Meeting Notice and Agenda
Community Advisory on Public Safety Commission

Tuesday, July 26, 2022 at 5:00 pm
Allison Conference Room (#225), Showers Building, 401 N. Morton Street

The public may also access the meeting at the following link:
https://bloomington.zoom.us/j/86263992372?pwd=dVFPVCsxWXRLVnpxOVI2T1hkUS94UT09

I. ROLL CALL

II. APPROVAL OF AGENDA

III. APPROVAL OF MEMORANDA/MINUTES
- May 24, 2022
- July 5, 2022

IV. REPORTS
a. Co-Chairs
b. Committees
   i. Conflict Resolution
   ii. Reparations & Atonement
   iii. Research
   iv. Alternatives to Policing
   v. Housing
c. Staff
   i. Debrief after Commission's Annual Report
   ii. CAHOOTS Info

V. REPORTS FROM THE PUBLIC / PUBLIC COMMENT

VI. UNFINISHED BUSINESS
a. Ideas for signature Commission program
b. IU Student Agile Response Team (START) Program in IU Center for Rural Engagement – possible opportunity for collaboration?

VII. NEW BUSINESS
a. Response to overturn of Roe v. Wade
b. Review of Commission Committees

VIII. OTHER BUSINESS

IX. TOPIC SUGGESTIONS FOR FUTURE AGENDAS

X. ADJOURNMENT

CAPS Commission Goals and Purpose:

Perform research and gather data on the perceptions and preferences about public safety from community members, with specific focus on perceptions and preference data gathered from minority community members, individuals who are disabled, and other often marginalized community members

Research evidence-based alternatives to traditional policing

Identify best practices in public safety globally and evaluate the efficacy of such practices for implementation in Bloomington.

Make recommendations to the Common Council, the Board of Public Safety, and/or the Mayor or the Mayor's designee on policies and programs that enhance public safety for all community members.

City of Bloomington

NOTICE

Tuesday, 26 July 2022 at 5 p.m.

Community Advisory on Public Safety Commission

This meeting will be held in the Hooker Conference Room (Suite 245, City Hall, 401 N. Morton St) and may also be accessed electronically via Zoom (see information below).

Join Zoom Meeting
https://bloomington.zoom.us/j/87996200821?pwd=UGlOS2NnN091eU5IWlJmVGR4NExBZz09

Meeting ID: 879 9620 0821
Passcode: 532354
One tap mobile
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+13017158592,,87996200821# US (Washington DC)

Dial by your location
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Find your local number: https://bloomington.zoom.us/u/kRozyeDar

As a quorum of this Commission or its committees may be present, this gathering constitutes a meeting under the Indiana Open Door Law (I.C. § 5-14-1.5). For that reason, this statement provides notice that this meeting will occur and is open for the public to attend, observe, and record what transpires.

MEMORANDUM
Community Advisory on Public Safety (CAPS) Commission
Tuesday, July 5th, 2022

The Regular Session meeting was called to order at 5:07 p.m.

Commissioner members present in person: Renee Miller, Nejla Routsong, Eliza Carey, Jason Michálek, Shelby Ford
Commission members present via Zoom: Kamala Brown-Sparks

Commission members absent: Alex Mann

City staff present: Stephen Lucas

5:07pm - INTRODUCTION AND ROLL CALL

5:07pm - APPROVAL OF AGENDA: No changes were made to the agenda.

5:07pm - Staff member Stephen Lucas selected to keep a meeting memo.

5:12pm – It was moved and seconded to elect Cms. Eliza Carey and Jason Michálek to serve as co-chairs for three months. The motion was adopted by roll call vote (6-0).

5:13pm - REPORTS

5:13pm – Cm. Brown-Sparks reported on the CHIPS Kick-Off event.

5:16pm – Cm. Michálek presented a report on the activity of the Research Committee and committee members answered questions about its work and its planned contributions to the Commission's upcoming annual report to the Bloomington Common Council..

5:54pm – Cm. Routsong reported on the activity and future plans of the Alternatives to Policing Committee.

5:57pm – Cm. Carey stepped off of the Housing Committee.

6:01pm – Lucas reported on the resignation of Cm. Satish Vuuyuri. Lucas stated he would pass along recommendations to reach out to Asian American and Pacific Islander, Indigenous, Muslim communities in an effort to solicit applicants to the Commission.

6:13pm – REPORTS FROM PUBLIC: Jim Shelton spoke and suggested that the commission reach out to and coordinate with relevant county agencies and officials on the ongoing criminal justice studies and resulting recommendations related to public safety issues.

6:25pm – UNFINISHED BUSINESS

6:29pm – Cm. Miller moved and it was seconded to approve the following bylaws included in the meeting packet. The motion was adopted by unanimous consent.

> Attendance. BMC Section 2.08.020 (4) or its successors specify attendance requirements. Members shall give prior notice to the Chairperson(s) or the Council Office liaison if they are unable to attend a regular or special meeting.
>
> Removal of Members – Under BMC Section 2.08.020 (4), a member may be removed for cause. Cause shall include, but not be limited to, failure to attend three consecutive regularly scheduled meetings of the Commission or four regularly scheduled meetings in any twelve-month period. If a member meets these criteria, the Commission may add to the agenda of the next regular meeting a recommendation for removal. Acceptance of extenuating factors puts the member on notice that further excessive absenteeism shall result in removal.
>
> Selection of Chairperson – The Commission shall select a member to serve as Chairperson or may select two members to serve as co-chairs. Members selected to serve as chairperson will serve for three months. At the last regular meeting before the term of the current chairperson(s) has ended, the Commission shall select a new chairperson or new co-chairs. Members selected to serve as chairperson may not serve two consecutive terms in a row.

6:30pm – The Committee discussed the upcoming annual report to the Common Council. Cms. Routsong and Michálek would jointly present the report. Cm. Routsong would finalize the language of the written report.

6:44pm - TOPIC SUGGESTIONS FOR FUTURE AGENDAS

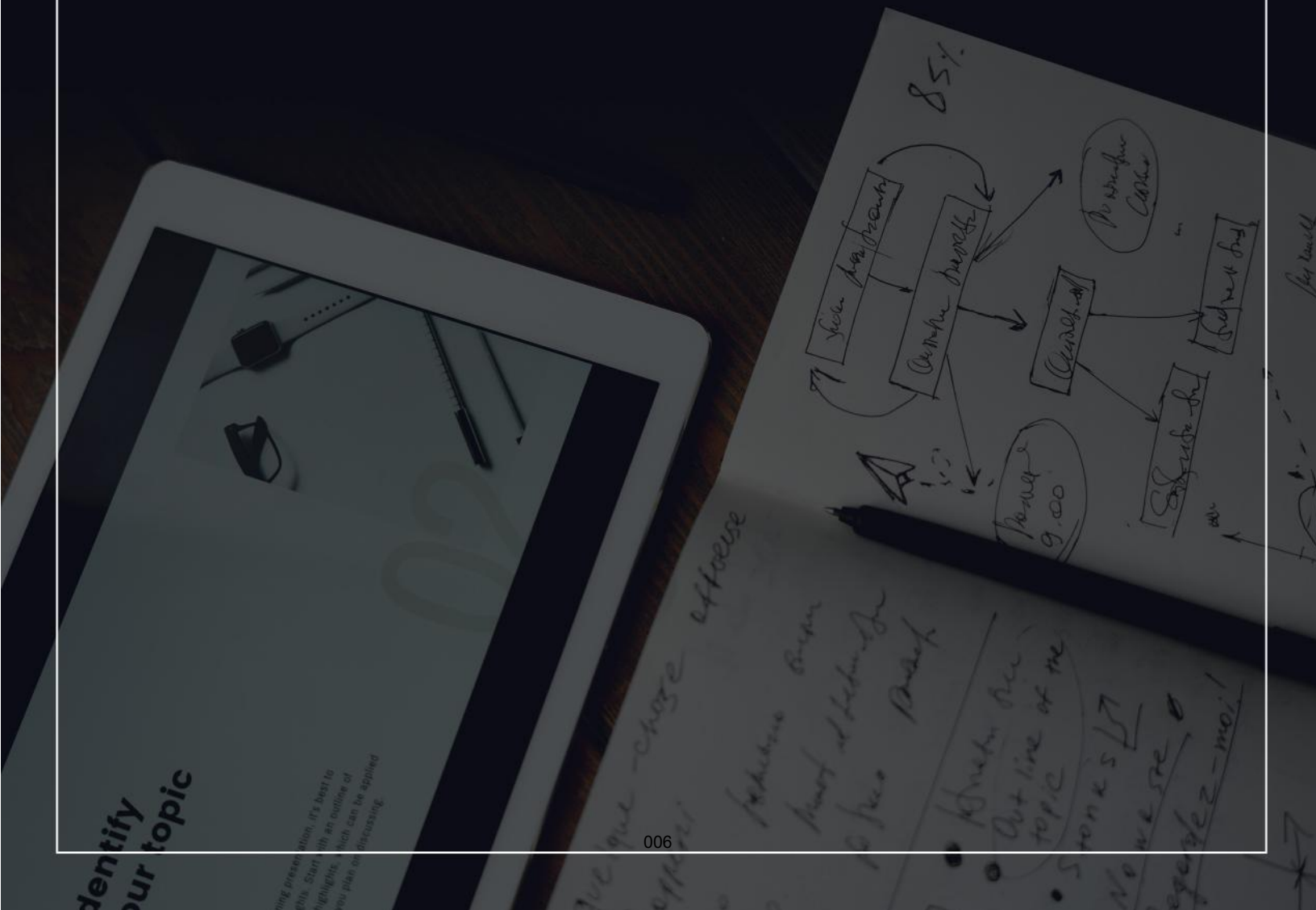
- Overturn of Roe v. Wade – Calling on Prosecutor's Office to not prosecute
- Review of Commission committees

6:47pm - Meeting is adjourned.

Memorandum prepared by:
Stephen Lucas, Staff

BASIC-MCR

BUILDING AND SUCCESSFULLY IMPLEMENTING COMMUNITY MOBILE CRISIS RESPONSE



BASIC-MCR TOOLKIT

CONTENTS

INTRO; history, principles, and program overview

CAHOOTS, a mobile crisis response model in Eugene, Oregon, has been in the spotlight recently as our nation works to re-imagine public safety. The model has been looked to as an important and innovative public-private partnership delivering crisis and community health first response. Communities across the country are requesting training and guidance in order to replicate the CAHOOTS model. This course and accompanying materials are meant to help start conversations and initial research for your own mobile crisis response needs in your community.

When George Floyd was murdered by Minneapolis Police in May 2020, the nation saw an uprising of demand and advocacy to reallocate funds from police departments into community safety initiatives and divert unnecessary encounters with police. While White Bird Clinic has been assisting other communities on alternative emergency response in the Pacific Northwest for years, the rise of activism around reimagining public safety put CAHOOTS in the national spotlight.

CAHOOTS focuses exclusively on meeting the medical and mental health needs of our community here in Eugene, making it both more economical and more effective than traditional models involving institutions and agencies with a much larger scope of responsibility. The CAHOOTS model ensures that medical and behavioral health care are integrated from the onset of intervention and treatment, adding to the efficacy - and cost savings - of the model.

The CAHOOTS model cannot be replicated with a cookie-cutter approach. Our model is catered specifically to the needs, population, and demographics of our community. Identifying the needs of your community when establishing an alternative response program is essential; this is done successfully by consulting with community members from the start, holding share-ins, informational and listening sessions, including community-led grass-roots organizations and advocates in the development process from early stages to execution, and continual re-iteration throughout the lifespan. This is crucial for the success of any program.

We attribute the success of the CAHOOTS program to the following underlying factors:

- A robust human services network, including sobering centers, housing crisis case management, and accessible healthcare services.
- Trust of the population we serve, based on a 50-year history in the community. This trust is solidified by our independence from civic institutions and the consent-based, least-intervention-necessary nature of our services.
- A community-culture of care and compassion supporting human-centered, trauma-informed response in our communities.

HOW TO USE THESE MATERIALS

BASIC-MCR is meant to help guide the beginning stages of a pilot crisis response program by outlining the history, development, and logistics of the CAHOOTS program as designed by White Bird Clinic for the needs of our community members in Eugene, Oregon. It is not a report of best practices for mobile crisis or alternative emergency response overall, or a pillar of expertise for how to implement a model in your community.

The purpose of the course is to provide resources, statistics, and anecdotes to help guide the process of development for other pilot programs by sharing our insights and experiences from over 30 years of service, including what we've found to be successful, challenging, and the mistakes we've made along the way.

There is no one-size-fits-all solution for the issues of over-policing and public safety. Solutions need to be innovative, flexible, ever-evolving, community-informed, and designed to fit the needs of each community and the individuals who will be receiving the services within them.

A mobile crisis response team will not resolve the issues of over-policing or systemic racism. It is not the save-all solution for people experiencing incidents related to mental health, substance use, housing crises or other basic human needs in our communities. A mobile crisis response program is only one part of a huge network of necessary services and innovative reimagining's that must take place in order to begin solving the issue of public safety. When planning a mobile crisis response team, please spend equal time and resources examining the other necessary components of this supportive network; your mobile crisis team will need places to take the people they are serving, they will need to be able to refer people to longer term support such as housing, sobering centers, substance use programs, healthcare and food assistance, and long term counseling. Where will your mobile crisis team take someone after they've addressed their immediate need in the field? These broader issues need to be addressed when considering implementing a mobile crisis unit in your community; mobile crisis services will not be successful unless there are other avenues for people to receive longer-term support.

HISTORY OF WHITE BIRD AND CAHOOTS

CAHOOTS is a mobile crisis response program within White Bird Clinic, a Federally Qualified Health center committed to providing accessible, patient-centered human services in Eugene, Oregon. Founded in 1969 as a consensus-based collective, a structure which still exists today, White Bird Clinic is dedicated to helping individuals gain control of their social, emotional, and physical well-being through direct service, education, and community.

White Bird began as a free clinic organized by student activists and concerned practitioners, offering a crisis hotline and medical care for travelers and counter-culture youth in Eugene. White Bird has continuously grown in response to the community's needs, and now operates ten programs, including a medical clinic, 24-hour crisis-line, counseling, outpatient drug and alcohol treatment, a human services information and referral center, CAHOOTS mobile crisis intervention, dental clinic, insurance and benefits enrollment, and mental health outreach in schools. White Bird's model capitalizes on the wide variety of services offered, allowing it to provide comprehensive integrated care by treating the whole person.

Our mission is to provide compassionate, humanistic care and supportive services to individuals in our community, prioritizing those who are unserved, underinsured, unhoused, underrepresented, or otherwise systemically unsupported.

After many years of servicing the community with a 24-hour crisis call line, it was decided that a mobile "Bummer Squad" crisis response program was needed at request of the community, in order to provide support on site. In 1989, White Bird Clinic launched CAHOOTS (Crisis Assistance Helping Out On The Streets), an innovative community-based public safety system to provide mental health first response for crises involving mental illness, homelessness, and addiction.

CAHOOTS PROGRAM OVERVIEW

The CAHOOTS program mobilizes two-person teams consisting of a medic (a nurse, paramedic, or EMT) and a crisis worker who has substantial training and experience in the mental health field.

The CAHOOTS teams deal with a wide range of mental health related crises, including conflict resolution, welfare checks, substance abuse, suicide threats, grief and loss, and more, relying on trauma-informed de-escalation and harm reduction techniques. CAHOOTS staff are not law enforcement officers and do not carry weapons; their training and experience are the tools they use to ensure a non-violent resolution of crisis situations using the least intervention necessary. They also handle non-emergent medical issues, avoiding costly ambulance transport and emergency room treatment.

According to the Natural Alliance on Mental Illness (NAMI) 50% of fatal encounters with law enforcement involve an individual with a disability.[1] The CAHOOTS model demonstrates that these fatal encounters are not inevitable.

CAHOOTS services two side-by-side municipalities, Eugene and Springfield, Oregon, a combined population of about 260k. As of July 2021, The CAHOOTS team is comprised of around 45 staff members, including office and administrative roles, and around 35 first responders. There are 3 vans on the road between the two municipalities during peak hours, with one overnight van. It should be noted that our program is in need of a 50% increase in funding in order to stabilize and meet the needs of our community, including further funding for increased staff and higher wages, and more vans on the road.

The cost savings of the program are considerable. The CAHOOTS program budget is about $2.1 million annually, while the combined annual budgets for the Eugene and Springfield police departments are $90 million.

In 2017, the CAHOOTS teams answered 18% of the Eugene Police Department's overall call volume. The program saves the city of Eugene an estimated $8.5 million in public safety spending annually.

GROWTH:

1969 – Bummer Squad Response through White Bird Crisis Line

1989 – CAHOOTS services begin Tuesday – Saturday, 4pm – midnight

2011 - Expansion to two vans for 16h/day

2014 - expansion to Springfield for 12h/day

2017 - (Jan) expansion to 24h in Eugene

2017 - (April) expansion in Springfield to 18h/day

2017 - (September) expansion in Springfield to 24h

2020 - (January) expansion with additional services hours in EUG

HOW IS CAHOOTS DISPATCHED?

CAHOOTS calls come to Eugene's 911 system or the police non-emergency number. Additionally, there are some calls that are self-initiated through White Bird's crisis call line or calls where CAHOOTS vans are flagged down by individual members of the community when on the road.

Dispatchers in Eugene are trained to recognize non-violent situations with a behavioral component, or an issue related to homelessness or substance use, and route those calls to CAHOOTS. CAHOOTS supports Eugene and Springfield Police Departments by responding to crisis situations, behavioral and mental health concerns, suicide prevention, intoxication and disorderly conduct, trespassing, welfare checks, death notices, and other situations needing de-escalation. A team will respond to the scene, assess the situation and provide immediate stabilization in case of urgent medical need or psychological crisis, assessment, information, referral, advocacy and, when warranted, transportation to the next step in treatment.

CAHOOTs is not a co-responder model. This means that our teams are not dispatched at the same time as an officer, and are not embedded in to law enforcement teams. Our teams are unarmed. Each responder wears a two-way radio on the same channels as active officers on duty, which allows CAHOOTS to call for police if the call merits a police response, and vice versa.

CAHOOTS does respond to calls alongside police if they request our services or we request them as backup. The majority of our calls for backup are not due to threat of injury to a first responder, but rather the safety of the

[1] https://namiillinois.org/half-people-killed-police-disability-report/

client; this could include the need to relocate a client against their will (something the CAHOOTS team is unauthorized to do) or to assist in scene safety, such as diverting traffic. Out of 24,000 calls taken by CAHOOTS in 2017, police were called for backup about 300 times. Of those, 'code 3' (lights and sirens) were needed about 25 times. This response is usually because a CAHOOTS first responder failed to respond on the radio to a safety check, often because their radio was turned down during a crisis call; otherwise, need for 'code 3' is likely due to an immediate threat to the safety of a client.

HOW ARE CAHOOTS FIRST RESPONDERS TRAINED?

Our teams are trained internally. All team members complete over 500 hours of in-field and classroom training that emphasizes de-escalation and crisis-intervention to resolve situations where a social service response is more appropriate than a police response. CAHOOTS workers are not trained to be police and they do not have the same powers as police.

