same mechanism as Eugene Police Department and Fire Department (911 phone calls) or through the non-emergency line. They can be dispatched alone (medic and crisis responder) or together with police and fire services, as determined by dispatchers. In 2019, CAHOOTS executed nearly 21,000 responses in Eugene and Springfield with free service to anyone in crisis, diverting between 5-8% of calls coming into the emergency and non-emergency lines. CAHOOTS provides immediate stabilization in cases of urgent medical need or psychological crisis, assessment, information referrals, advocacy, and in some cases transportation to the next step in treatment. Other services include, but are not

limited to: grief and loss, conflict resolution, suicide prevention, and more. The most common calls involve welfare checks, assisting the public, and transport.

The CAHOOTS budget is $2.1 million a year and funded by the City – a fraction of the combined Eugene and Springfield police budgets of $90 million. This includes 31 hours of service per day (including overlapping coverage) 7 days a week. One van is on duty 24 hours a day, and another provides overlap coverage 7 hours per day. There is an estimate that CAHOOTS has saved the city $8.5 million annually in public safety costs and $14 million in ambulance trips. CAHOOTS instances of requesting backup from police are slightly higher than what the program has been aiming for, though backup rates for their most consistent calls (above) are very low. Backup calls usually happen when CAHOOTS is dispatched to a traditionally police-centric call like trespassing, where the likelihood that police backup will be requested increases significantly.

STAR in Denver, CO: The Support Team Assisted Response (STAR) program is located in Denver, Colorado and responds to calls coming into the 911 system that dispatchers deem as low risk, low acuity calls. This model took inspiration from the aforementioned CAHOOTS program to create its structure and services. Individuals from the City of Denver, the Denver Alliance for Street Health Response (DASHR), and local non-profits traveled to Eugene, Oregon in June of 2019 to learn more about the CAHOOTS program directly from staff members. STAR is in the process of expanding city-wide to be in operation 7 days a week between 6am and 10pm. These hours were determined by data that show call volume is highest during those hours. In its first 6 months of service, the STAR program responded to 748 calls. Of the 748 calls handled by the STAR van during the initial 1-year pilot program period, no calls involved the assistance of Denver Police, and no individuals were arrested – an important goal that the program has identified.

Based on estimates, these STAR services could reduce Denver Police Department responses by 2.8%. STAR has created a new path into the service connection system by linking callers with other providers and services, increasing efficiency and cost savings and avoiding hospitalization and the criminal legal/punishment justice system. STAR is made possible through a collaboration including Caring Foundation for Denver, Denver Police Department, Mental Health Center of Denver, and additional community support. The STAR program deploys emergency response teams including emergency medical technicians and behavioral health clinicians to engage individuals experiencing crises related to mental health, poverty, homelessness, substance use, and more. The team is then able to provide medical assessment/triage, crisis intervention, de-escalation, transportation, and resource connection for community members in need. Inspired by STAR, other cities in Colorado are following suit to try to develop similar programs.

The STAR program is currently funded through a .25% sales tax increase that has generated roughly $35 million annually. Of the funds generated, 10% were allocated for specific public safety services related to mental health and substance use; part of this amount provided funding for STAR. In January of 2022, the STAR program was granted a $1.4 million budget which will allow for the program to pay for 5 additional vans and hire additional staff including 7 clinicians, 4 paramedics, and two emergency medical technicians. The program was also able to receive a matching grant bringing their budget to just under $4 million. The STAR program has been able to clearly define their capacity for calls resulting in – thus far – no involvement of police and no arrests. Some of the challenges include: 1) limited service hours: although the current service hours are based on data showing highest call volume, there are still hours where STAR is unavailable; 2) funding: currently, the STAR program is funded through a sales tax increase

instead of re-allocating existing Denver Police Department budget funds to cover that percentage of calls; 3) this program is still in its beginning stages and is not as well established so there is less stability but still a great deal of promise based on results thus far. Due to the demonstrated efficacy in Denver, many surrounding Colorado towns are exploring similar programs.

Despite its successes, STAR has also experienced some challenges. STAR is situated in the Denver Public Health department, and although there are many benefits associated with being embedded in the health department, community control is limited despite early agreements to have a community board. This has raised concerns from those who fear the health department over time may begin to replicate carceral practices, as well as concerns that white folks calling 911 are more often being diverted to STAR and calls from Black folks and people of color are more often being diverted to the police

B-HEARD in New York City, NY: The Behavioral Health Emergency Assistance Response Division (B-HEARD) is a program located in New York City. The initial pilot program included East Harlem and parts of Central and North Harlem. In March of this year, B-HEARD expanded to Washington Heights, Inwood, and part of South Bronx. In the coming months, B-HEARD will expand to two additional police precincts in the South Bronx. Due to its success, the program has been funded for continued services and expansion. In June of 2021, New York City launched the pilot program where both mental and physical health professionals would respond to 911 mental health emergency calls. Under the pilot, teams operate 7 days a week for 16 hours a day in Zone 7, which includes East Harlem and parts of Central and North Harlem. The goal of the program is to route some 911 calls to a health-centered response. The B-HEARD teams include emergency medical technicians from the fire department and social workers from NYC hospitals. 911

dispatchers are trained to filter calls and send the most appropriate and available response service according to department parameters. During the first month of the pilot, 911 operators routed 25% of mental health emergency calls (138 calls) to B-HEARD teams. This number is expected to grow to 50%. The remaining calls involve suspected violence or imminent harm and require, according to department parameters, a different response strategy. B-HEARD responded to 80% of the calls routed to them, the other calls received typical response due to B-HEARD being unavailable and responding to prior calls. There is higher trust for the B-HEARD team with people electing to receive assistance from B-HEARD 95% of the time compared to 82% of the time for NYPD/EMS response. The B-HEARD program is still in early development. The pilot began in FY2021 ($1.2 million) and funding was approved for FY22 ($2.8 million). B*HEARD represents a coordinated effort by FDNY/EMS, Health & Hospitals, the Department of Health and Mental Hygiene, the NYPD, and the Mayor's Office of Community Mental Health, aiming to move towards a more health-centered approach to mental health emergencies. There have been instances where police arrived on a scene and requested backup from this alternative response team. Services provided include mental health support, counseling, referrals to community-based care, and more. Everyone served by B-HEARD is offered follow-up care.

This program is new, the pilot having launched last year, but has some clear strengths. As mentioned, there is higher trust with B-HEARD teams and community members are more likely to be open to care from this team compared to NYPD/EMS. Second, there have been instances where NYPD has requested onsite assistance from B-HEARD teams (14 calls). This demonstrates the value of the B-HEARD team and their skills, but it is also a point of opportunity as it reveals that B-HEARD could be employed in more circumstances instead of the police. The B-HEARD team

will be expanding to cover more areas in NYC, but the hours seem to remain the same, leaving gaps in coverage in some instances. Local mental health advocates have cautioned that the dispatchers have too much discretion in choosing to deploy police over B-HEARD responders. Additionally, these advocates have stated that there are still not enough mental health responders to meet the true need.

CAT-911 in Southern CA: Community Action Teams-911 (CAT-911) is located in Southern California and its vision is to create cities and a region where local communities have the resources and the strong interpersonal relationships needed to respond constructively and intentionally to problems together. CAT-911 is about building transformative justice that lets community members take control of their lives and nurtures growth, shifting away from the criminal legal system and reliance on 911. CAT-911 is building a network in Southern California of Community Action Teams (CAT) to respond as an alternative to the traditional 911 model. This model is about four years old and has built a network of organizers that now encompasses about 15 independent teams across Southern California from Riverside to Long Beach. CAT-911 hopes eventually to provide rapid response services and currently provides workshops and trainings to equip community members to support themselves and others covering topics such as: transformative justice, wound care, cop watch, and peace building. Community Action Teams hope to provide alternatives in situations of police violence, domestic violence, sexual violence, mental health crisis, acute first aid, and in peacebuilding and conflict resolution between individuals or groups in communities. This work is founded on a framework of transformative justice and is a mental health first type model. This model will be completely non-police in terms of dispatch, and the design and implementation are community-centered. The hope, in the

future, is to offer rapid response services as funding and expansion allow. CAT-911 is community-oriented and founded by organizers responding to community needs. Currently the group is volunteer-run and has limited donor and grant support, but the funding outlook could change with the increase in statewide budget allocation for mental health services in California.

Mental Health First in Oakland and Sacramento, CA: Mental Health First Oakland and Mental Health First Sacramento are models stemming from the Anti-Police Terror Project, cutting-edge programs focusing on community-based non-police responses to mental health crises. The overall goal of MH First is to respond to mental health crises including psychiatric emergencies, substance use support, and domestic violence safety planning. MH First aims to interrupt and eliminate the use of law enforcement in situations of mental health crisis by providing mobile peer support, de-escalation assistance, and non-punitive and life affirming interventions and addressing the root causes of mental health problems: White Supremacy, capitalism and colonialism. Mental Health First is a community-driven, volunteer-run effort led by the Anti Police-Terror Project (APTP), a Black-led, multi-racial, intergenerational coalition that seeks to build a replicable and sustainable model to eradicate police terror in communities of color. APTP supports families surviving police terror, documents police abuse, and connects impacted families and community members with resources, legal referrals, and opportunities for healing . Both locations are currently available for phone support only, a decision made by the organization to help keep their volunteers safe and healthy due to funding and COVID. Those in need can reach out by phone (call/text) or direct message on Instagram for help which is available on weekend nights, Friday and Saturday from 8:00pm to 8:00am. The team has shared that some nights they field as many as 10 calls. The M.H. First team is putting up billboards to try and spread

the word about its services and will continue to expand. This program is rooted in values of racial and social justice and is community-oriented.