We do not require that our crisis workers are licensed clinicians. Rather, we prioritize those with lived experience and natural de-escalation and peer-counseling skills; our crisis counselors are Qualified Mental Health Associates (QMHA), a qualification unique to the state of Oregon which is based on contact hours, similar to a peer counselor in other states. Necessary qualifications for our medics are EMT-Basic training or higher. Our team includes registered nurses, social workers, and other clinicians, who work alongside QMHA's with their own lived experience in mental health, incarceration, homelessness, addiction, and others who exhibit natural or learned de-escalation skills, such as former bartenders, bouncers, and baristas who have an intimate knowledge of working with people in their community.

Some of our first responders are cross trained, meaning they came to the program as a crisis counselor and go on to receive their EMT training, or vice versa, to be able to fill either role on shift.

HOW IS CAHOOTS FUNDED?

CAHOOTS is funded by the Eugene and Springfield city governments with a budget approved by City Council, along with grants, private donations and through its federally funded coordinated parent organization. Total operating costs for the program in the 2019-2020 fiscal year was $2.4 million.

Breakdown of funding streams for the program, using rounded figures:

City of Eugene: $800,000 as approved by City Council

City of Springfield: $210,000

Lane County Health and Human Services: $630,000

Medicaid Wrap-around Services Funding: $100,000

Foundations/Fundraising: $300,000

WHAT KINDS OF CALLS DOES CAHOOTS RESPOND TO?

CAHOOTS was not designed to replace policing; CAHOOTS team members are not law enforcement officers and do not carry weapons. Instead, CAHOOTS offers a service that responds to non-criminal crises so police don't have to. CAHOOTS responds to a diverse range of calls, including but not limited to: non-emergency medical care, counseling for people in crisis, welfare checks, conflict resolution and mediation, grief and loss, substance use and harm reduction, housing crises, resource connection and referrals, and requests for transportation to social services, substance abuse treatment facilities, and medical care providers.

More than 60% of our clients are homeless, and 30% live with severe and persistent mental illness (SPMI).

The most common types of calls diverted to CAHOOTS from the police are welfare checks (32.5% of all CAHOOTS calls), public assistance (66.3%), and transportation to services (34.8%). Some of these crisis responses involve more than one call type.

EMERGENCY ROOM DIVERSION

CAHOOTS is also able to attend to non-emergency medical calls that would have otherwise been responded to by Emergency Medical Services (EMS). CAHOOTS receives wrap-around services funding from Medicaid for cost savings in ambulance and emergency room diversion. CAHOOTS can respond to suicide or self-harm calls, calls for basic medical treatment such as wound care, and provide assistance for clients who are presenting as disoriented or delusional, or who have other symptoms of psychosis. Treating these symptoms in the field prevents inpatient hospitalization and infections, which are common among unhoused populations, as many have no way of keeping wounds clean. This in turn also keeps patients out of the emergency room in the long term.

The CAHOOTS teams divert a large number of medical calls for service from Fire/EMS and/or the emergency room, transporting or treating according to need, including Primary Assessment, Wound Care, Medication Management, Substance Use and harm reduction, Suicidal Ideation and Risk Assessment, Failure to Thrive, Isolation and loneliness, Lift Assists, Chronic Utilizers/Frequent Flyers.

JAIL DIVERSION

CAHOOTS services divert patients from the criminal legal system by responding to many call types which may have otherwise resulted in contact with law enforcement, including public intoxication, disorderly behavior, trespassing or prohibited camping, dispute and mediation, in traffic/roadway, and secure sobering.

PRINCIPLES OF TRUST AND INTEGRITY: HARM REDUCTION + TRAUMA-INFORMED CARE

The trust we have within our community is based on our independence from other institutions. We are not law enforcement and we do not work for the city. The trust we have built over several decades depends on people knowing that they can invite us into their homes without being judged or forcibly removed, and that they can be honest with us about their lives and their choices.

> *"…you respect the person as a human being with agency to choose how to respond to their situation and that no matter how dangerous or dysfunctional they seem to be they [deserve access to support]."* *-Stephen Joseph*

Our teams are trained to use a client-centered approach rooted in harm reduction and trauma-informed care. First responders meet the client where they're at with unconditional positive regard. CAHOOTS responders recognize that our patients are experts in their own lived experience. Interventions are guided by the patient's priorities with responders setting realistic expectations of available resources and reinforcing boundaries and limits.

TRAUMA INFORMED HARM REDUCTION

Our teams are often asked to assist people who will disclose intensely personal behaviors, actions, and lifestyles which are often considered taboo or socially unacceptable. All of us have coping mechanisms that are partially damaging. Our principles keep us grounded to provide care to everyone regardless of their choices, and to redirect our clients to use the skills they have in order to avoid collateral damage.

> *"We do not decide for someone what changes they should make in their environment or lifestyle. Positive changes take time, and only happen when someone is ready to embrace them. No change will be effective without the client's agency in the decision." - Henry Cakebread, Medic Team Lead*

REFUSAL OF SERVICE

We do not forcibly remove or transport people against their will or force our services on anyone without their explicit consent. People are able to retain their rights and refuse our services unless they are an imminent danger to themselves or others, or in the case of abuse of a child, senior, disabled person, or other protected population. These incidents usually require the involvement of police. Otherwise, we are not concerned with issues of illegality.

We are able to refuse services or redirect a client if our involvement is inappropriate or not therapeutic, if the request is something the client should do for themselves, or if it's deemed unsafe for any involved party.

STATISTICS / SAVINGS

In 2019, the CAHOOTS program saved roughly $14 Million in emergency medical systems costs, including ambulance transport and emergency room services. According to a 2020 Program Analysis by EPD, CAHOOTS diversion rates are likely between approximately 5% to 8% of EPD Calls For Service (CFS).[2]

In 2019 CAHOOTS had some level of activity in 20,746 public-initiated calls for service in Eugene (not including CFS in Springfield.) This number is not indicative of a response, dispatch or arrival, simply an association between a CAHOOTS unit designator and an event in dispatch.

In 2019 CAHOOTS was dispatched to 17,700 public-initiated calls for service in Eugene. This includes calls that are both CAHOOTS only and a joint response with other emergency services.

Lack of dispatch can be for a variety of reasons ranging from a call not requiring a response, to a caller not providing complete information, or a caller calling back and canceling a call. CAHOOTS dispatch rates are higher than EPD due to the nature of the calls they receive. CAHOOTS calls are generally not for information only or calls to report crimes, those types of calls, which are common for EPD are often not dispatched.

WORKING WITH POLICE

By diverting crisis calls that are appropriately handled by a CAHOOTS team, the CAHOOTS program takes a substantial load off of Eugene and Springfield Police Departments and saves taxpayers an average of $8.5 million every year. CAHOOTS' efforts focus on a set of problem areas that otherwise would take up a lot of police time and attention. Police training doesn't provide adequate preparation for dealing with mental health, homelessness and other front-line social interventions. The CAHOOTS model provides a comprehensive solution that allows the police department to focus on law enforcement issues while ensuring that appropriately trained responders are dispatched for each unique situation.

[2] CAHOOTS | Eugene, OR Website (eugene-or.gov)

RACIAL INEQUITY and effects of over-policing

When considering the landscape in which an alternative emergency response team will operate, it is crucial to understand exactly how over- policing affects the local community in which an alternative response team will be implemented, and why there is a need to move toward alternatives.

On average, police kill over a thousand people in the United States every year[3]. Sixty percent of those victims do not have a gun or were otherwise involved in activities that should not require police intervention, such as harmless *quality of life* behaviors or mental health crises[4]. Between 2017 and 2020 mental health and welfare checks led to the second highest rate of police involved murders, the first being traffic stops[5].

A 2015 report by the US Department of Justice released found that the Portland Police Department had a pattern of using excessive force, particularly against individuals with mental illness. In February of 2021, OPB reported that according to data from Campaign Zero, a group devoted to reducing police violence, in Portland, a city with an 80% white population, police "arrest Black people at a per capita rate 4.3 times higher than white people, the fifth worst in the country. Officers in Portland also kill Black people 3.9 times more than white people."

[3] https://www.nytimes.com/2020/05/27/briefing/coronavirus-george-floyd-spacex-your-wednesday-briefing.html
[4] https://www.joincampaignzero.org/problem
[5] https://mappingpoliceviolence.org/

OVER-POLICING AND ALTERNATIVE EMERGENCY RESPONSE

“A decades-long focus on policing minor crimes and activities - a practice called Broken Windows policing - has led to the criminalization and over-policing of communities of color and excessive force in otherwise harmless situations. Nationwide, only 5% of all arrests made in 2018 involved alleged violent crimes and only 4% of what police spend their time doing overall involves enforcing violent crime. Meanwhile, the vast majority of arrests are for low-level, non-violent activities in encounters that often escalate to deadly force. For example, in 2014, police killed at least 287 people who were involved in minor offenses and harmless activities like sleeping in parks, possessing drugs, looking "suspicious" or having a mental health crisis. These activities are often symptoms of underlying issues of drug addiction, homelessness, and mental illness which should be treated by healthcare professionals and social workers rather than the police.”[6]

Over-policing, especially in communities of color, creates an atmosphere of distrust and broken relationships between the public and first responders. This breach often leaves on-duty police chasing calls for minor infractions instead of effectively building positive relationships with the communities they patrol. This distrust for police means people are hesitant to call 911 when in need, or that anxiety and fear escalate to a point of resistance or violence when police arrive on a a scene where people are already in distress. Studies show a potential snowball effect which can lead to violent and deadly police interactions.

A nascent group of alternative emergency response programs are developing across the country to assist communities, police departments and local governments in steering their responders toward a more equitable outcome when contacting and supporting people experiencing houselessness, mental health crises, and substance use. While White Bird Clinic and CAHOOTS have been working at this for over thirty years, we feel it is important to note that while we are still learning, growing and updating our model to remain relevant to the ever-evolving landscape of social justice, we recognize that our model is imperfect and will continue to require community input and re-tooling.

A mobile crisis unit is one piece of a huge integral movement of requisite system changes. Having a CAHOOTS-like program alone will not put an end to police violence.

DATA SHAPES THE LANDSCAPE

From the AISP toolkit, “Data sharing and data integration to inform decision making across government entities is now commonplace, and occurs at every level—local, state, and federal. While most data sharing and integration occurs within a legal and governance framework, an emphasis on racial equity, transparency, and community engagement is often peripheral. This is especially troubling because government policies and programs that produce administrative data have often played a direct role in creating, enabling, and sustaining institutional and structural racism.”[7]

We know that much of the current data collected and aggregated by first responders is based off *perceived race* rather than actual race. When a first responder is unsure of race and marks white this leads to disparaging data in communities that are primarily Hispanic/Latinx and Indigenous. This data flows in such a way that once contact is made, race is assumed and recorded, the data is then pooled with other records that ultimately influence policy.

Again from the AISP toolkit, “We are at a pivotal moment, one in which the use of data is accelerating in both exciting and concerning ways. We have access to greater amounts of data than at any other point in our history, but privacy laws and practice lag behind, placing Black, Indigenous, and communities of color at the greatest risk of the “data-ification of injustice.”8 Acknowledging history, harm, and the potentially negative implications of data integration for groups marginalized by inequitable systems is a key first step, but it is only a first step. To go

[6] Campaign Zero, Broken Window Policing

[7] https://www.aisp.upenn.edu/wp-content/uploads/2020/08/AISP-Toolkit_5.27.20.pdf

beyond this, we must center the voices, stories, expertise, and knowledge of these communities in decision making, and take collective action with shared power to improve outcomes and harness data for social good."

COMMUNITY LEADERS ARE ALREADY DOING THE WORK

Racial equity is the condition where one's racial identity no longer influences how one fares in society. This includes the creation of racially just policies, practices, attitudes, and cultural messages, and the elimination of structures that reinforce differential experiences and outcomes by race[8]. Local governments, non-profits, activists and community leaders are currently creating initiatives to realize this new vision for racial equity in their localities. Portland, OR, for example, recently formed a racial equity steering committee to advise a path that will lead to a more equitable city for Portland's residents of color. From an article by Michael Kelly[9], "The early recommendations [from the committee] include strengthening the citizen panel that reviews internal investigations at the police department; a racial equity audit and annual anti-bias training for police officers, city staff and City Council; and having a special crisis team, rather than police officers, be the first to respond to calls involving homelessness, substance misuse and mental health." Along with the steering committee, the city of Portland has worked to develop equity initiatives, including a racial equity toolkit (RET) and a Diversity, Equity and Inclusion (DEI) evaluation form. When working through this Cahoots model toolkit it may be beneficial to research your local community's own initiatives, while keeping your community's equity experts, activists and community leaders at the forefront and along every step of the way. They are already doing the work and as the saying goes *nothing about us without us*[10].

[8] https://www.racialequitytools.org/glossary

[9] https://www.pressherald.com/2021/02/23/portland-racial-equity-panel-makes-first-recommendations/

[10] https://denverite.com/2021/04/01/people-who-have-been-demanding-police-alternatives-for-years-want-the-city-to-yield-some-control-of-its-young-program/

THE CRISIS RESPONSE LANDSCAPE summary and evidence

In November 2020, The Vera Institute for Justice released a report on Behavioral Health Crisis Alternatives: Shifting from Police to Community Response. The report concluded that “police are ill-equipped to safely and effectively serve people experiencing behavioral health crises” and that "many existing programs are hindered by an overreliance on police, limited community collaboration, and underinvestment in community-based resources. Communities must pursue new approaches that **minimize trauma and distress, promote dignity and autonomy, and reduce repeat encounters with police** for people who experience behavioral health crises. Reducing law enforcement involvement in crisis calls is a critical step toward these goals.”[11]

The report provides an overview of wide-ranging crisis response programs with varying degrees of police involvement. Some communities choose to pursue multiple, layered approaches, a decision based on the specific needs of their community and the resources available to address them.

The Substance Abuse and Mental Health Association (SAMHSA) states that there are three core elements to a successful crisis care system:

Someone to Talk To (*Crisis Call Services*)

Someone to Respond (*Mobile Crisis Services*)

A Place to Go (*Crisis Receiving and Stabilization Services*)

"unfortunately, few communities have [all three core elements] and even fewer have them operating in a manner consistent with the SAMHSA Best Practice Guidelines"

- SAMHSA National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit[12]

Few communities in the United States have an organized system of coordinated care services that include all three core elements, and fewer still are successfully collaborating in order to successfully divert from jails, minimize involvement of law enforcement, reduce hospital visits, and provide continual care. These systems are not created overnight and are reliant on considerable planning, cross-collaboration, and creative methods of blending funding sources.

ALTERNATIVE RESPONSE CATEGORIES

The types of Mobile Crisis and Alternative Response can be divided into three separate categories: Police Based Response, Co-Responder Teams, and Community Based Response.

POLICE BASED RESPONSES:

Crisis Intervention Team (CIT)

A crisis intervention team, or CIT, is a model where police officers with specialized training respond to crisis calls. For most programs, this involves 40 hours of de-escalation training. The CIT model emphasizes partnership between police, service providers, and advocates. The elements of this model include training for 911 dispatchers, additional training for police officers, and designated drop-off sites and receiving centers. Over 2,700 CIT programs have been implemented across the United States since 1988.[13]

[11] Vera Institute
[12] https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf
[13] Effectiveness of Police Crisis Intervention Training Programs | Journal of the American Academy of Psychiatry and the Law (jaapl.org)

Case Management Teams

According to Vera, a case management team is when “Police convene multidisciplinary teams that use law enforcement and health data to identify people who frequently use emergency and behavioral health services and develop individualized response plans to connect them to services and other supports. The teams might involve proactive outreach of co-responding clinician/police officer teams, with the goal of developing solutions that reduce repeat interactions.”

Research shows that CIT trainings improve the mental health knowledge, attitude, and confidence of police officers who complete the training. They may improve referral and links to mental health services. Statistics show that CIT training increases the likelihood of referral or transport to mental health services and decrease the likelihood of arrest during encounters with individuals thought to have a behavioral disorder.[14] However, the evidence on arrest and use of force in CIT response is mixed and limited. Dr. Robin S. Engel, a criminologist with the Center for Police Research and Policy, testified before President Donald Trump's commission on law enforcement that "de-escalation use of force policies and training are widely viewed as a common-sense approach, [but] there is no uniformly accepted definition of de-escalation within the policing field, and little is known about the development, delivery, and impact of police de-escalation training."[15] Garrett Rolfe, the officer who was charged with fatally shooting Rayshard Brooks in Atlanta, was trained in de-escalation and cultural awareness just two months before the shooting, according to the Atlanta Police Department. Prior to George Floyd's killing, the Minneapolis police department had begun including trainings sessions as an alternative to disciplining their police officers.[16]

Studies indicate that de-escalation training results in positive outcomes pertaining to the attitudes, perceptions, and self-reported behaviors and experiences of police who participate. They report an “enhanced awareness of effective strategies for the prevention and management of violence and aggression, as well as greater confidence in their abilities, and the abilities of co-workers.”[17] Given this evidence, an emphasis on de-escalation in the training of police officers could have a positive effect on their interactions with the public; however, the potential increase in confidence and situational-awareness on behalf of the officer does not address the deep distrust that the history of policing has already established within our communities, or counteract the deeply established culture and conditioning withing police departments.

CO-RESPONSE

Co-Response models are when behavioral health professionals, commonly Social Workers, respond alongside police officers. These services are typically not available 24/7. Police officers on co-response teams are often CIT-trained, and some teams may involve peer counselors and EMTs.

According to the National Police Foundation, of 369 small law enforcement agencies surveyed, 4% have in-house mental health, 27% have local mental health partnership for on-scene response, and 23% have local mental health for telephone consult.[18]

Primary co-response teams—Behavioral health clinicians co-respond with officers in patrol cars as first responders to situations involving someone in behavioral health crisis. These teams may include peer specialists. Clinicians may also co-respond remotely via phone or telehealth support.

[14] The Police-Based Crisis Intervention Team (CIT) Model: II. Effects on Level of Force and Resolution, Referral, and Arrest | Psychiatric Services (psychiatryonline.org)
[15] Police reformers push for de-escalation training, but the jury is out on its effectiveness - ABC News (go.com)
[16] Police reformers push for de-escalation training, but the jury is out on its effectiveness - ABC News (go.com)
[17] https://onlinelibrary.wiley.com/doi/epdf/10.1111/1745-9133.12467
[18] Home | National Police Foundation

Secondary co-response teams—Behavioral health clinicians co-respond with officers in patrol cars at the request of police officers who respond first to situations involving someone in behavioral health crisis. Clinicians may also co-respond remotely via phone or telehealth support.

Co-response teams may reduce police detention and involuntary transports, and may reduce unnecessary emergency department use and increase connection to community mental health services. These programs often have a mixed response among staff and service users. In an open letter, Social Service Workers Chicago stated "If all we do is replace police with social workers without eliminating these carceral aspects of social work, we will simply subject vulnerable people to cops by a different name."[19] The Vera Institute found that "the mere presence of armed, uniformed officers with police vehicles can exacerbate feelings of distress and escalate mental health-related situations, particularly in Black communities and other communities of color, where relationships with police are historically characterized by tension and distrust."[20]

Assessing co-response models should come with critical investigation of the ways in which Social Work as a formal practice and institution has historically upheld carceral systems and institutional racism. Social workers, like police officers, enforce laws and social order, and are similarly susceptible to implicit racial biases.[21] Social work as a field is predominantly white, and researchers have pointed to an "empathy gap" between providers and their clients who are people of color[22]. Studies show that mental health clinicians disproportionately misdiagnose Black clients with psychotic disorders.[23] Social work is already deeply interconnected with law enforcement, and often involves punitive practices that disproportionately harm communities of color. When Social Workers or other behavioral health professionals arrive on a scene alongside police, community members may begin to associate and eventually identify them as law enforcement. And this assumption is not inaccurate; given that social workers are lacking in the same scene-assessment training as police, they are more vulnerable when responding to high-risk calls, and may begin to develop bias towards the police officers they work with – their co-workers – and begin to trust and rely on them as a proponent of their personal safety.[24]

For these reasons and others, CIT International's Best Practices[25] guide cautions against co-response models.

COMMUNITY BASED RESPONSES

A Community Organized Response Model is a participatory decision-making process that empowers communities to improve their overall collective health. It emphasizes active participation from the community in identifying key health issues and strategies to address them. Communities focus on their strengths and collectively mobilize to develop programs to achieve health goals.[26]

Characteristics of the Community Organization Model include:

Understanding the context and root causes of health issues

Collaborative decision making and problem solving

Focusing efforts on specific issues

Actively engaging participation from various groups and organizations within the community

Developing and maintaining capacity and power to produce lasting change

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[19] The NASW is failing us. Either it changes, or we will change it ourselves. | by Social Service Workers United-Chicago | Medium
[20] Vera Institute
[21] https://imprintnews.org/opinion/self-reflection-needed-around-role-social-work-in-police-reform/45186
[22] https://www.cswe.org/Centers-Initiatives/Initiatives/National-Workforce-Initiative/SW-Workforce-Book-FINAL-11-08-2017.aspx
[23] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4274585/pdf/WJP-4-133.pdf
[24] https://imprintnews.org/opinion/self-reflection-needed-around-role-social-work-in-police-reform/45186
[25] CIT guide desktop printing 2019_08_16 (1).pdf (citinternational.org)
[26] Community Organization Model - Rural Health Promotion and Disease Prevention Toolkit (ruralhealthinfo.org)

Reciprocal feedback between the community and the models that serve them.

Components of a community-led response model may include an interworking network of the following services, among others at request of the community:

Crisis and "warm" lines— Crisis telephone lines staffed by trained call-takers who provide remote counseling to people in crisis as an alternative to calling police. Peers are specially trained and often have lived experience with mental illness.

Peer navigator programs— These programs hire and train peers who have lived experience with mental illness and/or substance abuse. Programs may focus on people at risk of criminal justice involvement, offering support to avoid calls to police or trips to the emergency department.

Mobile crisis teams (MCTs)—Teams composed of medics, crisis workers, and peers who respond to people in crisis and provide immediate stabilization and referral to mental health services and supports. Police may coordinate with MCTs for an alternative to police response, or community members can request them by calling appropriate service providers. MCT's reduce reliance on emergency department and hospitalization and increase linkage and use of community mental health services.

EMS-based responses—Teams consisting of licensed counselors, clinical social workers, physicians, and EMTs who respond to people in crisis instead of police. The goal is to reduce arrests. These teams can transport people to services other than the emergency department to facilitate more appropriate treatment.

911 diversion programs—Procedures used by police, fire, and EMS dispatchers to divert eligible non-emergency, mental health-related calls to behavioral health specialists. These specialists manage the behavioral health crisis by telephone and offer referrals to needed services.[27]

Program Examples:

Pheonix, AZ – Crisis Response Network (CRN)

Olympia, WA – Crisis Response Unit (CRU)

Denver, CO – Support Team Assisted Response (STAR)

Portland, OR – Portland Street Response (PSR)

Oakland and Sacramento, CA – Mental Health First (MH1)

Philadelphia, PA – simultaneous rollout of co-responder program and expanded mobile crisis services linked to 911

New York City, NY – NYC Well

Rochester, NY – Person in Crisis Team (PIC)

San Francisco, CA – teams including peers provide trauma-informed responses to people experiencing crises in public places

St. Petersburg, FL – clinical staff and community navigators respond to BH calls and other issues like truancy and homelessness

KEY CONSIDERATIONS

GUIDING PRINCIPLES FOR PROGRAM DEVELOPMENT

Minimizing the response and role of police in noncriminal and crisis related calls.

[27] Vera Institute

Centering race, equity, and inclusion, and community collaboration in program design.

Situating on-scene approaches within a broader crisis care continuum.

Minimizing trauma and distress; prioritize the dignity and autonomy of clients.

COMMUNITY COLLABORATION

All programs should reflect the insights and participation of directly impacted communities – there's no one-size-fits-all approach and the success of a program is reliant on inclusion of the community it will impact. Collaboration should be inclusive and ongoing, from early planning stages to program oversight. Community involvement may include active participation in implementation (outreach, training, staffing, etc) and advisory boards may help programs remain inclusive and avoid replicating harms of police-based approaches

For more, See COMMUNITY INFORMED DESIGN

CALL DIVERSION / 911

Regardless of which communication channel is used (911, 988, or other), community members should have access to timely health-first responses. Distrust for 911 should be taken in to account as well as the implicit bias present within emergency dispatch. Offering alternative channels to dispatch crisis response is recommended. Legal staff should address potential liability for police or mental health service personnel by developing clear guidelines.

DATA AND EVALUATION

Programs should be guided by clarity and specificity in program goals and desired outcomes.

Service users and other community stakeholders should have input on what and how data is collected and what measures of success look like. Data should be shared publicly, used to evaluate effectiveness and equity, and used to inform program improvements and resource allocation.

FUNDING

Funding these programs usually requires creativity in blending methods and sources. Some examples include a combination of reallocation of police department budgets, state grants, including police association grants, public safety levies that explicitly carve out funding for enhanced non-police crisis response, Federal Medicaid matching through American Rescue Plan, 988 fees to support crisis lines and extended crisis services, and legislative efforts include proposed grant programs for 911 diversion and civilian response teams.

CORE VALUES

According to the National Alliance on Mental Illness,[28] the Core Values of a Mental Health Ecosystem are:

Accessibility – Services and supports should be made available based on need. Programs should evaluate and ensure that there are enough resources (*funding, staffing, number of providers, availability of services etc*.) to meet that demand. Are there enough psychiatrists to treat people who need medication? Are crisis services available outside of traditional business hours and on weekends?

Equity – While solving this issue of disparities in insurance coverage and income requires larger policy solutions, communities can creatively identify ways to eliminate these barriers to ensure that anyone can receive services despite their social location. For example, a community might pursue funding from a foundation to pay for case managers or work with local psychiatrists to provide pro-bono services.

[28] Divert to What? Community Services that Enhance Diversion | NAMI: National Alliance on Mental Illness

Effectiveness – All treatment and services should be trauma informed, culturally competent, evidence-based, and patient centered. Services should consider someone's unique identity, which will significantly contribute to their overall experience and successful engagement.

Further Reading:

Social Workers Are Rejecting Calls For Them to Replace Police - The Appeal

The NASW is failing us. Either it changes, or we will change it ourselves. | by Social Service Workers United-Chicago | Medium

DiverttoWhat.pdf (nami.org)

WHAT THE WORK REALLY IS

a day in the life of a first responder

There is often a misconception that a Mobile Crisis Response Team is responding exclusively to high-intensity crisis calls, managing mental and behavioral health crises or medical emergencies. The truth is, the real work of a CAHOOTS first responder is far broader and more nuanced, and sometimes unexciting. 'Crisis response' is an incomplete descriptor. Each crisis is unique. Some crises are immediate, some crises are chronic. Sometimes a crisis is an emergency, some crises are ongoing. Our country suffers from the ongoing pathological crises of homelessness, poverty, addiction, mental health, and racism. There is no 'usual' day for a mobile crisis worker. Sometimes there is overlap in callers, tactics, or response, but every single call is different, even if they come from the same person.

Below is an example of what a day might look like for a crisis responder on the CAHOOTS team. This will not only look different from day to day here in Eugene, but will differ widely from what a crisis response shift might look like in Portland, Denver, or Atlanta.

A DAY IN THE LIFE OF A CAHOOTS FIRST RESPONDER

Elliott, a cross-trained CAHOOTS first responder arrives at the office around 4:45 AM to prepare for their 5 AM shift. Elliott began with CAHOOTS three years ago as a crisis worker, coming to the work with lived experience in substance use and a trauma-informed, harm-reduction approach to peer counseling. After completing CAHOOTS' required classroom and in-field training, Elliott worked on the van as a crisis worker for a year before going on to complete their EMT-Basic training with support from their mentor and the rest of the team, something that is sponsored and arranged by the agency. As a cross-trained responder, Elliott is able to fill either the role of a medic or a crisis worker, alleviating staffing and scheduling issues.

Upon arriving at the office, they cross paths with the overnight crew, who are returning from their 12-hour overnight shift. One of the responders from the previous shift is restocking supplies and sanitizing the van. The other responder is finishing up the details on some unfinished reports from earlier in the shift. The teams catch up as they change in and out of their work gear, sharing relevant information and anecdotal stories from their night, updating one another on the medical status of a repeat-client and letting the incoming team know that they can probably expect a call about a client they responded to early in the morning who refused services, but who is in a highly visible area and will likely draw attention from morning commuters.

Elliott and their partner, a former firefighter medic, strap on their radios and assign themselves roles – one of them will be driving the van, and the other will be filing reports on the laptop in the passenger seat. There aren't any calls yet in the queue, so they decide to get a coffee and wait in the parking lot of the coffee shop until they hear from dispatch.

Around 5:45 AM, they receive a call from dispatch requesting that they respond to reports of a shirtless man yelling from a bridge. Upon arriving on the scene, the team identifies and approaches the client carefully. He is extremely agitated and unable to calm down. The team uses active listening to validate and better understand the needs of the client in that moment; he refuses offers for basic supplies and doesn't want to leave his location. Elliott is able to identify that the client's behavior is consistent with recent drug use. Because the CAHOOTS team is trained to exercise nonjudgment when it comes to others' lifestyle choices, and because they are not in a position where they can punish or disempower anyone for these choices, the client feels comfortable sharing that they have an ongoing relationship with substance. Being open about this allows the client to calm down a bit, and Elliott sits on the ground with him while their partner stands nearby, giving them some privacy while also assessing for scene safety. After some counseling, the client feels that they could benefit from talking with someone at the local detox center, but the center isn't open yet, so Elliott tells the client that they will call ahead to let them know to expect him later this afternoon. The client plans to gather some of their belongings

from where they are staying nearby and will call the non-emergency line to request CAHOOTS when they're ready to be transported.

As they get back to the van, Elliott's partner clears the call with dispatch and informs them that they are planning to hear from the client later that day, while Elliott begins filling out the report for the call. As they're pulling out of the parking lot, the van is waved down by someone standing on the sidewalk. The person needs to get to their 8am appointment at the local Mission. Elliott gets on the radio and alerts dispatch that they are 'flagging' themselves down and that they will be enroute to the Mission.

When the team arrives at the Mission, they cross paths with a familiar service worker employed there who asks if they heard that a repeat-client they share has just become eligible for housing. The last they heard, she's been staying in the nearby park, and they ask if the CAHOOTS team can try to go find her. Elliott checks in with dispatch, and since it's been a slow morning, the team is given the go-ahead to go look for her. After a few circles around the perimeter of the park, the team is dispatched to reports of someone convulsing on a sidewalk fifteen blocks away. Dispatch provides identifying details of the subject, the caller, and gives identifying landmarks in addition to the cross-streets, but when CAHOOTS arrives on the scene they can't find the subject or the caller. The team circles the area several times before reporting to dispatch that they couldn't locate the call, and that they're on their way back to the park.

A block away from the park, dispatch calls the CAHOOTS radio with a request for a death notification. A detective in a neighboring state has called the local police department in Eugene to locate and notify the family. Dispatch provides CAHOOTS with the name, address, and relationship to the deceased, as well as the contact information for the out-of-state mortuary and detective. No further details are provided via dispatch, so the team contacts the out of area detective to confirm the details prior to contacting the family, knowing that notifications are often followed by the instinct to ask many questions when family members are in shock or in the denial stages of grief. The team arrives at the home of the mother of the deceased around 9am with the details from the detective written down on their official letterhead, knowing that it may need to be referenced later for logistical reasons. They knock on the door and introduce themselves as part of public safety, and confirm the identity of the person answering the door before they announce that they have an emergency message for her and ask if she'd like to sit down. At this point, the client knows something is wrong. Elliott's CAHOOTS training includes counseling on death and loss. They are direct with the message, there is no sugarcoating the language. They inform the client that her daughter has died. Elliott is prepared for different reactions to these messages, with varying degrees of calmness and chaos. The team's job is to provide emotional support and resources. The client is in disbelief, and begins to weep. Elliot asks her about what her daughter was like. This moment is important and precious to honor before moving in to plan-making. The client needs space to process their shock and grief, and taking time to listen to her or to just sit in supportive silence helps to establish the trust to move in to next steps. Elliott asks if she has a religious practice that is important to her in this moment. They remind her that there's support available, and asks if she has any family who can come be with her, or if there's anyone else that the team can call for her. The client asks the team to call her sister and request that she come to the house. While Elliott's teammate steps away to make the call, Elliott hears another request for them from dispatch on the radio, and hears their teammate alert dispatch that they're not yet available. Elliott signals silently to their partner that they're turning down their radio in order to be fully present while they sit with the client, transferring the task of listening to radio traffic to the medic while Elliott continues counseling. Elliott encourages the client to make a list of what to do next, and offers to help her write it. Their teammate returns and reports that the client's sister didn't answer the phone, so the CAHOOTS team offers to take the client to the local crisis center. Their goal is to gently hand her off to a different support system so that they can respond to the pending call. When they arrive at the crisis center, they share the contact information for the client's sister with the crisis worker on shift, as well as the information shared with them via dispatch. The crisis worker helps the client inside, offering her a glass of water and a place to lie down.

It’s now 11:00 AM, and the mid-shift is coming in to service and joining Elliott and their partner on the road, providing extra coverage during peak hours, meaning the call load is now shared. Elliott uses their van phone to call the other team directly to tell them to keep an eye out for the well-known client who has just received an offer for housing, and to tell them about the first call of the day; they share that if the other team receives a repeat call from someone for the man on the bridge, or that if they’re the ones who receive the dispatch when the client calls to request transport, that the sobering center is expecting him.

The team clears the death notice call with dispatch and checks in about the call that came in while they were counseling the last client. Someone has woken up at their assisted living center with a panic attack. Elliott knows this client well; he calls for counseling twice a week. The client is expecting them and meets the van outside. They sit together on a bench and talk for a while, as they do each time he calls. Elliott reminds the client about some of the tools they’ve talked about before, some skills rooted in mindfulness and cognitive behavioral therapy.

The team returns to the office, since there are no pending calls in the queue, and grab the lunches they’ve stored for themselves in the fridge. A half hour goes by with no calls; they hear on the radio that the other van has flagged themselves down for something, but no calls are coming in through dispatch. The team decides to go back to the park to continue looking for the client from earlier that morning. After a few loops around the park, the team is dispatched to respond to reports of a person sleeping in the doorway of a business downtown. When they arrive, they gently wake the person up and ask if there’s anything that she needs. She accepts a bottle of water and a snack. The team notices that she doesn’t have any shoes and that her feet are in need of care. Elliott’s teammate begins treating the wounds on her feet while Elliott gets her a pair of clean socks and shoes from the van, as well as a harm reduction kit with clean sharps and other supplies. Once her feet are cleaned up, the team informs her that she’s not able to stay where she is, and that she’ll need to relocate. They ask where she might like to go instead, and if they can take her there. She declines the transport, and instead gathers her belongings and goes about her way.

Elliott gets on the radio to clear the call and is immediately dispatched for a welfare check; a woman has called on behalf of her husband who is expressing suicidal ideation. If he was actively attempting self-harm, the police would need to take the call, but since he’s only verbalizing, it’s a call for CAHOOTS. The caller shares that her ex-husband does own a gun, but the plan he’s verbalized is to take an excess of his medication. The dispatcher asks the CAHOOTS team if they feel safe taking the call given that there are weapons in the home. The team confirms, and Elliott calls ahead to inform the client that someone has called CAHOOTS on their behalf, identifying themselves and that they will be arriving soon, and asking if the subject could please meet them outside his home. When the team arrives, their first goal is to get a read on the situation and to do a general risk assessment before entering the home. The client is not behaving erratically, and it’s decided that there is no indication of a desire to harm others and no visible weapons. The team feels safe and asks permission to enter the client’s home. Elliott begins counseling the client on the couch and performing a conversational suicide risk assessment, while their teammate sits quietly by, constantly assessing for scene safety. Elliott uses their counseling skills to identify whether the client is able to contract for safety, and what brought them to where they are at today; what has changed that is making their pain so acute in this moment. The client is not able to get to a place where they are able to think about the future, continuing to talk about their plan to harm themselves. Elliott tells the client that it looks like they’re not going to be able to get out of this unsafe space together, and that the team’s goal is to keep him safe today. They ask if he's willing to let them take him somewhere safe. The client agrees that he doesn't think he is safe by himself in his home and agrees to have the CAHOOTS team take him to be evaluated in the psychiatric unit of the emergency department, which is a referral point for the inpatient behavioral health unit. Elliott calls ahead to the psych unit and speaks to the nurse on shift, someone they are familiar with from previous similar scenarios, and alerts him that they’ll be arriving soon, avoiding triage and coming in through the back door. As Elliott assists the client in to the psych unit and debriefs the nurses on staff, their partner updates dispatch who will alert the original caller of the status of the client.

In between the heavy grief and suicidal subject calls, the team performs a repeat welfare check for the subject convulsing but are still unable to locate them. They also assist on a police call to provide first aid, help to de-escalate and provide some basic supplies to someone who called for a public assist for themselves, and transported someone from the mission to their housing services appointment. CAHOOTs teams take an average of 12-20 calls per shift.

It's now 4:30. The team heads back to the office, since it's nearby. The night crew is arriving at the office as they pull in. Elliot's partner begins cleaning and restocking the van for the next shift, and Elliott catches up with one of the new trainees who will be shadowing this evenings' shift. On the radio, Elliott hears that the other team has just run in to the client in the park, and will be flagging themselves down to transport him to the housing-placement services office before they close.

COMMUNITY INFORMED DESIGN

The CAHOOTS program exists because of direct input from community members in Eugene. The service was born out of requests from people who used White Bird Clinic's crisis call line who were expressing a need for response on site; they were asking for crisis workers to meet them where they were at. From this, the 'Bummer Squad' was formed, a team of volunteers who would respond to these requests in a white van with the White Bird Logo painted on the side.

Unfortunately, this was the only community-led influence on the program for many years afterwards. It wasn't until the summer of 2020 that a stewardship council was formed in response to feedback from community members and first responders on the team that the service was inaccessible to certain individuals in the community, notably the Black and Latinx community.