Ultimately, M.H. First aims to interrupt and eliminate the use of law enforcement in mental health crisis response by providing mobile peer support, de-escalation assistance, and non-punitive and life-affirming interventions and addressing white supremacy, capitalism, and colonialism, the root systemic causes of psychological crises and stigma around mental health, substance use, and domestic violence. Challenges here include that the model is currently volunteer-run, is limited to phone-based support during the COVID-19 pandemic, and is only available during select weekend hours. These sites are moving to secure funding to support the expansion of services and hope to be able to shift to in-person care with more hours soon.

Cambridge HEART in Cambridge, MA: The Cambridge Holistic Emergency Alternative Response Team (HEART) envisions interconnected communities that practice care, healing, transformative accountability, self-determination, and that are free of the carceral system. The team aims to center marginalized people and build local capacity to disrupt cycles of harm by responding to crises, conducting research, and facilitating community cohesion. It is a community-led proactive public safety program that aims to address the immediate needs of people in conflict or crisis, at the moment of crisis. In the future, the team plans to directly deploy HEART responders for emergency calls, including for those with mental illness and/or substance use disorders in public spaces as well as within homes. The Cambridge HEART model was convened by the Black Response, an advocacy organization composed primarily of young Black and Brown current and former Cambridge residents who are advocating for a broad vision of social justice in Cambridge. The process to create Cambridge HEART was also inspired by models

around the nation such as CAHOOTS in Eugene, OR as well as M.H. First in California. HEART was proposed as a new program for community based public safety in Cambridge and received unanimous support from the City Council in the Spring of 2021. HEART is in the process of raising $2 million to become fully operational by 2023. Within this funding, $1 million will go toward hiring twenty full-time HEART responders and the remaining funding will cover operating costs including administrative and support staff, supplies and equipment, and training costs. Thus far, HEART has received over $300,000 from various foundations including Borealis Philanthropy, Black-Led Movements Fund, Social Justice Ecology, Resist, and more.

Portland Street Response: The Portland Street Response team (PSR) is unarmed and composed of a mental health crisis therapist, firefighter paramedic, and two community health workers who are dispatched to 911 calls regarding mental health crises or issues surrounding the homeless population in the area. The team currently works Monday through Friday from 10am to 6pm. Initially, this program was a year-long pilot created to lessen the workload of the short-staffed Portland Police Bureau. During the pilot, primarily focusing on the Lents neighborhood due to fewer resources being provided to that area, the team responded to 383 incidents (between February to mid-August of 2021) with the majority being calls such as welfare checks or reports of unwanted persons. Within these calls, less than 4% resulted in a trip to the hospital and none resulted in arrests. The team estimates that they were able to lessen the call load to the Lents neighborhood by 5% and the Fire Bureau saw its calls for behavioral health and illegal burns reduced by 11.6%. Since March 28th, 2022, the program has been expanded to include the entire city and the hours of operation have been expanded to 8am-10pm seven days a week. If the budget for the next fiscal year is approved, the service will be available 24 hours a day, 7 days

a week. To access the services, those in need call 911 where the dispatchers have a list of questions, they ask to determine which responder will be sent: police, fire, Portland Street Response, or AMR ambulance service. Currently, PSR is dispatched when a caller reports a person who is experiencing a mental health crisis, intoxicated, needs referral for services, outside and yelling, or outside and down and has not been checked. Additionally, the call needs to meet the following criteria: no weapons seen, the person is not in traffic or obstructing traffic, person is not violent towards others, person is not suicidal, and person is not inside of a private residence. At the time of the writing of this report, concrete fiscal information around the program costs were not available; however, in a report detailing the program, each 24-hr unit is estimated to cost about $800,000 annually including salary and operating costs. If six units operated around the clock every day, the program would cost about $4.8 million per year. It is estimated that six teams would allow for prompt response and outreach.

Each of these models attempts to address the needs of their communities through leveraging the funding and capacity-building available. Some (CAHOOTS, STAR, PSR, and B-HEARD) work directly with the current emergency response systems to create their own acuity scales and to triage calls appropriate for alternative response. In these instances, funding for the programs is through the city's budget. Alternatively, CAT-911, Cambridge HEART, and M.H. First are models that are attempting to break from this connection and create models that are free-standing and not interdependent on existing emergency response services. Each of the models also includes differing groups of people that were part of the creation process – some are entirely focused on community members (CAT-911, HEART, M.H. First), others rely on a collaborative process across different sectors such as non-profits and community organizations, hospitals,

government staff, and more (B-HEARD, CAHOOTS, STAR, PSR). All have an overarching goal of more appropriately serving those that are experiencing mental health crises but use different approaches based on whether or not they are connected with traditional emergency response services.

Contextualizing the models locally. After critically assessing existing models, the design team met with organizations currently working with impacted populations during session seven. They specifically heard from Boston-based groups focused on supporting unhoused communities, substance use response, neighborhood trauma response, those organizing mutual aid work and those working with undocumented communities. These groups included, but were not limited to: Health Resources in Action, Material Aid and Advocacy Program, Boston Immigration Justice Accompaniment Network, and a BIPOC young adult mutual aid collective. The Steering Committee and facilitation team also had a conversation with Boston Healthcare for the Homeless providers as background for this session. In the session, design team members examined community needs, barriers to implementation, types of response, service access, and follow-up. They further reflected on limitations and service gaps by mapping what different community members (e.g. people who use substances, unhoused people, youth and young people, etc.) might need from a community mental health response model. The design team then participated in a full-day retreat to develop the elements of a community mental health response model for the City of Boston.

THE BOSTON COMMUNITY DESIGN TEAM PROPOSED RESPONSE MODEL

In the section that follows, we describe the Community Design Team's proposed response model for Boston. Of note, this model was developed by the team using an iterative data-driven planning approach. Primary and secondary data described above and below, shaped design-team planning. Outputs from planning sessions were synthesized and informed proceeding discussions. An initial model was framed by the team and vetted through community listening sessions and a survey. SWOT analysis was used to synthesize model feedback and by the Design Team to develop a final proposal, which is described in detail. The values underlying the model were previously discussed (see Table 1). The scope of the response is followed by a proposed dispatch model. We then describe the staffing structure and operations plan determined by the team to be most appropriate. We conclude this section with a discussion of where the model should be situated and how it should be governed to ensure the success of the response team.

Scope of the response. The scope of response (see Table 2) was determined by the team using key sources of data, key informant interviews with, and documents from sites across the country who are currently implementing community led mental health response models, as well as publicly available Boston Police Department (BPD) incident data from 2021, listening sessions, one-on-ones with Boston area providers and outreach workers, and peer-to-peer youth surveys. We found that nationally, response models typically include assists; intoxicated persons; suicidality; welfare checks; indecent exposure; trespassing/unwanted person; syringe disposal; and de-escalating unwanted police involvement. However, this varies; for example, in some states, suicidality requires a paramedic response, which some community teams may not be able to accommodate.

Publicly available BPD data indicate there were 65,536 incidents in 2021. A number of incident categories were identified that might be appropriate for a community response based on the available literature (scholarly and gray) and interviews with response sites from across the country. These included simple assaults, disturbing the peace, drunkenness, harassment, sick assists, verbal disputes, threats to bodily harm and suicide attempts. In total these accounted for

18% (n=12,091) of incidents in the dataset. Of note, these are broad incident categories, and the actual determination will be made by the dispatch unit after a series of questions. As such, a

successful community led mental health response model will necessitate coordination with dispatch from conceptualization to implementation.

Listening sessions and one-on-ones were conducted with local providers and outreach workers who raised a number of priorities for community response that were factored in by the Design Team. Providers discussed transport as a major gap in services, more specifically they explained how for example during street outreach, individuals who voluntarily agreed to more intensive services required 911 for transport, which posed danger.

> *"We have the… experience in the Mass and Cass area of calling the police and having them not respond to help get them [patients] to the hospital…when folks are ready to go we are well poised …the ethical piece is so profound because you don't know if you are going to cause your patient harm [by calling the police]…."*

In addition to listening and one-on-ones with providers, surveys were conducted with youth, by youth, to explore their priorities related to mental health response and the acceptability of mental health services. Survey participants reported wanting a mental health response system that is more representative of local residents and that can relate to the people they are serving. The majority of youth participants wrote no police involvement, explaining that police involvement can escalate mental health crises and might lead to police violence. This survey finding was consistent with frontline medical provider feedback, which indicated that involving police causes unnecessary harm to clients as well as the provider-client relationship. These data points were consistent with national trends: A 2015 survey by the Washington Post found that 25 percent of people fatally shot by police were mental ill or in emotional crisis (Washington Post, 2015). In addition, data shows that in Boston specifically from 2013-2020, a Black person was

17.6x as likely and a Latinx person was 2.3x as likely to be killed by police as a White person (Police Scorecard, 2022). As such, we propose a plan to eliminate police involvement.