Because CAHOOTS is only accessible via 911 or the police non-emergency line, anyone who does not want their information shared with police – their name, address, the nature of their need, or that they have a need at all – have no way of accessing CAHOOTS. Sometimes, due to lack of resources, a caller may explicitly request CAHOOTS and receive police instead, because a CAHOOTS team is tied up or inundated with other calls. In some cases, these calls can result in police violence or arrest. The next times someone in that household or wider community is in medical or mental crisis, they will not call CAHOOTS.

The CAHOOTS team recognizes that this part of the program's structure is racist, and a failure to our community. In these cases, CAHOOTS is complicit in systemic racism and is responsible for the outcome of those calls. The program has had repeated requests to provide a means of access that does not involve calling 911. Unfortunately, having a program that is already well-established and cemented within the structures and relationships that it was built around means that feedback and shifts are extremely hard to implement at this stage.

This serves as an example for why community-driven planning and steering is integral to the success of any program. A stewardship council or similar should have been an integral part of the CAHOOTS program from the beginning, providing input through planning, implementation, and iteration. The stewardship council that advises CAHOOTS now is comprised of about 8 individuals including community leaders, agency representatives, advocates, individuals who are invested in improving the program, and people who have utilized the service and have direct feedback about their experience. A committee of CAHOOTS team members meets with the stewardship council once a month to share and receive feedback and discuss initiatives such as arranging educational seminars and listening sessions. The members of the stewardship council receive a stipend in respect and gratitude for their time and expertise.

A few of the initiatives that have come from feedback provided by the stewardship council and Ad Hoc Committee on Police Policy are:

- An initiative to have mental health dispatchers in a separate department of call dispatch, with the goal to reverse the priority of response so that CAHOOTS will always be the first to respond to a crisis call. These dispatchers would be specially trained in de-escalation, crisis, and mental health.
- A means for community members and clients to provide feedback or file a formal grievance; currently, the grievance process requires a person who is willing to advocate for themselves and contact the CAHOOTS program directly, which is not entirely accessible. There are efforts to standardize a better way to receive anonymous feedback from clients.
- Educational initiatives and outreach to the Latinx community, including de-escalation trainings and informational seminars about our services in Spanish, working more directly with local agencies who

work with the Latinx population, and introducing an outreach role to the team filled by someone who speaks Spanish.

- Access to continual education and training opportunities for CAHOOTS team members including seminars by representatives from local agencies who can present on how the service can be helpful to them and their clientele and continual education in areas of social justice and equality in healthcare.
- A long term goal of offering an alternative to calling police in order to access the service.

One of the most important pillars of these organizations needs to be community feedback; otherwise the programs will become too deeply cemented within other institutions without having the input of the evolving population which it serves. It will not be successful without this. People will not trust it, which means they will not use it.

CASE STUDY: PORTLAND, OREGON

When Portland began strategizing how they would reimagine public safety response, they first looked towards arrest data to identify what the focus of their program needed to be, and what further research was necessary to identify the needs of the community who would be receiving service. Data showed that 52% of all arrests in 2017 were of people who identified as homeless[29], and the city's dispatch center showed that Portland residents call 911 to complain of an "unwanted person" more than any other reason. Other studies showed that between 2017 and 2018, 72% of arrests at local hospitals targeted unhoused people.

Portland homeless advocacy group and weekly alternative newspaper Street Roots called for a better model of response. They gathered activists, advocates, volunteers and peer counselors across a variety of grassroots organizations and community coalitions to reach out to the community that would be most impacted by this service. They developed teams to begin interviewing people experiencing homelessness to inform the design for the project.[30]

A survey was drafted with input from advocates, service providers, and elected officials' staff. Teams learned about the best ways to approach people and enter interviews respectfully, about ethnographic research techniques, including not leading the questioning, active listening and flexibility, and allowing participants to respond in an open manner and at their own pace. Survey teams brought outreach supplies with them, including toilet paper, water bottles, and batteries.

The teams visited camps, shelters, and identified people who were couch surfing or living in their cars. They asked these community members what would be most helpful; who the first responders should be, how they would like to be approached, what types of services and resources would be helpful, and how the first responders should be trained. A universal and emphasized request was to be treated with respect. Regardless of whether unhoused people had positive or negative interactions with current first response models, the most widely shared experience was that they were treated impolitely rather than with dignity and respect.

The researchers reported the most illuminating information came from hearing the experiences of those experiencing homelessness in their own words.

The recommendations for the Portland Street Response that emerged from the survey synthesis were:

- Portland street response needs to be entirely separate from the police.
- Prioritize training in mental health, de-escalation, trauma and listening.
- Teams should not be armed or run warrant checks.
- Uniforms should be recognizable and distinct from other first responders.
- Referrals and transportation services would help the teams be effective; PSR needs to connect people with places where people can go.

[29] https://www.oregonlive.com/portland/2018/06/portland_homeless_accounted_fo.html
[30] BelieveOurStories.pdf (pdx.edu)

- The community should be educated about emergency calls and how to call 911.
- People should be treated with compassion and dignity.

More information about Street Roots and the implementation of Portland Street Response can be found in their Research Report.

CASE STUDY: Phoenix

The Neighborhood-Organized Crisis Assistance Program (NOCAP) is a coalition made up of representatives from multiple organizations with non-hierarchical structure dedicated to creating a first responder program specializing in behavioral health, substance abuse calls, and dispatches impacting the Unhoused Community.

Developing a diverse and intersectional representation of different communities on the committee was a priority for the team and involved reaching out to people in personal networks and as many local organizations and agencies as possible. Before doing outreach, members of the coalition first developed a mission statement and points of unity to be shared with others who might be interested in joining the group; they found that people are more likely to engage if they can see clear goals and energy moving in a specific direction.

NOCAP emphasizes the importance of developing a coalition from an intersectional standpoint with representation across multiple communities. They reached out to black liberation groups, abolitionist groups, LGBTQ groups, advocates for the unsheltered community, HIV alliance and harm reduction groups, youth groups, and substance use peer counselors. They found church communities to be an important touch point, as they often represent a broad and diverse subset of voices and are often a very socially active hub of politically engaged community members.

Once their coalition was formed, NOCAP developed an education campaign to spread the word about what a Mobile Crisis Team is, how it would impact the community, and sharing examples of models in other communities to indicate how they are working. They arranged seminars and distributed educational materials to the public and officials. The goal was to provide clear examples and evidence that alternatives were possible. NOCAP found that they needed to do a lot of their own research to present to city officials, and that it's not uncommon for the city to be unfamiliar with the specific numbers of mental health calls or arrest data.

"Sometimes it requires lots of research on the part of those trying to advocate for this work."

Through community research, NOCAP consolidated and synthesized the requests of the community in to a list of 18 Fundamentals to steer the implementation of the MCT program in Phoenix. They have since been working to turn these fundamentals in to an ordinance. NOCAP presented these fundamentals to officials as follows:

The Neighborhood-Organized Crisis Assistance Program (NOCAP) coalition is proposing the following items as fundamental to the establishment of this crisis assistance service:

1. This program and its First Responders are separate from all other current first responder departments.
2. This entity will be the only First Responder department responding to dispatch for non-violent and non-criminal calls.
3. All mental health organizations will be thoroughly vetted for their efficiency and success for working with disenfranchised and underrepresented communities in Phoenix, Arizona. Vetting should include researching if organizations work with police, ICE, and other law enforcement agencies. Vetting and decisions for which mental health organizations to collaborate with will be preformed by the Steering Committee.
4. Responders will have a unique uniform that is distinguishable from all other current departments.
5. Responders will not run background checks, report drug use or drug possession, or report someone they believe is undocumented.
6. Responders will not report calls or cases to the police or ICE.
7. Responders will be required to have professional training in de-escalation.

8. A minimum of two individuals will respond to each call, one skilled medical professional and one responder certified in social sciences and behavioral health.
9. Responders will not carry weapons of any kind, including less-than-lethal weapons not limited to pepper spray, tasers, or any incapacitating tools.
10. Responders cannot have been former police or be involved in PPD activities.
11. Funding will involve providing resources to people in need. Including but not limited to food, blankets, medicine, transportation, and assistance/resources for leaving a bad living situation.
12. Recruitment for responders will prioritize the hiring of local individuals with knowledge of Phoenix's diverse neighborhoods.
13. The first responder unit will be accessible through the 9-1-1 dispatch system.
14. When responders are dispatched, responders who live in the area of the call will be prioritized if available.
15. The budget for 911 operators and call centers (Communication Bureau 911/Crime Stop Call Center) will be reallocated to this entity's budget instead of the Phoenix Police Department.
16. Ongoing funding to be $20 Million/per year for a functional Crisis Assistance Program department.
17. Because this program will free up hundreds of thousands of calls to service, funding should not come entirely from surplus funds, but instead from the already over-funded police budget. Operations dictate budget, and this will move operations away from police.
18. A Steering Committee shall be created to guide the establishment and implementation of the CAP program.

CASE STUDY: KINGSTON COUNTY

Rise Up Kingston, a grassroots organization supporting their community needs in upstate New York, performed an in-depth qualitative research analysis where they surveyed their community about their public health needs and what areas of training and expertise they would like to see included in the qualifications of their alternative first response team. Below are the results of that survey.

Requisite areas of training for first responders in Kingston County, as requested by community members:

- Mental health awareness, suicidality, safety planning trainings
  - Emphasis that suicide assements can be harmful, psych wards are violent and harmful to QTPOC & others
  - Harm Reduction, Narcan use
- Communication
  - Motivational Interviewing
  - Crucial Conversations
  - De-escalation
- Harm Reduction Training
  - Harm Reduction Coalition
  - Local trainers; narcan use
  - Certified Recovery Peer Advocate Training
  - Cultural Competency
- Anti-racism
  - LGBTTTQA+
- Class issues
- Gender Oppression
- Traditions & Customs within other cultures & how to respond
- Political analysis of child welfare
- Disability Community
- Training for responders to deal with neurodivergent people

    - Sensory processing
    - Executive dysfunction
    - Developmental motor dysfunction
    - Comorbidities
    - Autism Acceptance
- Trauma Informed care training
- Trauma Care
    - Mindfulness
    - Somatic
    - vicarious traumatization
    - Grounding practices for trigger situations
- Medical
    - Overdoses
    - Street Medic Trainings
    - CPR
- Domestic Violence
    - Between all genders

Additional references and resources:

WE Rising Project; thewerisingproject.org

EFR_Sample-Legislation-and-Process-2.pdf (netdna-ssl.com)

Believe Our Stories and Listen – Portland Street Response

DISPATCH PROTOCOLS

CAHOOTS is dispatched for non-criminal, non-violent calls, through the same number and system as the police department.

Dispatchers in areas without mobile crisis intervention programs are already trained to investigate and triage calls to identify the appropriate response among existing emergency response resources such as fire, police, and ambulance. Each emergency is unique; call-takers are trained to ask a lot of questions to get the right resources to the right place at the right time. Some calls require a response from a single emergency unit, some calls require overlapping response.

Appropriate resources and procedure are specified by department policy as well as the training and experience of dispatchers, who must consider the safety of the public, the responders, the unique needs of the citizens in the emergency, and the nature of the call; including immediacy of the emergency, presence of a weapon, and other environmental cues.

Emergency dispatchers are doing this type of triaging already; a mobile crisis team just adds another response option to the wheelhouse. CAHOOTS diverts some calls from EPD and other emergency services, as well as handling unique calls that wouldn't normally be responded to by law enforcement or other emergency response. For this reason, quantifying true diversion rates is difficult, as much of this work is preventative; it is hard to identify what kinds of calls CAHOOTS may respond to and deescalate that may otherwise have led to an arrest or medical emergency.

If a request for service involves a crime, a potentially hostile person, a potentially dangerous situation (to oneself or to the public) or an emergency medical problem, the call is referred to the police department or Fire/EMS. If there is any question about whether a call is safe for CAHOOTS, call takers are told to err on the side of caution and send police first, or together with CAHOOTS as a joint response.

CAHOOTS calls are triaged based on urgency and not length of time in the queue. Calls such as suicidal subjects or those posing a safety risk, such as an intoxicated subject with a risk of falling in to traffic, are dispatched before non-urgent requests. For non-emergency medical evaluation and transport requests, the call taker confirms with the caller that EMS or ambulance is not needed. Dispatchers prioritize more urgent events, and requests for CAHOOTS from patrol officers and sergeants often take priority over citizen requests.

In Eugene, many people are familiar with CAHOOTS and will usually ask for them upfront when they call the non-emergency line. When a dispatcher is speaking to a citizen about a call for service that they believe would be most appropriate for CAHOOTS, they may ask whether the caller is familiar with the service and ask if a CAHOOTS response would be acceptable or preferred. If the caller would like CAHOOTS to respond, and there are several calls pending in the queue, the dispatcher will advise the caller of the possibly delay, but they are not able to provide an ETA for CAHOOTS. It is important that call details are collected and communicated clearly so that the dispatchers can appropriately prioritize calls.

CAHOOTS provides a unique service; is it not unusual for them to spend an hour or more on a counseling or transportation call. Immediate service is not always possible when citizens request it. If the call can't hold, it is at the discretion of the call-taker to evaluate, carefully, whether it would be more appropriate to send police or Fire/EMS. Because CAHOOTS has fewer resources on the road at a time, police are the only ones available to arrive at a higher-priority scene that would otherwise be more appropriate for the mobile crisis team. In this instance, police may stay at the scene until CAHOOTS is available and hand off the call.

What designates a 'violent' call? How presence of a weapon is a gray area.

Deciding what is an appropriate call for CAHOOTS is based on detailed communication on behalf of the dispatcher, consent of both the responder and the client, and any past associations or information about the

client. This balance can sometimes be specific to the individuals who are on shift at the time; the dispatcher, the officer on scene, the sergeant on duty, and each of their respective relationships, trust, and respect for CAHOOTS. This is why having a relationship with dispatch, police and other partner agencies is so important.

One of the more complicated call-designations is when there is the presence of a weapon on scene; context is everything when deciding whether it is appropriate to send CAHOOTS to a scene that involves a weapon. Often, dispatch will ask for contextual clues about the use of the weapon and ask the CAHOOTS team whether they feel comfortable taking the call.

"You cannot determine that someone in possession of a weapon has intent to harm themselves or someone else. What is the nature of the presence of the weapon? Is the weapon actively being used by or on the client themselves, or is it nearby with the possibility of use? The consideration of whether CAHOOTS were requested by the caller or client should be considered; police are the ones who often escalate the presence of a weapon in to a dangerous situation. Often, if the weapon is actively being used to menace someone, this is the standard bar for when police are expected to be on scene; but we feel that the simple presence of a weapon on scene should not be the bar. If people are posturing, presenting as hostile, or make it clear that they're not open to accepting our services, our teams can always leave and involve police if we feel it's necessary."

- *Ebony Morgan*
  CAHOOTS Program Director, Registered Nurse and Crisis Worker

MCT RESPONSE CRITERIA

The following criteria indicate when a call may be considered for Mobile Crisis Team (MCT) response:

- Direct request for MCT services.
- Subject is unable or unwilling to contract for safety of self or others.
- Subject is experiencing profound deficits in personal care/hygiene/sanitation.
- Subject has access to means to attempt suicide or self-injury without use in a menacing manner towards others (excluding firearms, which merit police response).
- Crisis requires hands-on support for intervention (such as transport, harm reduction, supplies/basic needs provision). Request for these supplies alone does not merit an MCT response.
- Assistance is needed in accessing housing/shelter resources.
- Subject is incoherent or 'fading out.'
- Subject requires assistance in accessing higher level of care without emergency transport (such as Emergency Room, Urgent Care, Walk-in Clinics, Crisis Stabilization/Respite, Detox/Sobering).
- Transport Request (ie, from shelter to services)
- Subject's immediate environment does not allow for safe and private conversation via phone/text/video.
- Subject requires Medical Eval or support of First Aid/Chronic Medical Conditions/Wound Care.
- Other mitigating circumstances in the event environment indicate MCT response.

The following information is gathered when dispatching a MCT response:

- Name of involved (nickname/street name appropriate, last name is not required.)
- Location of event
- Nature of Call: Welfare Check, Suicidal Subject, General Counseling, etc.
- Chief complaint/primary need articulated by caller
- Safety alerts and/or physical environment considerations
- Identifying Information (physical description, belongings, landmarks)
  - *"Male, early 20s, short blonde hair, brown eyes, approximately 6 feet tall, thin build, wearing blue hat, glasses, yellow flannel, and black pants with rubber boots, tattoos on both hands, carrying orange backpack with reflective panel. Seated under the fir tree at the park entrance."*

Considerations for assessing urgency in calls for service:

- Physical Environment: inclement weather, temperature, shelter, sanitation
- Acuity of symptoms
- Volume of callers reporting situation
- Subject and/or public Safety
- Presence of other Public Safety resources in event environment.

DISPATCH DATA

In 2019, CAHOOTS was dispatched to almost 18,000 public-initiated calls for service, about 20% of all incoming calls. This does not indicate a response. CAHOOTS top call types are Welfare Checks (28%), Public Assists (25%) and Transport (21%.)

WELFARE CHECK

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

EXAMPLE:
LOC/ SOUTH OF THE INTERSECTION, ON THE OVERPASS FEMALE WALKING BAREFOOT AND NOT WEARING MUCH CLOTHING -- REQ CAHOOTS TO GO AND CHECK ON HER LAST SEEN 5 AGO NO WEAPONS OBS

NE CORNER OF 2ND AND VAN BUREN. C/ADVI THERE IS POSSIBLY A PERSON SLEEPING ON SIDEWALK, OR POSSIBLY ITEMS COVERED BY TARP. HASN`T MOVED IN 5 HOURS. C/IS CONCERNED THE PERSON MAY NEED A WELFARE CHECK

PUBLIC ASSIST

This is not considered a traditional police call. It generally involves non-emergency service requests from the public, from counseling, to injury evaluation after a person declined to be evaluated by a medic, to providing general services.

EXAMPLE:

C/ REQ CAHOOTS FOR COUNSELING AND ASSISTANCE C/ HAVING SUICIDAL THOUGHTS NO PLANS OR MEANS AT THIS TIME

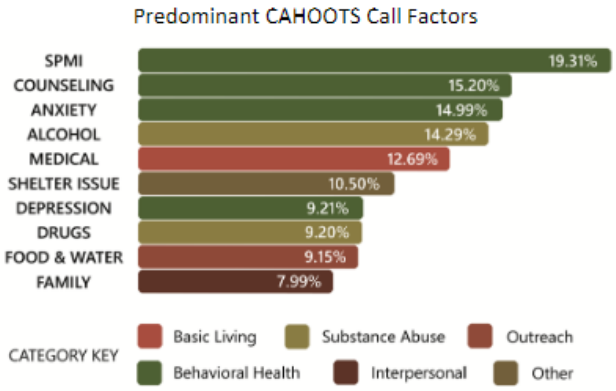
C/ REQ TRAN FOR HERSELF AND HER SON TO A MEAL THIS MORNING

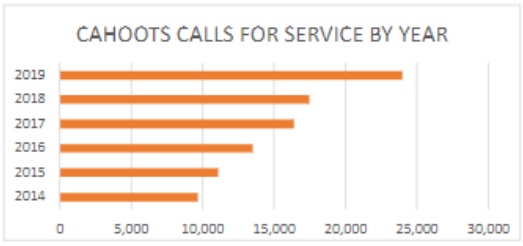
TRANSPORT

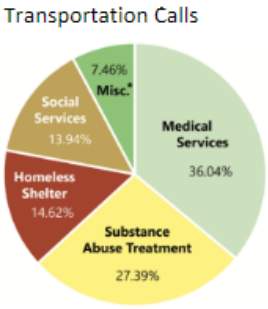
A CAHOOTS transport call generally involves moving an individual, often unhoused and in need, or dealing with mental health issues, from one location to another for non-emergency services.

EXAMPLE

C/ NEEDS XPORT TO SERVICE STATION - WAITING IN ED LOBBY







The 18,000 CAHOOTS calls in 2019 includes calls that were both CAHOOTS-only and also those that were a joint response with other emergency services. The break down of those call types are as follows:

1. Check Welfare 28.7%
2. Public Assist 25.7%
3. Transport 21.2%
4. Suicidal Subject 7.85%
5. Disorderly Subject 2.58%
6. Intoxicated Subject 2.01%
7. Found Syringe 1.75%
8. Traffic Hazard 1.68%
9. Criminal Trespass 1.21%
10. Other 6.07%

CAHOOTS called for backup from EPD 311 instances in 2019; of those, an immediate response with lights and sirens were needed only 25 times. The term backup does not indicate an emergency response, but simply that after CAHOOTS arrived on scene it was determined additional police response was required. Most calls for backup are because of the limits of authority on behalf of the crisis response team. Since CAHOOTS can not force services or transport on clients, the police are called in instances where more intervention is needed. Police are called when a subject is refusing service and is a danger to themselves or someone else, or when the crisis team needs help diverting traffic if a crisis is taking place in the street. Backup rates are higher in calls that are traditionally dispatched to police, like Criminal Trespass; if CAHOOTS is called to a report of trespass, and the individual chooses not to relocate by their own accord, then the police are called.

The following are the categories of all joint CAHOOTS / EPD calls for service in 2019: these numbers do not differentiate which unit arrived on scene first:

1. Suicidal Subject 20.1%
2. Check Welfare 19.1%
3. Disorderly Subject 10.2%
4. Dispute 9.17%
5. Criminal Trespass 6.34%
6. Public Assist 4.36%
7. Suspicious Conditions 2.53%
8. Disorderly Juveniles2.38%
9. Traffic Hazard2.33%
10. Overdose 2.18%
11. Other 21.4%

The following are calls where CAHOOTS called for backup when they were dispatched independently; EPD arrived after CAHOOTS. The percentage of calls beginning as CAHOOTS-only which then required backup was 2% overall. However, when you look at the calls outside of CAHOOTS' normal top 4 categories of calls for service, need for backup increases.

1. Welfare Check 37.3%
2. Suicidal Subject 13.5%
3. Public Assist 10.9%
4. Criminal Trespass 7.40%
5. Transport 6.43%
6. Disorderly Subject 5.14%
7. Traffic Hazard 4.5%
8. Intoxicated Subject 2.89%
9. Missing Person 1.61%
10. Suspicious Conditions 1.29%
11. Other 9%

SCREENING CAHOOTS CALLS

Mental Health Call / Mental Subject

Call takers are trained not to use the code 'mental subject' on the initial entry of a call; diagnosing mental illness from secondhand information on the phone is not reliable. The job of the call taker is to note the behavior and let the responding units make the determination. In this situation the call is often entered as a disorderly subject or other similar incident type. If it is suspected that the subject is having a mental health issue, this information is added to the call details. In these cases, the call taker should attempt to find out what kind of long-term mental health issues they may have and if they take any medication. It is important to relay to responders any details regarding whether the subject is taking medication and/or seeking professional help. Other important questions include:

- Whether the subject is violent or has a history of violence
- If the subject has any weapons or any access to weapons
- If the subject has made any threats to harm themselves or anyone else.
- If the subject will be cooperative with responders / who they will be most responsive to

If the subject is non-violent, these calls may be handled by CAHOOTS. Often, the caller even requests CAHOOTS. These calls are screened closely to make sure they are appropriate and to identify whether there is indication of violence or weapons.

MENTAL HEALTH TRANSPORT

Mental health transports are generally handled based on the behavior and demeanor of the patient. Mental health transports are rarely handled by medics except when the subject has harmed themselves and needs medical care. Another exception is when the subject's condition requires a stretcher transport, such as people with disorderly dementia or Alzheimer's who are physically disorderly due to cognitive impairments. These transports are handled collaboratively with police and EMS.

Otherwise, most mental health transportation is handled by CAHOOTS as a result of welfare checks and public assists. CAHOOTS does not ever transport anyone against their will. Instances where an officer is involved in a mental health transport include 'mental holds'; CAHOOTS is not authorized to perform the following mental health transports:

Two-Physician Hold

Gives a police officer authority to take a person in to custody. This is not a criminal charge; it is a psychiatric hold authorized by a physician on a subject who is at large in the community and thought to be a danger to themselves or the public. People can not be transported against their will without a Two Physician Hold and the involvement of a police officer.

Director's Hold

Gives the officer authority to take a person in to custody. Occasionally there are requests from family members or physicians to transport a person against their will to a mental health facility. This will only happen if there has been a Director's Hold issues by an authorized person.

Police Officer Hold

In order for a citizen to be taken into custody for a mental evaluation against their will, the officer must observe behavior that clearly demonstrates an immediate threat to self or others. Only under those conditions does a police officer have the authority to take a citien into custody for their safety.

INTOXICATED SUBJECT

The call taker is to confirm that no medical condition exists that would constitute an EMS dispatch, and that the subject is not being disorderly or committing a crime. If the subject is in immediate danger (ie, stumbling into traffic) priority ode 3 for police to respond. If the subject is not in immediate danger, priority is 5 for CAHOOTS to respond.

DISORIENTED SUBJECT

It is not unusual, or illegal, for people to pace or talk to themselves in public. This alone does not constitute a disoriented subject or the need for MCT response. However, if the subject appears dazed, unable to tell the caller their name or address, or awake but not responding, someone should be dispatched as soon as possible. Call takers should screen these types of calls to ensure there are no medical problems. If the subject is dangerous or hostile, police will respond in lieu of CAHOOTS. If the subject is elderly or appears confused, care facilities should be contacted to see if they are missing anyone.

WELFARE CHECK

Welfare checks are to ensure that there isn't something amiss that might affect someone's health, safety, welfare, present a hazardous condition, or that may be the result of a crime.

Callers requesting welfare checks are questioned carefully. There must be a valid reason why the caller or someone else can't check on the subject. There has to be a suspicious or unusual event that happened and/or a behavior that is out of character for the subject involved, such as an elderly person who hasn't been heard from

for several days. While CAHOOTS can handle most welfare checks, if hazardous conditions exist or the caller suspects a crime may have been committed, then police will need to respond.

CAHOOTS cannot force entry into a building to check a subject's welfare. If the caller articulates that someone will need to break in to the premises, officers will need to assist.

PUBLIC ASSIST

Public assists are a broad request and not all are honored. As a rule, if the caller or a friend of the caller can do what it is that is being asked, they should handle it themselves, as CAHOOTS does not have the resources to do all that is needed to assist the public. This code is normally used to request a CAHOOTS response for subjects who need assistance with housing, counseling, or mental health problems.

TRANSPORTS

CAHOOTS may handle the following types of transports:

Detox transport to sobering center

Transport to family shelter, the mission, or warming centers

Transport of a cooperative, voluntary, non-violent subject for mental evaluation

Transport to crisis counseling centers for mental health care

CAHOOTS will not transport people to a private residence; only to staffed, attended facilities or shelters.

EMERGENCY MESSAGE / DEATH NOTIFICATION

CAHOOTS will deliver a generic message for someone in an emergency. We will not divulge the nature of the emergency and don't require more than a name, address, and phone number of the caller.

FOUND SYRINGE

CAHOOTS can be dispatched to pick up found syringes. Call-takers request information about exactly where the syringes are (ie, under large oak tree at north east side of parking lot) and how many there are. Citizens wanting to dispose of their own syringe are referred to their trash collection service for guidance on the proper disposal of syringes.

PARTNERING WITH OTHER AGENCIES;

Police, Dispatch, EMS, Fire, and Hospitals

In order for a mobile crisis response program to be successful, there must be regular and extensive communication and collaboration with other public health agencies and service providers, as well as with local government, police and fire departments, local hospitals, and community members. Opportunities for cross-agency check-ins on policy, communication, budget, and procedural feedback and support can be built in structurally by establishing cross-agency meetings at regular intervals (weekly, monthly or quarterly) with attendance from a diverse range of representatives from different agencies and departments, including dispatch, police, fire and EMS, city representatives, representatives from the ER, homeless advocates and volunteers, and the mobile crisis response team. Ideally, the mobile crisis response team will have an equal voice and seat at the table as any other EMS or public safety entity when discussing policy, funding, community needs, and contract negotiations.

WORKING WITH THE CITY

CAHOOTS is a partner organization with the City of Eugene and the neighboring City of Springfield, and is run through a federally qualified non-profit health organization, White Bird Clinic. CAHOOTS receives its funding through city and county subsidies, as approved by city council. The program's funding is incorporated into its contract with the police department, which manages budget allocation and contract agreements. City council can increase or decrease funding, and CAHOOTS is often a point brought up by community members during open-floor sessions of community council meetings.

WORKING WITH POLICE

CAHOOTS works closely with the local police department. After several decades, the two programs are deeply entrenched and rely heavily on one another. Trust has been built and steadily increased between CAHOOTS and the police department over time; the police have come to trust that CAHOOTS first responders can handle themselves in a variety of situations, and have come to understand which scenarios are best suited for a CAHOOTS response.

The CAHOOTS Program Director meets with the Chief of Police monthly to discuss ongoing projects like contract negotiations and funding, and to discuss feedback on specific calls, complaints from callers and community members or from responders, and clarifications on policies and procedures.

The CAHOOTS teams are dispatched using the same system as the Eugene police department, through either the emergency 911 system or the non-emergency line. The team is dispatched to a variety of calls, diverting from EPD and other emergency services, as well as handling a subset of unique calls that would not normally be responded to by law enforcement.

From a Program Analysis released by EPD on their website:

"CAHOOTS is a valued partner within the city of Eugene and provides a needed service within the community. In examining interplay between EPD and CAHOOTS, they are partner organizations where they both meet specific and unique needs. Additionally, CAHOOTS and EPD are often jointly dispatched to CFS (calls for service) to meet those needs."

Most tension regarding the program's collaboration with police comes from being associated with them publicly; whether people don't realize that the teams are dispatched through the same system, or they're disappointed that it is the only way to access the service. People may be upset when CAHOOTS arrives alongside police, or when CAHOOTS is in a position where they are required to include the police in the call, such as an incident that requires mandatory reporting or a safety issue that may merit a mandatory hold. While CAHOOTS is not the one

physically performing these, they are still instrumental in their happening if they are a result of the individual calling CAHOOTS for support. While police don't have access to CAHOOTS records by default, the department does have access to all call-taking records, which means if a community member doesn't want to go on record as needing or receiving support or services, then they can't access CAHOOTS. This has shown to be a detrimental barrier for some people and has contributed to an erosion of trust within the community.

There are two significant differences between CAHOOTS and the police; CAHOOTS does not have the authority to make someone do anything against their will, and they are not required to report or take action on an individual's lifestyle choices, regardless of its legal standing.

Another distinction is that CAHOOTS is a federally qualified healthcare service, and the program's funding is heavily reliant on HIPPA compliance. Procedure and policies around HIPPA are not a part of police training or culture, and can often be disregarded or neglected by police. CAHOOTS first responders regularly find themselves reminding police about the importance of HIPPA when an officer calls for a follow-up or requests information about an incident; first responders often need to remind them that they are unable to share patient's health information with them in person, over the radio, or via email.

It is important to note that CAHOOTS involvement and safety is based on communication, consent, and existing information from any past records or encounters with the client in question. If there is a reasonable assumption that it might be dangerous for someone who is unarmed to be called to the scene, then CAHOOTS is not dispatched. Dispatch may ask the CAHOOTS team if they feel comfortable taking a call when providing relevant information, and a CAHOOTS team can accept or decline, either at the time or dispatch or after having arrived at a scene that they decide is uncomfortable or unsafe for them. This is reliant on communication between all entities, and is specific to who is on shift at the time, including the dispatcher, the officer on scene, the lieutenant, and each of their respective relationship and trust for CAHOOTS.

This is why a positive and consistent working relationship with all partnering agencies is so important, and can also be tricky; balancing the maintenance of the relationship while also maintaining the program's values and requirements can be a challenge.

FOR MORE INFORMATION, SEE DISPATCH.

In the Field

Working with police in the field requires a relationship built on trust and effective communication. Police are not trained or equipped to handle every situation they are presented with, especially those involving mental health and homelessness. Having a positive working relationship allows the local police to call on CAHOOTS via a shared radio channel and hand off a scene to those properly trained in de-escalation, trauma informed care, substance use and harm reduction, and general crisis response.

When a scene is handed over, whether from police to CAHOOTS or in the reverse, an exchange of relevant information takes place, usually in the form of a shorthand report to explain what the goals and expected outcomes of a situation are.

In a dynamic work environment like mobile crisis response, scenes can change quickly and CAHOOTS may require police assistance. While rare, some instances require that CAHOOTS calls Eugene Police for backup. When police are called for backup, CAHOOTS will often stay to offer oversight and advice if required.

Note on Co-Response Models

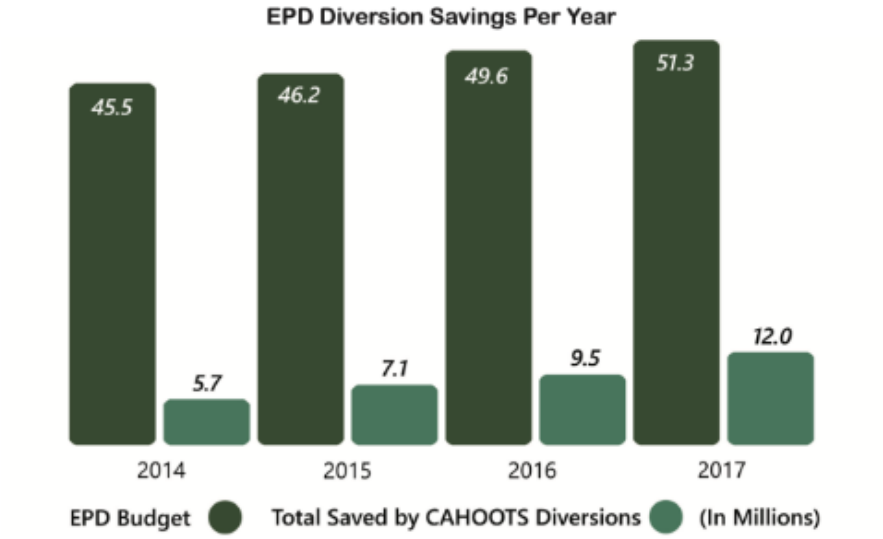
When considering teams that work closely with police, it is important to make a distinction between a mobile crisis response team and a co-response team. Co-response models pair a mental health clinician with a police officer to respond to people experiencing behavioral health crises in the community. Such teams in the United States are often created as part of larger CIT (crisis intervention team) program efforts, although they may also

be implemented as part of other comprehensive models of police–mental health collaboration or as stand-alone programs. The model is implemented with significant variation (Puntis et al., 2018). Co-response teams can include clinician-officer teams that ride together in the same police car (marked or unmarked), teams in which the officer and clinician arrive at the scene separately, and teams whose clinicians respond remotely via phone or telehealth support.[1]

CAHOOTS does not use a co-response model. This is what works best for our community, and is a choice based on the carceral nature of social work and problems associated with over-policing, and the feedback from our community that offering an independent service is essential to the community's trust and, consequently, the success of the service.

Additionally, the cost of co-response is higher; our experience is that using people from the community who already have public trust is cheaper and more efficient. Studies show the overall cost of a co-response model tends to be higher than a mobile crisis response team that acts independently from the police department. Remember, organizations in your city are already doing the work – pilot programs should be identifying and supporting these community members to expand their impact and involvement.

FOR MORE DETAILS SEE 'COMMUNITY INFORMED DESIGN' and 'THE MOBILE CRISIS LANDSCAPE'



The EPD quotes $800 per police response. Using the number of calls that would otherwise be handled by police, including suicide risk, homicide risk, self harm, intoxication, rage, welfare, and transport, CAHOOTS has saved the EPD an average of $8.5 million each year from 2014-2017.*

**www.eugene-or.gov/DocumentCenter/View/10635*

It is not possible to find an exact divert rate for a specified time period. It is likely that the true divert rate falls between approximately 5% - 8%. Additionally, EPD does provide backup for some CFS where CAHOOTS was the only unit initially assigned.

It should be noted that backup rates for more "traditional" CAHOOTS-centric calls, *[such as*] Check Welfare, Assist Public and Transport are relatively low. It is when CAHOOTS is dispatched to a traditionally police-centric call, like Criminal Trespass, that the instances of CAHOOTS requiring backup from the police jumps significantly.

With "Criminal Trespass," backup was requested 23 times out of 69 CAHOOTS responses where they arrived and located the subject. That equates to CAHOOTS requesting backup in 33% of the CAHOOTS ONLY Criminal Trespass CFS. For the top 4 natures that make up the bulk of CAHOOTS dispatches, the backup rate is as follows:

Transport (>1%)

Assist Public (1%)

Check Welfare (4%)

and Suicidal Subject (5%).

The term backup does not indicate an emergency response, it simply indicates that after CAHOOTS arrived on scene it was determined additional police response was required. We were able to isolate 25 instances (8% of backup calls) where the terms “C3” or “CODE 3” were used in the call notes, this would indicate an immediate and emergency police response to the call.”

WORKING WITH OTHER AGENCIES

CAHOOTS is consistently in contact with and utilizing other social service agencies and support programs in the community. The program has been described as the hammock that hangs between all the other local systems of social, mental, and medical support. This requires easeful communication between all entities, for other agencies to be educated in the nature of service that CAHOOTS provides and that first responders be well versed not only in our own program structures, policies and regulations, but also those of all other service providers in the area. They need to be well educated on laws, regulations, limitations and capabilities of different agencies and entities, creative means of access and problem-solving and an extensive toolkit of other ways to advocate for clients.

Advocating for the needs and rights of a client can be a point of conflict when negotiating with partner agencies. This is often a result of individual or systemic biases against drug use, mental and behavioral health stigma, a tendency to over-diagnose, and general fatigue or resistance to providing service to someone who is perceived as difficult, dirty, or under the influence. First responders often find themselves in a position where they are reminding hospital staff or other agencies of their own policies, or having extended conversations with the staff in admitting about whether a person qualifies as appropriate for admission. CAHOOTS has to hold firmly that someone is entitled to care even when no one wants to provide it.

This often requires mobile crisis first responders to be just as informed, if not more so, about an agency’s policies than they are. This emphasizes why a regular and sustained relationship between all working partners is so important; for CAHOOTS, this is maintained by hosting regular meetings with liaisons from our local hospital (often a lead ER charge nurse and ER social worker) where we clarify policy, go over specific cases, pass feedback back and forth.