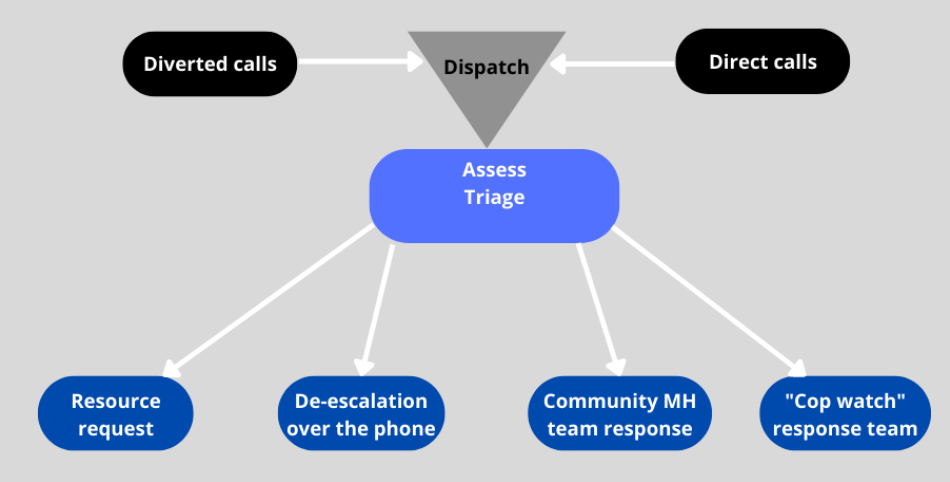
Table 2: Scope of Response

Someone having a mental health crisis
Sick visits and wellness checks
Safety or health concerns related to substance overuse, or syringe disposal
Gender or intimate partner violence
Safe non-police transportation to a hospital or a different location related to a mental health crisis
Neighborhood noise concerns
Support for caretakers when someone in their community has a mental health crisis
Significant incidents of trauma, including support around community violence, and/or community-wide incidents of racism or other systemic oppression, including police violence
Neighbors or community members unsure how to respond to a situation they're witnessing
Providing support to community members if police are called to a mental health crisis

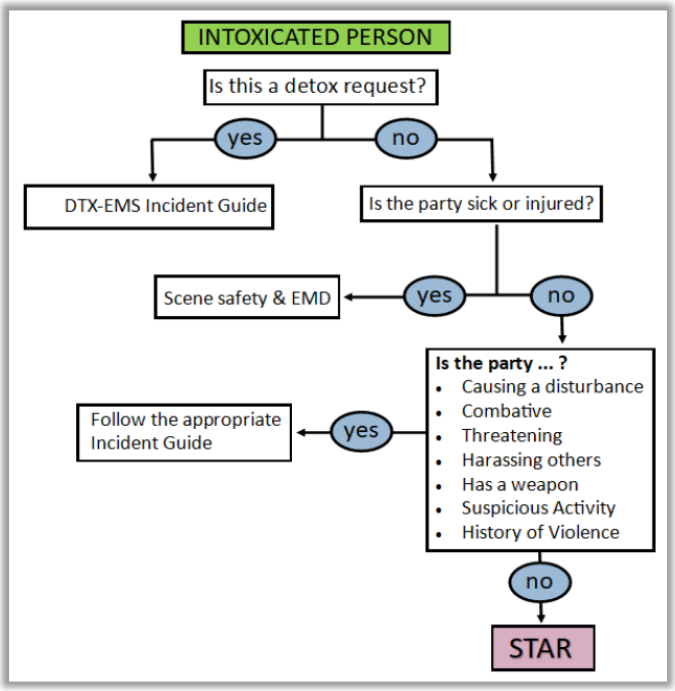
Of note, this descriptive list of incidents cuts across multiple incident categories. Moreover, for some of these incidents there are dedicated lines that already exist in the city, for example, the party and syringe disposal lines. However, these numbers are currently routed to the police and the public health department respectively, although in some cases both incident types are directly reported to police via 911. As will be discussed in the section that follows, successful implementation of the proposed plan will require close coordination with dispatch, which is situated in the police department. Sites we spoke with across the country highlighted the ways in which they coordinate and train with dispatch, even in cases where 911 is not the primary point of contact because 911 diverts calls to community responders when appropriate. An important next step will be working with dispatch to develop an agreed-upon standardized call processing protocol for each incident and flowchart to allow dispatchers to determine how to route the call (Figure X for an example).

Dispatch. The design team determined it was important to have a dedicated community mental health response number that was separate and not associated with 911. One reason for this separate phone number is that some community members have named that they do not feel comfortable and safe calling 911, particularly community members most impacted by police violence. However, because people are accustomed to 911, the design team elected to have multiple means by which to access the community mental health response team. As such the recommendation is to have 1) an independent 3-digit call number accessible through an app such as Raheem, and 2) the diversion of appropriate calls from 911 and 988. It is also recommended that the response team be reachable via direct messages on social media (specifically Instagram and Twitter) to offer greater accessibility for youth. Community members who reach the program via social media will then be encouraged and redirected to use a text-based app such as Raheem, in order to increase confidentiality. Dispatch also needs to be accessible to all communities (ie. deaf and blind people, neurodivergent people, and non-English speaking communities). It is essential that all dispatch services also be provided in multiple languages, including, but not limited to: Spanish, Haitian Creole, Cape Verdean Creole, Vietnamese, Cantonese, Mandarin, Arabic, and many others.

With respect to dispatch, the team envisioned a spectrum of options for triaging calls referred to the community mental health response team. This included: 1) calls requiring a team to be dispatched to the location of the crisis for direct intervention, 2) callers in need of resources or referral, resolved remotely over the phone and 3) situations called in that teams should watch (for example, cases where police have been called without consent). An example is provided in figure X.



Dispatch also will need to develop a workflow for each incident type to determine the appropriate response (see Figure X for an example from the STAR program).



Leaders from national community led mental health response teams that we spoke with described the importance of engaging in conversation with dispatch early on to determine the feasibility of call diversion. Sites reported bringing dispatch staff to site visits and training to ensure buy-in and engagement. One site reported providing ongoing monitoring of dispatch call logs to identify patterns among diverted calls. This data is used by dispatch and community responder teams to identify strategies to improve the triage process. As Boston moves forward with implementation, an important next step will be conversations and collective planning with 911 dispatch. Our recommendation is for 911 dispatch to receive mandatory training from the response team in the pilot stage of implementation.

Operations. The Design Team determined calls should be assessed using standard protocols and that responses should be dependent on the nature of the call. Responders should work on teams outfitted with resources to support the response needs of each assigned call. It was determined by the design team that the minimal data needed should be collected for response from callers and that identification should not be collected. After speaking with existing programs in Boston, the team learned that the collection of identifiers may lead to unnecessary barriers for community members in need of emergency support (e.g. it is not necessary to collect home addresses from callers). The team also recommended that in cases where an incident is not appropriate for the community mental health response, callers should be notified as such but that the call should not be diverted to 911. More specifically, the decision to call 911 would be left to the individual caller.

Based on examining models from across the country and speaking with local groups, the Design Team determined that Boston needs access to community-led mental health response 24

hours a day, seven days a week, across all neighborhoods. For example, one group of frontline providers we heard from during a listening session expressed that Boston needs:

> *a 24-7 [non-carceral] emergency line, … with deep de-escalation skills…that can de-escalate…follow-up…[be] responsive, [a response team] able to come into the community, that is familiar with [the] area…able to collaborate…*

Based on feedback from early discussions with local providers, available data, and their own expertise, the Design Team proposes that response teams have a central location in the city with hubs situated across Boston neighborhoods. As such, they will be embedded in the community and able to establish relationships in the community with individuals and organizations.

Services available through the community-led mental health response program would include harm reduction services, street outreach, naloxone distribution and education, de-escalation (including in cases of unwanted police involvement), first aid, peer support, resource information and referral, transport, and follow-up. In line with the program value of being consent-based, the option of follow-up would be offered at the time of services and consent would need to be gained in order for follow-up to take place. These services are consistent with other models nationally and are responsive based on discussions the team had with local organizations and outreach teams.

Staffing. The recommendation for staffing structure, based on the scope and values of the model, is to have a centralized office out of which the operations staff would work, along with neighborhood-based response teams rooted in each Boston neighborhood. On shifts without active calls, response teams will do outreach work in the neighborhood to increase awareness and use of the model, and build community partnerships.

The Design Team recommends that staff be people with lived experience; people from the community and that know the community. More specifically they insist that staff be:

- BIPOC people;
- linguistically diverse;
- people with different abilities;
- people with a strong racial, gender, economic, queer and disability justice and systemic analysis, and commitment to learning

This is consistent with recommendations we heard from community groups during our listening sessions.

> *"For monolingual Spanish speakers and other non-English speaking patients I don't see many providers who are able to provide services crisis or otherwise…It is a huge need."*

> *"I underscore the points made… community-based teams rooted in communities who have relationships in communities, multilingual service teams, some way for teams to have connection to service providers to refer to outpatient providers."*

With respect to operations, personnel should include dispatch, administrative staff, and responder support/clinical triage support. Staffing would also include at least two community organizers who will implement a community engagement strategy and support community partnerships around the model. The Design Team recommends the actual response team should include teams of community responders and drivers, with at least 3 responders and 1 driver for each shift in every neighborhood.

In considering the role of clinical staff, the Design Team reviewed the staffing structure of other models. Three of the five models they examined include clinical mental health staff, such as social workers. Similarly, some recommendations from community groups indicated that teams should include clinical staff.

> *"I love the geographically based, at least someone with behavioral health or a psych degree along with a medical professional…for example we have EMTs on our outreach team...they [EMTs] know high acuity medical intervention… [someone] licensed…de-escalation… …it makes us more able to respond…."*

However, in considering the staffing model for Boston's Mental Health Response, the Design Team focused on feedback collected during the listening tour in which the model was vetted with community groups, including mental health service users, peer specialists, and providers. They also looked at data from a feedback survey that asked community members to reflect on the strengths of the staffing model. Based on the data and community feedback, the Design Team determined that the strengths of the proposed staffing model for Boston (with a focus on community responders) outweighed the access barriers and potential risks of having clinicians on the response team. Reasons cited by listening tour and survey respondents included: (1) *"not having clinicians would help to ensure a non-carceral response;"* (2) clinical professionals are mandated reporters and may be required to enact a non-consent-based response; (3) participants in listening sessions named that some callers would be less likely to trust and feel comfortable with mental health providers as responders, especially some community members of color and others who have been harmed by non-consent-based approaches in the mental health field and (4) a peer and/or community responder model is consistent with best practice in many mental health communities, including Recovery Learning Centers. In terms of where clinicians could play a role, the Design Team acknowledged the value of having support from trained mental health professionals, which could include a clinician as part of the Operations Team, as well as having a mechanism through which community members could check in with a

clinician if they requested to do so. Finally, the Design Team noted that follow-up planning may involve clinician referral.

Situating the model and funding sources. As is evident in the model summary provided, there is variation in how community-led mental health response teams are situated and funded. For each of these models there are pros and cons. For example, we found nationally that smaller grassroots groups had high levels of autonomy and community control but low response capacity.

Approaches to Situating Community Led Mental Health Response				
	Grassroots, coalitions, steering committees, boards	**Community Non-profit**	**Quasi-Public**	**Public**
Definition	Community-led entities are privately funded by a mix of streams, which may or may not include public grant funds. Of note these entities require a fiscal agent or member willing to carry the risk. They are largely voluntary and rely heavily on mutual aid and donations.	Non-profit entities are organizations established for reasons other than revenue generation. There are 28 tax designations that govern these organizations, most commonly referenced are 501c3 or c4.	Quasi-public entities are sanctioned by charter to provide a public service. They are governed independently by a board or commission. They can be publicly financed but do not rely on the general fund to operate.	Public entities are governmental agencies.
Governance & Decision-making	Governance and decision-making sits with the community.	Governed by a board structure, bylaws vision of the board is operationalized by organizational leadership.	Governed independently by board, commission, or other independent body. To increase accountability to the community a community monitoring board could be established.	Government run. Accountable to the public, but the least amount of community control. To increase accountability to the community a community monitoring board could be established.
Staffing	Staffing is voluntary, but can also be paid as funding permits	Paid staff as funding permits and volunteers.	Paid staffing, benefit from public resources and infrastructure.	Staff are government employees and receive government benefits.
Service area and scope of response	Services and scope of response are restricted based on resource availability. Determined independently by the community.	Services and scope are restricted by the mission of the organization. Determined by the organization and board.	Determined in collaboration with the public sector, may have a charge from the public sector.	Part of the local government infrastructure.
Dispatch	non-911 community generated number	non-911 community generated number, calls can be diverted by 911 to the community generated number	possibly 911, but could also be independent non-governmental number with calls diverted from 911	911 or other government-controlled line

Meanwhile, organizing groups that partnered with public entities created well-compensated government jobs as well as good infrastructure and response capacity. However, community

groups experienced that overtime their models became less and less community-led and were co-opted by local officials, despite agreements that outlined a role for community input in decision-making.

We are recommending the model be situated in a public agency. Of note, this was not our initial thinking. Initially we believed that a community-based organization would be a more effective strategy; however, based on multiple listening sessions and one-on-ones, we have concluded a public agency is the best setting. Our reasoning is as follows: 1) a public setting guarantees well-paying positions for response team members, 2) response infrastructure is established in the city, 3) there is not a local non-profit that has the infrastructure and values alignment to hold the program, and 4) the program is more likely to be sustainable as a public program.

Of note, if the model is to be successfully situated in a public agency it will need to have a Community Oversight and Accountability board, selected by the community (see example in Appendix 2). The Community Oversight and Accountability board will be a decision-making body that guides the direction and implementation of the program inclusive of decisions related to staffing, operations and dispatch. The board would have hiring authority over program leadership and key staff positions. The board should be at minimum a 12-member body and that membership be selected jointly by the community coalition and the city as part of an application process. The board will be responsible for contracting an independent evaluation team and will meet at least quarterly to review program data. Monitoring reports should be made publicly available.

It is recommended that funding be allocated from the **public safety budget, more specifically from the police budget to another city agency, such as the public health department** to run the program. Despite cost savings associated with diverted calls (Pyne & Dee, 2022; White Bird Clinic, 2020), few municipalities actually divert funds from the police. Instead, programs are funded via grants and allocations in city budgets (Case, 2022; City of New York, 2022). This is ironic given that the direct cost of having police as the first responders to individuals in mental health and substance abuse crises are over four times those associated with a community response model (Dee & Pyne, 2022). In addition to diverted calls, we anticipate that the scope of this model, and the non-carceral approach, will mean increased use by BIPOC communities and communities most impacted, use not predicted by the current BPD data.

RECOMMENDATIONS FOR COMMUNITY AWARENESS AND OUTREACH CAMPAIGN

The Design Team identified a number of tactics for building broad community awareness for the model, all embedded within the context of a community organizing strategy. The team envisioned community response teams doing proactive outreach, through building relationships with neighborhood organizations and community members in neighborhoods they

work in, to spread awareness and encourage use of the model. The team also envisioned a public health campaign promoting the model. This would include social media, billboards, radio, TV, and social media tagging. They noted that the campaign should target messaging through hospitals, medical providers, libraries, Boston Public Schools, public housing, and the MBTA. Finally, the team highlighted the need to ensure early engagement of the existing 911 dispatch through the use of collaborative strategies which we discuss in the section that follows.

Next Steps:

The proposed model has been vetted with diverse community-based organizations and community organizers. We have also circulated a summary of the model and solicited feedback through a survey. Key next steps for the city will be as follows.

1. Establish a Community Oversight and Accountability Board. Plans for the establishment of the board can be seen in Appendix 1.
2. Determine a public agency, such as the Boston Public Health Commission, within which the model will sit and allocate funds.
3. Convene an implementation team. The implementation team should include a liaison from the community monitoring board as well as champions from dispatch and other relevant municipal stakeholders (see appendix 3). The main task of the implementation team is to design protocols and procedures needed to start up the program pilot.
4. Implement and evaluate a pilot. A sample, participatory process for designing the pilot can be seen in appendix 4.
5. A sample budget justification for the pilot phase is included in appendix 5.

6. Plan for full scale implementation. Use the data from the pilot to develop a full-scale program, including an extensive and broad-based community awareness campaign.

Non-Negotiables:

This proposal offers recommendations from community members and stakeholders on a community-based mental health crisis response model that will best meet Boston's community members' needs. While many details of the model will have to be worked through in the pilot phase, the Design Team hired by the city to complete this project would like to highlight some of the elements that are non-negotiable when it comes to the needs of community members surveyed:

1) **There can be no law enforcement involvement** in the development and design process or execution of this model, including but not limited to, police involvement in the planning, design, or implementation of the model.
2) **All final implementation plans must be approved by a Community Oversight and Accountability board** (described in detail in appendix 1).
3) **Full funding from this model must be diverted from the city's law enforcement budget.** This model will significantly reduce the involvement and scope of police intervention in mental health calls in the city of Boston. Based on our estimated percentage of calls being diverted by this model, we anticipate an allocation of 6-10% of Boston's law enforcement budget to fully fund both this model and other community efforts relevant to the scope.
4) **This model must be non-carceral and consent-based in its implementation.** Our proposed model centers and amplifies the vision of communities most directly affected by our current law enforcement response to mental health crisis. Limiting the impacts of

mandated reporting is a critical part of being non-carceral and consent based. Ultimately, the only way to truly support families is to dismantle carceral systems and replace them with systems of care that are meeting families' needs, keeping people safe, and preventing violence, not reacting to it after it already occurs (Roberts, 2022).

LIMITATIONS

The community led design process was not implemented without limitations. From the start, the process was delayed by three months due to transitions in the Mayor's Office. Consequently, the project did not begin until the last week in March. This meant community design team members had less time to coalesce, co-create and to promote their proposed model in the broader community. Despite this challenge, the group was able to draw on research reports assembled by our team inclusive of interviews with response teams in other municipalities across the country, literature review, social indicators and secondary analysis of publicly available incident data.

Another challenge experienced by the facilitation team was attrition. Over the course of the design process two design team members left the group. The first member left as the result of unexpected commitments that did not allow for participation. Of note, the late notice of acceptance to the group in addition to pushing back the timeline meant that additional opportunities came up for team members. It also meant that the formation of the team was rushed and did not have as much time for the process. The second member who attrited did so as the result of dissatisfaction with the facilitation process and associated follow-up. They would

have preferred to have been able to participate remotely and also noted that communication could be improved. These limitations point to the importance of integrating time for process and ensuring that all team members have the opportunity to participate in a way they find meaningful. This will be important in planning for the Community Oversight and Accountability Board. Despite the challenges, the level of attrition overall was low given all meetings were held in person, with zoom accommodation for ASL interpretation. Similarly, attendance was high at all sessions, with the average per session attendance being 85% (an average of 11 out of 13 members at every session).

Acknowledgements

First and foremost, we want to acknowledge the tremendous effort of the organizing groups without whom this project would never have gotten to this stage: Youth Justice and Power Union, For The People Boston, Muslim Justice League, Asian American Resource Workshop, Boston Liberation Health, Boston Immigration Justice Accompaniment Network, Material Aid and Advocacy Program, Families for Justice as Healing and more.

Equally important, we want to thank all the members of the Community-Led Design Group, whose lived and professional experience, critical engagement and thoughtful participation created this deeply necessary model. Delphia Bizzell, Terry Bizzell, Thomas Brown, Olivia Dubois, Lionel Frechette, Jesse Flores, Whitney Golden, Elizabeth Louis, AndreAs Neumann-Mascis, Lucia Milla, Markeisha Moore, Phillip Reason, Thia Simon -- this proposal could not have been as impactful or grounded without each of you offering your leadership.