Although many of the van workers at CAHOOTS are trained and certified EMTs, if a patient is exhibiting signs of an underlying or severe medical issue the scene will be handed over to EMS. Sometimes medics need to call the hospital to speak with the charge nurse on duty, just like any other EMS or fire department would do in the field. It is important to understand the local laws regarding emergency care and transport in your area.

While we are contractually required to meet with the police department, CAHOOTS does not currently have regular contact with the fire department, which means the teams only encounter the fire department on calls; we do not meet with them regularly or communicate with them on the radio. This can lead to miscommunications or mistakes in the field, such as questions around appropriate transport. Having a good relationship with these agencies is paramount to these programs working well. Mobile Crisis First response programs need to be able to communicate with fire in the field as well as at regular intervals to ask questions and receive support, and vic versa.

The CAHOOTS Program Director has regular quarterly meetings with dispatch, and a dispatch supervisor is sometimes in attendance at the monthly meetings between CAHOOTS and EPD. This is a time to give feedback on specific calls, complaints from callers and community members or from responders, and to discuss ongoing projects like contract negotiations or questions about funding or policy clarification.

PLANNING BY THE NUMBERS

The CAHOOTS program has been designed with the intent to fit the specific needs of our community. This is an iterative process. Eugene and Springfield have a combined population of about 240,000 and span a total of about 60 square miles. The combined populations are about 85% white, and we have one of the highest rates of homelessness per capita in the country. These factors makes us different than many of the communities wanting to establish similar programs. There is no formula for how to scale these programs for different communities. It is not recommended that mobile crisis programs be designed by prescribing a number of vans or number of first responders per person per capita, the way police departments are normally scoped, but rather to make choices based on call center and arrest data, public health data, and the needs your community is expressing.

The following is meant to help guide conversations about how to collect and synthesize local data to inform the development of a program catered specifically for your community.

PUBLIC HEALTH DATA

A mobile crisis response team is going to encounter a diverse range of public health needs; while the program should be prepared for all of them, it is helpful to research which chronic illnesses are prevalent in your area to inform the focus of your services. The CDC is a reliable source for this information, and often breaks down statistics by state. You can also check with local public health entities to hear about what they see most. Identify statistics about substance use, mental health, and other chronic illnesses, and compare these rates to the number and types of services available in the area. Eugene has one of the highest rates of homelessness in the entire country, which is reflected in the our program; CAHOOTS deals with a high amount of housing related crises, mental health and medical needs related to living on the street, and makes many referrals to housing assistance programs and other relevant services.

CALL DATA

Synthesizing local call-center data is a good way to identify not only the priority of different needs in the community, but is also a source for identifying high-need locations and peak hours. This information can help to roll out programs incrementally; depending on resources, you may choose to focus rolling out your pilot program only during peak hours, or within a specific jurisdiction with a high call rate.

Consider looking at the following Public Safety Calls for Service (CFS) in your area over the past 12 months:

- Misdemeanor calls (Criminal trespass, open containers, disorderly conduct)
- Houselessness-related calls
- Mental health calls
- Number of low-acuity medical calls
- Substance abuse and intoxication calls
- Welfare check calls / trespassing / unwanted person

Consider compiling and comparing information from local crisis call centers from the same 12 month period for situations which involve the following:

- Direct request for in-person response.
- Caller is unable or unwilling to contract for safety of self or others.
- Individual in crisis is experiencing profound deficits in personal care/hygiene/sanitation.
- Access to means to attempt suicide or self-injury
- Crisis requires hands-on support for intervention (transport, harm reduction, supplies/basic needs provision).
- Assistance is needed in accessing housing/shelter resources.
- “After-hours” referral/connection to services.
- Caller is incoherent or “fades out.”

- Caller requires assistance in accessing higher level of care without emergency transport (Including Emergency Room, Urgent Care, Walk-in Clinics, Crisis Stabilization/Respite, Detox/Sobering).
- Transportation Request.
- Caller's immediate environment does not allow for safe and private conversation via phone/text/video.
- Caller requires Medical Eval or support of First Aid/Chronic Medical Conditions/Wound Care.

ARREST DATA

Surveying the local arrest data for your area can help to identify which types of calls could be diverted to CAHOOTS and result in reduced police presence and jail diversion. Consider collecting and analyzing the number and percentage of the following categories of emergency calls and arrest data from the past 2-5 years:

- Misdemeanor arrests (criminal trespass, open containers)
- Houseless related arrests
- Arrests made with a mental health component
- Arrests made during low-acuity medical calls
- Substance and intoxication-related arrests
- Arrests related to trespassing / unwanted person

What were the critical outcomes of these calls? What percentage of the above resulted in arrest, transport to emergency department, or citations? What percentage of the arrests were of people who were unhoused, experiencing a mental health crisis, or were of people who were under age? What percentage were related to drug use? Was there any indication that most arrests happened in particular areas or during peak times?

PROGRAM PLANNING

Mobile crisis is a dynamic environment that is often under resourced and underfunded. First responders in this role are consistently under-supported. Programs should be planned with the mental, physical, and emotional wellbeing of first responders in mind; they should be paid a competitive living wage with career advancement opportunities and supportive benefits. Programs should be scoped and staffed with preparation for - and prevention of - burnout, turnover, and overtime. Consider including a therapist on staff for individual and group counseling sessions, or to be available on call. Mobile crisis first responders are steeped in first- and secondhand trauma in their day to day. Programs need to incorporate support in their structures, including compassionate scheduling, many personal and vacation days, competitive wages, and robust benefits, including life insurance and mental health counseling coverage.

CAHOOTS requires that people in administrative positions are also trained on the van and hold regular shifts in the field, in order to remain grounded in the work. Consider planning programs with incentivized on-call systems and shift differentials, and establishing a tiered wage system, with higher wages for cross-trained first responders to assist with scheduling and coverage. Identify tiered rates of pay across trainees, those who are fully trained, those who have been employed for a year or more, those who are cross-trained, people with higher licensure, people who fill roles of community engagement and education, and those who fill administrative and leadership roles.

Strategize for fleet management; CAHOOTS has three vans at a time on the road during peak hours, and consistently always has at least one van out of commission. It's recommended that fleets include 50% more vehicles than are on the road.

EXPANSION

When considering when it's time to expand, assess wait times and the length of the average call list; wait time for CAHOOTS exceed 45 minutes on average, and the queue can sometimes hold up to ten calls at a time. Are there times of day when wait times and call lists are consistently higher?

Identify the rate at which police are being sent to what would have been a mobile crisis call, due to being under-resourced. Identify the rate at which police call the mobile crisis team for backup or pass off a call.

STAFFING, TRAINING, AND DEPARTMENT STRUCTURE

CAHOOTS staff are hired in cohorts, with a mix of EMTs and Crisis workers. All new hires are assigned an Advocate who helps support onboarding and guides initial training, as well as a training and recruitment specialist who maintains consistency and support through training. By the third phase of training, new staff will identify a Mentor with whom they have a complementary working relationship. Mentors support completion of the training process and are an ongoing support for staff after completion of training. A Training Committee provides support to new staff and Advocates/Mentors and facilitates classroom instruction, as well as approves when a staff member has been fully trained.

In addition to classroom content on fleet operations, the City of Eugene and Eugene Police Department facilitate an Emergency Vehicle Operations Course (EVOC). EVOC for CAHOOTS emphasizes threshold braking, backing, point of egress, and defensive driving best practices. Lane Central Communications also facilitates occasional "Dispatch Refresher" in-service seminars.

Fully trained CAHOOTS Responders are eligible to cross-train after serving one full year in their primary role. Scholarships are available for EMT courses at the community college and are made possible through donations.

All staff must complete a minimum of 12 CEUs per year. EMTs generally obtain CEUs via standard recertification process bi -annually; other CEUs are obtained through a combination of independently-identified resources, conferences, and department- and agency-wide initiatives.

Clinical Supervision is provided to all responders.

ENTRY STANDARDS

Medical Staff Minimum Entry Standards:

Must have current Oregon certification as an EMT-B/I/A, Paramedic or have current Oregon licensure as a Registered Nurse and have significant emergency experience or demonstrate the capacity to operate in such an environment and as the sole licensed medical response until care transfer is made if necessary.

Crisis Worker Minimum Entry Standards:

Must have a level of training and experience comparable to a White Bird Crisis Team "Trained" crisis worker or a CAHOOTS crisis worker. This training and experience can be obtained either at White Bird or through other mental-health or social-service work. We are looking for at least two years of work experience, especially work on the street or in other non-traditional settings, work with disenfranchised or alienated populations, and work that involves frequently initiating contact with new people. This experience should qualify the crisis worker as a Qualified Mental Health Associate (a credential unique to the the state of Oregon) and CAHOOTS will support crisis workers in obtaining and maintaining that certification through the Mental Health and Addiction Certification Board of Oregon.

CLASSROOM AND FIELD TRAINING

New staff will have completed background checks and credentialing applications as part of new hire paperwork. Observational shifts with response teams begin concurrent to classroom training, with 30-40 hours of instruction occurring over the first 6 weeks of training. Classroom content may include outside subject-matter experts, with proctors from Eugene-Springfield Fire and EMS supporting practical skills labs:

- Program orientation: History and Principles, Operational Overview, Consensus Decision-Making (White Bird Clinic is a consensus-based collective)
- Logistics and Operations: Radio Communication, Partner Agencies, Documentation/Reporting, Fleet Operations and Maintenance, Death in the Field, Critical Incidents, Employee Wellness
- Patient Care and Service Delivery: Restorative Justice, Trauma-Informed Care, Harm Reduction, De-Escalation, Scene Safety, Wound Care, Substance Use, Common RX, Skill Lab/Scenarios, CPR/BLS, Naloxone

Throughout field training, employees keep a Training Log with one entry per shift. This log includes the following prompts and is referenced frequently to track progress throughout training experience:

- Identify what phase of training you are currently in.
- Based on your current training phase, what skills did you learn more about or improve upon?
- With your trainer, identify things you improved upon and things you did that went super well in your shift
- With your trainer, identify things to work on for your next shift.
- Debrief with your trainer about thoughts/feelings/interesting things/unusual events which occurred during your shift (can also use this space to do some independent journaling).
- Identify one resource that you learned more about or should research later.

DEPARTMENT STRUCTURE

It is recommended that all employees who hold administrative positions come from a first response background and continue to hold regular van-shifts in the field to remain rooted in the work.

Deliver client care and support van/team uptime

- Van teams (medic + crisis worker)
  - X Medics
  - X Crisis Workers
  - X Cross Trained
- Operations and Logistics Specialist (fleet management)
- Scheduling Support

Gather and share information with external environment

- Program Director
- Bilingual Expansion Specialist
- Outreach Specialist
- Communications Specialist
- Community Education Specialist

Set shared rhythms and manage resources

- Program Coordinator
- Office Manager
- Admin Support
- Parent Agency Admin Liason

Safety, health, and growth of staff

- Clinical Supervision Coordinator
- Clinical Supervision Support
- Medic Specialist
- Internal Advocacy Specialist
- Training and Recruitment Specialist

OPERATIONS

Equipment, Reporting, Logistics

UNIFORMS

- Dark neutral colors (black, navy, green) with high-contrast white or high-vis reflective ink.
- Small logo on chest, text on right sleeve, large logo on back.
- Outerwear: small logo on chest, text on back with high-vis reflective stripes.
- Hat: 4-color embroidered logo on front, “WHITE BIRD” embroidered in white on back.
- Work pants (Carhartt, Dickies, etc.) or jeans
- Close-toed boots waterproof boots with ankle support (duty boots, hiking boots, etc.)
- No shorts or open-toed shoes.
- Avoid bulky accessories on belt—try to limit to multi-tool or folding knife and small flashlight or glove pouch.
- Long hair should be pulled back into ponytail or bun. No dangling jewelry (e.g. earrings, bracelets).
- Annual stipend for work pants, base layers. Reimbursement for boots every 2 years.
- T-shirts are offered in short- and long-sleeve. Sweaters available as hoodie, zip hoodie, or ¼-zip crew. Outerwear includes heavy-duty rain jacket and soft-shell fleece.

VEHICLES

Our vans are custom built through an agency that does custom builds for government vehicles. Vans should be expected to be out of commission and backup vehicles should be part of implementation planning. Our custom van builds are estimated to around $90k.

EQUIPMENT + RESOURCES

It should be noted that 24/7 road coverage means that teams may encounter incidents other than clients in crisis; consider keeping supplies on the van that aren't necessarily relevant to everyday work, such as a fire extinguisher, shovels, etc.

Standard supplies include:

• Antibiotic ointment • Burn Cream packets • Insect sting ointment • Alcohol pads • 4x4 gauze pads • Telfa	• Pulse-Ox • Glucometer • Halo dressing • Pocket face mask • Hot pack • Cold pack

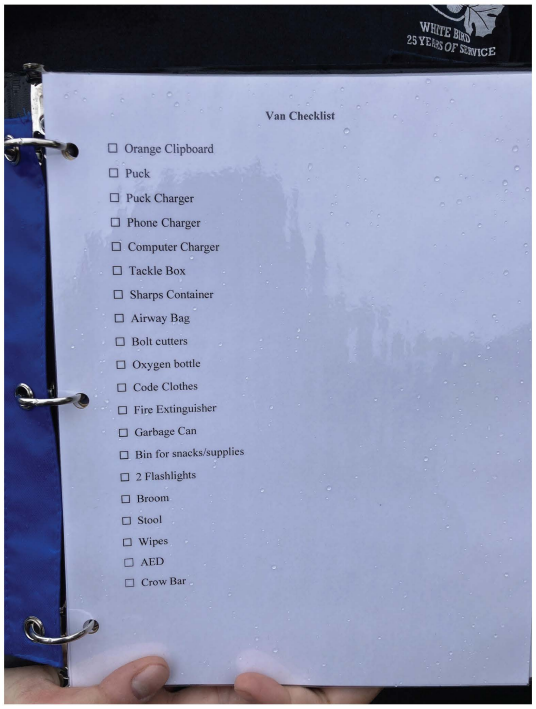
● Sizes? ● Gauze rolls ● Sizes? ● Tegaderm ● Sizes? ● Individual saline flushes ● Tongue depressor ● Q-tip ● Iodine soaked applicator ● Medical tape ● Multi tool ● Head lamp ● OPA's ● NPA's ● Tourniquet ● Oral glucose ● Naloxone ● Epinephrine ● Ammonia packets ● Ring cutter ● Flashlight ● Sharpie ● Trauma shears ● Spare batteries ● Spare thermometer probe covers ● Oral Thermometer with sheaths ● Spare glucometer test strips ● Window punch ● Sphygmomanometer ● Stethoscope ● Tympanic thermometer	● Chucks ● Pregnancy test ● Tissue box ● Large SAM splint ● Finger SAM splint ● Collapsible BVM ● Emergency blanket ● Small sharps container ● Emesis bags ● Biohazard bags ● Procedure masks ● Triangle bandages ● ABD pads ● Impregnated gauze ● Ace bandages ● Koban ● Airway Bag ● OPA's (ped and adult) ● NPA's ● Oxygen canister with regulator ● Adult and pediatric BVM ● Nasal cannula ● Spare oxygen tubing ● Adult and pediatric NRB ● Suction device ● Stethoscope ● Pulse-Ox ● Narcan ● Epinephrine ● Emesis Bag ● AED ● Tackle Box

The Resource Binder

Our resource binder is a critical tool for crisis workers. It serves as a mini hub of agencies and information that are very useful for all kinds of interactions. In addition to information, important contracts such as ROIs (Release of Information), housing applications, mandatory reporting forms, transfer of care forms, and other forms are kept in the resource binder.

Other resources for first responders are kept in this binder, including Mandatory Reporting forms, Transfer of care forms for when a client is handed off to another service, release of information,

Our resource binder is categorized by topic: Crisis, Unhoused Resources for Basic Needs/Transitional, Fast Access, Free Medical and Veterinary, Mental Health Supports, Drug and Alcohol, Domestic Violence, and Veterans.


WHITE BIRD
25 YEARS OF SERVICE
Van Checklist
☐ Orange Clipboard
☐ Puck
☐ Puck Charger
☐ Phone Charger
☐ Computer Charger
☐ Tackle Box
☐ Sharps Container
☐ Airway Bag
☐ Bolt cutters
☐ Oxygen bottle
☐ Code Clothes
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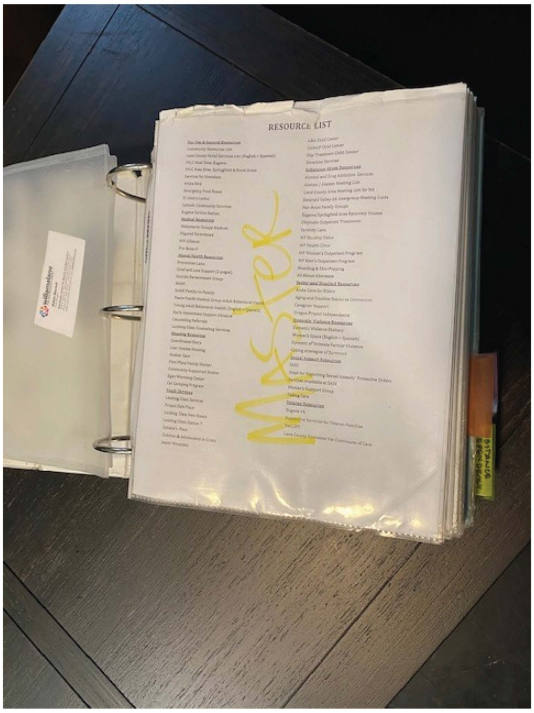
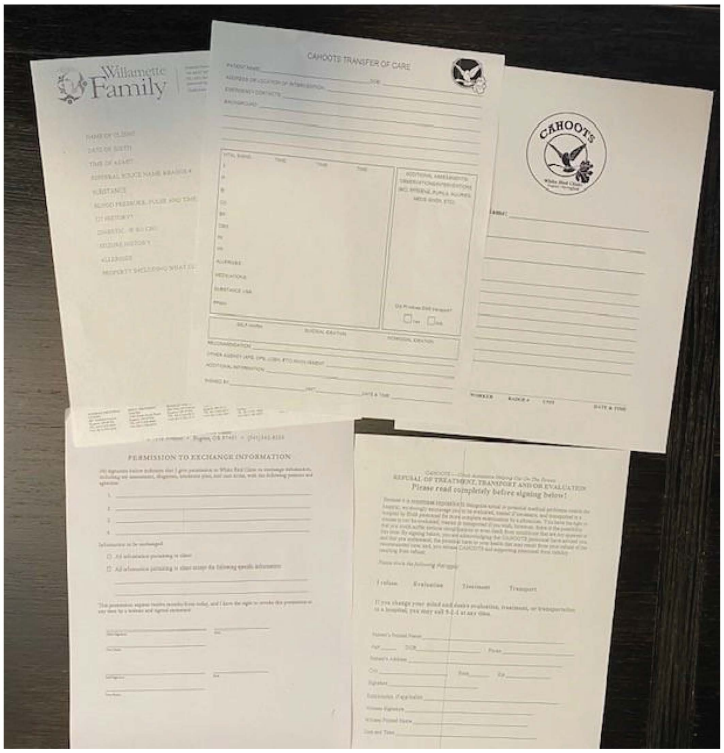
☐ AED
☐ Crow Bar


RESOURCE LIST
Master


Willamette Family
CAHOOTS TRANSFER OF CARE
CAHOOTS
PERMISSION TO EXCHANGE INFORMATION
REFUSAL OF TREATMENT, TRANSPORT AND OR EVALUATION
Please read completely before signing below!