We are also grateful for Krystal Garcia from Boston Public Health Commission's support and advocacy at every step of this process.

We also want to thank all of our guest speakers, presenters and consultants, whose insight and guidance was invaluable: Asantewaa Boykin and Niki Jones from Mental Health First; Stephanie Guirand, Dara Bayer and Virginia Cuello from Cambridge HEART; Vinnie Cervantes from DASHR; Robin Burek from Portland Street Response; Elizabeth Nguyen from Boston Immigration Justice Accompaniment Network (BIJAN); Angela Kelly from BIJAN and Health Resources in Action; Cassie Hurd and Rachel Bolton from Material Aid and Advocacy Program; and Anne Janks and Miss Millie from Coalition for Police Accountability.

Gratitude also to everyone who attended a listening session or completed a survey, and especially the organizations who helped host additional community listening sessions: Boston Health Care for the Homeless, The Meeting Point and Boston Immigration Accompaniment Network. Huge thanks also to Flamingo Interpreting for making our spaces ASL accessible, and WEPA Translations for providing a language justice framework and Spanish-language interpretation and translation.

Last but definitely not least, huge gratitude to other staff and members of The City School, Boston Liberation Health and our research team for their tireless efforts to ensure this project could be possible: Betiel Brhane for supporting youth leaders to engage deeply and survey their peers, and Patricha Paul for ensuring the smooth administration of this effort. Cecilia Flores-Rodriguez provided pivotal support on the research, and Emy Takayami provided crucial curricular guidance. Huge thanks to our TCS youth survey team: Ceci, Karmelo, Shaniyah, Valentina and Vedeline. Gratitude also to former TCS staff members Gabriella Gilbert, Kimberly Cajuste, and finally, Teresa Tran both for organizational support and the report design.

APPENDICES

1. Community Monitoring Board Plan
2. Sample Community Board Charter and Bylaws
3. Example of champion roles and descriptions
4. Example of protocol for a participatory pilot inclusive of a budget
5. Lists of community responder and staff trainings

Appendix 1: Plan for Community Oversight and Accountability Board

There are many types of community boards. Most referenced in the literature are community advisory boards (CABs). Advisory boards are generally governed by an MOU or a charter. However, there is a great deal of variation in how CABs function, as well as their purview. CAB activities may include providing feedback on intervention procedures or design, helping implementers work logistics and trouble-shoot challenges, or advising on the overall direction of implementation.

For example, the STAR program in Denver, which was implemented by the local health department, agreed to instate a community advisory board. The STAR Charter is provided in appendix 2 with permission in the text that follows. Of note, STAR ran into a number of challenges in their collaboration with the health department because the community advisory board did not have decision-making authority over the health department. There were no provisions in place to hold the health department accountable to the community.

As such, we propose that the city establish a Community Oversight and Accountability Board to provide program oversight as well as to advise on program implementation. Community boards with monitoring power have been used in local governance in both the US and internationally. The charge of the Community Oversight and Accountability Board for the Mental Health Response would be to oversee and monitor the program's implementation and fidelity to its values, to have hiring and decision-making power around program leadership, and advise and evaluate on strategic decisions. This would include fiscal oversight and monitoring of all program activities.

For the pilot, we propose a 15-member board with 5 community members selected and appointed by the city, and 10 selected and appointed by the Mental Health Response community organizing coalition, including members of the Community-Led Design Group, and organizations such as Material Aid and Advocacy Program, Muslim Justice League, Asian American Resource Workshop, Youth Justice and Power Union, The City School and Boston Liberation Health. The board should include a 75% majority of community members reflective of populations who stand to be most impacted by the program. In addition, at least a 75% majority of members should be members of Boston's BIPOC communities. For the full program launch, we propose the same criteria for selected board members, and for at least half the seats of the oversight Board to be elected.

Application: A standard nomination form should be used to solicit board members. Candidates can self-nominate or be nominated with their permission. The form should include contact information as well as a statement of interest and a summary of relevant lived experience or training that prepares them to participate. The application should be submitted broadly by the city and the community coalition.

Selection: The City should develop a standardized, publicly reportable process for selecting final nominees, as should the coalition.

Appointment: The five city and 10 coalition nominees should be officially appointed by the mayor.

Election: The application, selection and appointment process should be repeated on an ongoing basis to replace members who attrit or who's terms expire. The term limit for each member is 3 years and a member may not be appointed for more than two consecutive terms.

Compensation: The City should plan to stipend members a minimum of $100/hr (consistent with the city's compensation rate for CLDG member's work on the Design Team) for their participation on the board.

Roles and Responsibilities: Roles and responsibilities of the monitoring board include:

- Review programming to ensure that it operates with fidelity to the **Core Values** developed by the Community-Led Design Team.
- Have hiring and decision-making authority over program leadership roles.
- Provide advice to the implementation team and public agency charged with implementation.
- Advise on and monitor marketing activities inclusive of outreach data, outreach campaigns and public discourse related to the program.
- Monitor program reports and activities to ensure they are aligned with and reflect Core Values.
- Contract an external evaluator to assess program processes, outcomes, and overall impact evaluation as well as cost benefit analyses.
- Monitor external evaluation data and make recommendations to program implementers based on evaluation findings.
- Review program protocols and workflows to ensure they are aligned with Core Values.
- Review and frame all data reports and public communication.
- Ensure regular communication about program data to the public.
- Monitor and report on all program expenditures.
- Attend monthly board meetings and participate on relevant board subcommittees.

Budget: The Community Oversight and Accountability Board should have a budget that includes member stipends, as well as a board coordinator (.5FTE), and the program evaluation. The literature indicates evaluation budgets should be 15-20% of program cost.

Training: Once the board is established, there should be capacity building activities as well as activities designed to support group development. These trainings can be organized and implemented by the coordinator.

Appendix 2: Sample Community Board Materials

A. Charter: STAR Community Advisory Committee Charter (DRAFT)

Section 1: Goals of the STAR Community Advisory Committee

- Review STAR programming to ensure that it operates with fidelity to its **Core Values***
- Provide advisement to the Denver Department of Public Health & Environment (DDPHE) regarding the integration of community engagement services into the emergency response component of STAR
- Create awareness and understanding of the STAR Program within communities throughout the City and County of Denver
- In partnership with DDPHE, act as an ambassador for the program
- Ensure the program remains rooted in community and accountable to community
- Helps to define outcomes, things like “success” “stability” etc.
- Connect additional services to residents – actively in meetings but also via email and other forms of communication
- Act as a bridge between community, City agencies, and City contracted agencies
- Help to review data so that it can drive policy and develop programming
- Communicate to the community about what STAR is about – how to create a new way of seeking help without fear or stigma
- Think “outside of the box” in terms of getting people the help they need in ways that are not traditional
- Serve the movement of paradigm change – pushing for fundamental wellness rather than just fixing deficiencies

Section 2: Functions of the Committee’s Monthly Meetings

- Review data tracking and evaluation of outcomes for the STAR Program and give recommendations to the city
- Qualitative tracking and ensuring integrity to its **Core Values***
- Discuss feedback from the community regarding the STAR Program
- Recommend various data sets that help give the complete picture
- The Meeting Facilitator will provide timely and accurate meeting notes and recordings to committee members
- A quorum of 2/3 of committee members is needed for decision-making

    - This can be in-person or through follow-up email inquiries – there will be a specific timeframe given for responses on any item up for a vote.
- Any member can introduce a suggested change to the charter at any time
- If a change is proposed, there would need to be a vote by a quorum of committee members, leaving enough time for all members to review what is being proposed

Section 3: Scope of the Committee

The Committee will:

- Act to achieve the goals of the committee (Section 1), using the functions listed in Section 2

The Committee is advisory, and as such does not:

- Hold the authority to speak for the City and County of Denver or otherwise to commit City of Denver agencies, or their partners, to any course of action or inaction
- Involve itself in policies, decisions, and actions related to personnel
    - While it is expected that the STAR Community Advisory Committee will make recommendations on how to increase the diversity of staff in a way that best represents the population served and responds to the community in equitable ways, decisions related to pay, disciplinary actions, and hiring of the staff are left to the discretion of partnering agencies (under the oversight of DDPHE).
    - However, there needs to be transparency to the processes related to staffing decisions in a way that allows for community input and questions related to activities – this should be a two-way conversation between partnering agencies and SCAC and this information should be made public to the community so they can remain vigilant and active in the process.
    - SCAC may also suggest trainings and other resources to the partnering agencies, including cultural responsiveness trainings related to various communities.

Section 4: Membership

- Committee shall be composed of at least 15 members
- Every effort will be made to have at least one representative from each of the city's Council Districts, include a voice for the unhoused population, support diversity and representation of historically excluded communities within the group's membership, and address any barriers to attendance.
- Each member will serve a term of three (3) years, with a maximum two (2) terms. Terms of the initial members will be staggered so the entire committee does not turn over at the same time. If a member steps down before their term is over, they are charged with providing three individuals for consideration to replace them. Should a member vacate their seat due to death or other unforeseen circumstances that prevent them from nominating a replacement, the seat will open for public nomination.

Section 5: Schedule of Meetings

- The STAR Advisory Committee will have at least one meeting per month (and additional ad hoc meetings as needed)
- Additionally, the advisory committee will have one meeting per year with DDPHE to achieve alignment and strategy for the year

Section 6: Relationship to City Departments

- The committee will be housed in DDPHE and meetings will be organized by a DDPHE staff person

***Core Values** of the STAR Program

1. **Community-Driven Shared Control** – STAR is a program that initially started out of community efforts to create immediate response to urgent needs. The community-driven component of the STAR Program continues the spirit with which it was created. While it is understood that STAR is influenced by many different collaborating entities, including the Mayor's Office, City Council, Dept. of Safety, and the city office that administers the program and has supervision over its activities (DDPHE), the community, in part, reflected by the STAR Community Advisory Committee plays a key leadership role in influencing STAR programming.
2. **Culturally Responsive** – a program that is culturally responsive will include responders and providers who share lived experiences and identify with Denver's diverse population. In doing so, the program will be more trustworthy and responsible to the community that it serves
3. **Linguistically Specific** – a program that fosters the many languages that are spoken by the community it serves will ensure that people will trust and rely on the program to serve their needs;
4. **Holistic Care** – key to success for the STAR program is the recognition that the van itself is just one mechanism that lives within a continuum of care and support to people who are in crisis. Holistic care ensures connecting those in crisis with long-term support, services, and treatment to reduce repeat calls;
5. **Do No Harm** – the STAR program shall commit to a "do no harm" approach. In addition, the STAR program itself will use a harm reductionist approach recognizing that not every crisis can be "resolved" in the moment, but rather navigated and creating trust with the person in crisis to help them continue through programs and services that meet their needs;
6. **Healthy De-Escalation** – the STAR program will commit to de-escalation as a guiding principle of engaging with individuals and communities in crisis;
7. **Problem Resolution** – the STAR program will be dedicated to identifying, navigating, and solving problems that they encounter through serving individuals in crisis;
8. **Healthy Outcomes** – much of what the program will respond to will be public health issues and social determinants of health. Because of that, the STAR program will be dedicated to improving the health of those they engage with as components of improving community health;

9. **Community Empowerment and Resilience** – STAR will be dedicated to community empowerment and resilience through building trusted relationships and connecting people to services and support;
10. **Self Determination** – communities are supported in self-determination to decide and build safety, survival, and thriving. The STAR program will act as a vehicle towards empowerment and support;
11. **Alternatives to Policing** – the STAR program sends clinicians and medically trained responders to crisis instead of armed law enforcement officers with badges and ability to arrest;
12. **Non-Violence** – the STAR program will be committed to non-violence and de-escalation;
13. **Trauma-informed** – the STAR Program should have a trauma-informed approach to incorporating the needs of individuals impacted by systemic violence and trauma that they experience as the result of both systemic and personal harm. The program will understand that individuals served by the STAR program are disproportionately impacted by violence and trauma and should be driven by their needs first and foremost.

STAR Bylaws

STAR "Advisory Committee"

Proposed Structure and Bylaws

BACKGROUND

Support Team Assisted Response (STAR) is a program launched on June 1, 2020 to implement an alternative to a traditional 911 option, especially for calls that involve mental health crisis, substance use, and homelessness. It was created from a WORKGROUP that convened in June 2019 to envision such a program following a visit to Eugene, Oregon. Following the launch of the pilot program, Denver Alliance for Street Health Response (DASHR) and Jason Vitello were chosen by the group to continue facilitation of the program and to envision expansion after the pilot. In August 2020, the 60+ person workgroup agreed to meet quarterly for updates and to form an EXPANSION COMMITTEE to envision expansion for the STAR program beyond its pilot. The expansion committee drafted a CHARTER of agreed values and suggestions for the expansion. One suggestion that was agreed upon was the creation of an advisory committee that was composed of community members to serve as an accountability mechanism for the STAR program. This document is the start of a set of bylaws to accompany the CHARTER as a proposal for the advisory committee. The EXPANSION COMMITTEE came to a consensus agreement on this document on February 2, 2020.

ARTICLE I: NAME

Section 1. Name

The name of this body - which could become "advisory committee" , "board" , or "community nexus" or a number of names has not been determined. It is further referenced as "advisory committee" for now as a placeholder for what the name may eventually be.

ARTICLE II: MEMBERSHIP

Section 2. Composition

The advisory committee shall be composed of fifteen (15) members; one person from each city council district and four members who serve as "at-large" representation. The committee will include and prioritize BIPOC membership and members of the LGBTQ and disability community and people with lived experience. The members must live in Denver.

Section 3. Foundational membership

The initial advisory committee will consist of volunteers from the expansion committee to the STAR program. Volunteers will then review and vote to add additional members based on nominations, ensuring full city representation and considering the priority of experiences and identities. It is critical that historical knowledge of the program and the

process to create STAR form the foundation as a way to maintain fidelity to the "Northstar" envisioned over the course of the eighteen month process to create and expand STAR.

Section 4. Additional members

Members to the advisory committee shall be added through a nomination process. Individuals may be self-nominated or be nominated by other individuals. Requirements for nominations will include that they live in Denver and individuals will be prioritized based on lived experience and identities necessary to shape a diverse committee. Positions will be filled in accordance with gaps in council district representation with at-large seats filled thereafter. Current members of the advisory committee will review and approve applicants in consultation with DDPHE and formal offers will be extended to those who meet the needs of the advisory committee. Individuals who are invited to join the advisory committee shall file a formal acceptance of membership to the committee. It is noted that this body is responsible for making decisions about additional membership as one of the key values of the CHARTER is "Community-Driven Control", because the expansion committee carries conflicts of interest, and because the larger workgroup does not have membership that has been formally defined. The application to nominate or self-nominate shall live with DDPHE.

Section 5. Terms

Each member will serve a term of four (4) years, with a maximum three (3) terms (twelve years total). If a member steps down before their term is over, they are charged with providing three individuals for consideration to replace them. This will include members who move out of the district they represent (unless they are an at-large member). Should a member vacate their seat due to death or other unforeseen circumstances that prevent them from nominating a replacement, the seat will open for public nomination These terms shall be staggered as two years of service for their first terms will be applied to the first five members.

ARTICLE III: ROLES AND RESPONSIBILITIES

Section 6. Duties Outlined for Committee

- Accountability and ensuring fidelity of the STAR program to its CHARTER
- Public outreach and awareness about STAR
- Reviewing and advising on RFP's. This still needs to be defined and determined with DDPHE
- Liaison for media and other cities inquiring about the program in partnership with DDPHE and DOS

Appendix 3: Example of champion roles and descriptions

What is a champion?
Champions are individuals with knowledge, experience, credibility, and skills needed to drive the successful implementation of an innovation.

Implementation champions…
- are motivated to support a given implementation effort, and work to drum up the enthusiasm needed for successful implementation.
- can be on the implementation team, embedded in a department associated with implementation and/or in the community that will benefit from the intervention.
- take flexible approaches to problem solving, working with others, and communicating.
- are open to trying new approaches and encourage others to do so as well.

Key champions needed for this initiative will include:
- Dispatch Champions
- Community Champions
- Implementation Champions
- Emergency Medical Services Champions
- Marketing and Outreach Champions

Considerations for Champions
- Time
- Compensation
- Collective bargaining considerations

Appendix 4: Example of protocol for a participatory pilot inclusive of a budget

A. Pilot Plan
Pilot Aims: Once the implementation team develops workflows as well as response and triage protocols they should plan for implementation of a pilot. During our initial interviews with community response teams in other cities we found that they began by piloting services to assess resident acceptability as well as the feasibility of broad scale implementation. The pilot process also allowed teams to assess necessary programmatic components and to inform program processes. This pilot example is focused specifically on testing a system for diverting calls from 911 prior to introducing a dedicated call system such as RAHEEM, previously described. A such the primary aims of the initial pilot should focus on:

- Routing 911 mental health calls that meet the identified criteria to the community response teams in an identified region of the city.
- Refining workflows as well as triage and referral protocols.
- Increasing connection to community-based care, as well as reducing unnecessary transports to hospitals and the unnecessary involvement of police.

- Informing the rollout of the citywide intervention.
- Assessing resident acceptability of the community led response.

Procedures: The pilot should be rolled out in highly impacted areas, as indicated by available data. The implementation team will use focus groups with community stakeholders and Boston Police Department (BPD) incident data to identify neighborhoods where the pilot can be implemented. Incidents that meet the identified criteria for community response will be analyzed spatially using ARCGIS. Data and associated maps will be shared with the community monitoring board and champions who will advise the implementation team on the selection of the most appropriate neighborhood precincts to participate in the pilot. Based on lessons learned from other cities we recommend piloting in two neighborhoods, dependent on the distribution of incidents and identified community needs and priorities.

We envision three distinct phases of the pilot once precincts are identified as well as a pre-pilot preparation phase and ongoing evaluation and monitoring.

- ***Pre-Pilot preparation:*** The goal of the pre-pilot preparation phase is to finalize all workflows and protocols and to increase awareness of the model across city departments, including 911 dispatch. For example, the implementation team will likely hold information sessions and issue city-wide press releases describing the model and upcoming pilot phases.
- ***Phase 1: Start-up***. This will involve the hiring and training of staff as well as the purchasing of equipment. In addition, this phase will include community outreach and education during which staff will conduct community education sessions for residents and build partnerships with grassroots organizations in the pilot neighborhoods. The logistics will be informed by and vetted with the community monitoring board.
- ***Phase 2: Pre-Implementation.*** This phase of the pilot will involve response teams spending time in the precincts of focus and meeting with local leaders to spread the word about the upcoming pilot and initial hours of operation. This will also help teams to build relationships with community members and community organizations and to spread the word about the program. More importantly, they can connect with identified referral resources, learn about existing programs, and identify additional programs for referral.
- ***Phase 3: Implementation.*** During the implementation phase, appropriate calls to the identified precincts will be diverted from 911 to the community response team. In addition, residents can contact the team directly through the identified dispatch applications. The goal will be to launch a 24/7 pilot to most accurately build capacity for a pilot that mirrors the design of the full program.