Day Treatment Programs
The Child Center
The Child Center

REPORTING

We do not share our reports with anyone unless we are subpoenaed by a court of law to do so. Our reports are kept for us to record and document our interactions so that we can mine data appropriate to funding, so that we can have good continuity of care for our clients, and so that we can account for the work we do.

The following information is collected, when possible, and reported to Lane County Health and Human Services. *It should be noted that collecting demographic data like this during a crisis call is difficult and often based on assumption.*

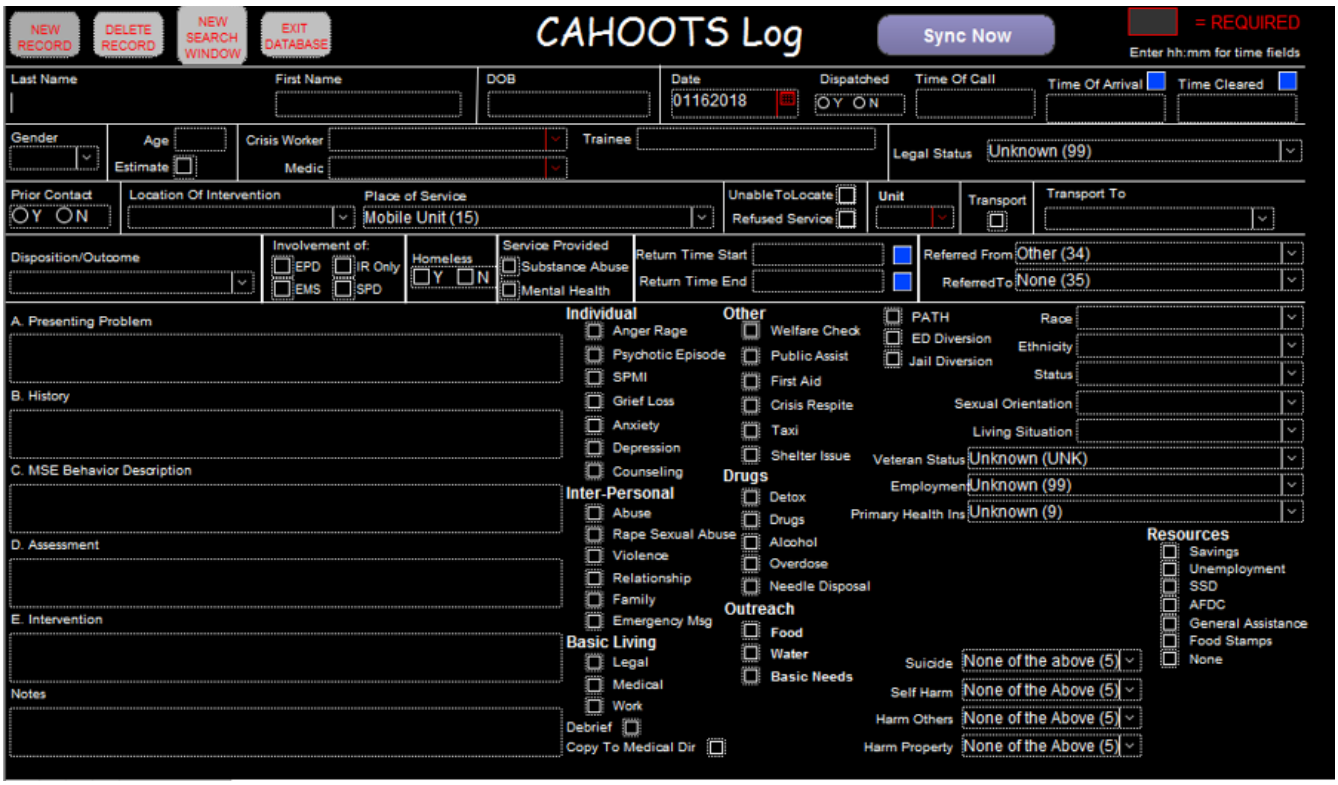
-Age
-Gender
-Living Situation
-Public safety contacts
-Outside agency referrals
-Times: response/intervention

CAHOOTS reports to the county funders using a data set called Measuring Outcome & Tracking Systems (MOTS). These reports are made once per month and involve various quantities or encounters which cross reference demographic information to demonstrate the effectiveness of the program daily in the Metro area. The information provided to the City of Eugene and Springfield is similarly intended to demonstrate the benefit the program to the community, our funders, and the efficiency of the partnership between CAHOOTS and law enforcement. These data sets may include more specific information about the expenditures of the program and budget suggestions as well as highlighting the ability of CAHOOTS to divert clients from the jail or the emergency department as well as the relieve law enforcement or EMS personnel from a scene where they may have initiated contact but can transfer care to CAHOOTS.

-Full Name
-DOB
-Demographics
-Referral from/to
-Public safety/LEO contact
-Legal status
-Housing status
-Insurance

-Age
-Gender
-Living Situation
-Public safety contacts
-Outside agency referrals
-Times: response/intervention

-Threat of harm to self/others/property



Presenting Problem

This section is very simple, and it is appropriate to write the least amount possible to describe the type of interaction that is occurring. This is typically an abbreviation of what dispatch has reported; 2 - 4 word phrases usually suffice, and language is kept cosistent for keyword searches. If it is not a dispatched call, then it will be a "Flagged" call, where someone on the street flags the van with a request for something like food or to ask to do a needle exchange. In this case, simply write what you were flagged down for.

Example: FLAGGED DOWN FOR MED EVAL.

History

The history section is the background of the situation, specifically about who, what, where and when. Responders write details here as they receive information from dispatch, when they exit the call, and will continue writing details here until the relevant background information is complete. The history section is filled based on what has been shared with by the patient, by other agencies that may be involved, such as police, and what the responders sense or identify based on their conversations and interactions. The history portion is kept clean and uses quotes rather than interpretations, and focuses only on what is relevant to the situation at hand.

Example: PER DISPATCH, CALLER IS RACHEL, AND IS REQUESTING A WELFARE CHECK FOR A PERSON WHO APPEARS TO BE INTOXICATED SLEEPING ON THE PORCH OF THE CALLER'S RESIDENCE. PATIENT IS OF UNKNOWN NAME, APPEARS TO BE IN HIS LATE 50'S, WITH A BLACK HAT, GREY BEARD AND GLASSES. PUBLIC ASSIST. WELFARE CHECK. HE IS WRAPPED IN A BLUE TARP AND HAS SOME BAGS WITH HIM. UPON ARRIVAL, PT IS ON THE PORCH AS DESCRIBED, AND THE CALLER GREETS THE TEAM AT THE DOOR. THE CALLER IS CONCERNED THAT THE PATIENT IS ON HER PORCH, AND NEEDS HIM TO LEAVE, BUT SHE ALSO "HEARD HIM COUGHING EXTENSIVELY" AND IS "CONCERNED FOR HIM".

MSE Behavior Descriptor

The Mental Status Examination, or MSE, is a tool for remaining objective and descriptive of behavioral observations. It is important not to attach any value to observations, which can be challenging.

Brief, objective description.

Consider the following:

Appearance (Observed)
Possible descriptors: Gait, posture, clothes, grooming
Behavior (Observed)
Possible descriptors: Mannerisms, gestures, psychomotor activity, expression, eye contact, ability to follow commands/requests, compulsions.
Level of Consciousness (Observed)
Possible descriptors:Vigilant, alert, drowsy, lethargic, stuporous, asleep, comatose, confused, fluctuating
-Level of Consciousness
-Orientation
-Speech/Language/Tangential or Perseverative Content
-Mood
-Affect/Eye Contact
-Thought Process/Form/Organization
-Environment
Orientation (Inquired) - See assessment tool.
Speech and Language (Observed)
Quantity—Possible descriptors: Talkative, spontaneous, expansive, paucity, poverty.
Rate—Possible descriptors: Fast, slow, normal, pressured.
Volume (Tone)—Possible descriptors: Loud, soft, monotone, weak, strong.
Fluency and Rhythm—Possible descriptors: Slurred, clear, with appropriately placed inflections, hesitant, with good articulation, aphasic.
Mood (Inquired)—A sustained state of inner feeling.
Possible questions for patient: “How are your spirits?” “How are you feeling?” “Have you been discouraged/depressed/low/blue lately?” “Have you been energized/elated lately?” “Have you been irritable/edgy lately?”
Affect (Observed)—An observed expression of inner feeling.
- Possible descriptors: Appropriateness to situation, consistency with mood, congruency with thought content. Fluctuations: Labile, even. Range: Broad, restricted. Intensity: Blunted, flat, normal intensity. Quality: Sad, angry, hostile, indifferent, euthymic, dysphoric, detached, elated, euphoric, anxious, animated, irritable.
Thought Process/Form (Inquired/Observed)—Logic, relevance, organization, flow, and coherence of thought in response to general questioning during the interview.
- Possible descriptors: Linear, goal-directed, circumstantial, tangential, loose associations, incoherent, evasive, racing, blocking, perseveration, neologisms.
Other Environmental Factors (Observed)—Any relevant information about the physical environment in which the intervention takes place, and/or how patient is interacting with or living in their immediate area. Can include inclement weather, shelter conditions, and/or access to basic needs and other resources.

Example of MSE Behavior Description: UNSTEADY GAIT, WEARING HEAVY WINTER COAT IN 80-DEGREE FARENHEIT WEATHER. AOX4, PRESENTS AS CONFUSED ABOUT CAHOOTS PRESENCE AND DOES NOT MAKE EYE CONTACT DURING INTERVENTION. RESPONDS TO QUESTIONS WITH SHORT PHRASES OR SINGLE WORDS.

Assessment
This is a brief statement that summarizes the intervention and how things resolved; includes description of wounds or injuries, level of orientation, vital signs, reported medications or recreational substances, reported diagnoses or chronic conditions, economic/social/environmental factors (ie, homelessness, lack of support network, family strife, exposure)
Example of Assessment:
AOX4 (alert and oriented by number you have assessed for). S/S (signs and symptoms)CONSISTENT W/HEAVY ETOH (alcohol)USE. HOUSING CRISIS. APPROPRIATE FOR TRANSPORT.INTERVENTION

Example of an Intervention: ALERTED RESIDENT OF OUR PRESENCE ON PROPERTY. ENGAGED CLIENT, LISTENED, EMPATHIZED, EXPLORED OPTIONS. TRANSPORTED TO BUCKLEY HOUSE FOR SOBERING

Notes

This is a place for additional information. You may put relevant phone numbers in this area, for instance, or police designators if you want to remember/share the specific officers who worked with you. If you return to a call you have cleared earlier in the shift, you will note the “Return Time Start” and “Return Time End” in the boxes specified, but you can explain what occurred during that follow-up call in this section. Example of Notes for Returning to a Call:PER DISPATCH, PATIENTIS REQUESTING TO LEAVE BUCKLEY HOUSE TO BE TRANSPORTED TO WHITE BIRD. UPON ARRIVAL, PATIENT IS FEELING BETTER AND NEEDS ADDITIONAL HOUSING RESOURCES. APPROPRIATE FOR TRANSPORT. TRANSPORTED TO WHITE BIRD.

Drop Down, boxes, and demographic information

Besides the written content in reports there are several other areas where the department captures information. In general, these are elements of a call that we can identify was a component in the intervention (i.e. Anxiety, Family, Drugs, Shelter Issue). There are also drop downs to help assess the demographic information about a client that helps us generate statistics for our funders or for others who are interested in the impact of the CAHOOTS program on certain subsets of the community. There are drop down boxes which are intended to capture the perceived imminency of threat and the level of the assessment that wasperformed on a client in the field. All of this information as it pertains to any specific client is protected by HIPPA and the collation of any information for the purposes of funding or consulting is drawn from the data in such a way that it would never reveal specific client data or be used for the personal or commercial gain of the CAHOOTS department.

BOXES: Identify key components of calls, used for quick data collection and report generation. If you can justify clicking the box then click it!

Drop-down menus: used to track specific demographic information. Also used for quick data collection and reporting.

Key Considerations

Will the report be helpful for teams in future interventions?

Is it comprehensive while remaining concise?

How would it sound being read aloud in court?

How would a client react to documentation and assessment?

ALWAYS gather as much identifying and demographic information as possible (Name, DOB, gender, sexuality, race/ethnicity, housing status).

START (Student Agile Response Team)

You're not alone in this fight

The whole world is different and we are all adjusting to a new normal. As you move forward and are working through a set of new challenges, consider working with our new IU Student Agile Response Team (START). We are working together as a campus to leverage the vast skills, passion, and time of our students to more efficiently and effectively support our community in getting back on their feet and creating a better, stronger future. Keep reading to learn more about our process and the diverse skills of our student teams.

Are you a student interested in being a part of our START team? Apply Here <https://forms.office.com/r/1K7bDtyAgE>

Community START Project Application Open

START will be accepting applications starting November 1 through December 31 for Spring 2022. Projects are estimated to begin in Februrary. If you have any questions about START, the application process, or project execution, please email Cassi Winslow-Edmonson.

Complete the start application <https://forms.office.com/Pages/ResponsePage.aspx?id=NL4TEdGuAE2rS83QJRC-kdBxuT_vkhJBsxJb5GflYrNUMDhHNk1TTDdlUlIEWFJaNUIEUTVLTTdGOCQlQCN0PWcu>

A sampling of our students' skills

We have more than 42,000 undergraduate, graduate, and Ph.D. students at Indiana University Bloomington, each with their own unique skillset and passions. Each of our students are at different places in their learning journey. Our students are constantly learning new skills and enhancing old ones. Throughout the entirety of the START workflow process, it is indescribably rewarding to see each student's individuality and creativity come to life. Our professional staff will come along with you

throughout this experience.

Below is a small sampling of skills and potential project themes organized by school that you may consider utilizing for your specific needs. Our students' skills are not limited to this list. Even if you don't see the specific skills are you seeking, please submit a project request form <https://forms.office.com/Pages/ResponsePage.aspx?id=NL4TEdGuAE2rS83QJRC-kdBxuT_vkhJBsxJb5GflYrNUMDhHNk1TTDdIUlIEWFJaNUIEUTVLTTdGOCQlQCN0PWcu> .

College of Arts and Sciences +

Team Leads: Lisa-Marie Napoli <https://news.iu.edu/iu-experts/profile/m/1029/napoli-lisamarie> and Mark Fraley <https://pace.indiana.edu/about/staff/fraley-mark.html>

Political and Civic Engagement (PACE) <https://pace.indiana.edu/> students, within the College of Arts + Science <https://college.indiana.edu/> , develop expertise in leadership, communication, effective citizenship, & public decision making. Here is a quick snapshot of their past work:

• Practicing facilitation skills to lead discussions about contentious public issues
• Supporting civic, non-profit, and government-related projects utilizing leadership skills
• Participating in electoral engagement projects such as voter registration, non-partisan voter education, and voter turnout
• Engaging advocacy skills to impact change
• Planning and implementing workshops on restorative justice, leadership, and other related topics
• Modeling and teaching civic skills as informed and engaged participants in democracy

Eskenazi School of Art, Architecture, and Design +

Team Leads: Jenny El Shamy <https://soaad.indiana.edu/faculty/directory/el-shamy-jenny.html> and John Racek <https://soaad.indiana.edu/faculty/directory/racek-jonathan.html>

The Eskenazi School of Art, Architecture + Design <https://soaad.indiana.edu/about/index.html> houses fourteen different areas in art, architecture, design, and merchandising. Some examples of their past work and ways they can serve include:

- Graphic design (printed materials)
- Signage, wayfinding design
- Feasibility studies, architecture

- Research/ideation, architecture

Jacobs School of Music +

Team Lead: Alain Barker <https://info.music.indiana.edu/faculty/current/barker-alain.shtml>, Director, Music Entrepreneurship and Career Development <https://music.indiana.edu/about/index.shtml>

Jacobs <https://music.indiana.edu/about/index.shtml> is one of the most comprehensive and acclaimed institutions for the study of music. They play a key role in educating performers, scholars, and music educators who influence music performance and education around the globe. Their students may to serve your organization in the following ways or areas:

- Music clinics for high school band and orchestra programs
- Music clinics for choral ensembles and vocalists
- Collaborative performances (from recitals to large ensembles) in community spaces
- Audio recording clinics for emerging artists
- Career preparation sessions for performing arts
- Strategic planning for performing arts organizations and community committees

Kelley School of Business +

Team Lead: Courtney Bidwell, <https://kelley.iu.edu/faculty-research/centers-institutes/institute-for-social-impact/about/contact-us/courtney-bidwell.cshtml> Director, Kelley Institute for Social Impact <https://kelley.iu.edu/faculty-research/centers-institutes/institute-for-social-impact/index.cshtml>

Fostering social change is important to Kelley School of Business <https://kelley.iu.edu/> faculty, staff, and students. As the hub of social impact for business-minded students, the Kelley Institute for Social Impact <https://kelley.iu.edu/faculty-research/centers-institutes/institute-for-social-impact/index.cshtml> empowers socially conscious undergraduate students to make a difference in local and global communities.

For more than 30 years, business-minded students from a variety of majors have used their skills to contribute to social impact organizations. Projects range from a single afternoon of

brainstorming to a full semester of team consulting, and they span business areas including but not limited to:

· Marketing
· Digital and Social Media
· Branding
· Business Analytics
· Entrepreneurship
· Digital Technology Management
· Operations
· Strategy
· Consulting
· Sustainable Business
· Supply Chain
· Management
· Accounting
· Finance

Samples of previous student projects:

Net Impact projects <http://netimpactiu.weebly.com/projects.html>
180 Degrees Consulting Engagements <https://180dc.org/branch/indiana/>
Social Enterprise Engagement at Kelley Consulting Roundtables <https://sites.google.com/iu.edu/seekiu/initiatives/consulting-roundtables>
Kelley Impact Competition <https://kelley.iu.edu/faculty-research/centers-institutes/institute-for-social-impact/campaigns/kelley-impact-competition/index.cshtml>

Luddy School of Informatics, Computing, and Engineering +

Team lead: Tiana Iruoje <https://luddy.indiana.edu/contact/profile/?profile_id=234>
, Director of Student Engagement and Success

The Indiana University Luddy School of Informatics, Computing, and Engineering <https://luddy.indiana.edu/> is one of the world's largest, broadest, and best technology and information schools.
We shape the future through interdisciplinary research and education that make the impossible possible and solve the problems of tomorrow today.

The students can do any of the following and more: build and update website, security and network upgrades, install different technologies to assist with any task one may have. The students are trained to sit down and help you complete any task within a specified budget.

Maurer School of Law +

Team Lead: Katie Beck <https://www.law.indiana.edu/about/people/bio.php?name=beck-katherine> , director of student affairs

Maurer School of Law <https://www.law.indiana.edu/> was founded in 1842 and is the ninth oldest law school in the U.S. Students serve the community in the following areas:

- Landlord / tenant disputes via the Tenant Assistance Project
- Advising and filing protective orders for victims of domestic abuse via the Protective Order Project
- Tax preparation assistance via the Volunteer Income Tax Assistance (VITA) project
- Family law issues, including divorce, establishment of paternity, guardianship, adoption, parenting, and custody via the Community Legal Clinic
- Intellectual property issues via the IP Clinic
- Advocacy training for LGBT+ communities and allies; support for changing gender markers on official documents via the LGBT+ Project
- Legal research and advocacy for incarcerated individuals via the Inmate Legal Assistance Project
- Mediating disputes involving children in family law cases through the Mediation Program and Viola J. Taliaferro Family and Children Mediation Clinic

O'Neill School of Public and Environmental Affairs +

Lead by Brian Seavey, Director of Undergraduate Student Engagement, <https://oneill.indiana.edu/about/directory/profiles/staff/seavey-brian.html> the O'Neill School <https://oneill.indiana.edu/> brings together management skills, science, policy analysis, and the humanities. They focus on governing, managing, and leading. A sampling of skills include:

- management
- statistics
- microeconomics
- law

- budgeting
- community & economic development
- energy
- environmental policy & natural resource management
- health policy
- information systems
- international development
- local government management
- nonprofit management
- policy analysis
- public financial administration
- public management
- sustainability and sustainable development

School of Education +

Team Lead: Tyna Hunnicut <https://education.indiana.edu/about/directory/profiles/hunnicutt-tyna-a.html> , Director, Early Field Experiences

The School of Education <https://education.indiana.edu/index.html> is known for preparing reflective, caring, and skilled educators who make a difference in the lives of their students in Indiana, throughout the United States, and around the world. Their students focus on the following projects and skills:

- Educational consulting, curriculum development, instruction systems design, pedagogy
- Counseling and Educational Psychology department that has a counseling center and researchers in various areas including Gratitude (and has been talking about using this as a tool during this pandemic)
- IST and a Maker's Space with a Maker's Space head faculty leader
- Higher Ed and Student Affairs specialists
- Art Education – focus also on community art uses and using art in various settings to increase understanding and expression
- Special Education – a couple of faculty and a graduate student have been working with schools on how to support SPED students in this quick transition and its importance despite the push to change the law to reduce this requirement
- Our Maker's Space made face shields with a Music Faculty member for local health folks
- Our librarian is fantastic at working with faculty and students on educational research, grant writing, implementation and programming for undergraduate and graduate students

View some work samples from School of Ed:

- REMC and Clark County Schools project <https://www.youtube.com/watch?v=wQD56PnY9xQ&feature=youtu.be&fbclid=IwAR14Ogs_QziwMPKFzneRZboe4czslLxre4_9wLFrvprpl3VvU2wn8rQZluE>
- Science videos by our candidates <https://m.facebook.com/IUSchoolofEd/>

School of Nursing +

Team lead: Marsha Hughes-Gay <https://nursing.indiana.edu/directory/hughes-gay-marsha.html> , Assistant Dean and Clinical Assistant Professor

School of Public Health +

Team leads: Alex Purcell, <https://publichealth.indiana.edu/about/people/profile.html?user=aspurcel> Director of Public Health Practice & Ta-Kisha Jones,Assistant Director of Health and Wellness Initiatives

School of Public Health-Bloomington <https://publichealth.indiana.edu/about/index.html> takes a comprehensive and holistic approach to disease prevention, wellness, and teaching with an emphasis on robust, reproducible, and transparent research. Some examples of their past work include:

- Statistical modeling
- Epidemiological methods and research design
- Population health and public health policy/research/assessments
- Intervention and program design/evaluation
- Behavior change theories and communication
- Planning & Management to Promote Health
- Event planning
- Recreation and leisure services
- Occupational health and safety
- Human performance and athletic training

School of Social Work +

Team lead, Carlene Quinn, <https://socialwork.iu.edu/FacultyAndStaff/profile.php?id=Quinn_Carlene_carquinn> Associate Clinical Professor of Field Instruction and Coordination <https://socialwork.iu.edu/FacultyAndStaff/profile.php?id=Quinn_Carlene_carquinn>

IU School of Social Work <https://socialwork.iu.edu/about/> is dedicated to developing competent, caring professionals who are qualified to assume leadership roles in social work practice, and who strive to enrich the lives of the people they touch. Their students enrich lives in the following ways:

- Community engagement
- Active listening
- Bridging diverse groups together
- Needs assessments
- Program development
- Bio-psycho-social histories
- Mini-mental health/depression/anxiety screenings
- Care plans
- Advocacy
- Policy briefs
- Broker/advocate for needs on behalf of those who aren't able to
- Socio-emotional support for children/teens/families who have experienced trauma
- Outreach/Home visits/Hospice
- Support group curriculum development and skill based delivery of services.
- Coordinate small projects, etc.
- Voter registration/ID processing/fraud prevention education for vulnerable folks
- Disability applications assistance
- SNAP benefits
- Medicaid enrollment and prescription drug plans
- Housing assessments, etc.

The Media School +

Eliza Erxleben <https://mediaschool.indiana.edu/people/profile.html?p=eerxlebe> , Director of Student Services

The Media School, which is housed in IU's College of Arts and Sciences, provides a variety of community engagement opportunities. Field experience courses (X478) offer students a curricular option to apply their learning within communities around the world within the familiar structure of a for-credit course. Other courses integrate service-learning into the curriculum by pairing students with local agencies for in-class assignments.

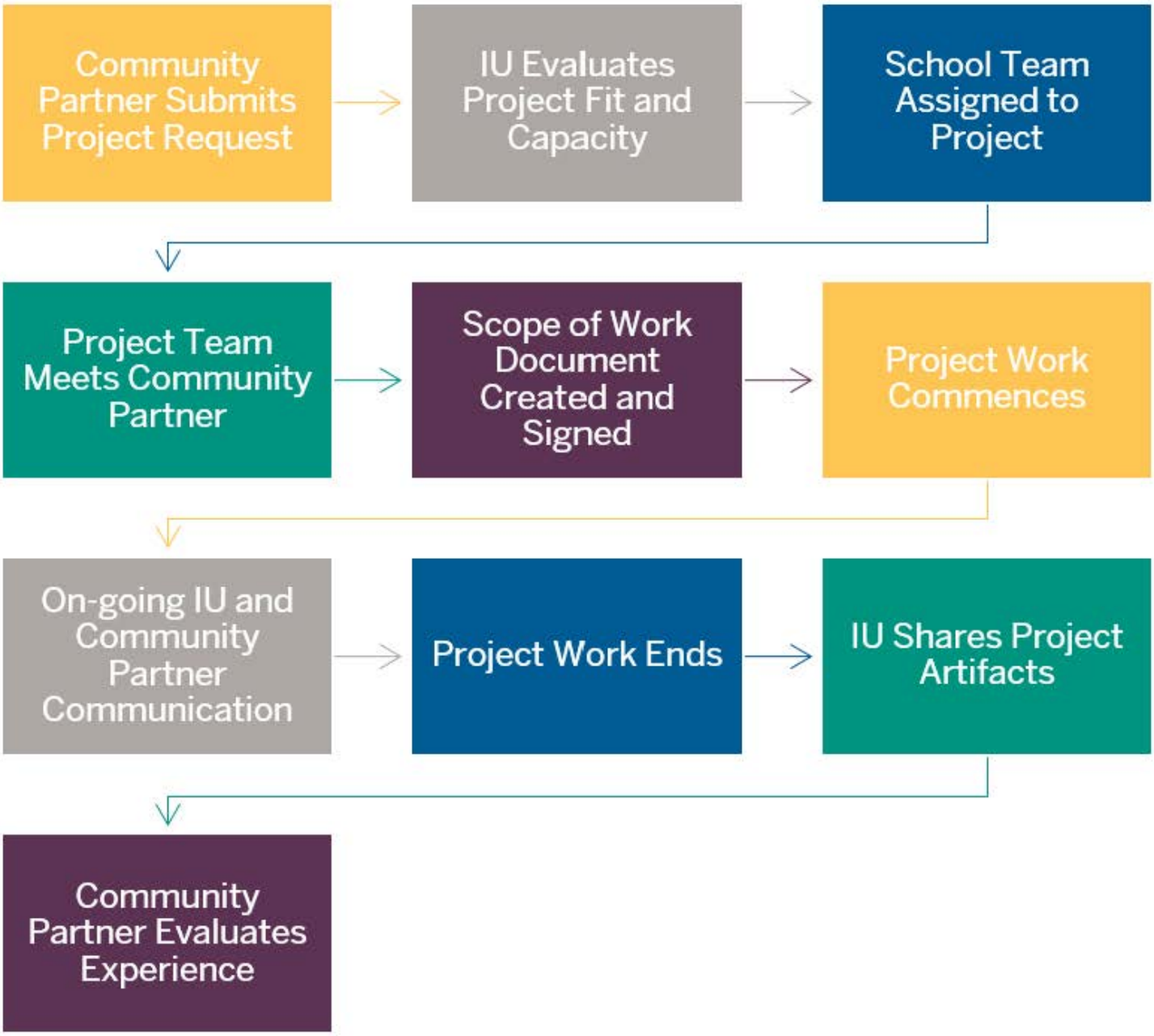
The school also supports service-learning through Alternative Service Break trips, both internationally and domestically, through a growing partnership with the National Park Service. Media School students can participate in a variety of service-project programming driven by the school's Experiential Education department.

View some work samples from The Media School:

- https://mediaschool.indiana.edu/experience/work/index.html <https://mediaschool.indiana.edu/experience/work/index.html>
- https://mediaschool.indiana.edu/news-events/news/item.html?n=national-park-service-partnership-provides-video-production-experience <https://mediaschool.indiana.edu/news-events/news/item.html?n=national-park-service-partnership-provides-video-production-experience/>

Our process

To help you get your head around our process, below you will see an ariel view of the steps we envision to get your project completed, meeting your expectations along the way.


Community Partner Submits Project Request
IU Evaluates Project Fit and Capacity
School Team Assigned to Project
Project Team Meets Community Partner
Scope of Work Document Created and Signed
Project Work Commences
On-going IU and Community Partner Communication
Project Work Ends
IU Shares Project Artifacts
Community Partner Evaluates Experience

RESOLUTION NO.

WHEREAS, the City of Austin honors the rights of pregnant people to bodily autonomy and control over their private medical decisions; and

WHEREAS, access to safe and legal abortion is a deciding factor in long-term health, safety, and quality of life; and

WHEREAS, the Supreme Court of the United States has overturned the 1973 landmark ruling, *Roe v. Wade*, which previously prevented individual states from directly banning such care; and

WHEREAS, on June 16, 2021, Texas Governor Greg Abbott signed into law HB 1280, that criminalizes abortion at the felony level with a sentence of up to 99 years in prison and no exception for rape or incest, and which will take effect statewide 30 days after the Supreme Court decision overturning *Roe v. Wade*; and

WHEREAS, anti-choice legislators have weaponized the language of criminal law to stigmatize reproductive choice, and the Council considers the phrase "abortion, miscarriage, or other reproductive healthcare act" to accurately encompass all criminalized acts under Texas laws which seek to criminalize pregnancy outcomes; and

WHEREAS, people have a basic human right to medical treatment, up to and including abortion; and

WHEREAS, eliminating legal access to abortion has been empirically proven to dramatically increase the risk of death, bodily injury, and infertility, especially within low-income communities and communities of color; and

WHEREAS, the resources of the City must always be dedicated to the health and wellbeing of its residents; and

WHEREAS, the City Council has repeatedly demonstrated its commitment to abortion access in Resolution Nos. 20130321-045, 20140925-082, 20141120-038, 20151015-039, 20170126-045, 20181004-035, and. 20210930-111; and

WHEREAS, in the 1973 *Roe v. Wade* majority opinion, Supreme Court Justice Harry Blackmun stated, "[The] right of privacy, whether it be founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action, as we feel it is, or, as the District Court determined, in the Ninth Amendment's reservation of rights to the people, is broad enough to encompass a woman's decision whether or not to terminate her pregnancy"; and

WHEREAS, the right to privacy should protect doctors, patients, and all others providing abortion-related medical care from any criminal investigation related to decisions made within the healthcare provider-patient relationship so long as those decisions occur without coercion, force, or negligence; and

WHEREAS, equitable access to abortion care requires financial and logistical support, most often provided by abortion funds, practical support organizations, and volunteers who have been targeted by the State for providing these services; and

WHEREAS, the City has a responsibility to protect its residents from any violation of their human rights and any criminalization of the free exercise thereof; **NOW, THEREFORE,**

BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY OF AUSTIN:

The City of Austin formally condemns any action intended to abrogate the fundamental liberties of its people and affirms its commitment to protecting the right of its residents to make reproductive health decisions, including abortion care, for themselves.

BE IT FURTHER RESOLVED:

It is the policy of the City that, except to the extent otherwise required by state or federal law, City funds will not be used to:

- Store or catalog any report of an abortion, miscarriage, or other reproductive healthcare act;
- Provide information to any other governmental body or agency about any abortion, miscarriage, or other reproductive healthcare act, unless such information is provided to defend the patient's right to abortion care or the healthcare provider's right to provide that care; or
- Conduct surveillance or collect information related to an individual or organization for the purpose of determining whether an abortion has occurred, except for aggregated data without personally identifying information or personal health information which is collected for purposes unrelated to criminal investigation, enforcement, or prosecution.

BE IT FURTHER RESOLVED:

The policy stated above does not apply in cases where coercion or force is used against the pregnant person, or in cases involving conduct criminally negligent to the health of the pregnant person seeking care.

BE IT FURTHER RESOLVED:

It is the policy of the City that the investigation or support for the prosecution of any allegation, charge, or information relating to the outcome of a given pregnancy, including abortion and abortion-related care, or any party thereto, will be the lowest priority for enforcement and the use of City resources and personnel, except in cases (a) where coercion or force is used against the pregnant person, (b) of criminally negligent conduct involving the health of the pregnant person seeking care, or (c) where the abortion, miscarriage, or reproductive healthcare is not the crime being investigated but evidence of another crime.

BE IT FURTHER RESOLVED:

The City Manager is directed to take appropriate steps to implement this Resolution and to provide an oral presentation and written report to Council on the implementation of this Resolution, including changes to policies and procedures, at the work session on July 26, 2022; and the City Manager may return to the Council for authorization of any needed policy clarifications or changes in the event of future changes to federal law, state law, or technology that affect this Resolution.

ADOPTED: _____, 2022 **ATTEST:** _____

Myrna Rios
City Clerk

Policy Questions

Why is your resolution called the GRACE Act?

The GRACE Act stands for Guarding the Right to Abortion Care for Everyone. Austin wants to be a source of safety and grace for the people suffering under the Texas trigger ban and other laws criminalizing reproductive health choices.

What is the GRACE Act?

The GRACE Act is a policy recommendation in 2 parts:

1. City funds shouldn't be used to solicit, catalog, report, or investigate reports of abortion.
2. Police should make investigating abortion their lowest priority.

Why just a policy recommendation?

Under Texas law and the Austin City Charter, the City Council cannot dictate to city employees how to handle a criminal case. We can declare the policy preferences of the Council and *recommend* that staff not use city funding, and we can *recommend* that they place it very low on their list of priorities. City executives, under the direct authority of the City Manager, decide whether and how to implement Council policy.

How does it help if it's just a policy recommendation?

City executives, under the direction of City Manager Spencer Cronk, will implement the GRACE Act's recommendations once it passes.

Who supports the GRACE Act?

Mayor Steve Adler and Council Members Vanessa Fuentes, Paige Ellis, and Kathie Tovo are our co-sponsors. Texas open meeting laws prevent us from talking to more than 4 fellow voting members about any resolution, but I can confirm everyone we have spoken with is in support. The population of Austin has demonstrated repeatedly that we are a city that supports reproductive health choices.

Will the GRACE Act pass?

I am confident that the City Council wants to protect abortion in Austin. CM Vanessa Fuentes's resolution banning reproductive discrimination passed 10-1 with no discussion. There is significant support for actions like the GRACE Act on the Council and among our constituents.

Legal Questions

How does the GRACE Act supersede state law?

The GRACE Act does not supersede state law. It is a statement of policy that provides guidelines for the city on how to prioritize enforcement of the abortion ban among hundreds of more important crimes, and it determines the amount of funds which can be dedicated to the project. It does not conflict with the state's designation of abortion as a crime, and it does not prohibit or limit the investigation of any crime.

Does the GRACE Act stop the State of Texas from investigating alleged abortions?

No. But state police and prosecutors often rely on municipal police to perform the actual investigations. We are establishing a policy of deprioritizing these cases, therefore Austin's police should not be conducting investigations. Additionally, we are saying the city will not collect or save any information pertaining to alleged abortion crimes. This limits the tools available to the state for a criminal prosecution.

Won't Texas just overturn the GRACE Act?

We are confident the GRACE Act is legal under current law and the Texas Constitution. That means the state legislature must pass a law specifically tailored to our protections. They may also attempt to circumvent the Act by taking abortion enforcement jurisdiction from local DAs and giving it to the Attorney General. That's why we need national attention on Texas once Roe is overturned - we need political pressure to keep people safe and informed.

Will the GRACE Act protect both providers and seekers of abortions?

The GRACE Act is designed to protect everyone involved in an abortion, but the abortion will still be an illegal act under state law. There will still be significant legal risk involved in any abortion procedure in Texas – we can only try to mitigate legal risk, not eliminate it completely. The GRACE Act targets the harshest and most draconian impacts of criminalization.

Are there any exceptions to the GRACE Act?

Yes. Abortions that are coerced, forced, or criminally negligent to the health of the mother can be criminally investigated, as well as abortions which may be evidence of other crimes such as sexual assault. There are also exceptions for data collection and reporting required by state or federal law.

Does the GRACE Act protect residents from SB 8, the "Heartbeat Bill"?
No. SB 8 allows for private citizens to sue people who perform abortions after 6 weeks of gestation, and Texas cities don't have the power to decide who gets to file what lawsuits. The GRACE Act addresses the Texas trigger ban, the "Human Life Protection Act," which establishes extreme criminal penalties for all abortion, as well as any other similar criminal laws, such as SB 4 restricting medication abortions.

The Texas trigger ban has an exception that protects the person receiving an abortion from prosecution. Why does the city need a policy to protect women from prosecution if state law already does so?
We agree that, under the current laws on the books, those receiving abortions cannot be prosecuted. However, nobody involved with a consensual abortion should be subject to prosecution, including those who perform them or assist in some other way. Our law protects everyone involved with an abortion, as long as that abortion is not criminal in other ways.

Additionally, elected officials with extreme anti-choice beliefs will try to stretch the law for their own agendas. The language of the exception is ambiguous – women receiving abortions are protected, but that exception is in the passive voice. The trigger ban is silent on whether a woman who self-manages her own abortion is "performing" an abortion and therefore at risk of prosecution. Additionally, Texas never repealed its pre-Roe statutes which criminalize both the performer and receiver of an abortion. Ultimately, reproductive choice shouldn't be left up to the interpretation of district attorneys and the Attorney General. We refuse to take chances with the safety of Austin residents.