Evaluation and Monitoring: Evaluation will be ongoing over the course of the pilot and will be used to inform program processes. The evaluation team will be contracted by the Community Oversight and Accountability Board. All aspects of pilot implementation will be studied to identify successful strategies and inform protocols for broadscale implementation, as well as to document processes, outcomes, and impact. It is anticipated that participatory evaluation will be

employed to assess the pilot with regular monitoring reports submitted to the Community Oversight and Accountability Board to review with the implementation team and staff. Through ongoing evaluation, the aim is to 1) demonstrate the efficacy of the program, while 2) simultaneously improving it. In short, we propose using a 'prove and improve' approach. This approach will allow the community monitoring board to provide real-time data to the implementation team and staff, allowing them to course correct and adapt response workflows, triage, and referral protocols on an ongoing basis.

Evaluation elements will include ongoing qualitative feedback and actionable recommendations from pre- and post-response reports, as well as dispatch and response team huddles, along with feedback from the community. Data should be reviewed by the community monitoring board and serve as quality measures to inform staff and dispatch training for ongoing real-time improvement. The proposed evaluation plan should be designed to document efficacy, promote continuous improvement, and demonstrate the extent to which we meet the pilot aims.

The plan should employ: (1) a systematic and manageable suite of evaluation methods; (2) performance measures that align with each measurable objective, key activity, anticipated model output, and cost; (3) strategic use of existing infrastructure such as data collection tools and measures available from community response model pilots in other cities (ie: Oakland, Denver, and Portland); (4) a monthly monitoring report, to track indicators which can be used to improve the program; and (5) real-time application of the evaluation data to improve the model. A continuous mixed-methods improvement approach will be used to monitor and evaluate program performance. The evaluator and community board, with input from the implementation team, will determine a set of process measures that will be used to measure program quality over time.

This process will drive real-time program improvement, based on the Plan-Do-Study-Act methodology. Additionally, examining preliminary outcomes will help to ensure the program is having its intended impact. This will allow the implementation team to make real-time adjustments to response workflows, triage, and referral protocols. In addition to these rapid-cycle improvements, the evaluator can share quarterly aggregated data with the community monitoring board. Areas in need of improvement can be discussed with the team and an action plan can be developed. We have found that a participatory approach contributes to meaningful course correction and team buy-in. Real time adaptations can be revised regularly to ensure their efficacy.

B. Estimated Pilot Budget

This draft budget is based on a six-month pilot with a three month start up. All staff is budgeted based on nine months or 75%. The fringe rate was calculated at 56% and salaries were determined based on BPHC and City of Boston job posting and classifications. In cases where postings were not available (i.e., dispatch) salaries were searched on the web. The total nine month budget was estimated to be $2.6 million, although could range as low as $2 million if resources are available through existing infrastructure. With the current Boston police budget

at $395 million annually, this accounts for less than 2.5 days of the current police budget (GBH, July 2022).

Personnel	***fringe is calculated at 56%**
Description (personnel is based on 9 months)	**Cost**
Program Co-Director: Operations ($95,000/year): This individual will co-direct the overall implementation of the pilot program. The Operations Co-Director specifically will liaison with the EMS and the police as well as City leadership, and the department of mental health. Requirements will include implementing social justice, antiracist and or non-carceral health services programming and the ability to operationalize program values in a public sector setting. This individual should have significant experience and educational background in public health, social work, public administration, community planning or a relevant field, and have significant experience working with communities of color.	$71,250 direct $39,900 fringe
Program Co-Director: Clinical ($95,000/year): This individual will co-direct the overall implementation of the pilot program. The Clinical Co-Director will be responsible for the clinical management and supervision of the program. This will involve planning and implementing the overall staff training plan. Requirements will include experience using and implementing the Liberation Health Model as well as transformative justice approaches and the ability to operationalize program values in the context of clinical practice. This individual will have a master's degree in social work, mental health counseling or a related field, and have significant experience working with communities of color.	$71,250 direct $39,900 fringe
Program Manager ($70,000/year): The program manager will manage the day-to-day implementation of the pilot under the direction of the operations manager. In addition, the manager will work closely with the external evaluator and will coordinate the community monitoring board ensuring that they receive monitoring reports and regular updates on program processes as well as outcomes.	$52,500 direct $29,400 fringe
6 Dispatchers ($63,000/year): Six dispatchers will work across 3 shifts with two dedicated dispatchers per shift with calls being diverted from 911 dispatch to the pilot call center. Dispatchers should have experience in emergency response and de-escalation will receive additional training in harm reduction, transformative justice, and racial justice and trauma	$283,500 direct $158,760 fringe

informed practice. *If the city diverts existing dispatchers from pre-existing dispatch this cost could be much less.	
15 Community Responders ($65,000/year): Community responders are outreach workers who specialize in the provision of harm reduction services and de-escalation. They will be individuals from the neighborhoods or with close ties to the neighborhood. They should have experience conducting community outreach education and or introduction as well as harm reduction and transformative justice practices. They will also receive intensive training as part of the pilot. Five teams of three including one driver will cover shifts across two neighborhoods 24/7. This is a union position.	$731,250 direct $409,500 fringe
2 Social Workers ($65,000/year): Two social workers will be hired to support response teams and to provide triage and follow-up services. The social worker will work with local communities to identify supportive resources and follow-up services for response teams to engage with. They will assist with ongoing-training and case consults. Requirements will include experience using and implementing the Liberation Health model as well as transformative justice approaches and the ability to operationalize program values in the context of clinical practice. This position will have a master's degree in social work or mental health counseling.	$97,500 direct $54,600 fringe
Administrative Coordinator ($50,000/year): An administrative coordinator will support the day to day activities of the pilot program. This is a union position.	$37,500 direct $21,000 fringe
Community Organizer ($65,000/year): The community organizer will conduct outreach and one on ones in focus areas beginning prior to the implementation of the pilot and following. The organizer will engage local residents and increase awareness of the work of the response teams in the neighborhoods as well as identify community related priorities as they relate to mental health response. This would include providing education for residents related to managing crises without involving police and helping to create a culture of collective care in the community. This position requires a deep understanding of crisis response and collective care as well as connection to Boston neighborhoods and at least five years of organizing experience, a master’s degree should not be a substitute for direct organizing. This is a union position.	$48,750 direct $27,300 fringe

Contracted Services	
External Evaluation: An external evaluation with expertise in participatory evaluation and program monitoring will be contracted to evaluate the pilot. The evaluator will carry out the evaluation as outlined, providing ongoing monitoring reports and a final summative report. The evaluation cost is estimated based on best practices which recommend 10-20% of the total program cost. We budgeted at 10% of program costs.	$238,811
Interpretation and Translation Services: Funds for the cost of real time interpretation. Most services we research provide a per-minute fee and contracts are charged only including the cost per minute. We have not included this item in our line item because the infrastructure is already in place. As such there would not be additional charges.	Existing infrastructure
Community Oversight and Accountability Board members (15): Board members will meet bi-weekly over the course of the pilot and will be compensated at $200/meeting for an estimated 18 meetings over the nine months of the pilot.	$54,000
Equipment	
2 Response Vehicles: Outfitted response vehicles would range from $20-50,000. Dependent on if they are new or used. This is based on a small minivan. *This cost would be less if there are existing city vehicles that could be repurposed.	$100,000
Laptops: 6 at $2,000 per machine for administrative clinical and operations staff. Based on the cost of a MacBook pro. * Could be less through city procurement agreements.	$12,000
Tablets: 15 for response team budgeted at $1,200 per device. Based on iPad pro with 5G. * Could be less through city procurement agreements.	$18,000
Cell phones & Service fees based on city infrastructure.	TBD
Other Expenses	

Harm reduction & Medic supplies. *Narcan is available free through the State, there may be additional supplies that are also already available through City and Public Health Commission outreach teams.	TBD
Racial, gender, economic, queer and disability justice training ($2,500); training on major mental health challenges ($7,500 for Wildflower Alliance's 24 hour training); EMT basic training for staff ($950/person), transformative justice and survivor support training ($2,500.00), De-escalation training for trainers ($3,500.00), additional training available through public programs. *This cost may be less if available from BPHC.	$30,250
Database and HIPPA compliant servers available though city.	No added cost
Estimated total costs	$2,626,921

Appendix 4: Training Plan for Boston Community-Based Response Pilot

The following is a foundational list of trainings that both community responders and all staff going through the pilot would engage in:

All staff:

- **Racial, Gender, Economic, Queer, and Disability Justice Trainings**: All staff must receive extensive and ongoing training around racial, gender, economic, queer, and disability justice, as these are foundational values that guide the model and its approach. Groups like The City School, Trinity Boston's Organizational Equity Practice, or Visions, Inc can provide strong racial and social justice training. Groups like Fireweed Collective and Wildflower Alliance can provide strong disability justice training.
- **Liberation Health Training**: All staff should receive training from Boston Liberation Health in the Liberation Health framework, a sociopolitical model for conceptualizing mental health challenges in the context of the economic, cultural, and historical conditions which contribute to them.
- **Trauma-Informed Care**: All staff should receive training in the principles and best practices of trauma-informed care, both for working with community members but also in working with other staff.
- **Working with Communities Most Impacted**: All staff should receive training on the specific needs of communities most impacted, including formerly incarcerated people, undocumented people, and unhoused people, from groups like Families for Justice as Healing, Boston Immigration Justice Accompaniment Network, and Material Aid and Advocacy Program

Specific to Community Response Team:

- **Peer Support Training and Psychological First Aid**: Responders will be trained in skills of trauma-informed peer support and the principles and approach of psychological first aid.
- **Street Medic Training, First Aid, and CPR**: All responders will be CPR certified and first aid certified and go through street medic training.
- **Conflict De-Escalation**: Responders would be trained in conflict de-escalation and mediation skills, including how to de-escalate if police are called to a mental health crisis without the consent of the person in crisis.
- **Harm Reduction Training and Narcan Training**: Responders will be trained to use narcan/naloxone, along with additional methods within a broader framework of harm reduction.
- **Domestic and Intimate Partner Violence Prevention and Survivor Support Training:** Responders will be trained in survivor-support frameworks or approaches, by organizations such as Center for Hope and Healing or Transition House, or national organizations like Survived and Punished.
- **Training on Major Mental Health Challenges and Alternative Responses:** Responders would receive trainings such as the Hearing Voices Training and the Alternatives to Suicide Training from the Wildflower Alliance in Western MA.

Appendix 5: Community-Led Design Group Sessions, Goals and Materials

Session Number	Goals	Materials Reviewed
Phase 1 Introductions and Groundings		
1: Introductions and Grounding	For CLDG members to feel clear on the process for designing a community-based mental health response, and the work plan and decision-making process for our group To establish the values and framework around racial, gender, economic, queer and disability justice that will ground this project	Interrupting Criminalization Guide: Non-Police Crisis Response Guide — Interrupting Criminalization Optional: 3-hour Module on Structural and Institutional Racism- Understanding Structural & Institutional Racism - The Network for Professional Education PowerChart Story sharing/storytelling questions
CLDG session 2: Political Education Part 1 (Liberation Health Analysis)	Develop shared definitions/shared language around "optimal mental health" and "ideal crisis response" Introduce some context/background around the history of police, history of mental health institutions, psych holds and carceral aspects of mental health care system Using a Liberation Health triangle, explore why people call the police	Liberation Health Example (ppt slides) Liberation Health Book Chapter 4 Liberation Health Model PowerChart Defund Police 5 Ways The U.S. Mental Health Care System Is In Crisis
CLDG session 3: Political Education Part 2 (Understanding our Current Historical Moment)	Draw distinctions between types of alternative models we are looking at and not (difference between co-response models and community-based/mental health first models) Understand history of alternative and community-based responses to mental health crises (locally and nationally) Engage in some participatory research on best practices for different types of models	Interrupting Criminalization document pages 10-11 and 18, 4-quarter axis for MH crisis response; Discussion Questions / Session Group Work
CLDG session 4: Assessing the Current Model and Needs	Continue discussion of research compiled by Research Team on local and national models for Alternative Mental Health Crisis Response Develop values that will anchor the model that we are going to develop (what is most important to the group in designing a model)	Interrupting Criminalization document pages 18-20 Alternative Response Teams: Implementation Data Gallery Walk Discussion Questions Mental Health Resources

	Develop criteria and needs for the Boston community-based model	
Phase 2: Researching and Developing the Proposal		
CLDG Session 5: Understanding National and Local Models	For group to learn from guest presentation and discussion with nationally recognized leaders around community-based mental health crisis response, as well as local efforts around community-based models that are still in development	Mental Health First Community First Response Model Video about Cambridge HEART
CLDG Session 6: Local Crisis Response Models	To explore and begin synthesizing the information the group has learned so far around best practices and begin to envision possible models To hear about current smaller-scale crisis response models that are working to meet needs of communities most impacted	Interrupting Criminalization Guide: Non-Police Crisis Response Guide — Interrupting Criminalization (Kim, Chung, Hassan, Ritchie et al 2021) Key Mental Health Crisis Response Models
CLDG Session 7: Needs of Boston's Communities Most Impacted	To continue to and begin synthesizing the information the group has learned so far around best practices and begin to envision possible models To begin to wrestle with key questions for the Boston community-based response To understand specific needs for the crisis response model for community members most impacted -- specifically Black communities and communities of color, undocumented people, people experiencing substance use dependency, young people and young adults of color	Optimal mental Health/Optimal crisis response Notes from Session 6 Notes from Session 7 Values Scope Training: Wildflower Alliance Training List Cambridge HEART's Training List Design Team worksheet
Phase 3: Developing and Presenting the Proposal		
CLDG Session 8: Half Day Retreat - Developing the Model: Initial Design	In design teams, develop a clear, specific vision for key components of the model (operations, dispatch, staffing) Share feedback in order to refine and create a first draft of the design proposal	
CLDG Session 9: Virtual Community Listening Session	To vet the Community-led Design Team Proposal with key stakeholders in the broader community. Share the details of the plan with the	

	group.	
	Solicit specific feedback through critical reflection and discussion.	
	Gain specific feedback related to strengths, weaknesses, opportunities, and threats.	
	Identify gaps as well as additional resources to enhance specific plan elements.	
	Use the information to strengthen the final proposal.	
CLDG Session 10 - Discussion of Full Report	to review community feedback on our proposed community-led response mental health response plan and discuss new updates Recap places the plan has been updated. Collectively review and reflect on the feedback. Discuss proposed changes or edits based on the feedback. Recap next steps in the context of our timeline	
CLDG Session 11- Conclusion and Evaluation	to review and summarize our work to evaluate the design process to establish next steps to advocate and organize for implementation of the model to celebrate each other's contributions	

Appendix 6: Proposal Summary for Community Stakeholders

who we are

Boston-based community organizing groups successfully organized and advocated for the development of **a community-led mental health crisis response that does not involve law enforcement**. Last year, the City of Boston agreed to allocate funding to develop a community-based crisis response model. **The City School and Boston Liberation Health and 14 community members** from across the city responded to the call to design this model. We then sought feedback from community groups, residents, and providers from across the city. We invite you to read further about the elements of our plan.

COMMUNITY-BASED MENTAL HEALTH CRISIS RESPONSE

values

- Mental health crisis response that doesn't involve the police in any way and is rooted in community
- Accessible citywide across Boston
- Accessible 24/7
- FREE and fully funded, so there is no charge to callers
- Centering needs of communities most impacted by policing: Black and Indigenous people and people of color; undocumented people; disabled people; unhoused people; people who use drugs; survivors; young people and young adults; and trans, non-binary, and queer people
- Responders reflect these communities and include peers who have similar lived experiences
- A non-carceral and consent-based response

CRISIS RESPONSE FUNDING, SERVICES, AND SCOPE

funding & implementation

Divert funds from law enforcement in city budget to create a new city program focused on community-based mental health response

Engage the community in all aspects of implementation

Establish a community oversight and accountability board that will evaluate the program

services

- Harm reduction services, including naloxone distribution
- Warmline services and peer phone support for callers
- Street outreach
- Conflict de-escalation, including in cases where police have been called without consent
- Medical and psychological first aid
- Resource information & referral
- Safe transportation to hospital
- Optional follow up with clinicians, including mental health treatment referral

scope of response

- Someone having a mental health crisis (suicidality, etc)
- Sick visits and wellness checks
- Safety or health concerns related to substance overuse (people being intoxicated, alcohol or drugs) or syringe disposal
- Gender-related or intimate partner violence
- Safe non-police transportation to a hospital or a different location related to a mental health crisis
- Noise-related concerns
- Support for caretakers handling someone's mental health crisis
- Significant incidents of trauma, including support around community violence, and/or incidents of racism or other systemic oppression, including police violence
- Neighbors unsure how to respond to a situation they are witnessing
- De-escalation support to someone if police are called to mental health crisis without consent

BOSTON'S MODEL: OPERATIONS, DISPATCH AND STAFFING

staffing

staff characteristics

- Black and Indigenous people and people of color
- People with lived experience of mental health crisis
- People from the communities served
- Linguistically diverse and with different abilities
- People with strong analysis of racial, social and disability justice

staffing model

- **Community response teams in each neighborhood** including both responders (trained as outreach workers and street medics) and drivers
- **Operations staff in central location** including dispatch staff, administrative staff, clinicians and community organizers
- While clinicians will not be part of the response team, mental health professionals can be part of the operations staff to provide consultation and supervision to responders in the field

staff training

Trauma informed care | EMT training, first aid, street medic & CPR training | De-escalation, conflict resolution and mediation | Domestic and gender-violence response and survivor support training | Racial, economic, gender, queer and disability justice training | Psychological first aid | Harm reduction training including using naloxone training | Training on major mental health challenges, including supporting individuals with auditory and visual hallucinations, such as Hearing Voices, and Alternatives to Suicide Training | Certified Peer Specialist Training

to reach support

- Independent 3-digit call number accessible through an app and by text
- Diversion of appropriate calls from 911 and 988
- Direct messages through social media platforms
- **Dispatch team accessible to all communities** (ie. deaf and blind people, people with intellectual challenges, and reachable in multiple languages)

dispatch and response process

- Calls will be assessed using standard protocols
- Response will be dependent on the nature of the call
- Dispatch staff will provide phone-based support to callers
- Team will collect the minimal data needed for response from callers and individuals. Identification will not be collected
- In cases where an incident is not appropriate for the team, callers will be notified as such. Calls will not be diverted to 911
- All responders will work on teams outfitted with resources to support response needs
- Response teams will be located throughout the city in every neighborhood
- Responders will be familiar with neighborhoods & neighborhood organizations
- They will coordinate and collaborate with other outreach teams