



Transforming Dispatch and Crisis Response Services: Meeting Challenges with Innovation

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Webinar Description

Historically, law enforcement has been the default response to all 911 calls for service, including incidents involving individuals experiencing crises related to behavioral health conditions and/or intellectual and developmental disabilities. It has been observed that many of these incidents are service-based calls, where the presence of law enforcement may not be needed. In recent years, communities have increased efforts to reorganize their crisis response systems, training 911 call-takers and dispatchers to shift away from directing law enforcement as first responders to these calls. This webinar features four programs that have leveraged the training, policies, and procedures of 911 call-takers and dispatch when restructuring their community's response to crisis incidents. Panelists present the innovative approaches in crisis response implemented by their programs and discuss the challenges of ensuring appropriate services are dispatched to crisis incidents to best meet the needs of individuals.

For the webinar recording, slides, and supporting document – *911 Distressed Caller Diversion Program in Broome County, New York*, please visit the [Academic Training to Inform Police Responses website](#).

Presentations

(1) Training of CIT Dispatch Trainers

Ruth H. Simera, Med, LSW, Executive Director

Coordinating Centers of Excellence, Northeast Ohio Medical University

(2) Colorado Justice Mental Health Collaboration Program: Dispatch / Crisis Services Collaboration

Peggy Heil, LCSW, Behavioral Health Specialist

Colorado Division of Criminal Justice

Abigail S. Tucker, PsyD

SHE Consulting, LLC

(3) Albuquerque Police Department's IDD Training for Telecommunicators

Ben Melendrez, Detective

Albuquerque (NM) Police Department

(4) Transitioning 911 Response: San Francisco's Street Crisis Response Team (SCRT) Pilot Program

Robert Smuts, Deputy Director

San Francisco Department of Emergency Management

Simon Pang, Section Chief of Community Paramedicine

San Francisco Fire Department



Webinar Transcript

Michael Hatch: I see our participant numbers are going up considerably here. I'm just gonna wait another minute or so before we actually get started. Okay, I think we're gonna get started now. Good afternoon, or good morning, depending on where you're joining us from. On behalf of the entire team at the Academic Training to Inform Police Responses, I would like to welcome you to today's webinar, Transforming Dispatch and Crisis Response Services: Meeting Challenges with Innovations. We have six incredible speakers from across the country that are joining us today, and they will be presenting four different presentations for you throughout this webinar. I'll do some housekeeping things before we get started. But before I do that, I want to introduce Dr. Robin Engel who is the principal investigator for the Academic Training to Inform Police Responses from the University of Cincinnati. Dr. Engel?

Dr. Robin Engel: Great, thank you. And good afternoon and welcome to our over 1,800 attendees from all around the globe. I am Robin Engel and I'm a professor at the University of Cincinnati and also serve as the director of the IACP/UC Center for Police Research and Policy. This webinar that you're about to experience today has been made possible through the generous support of the Bureau of Justice Assistance, as part of the larger project for the Academic Training to Inform Police Responses. Now, the University of Cincinnati has partnered with a great team for the Academic Training Initiative, including colleagues from Policy Research Associates, the International Association of Chiefs of Police, and The Arc of the United States. The Academic Training Initiative was born out of a recognition that, as communities across the country continue to critically examine the methods used to respond to crisis situations involving people with behavioral health disorders and intellectual and developmental disabilities, it's also important that we learn from both researchers and practitioners to identify best practices in the field and build our evidence base. And so, as a result, the Academic Training Initiative is designed specifically to support the development and delivery of training, technical assistance, and companion resources that are found in current best practices and supported by research. The primary goals of this work are to assist law enforcement agencies and communities in their responses to people with behavioral health disorders and intellectual and developmental disabilities, and to ensure that these encounters are safer, more effective, and equitable.

We all know that there've been recent conversations surrounding the role of 911 call centers and dispatch for crisis response, and this has really been critical for our work. Given that 911 call-takers and dispatchers have this responsibility of directing resources to calls for service, it's really important for us to consider how we might better leverage their training, policies, procedures to ensure appropriate services are dispatched in a manner that best meets the needs of people in crisis. And what better way to do that than to learn directly from the field? So, the presentations you see today are gonna highlight how different communities across the country have considered 911 call-takers and dispatch when enhancing and restructuring their crisis response systems. But before we hear from our presenters, I would like to introduce you to another very important partner of this effort, Cornelia Sigworth, who's the Associate Deputy Director at the Bureau of Justice Assistance.

Cornelia Sigworth: Thank you, Robin. Good afternoon, everyone, and thanks for taking time to join us today. I don't wanna take a lot of time, but I did wanna give you a little bit of background about BJA and what we do, and how we might be able to help you. So BJA is part of the Department of Justice, and serve as a resource to state and local law enforcement. At BJA, we primarily administer grant funding through our programs, but we also provide subject matter expertise and guidance to the field through our Training and Technical Assistance Program, such as what we're doing today. That specifically, today, I wanted to mention a few activities that BJA has under way, just for your awareness.

First, BJA administers the Justice and Mental Health Collaboration Grant Program. This program provides grant funds to state and local law enforcement to partner with mental health providers to develop programs. So, as you're hearing about these programs today, keep that in mind that we do have financial resources to support this kind of work. Through this program, BJA can fund such things as co-responder models, embedded clinicians, CIT programs, and more. We do anticipate that solicitation for those grants' awards will be released in the next few months. So, I would encourage you to check [grants.gov](https://www.grants.gov) or BJA's website for that announcement.

And then, as I mentioned, in addition to direct funds, BJA also supports free training, expert consulting, travel for practitioners for peer-to-peer exchanges to other police departments, or to one of many law enforcement learning sites that we support. So, if you



have activities that you're thinking about within your department that you could use some expert guidance on, or you want to learn more about something else that's going on in the field, that's where BJA can assist you. So, in order to access that training and technical assistance, we recently launched the Center for Justice and Mental Health Partnerships, it's a website which offers this free training and technical assistance and these resources.

Additionally, BJA has funded a number of written resources and policy guidance to support the development and dissemination of best practices nationally. For your awareness, most recently we launched the Police Mental Health Collaboration Self-Assessment Tool, which allows you to go online and assess where you are in a collaboration with your mental health providers. And it provides you guidance and next steps if you're trying to implement a program. So, it's an excellent resource that walks the user through it and has a lot of other resources attached to it. So, I'll stop there. I could go on for a long time, but there are links to these resources, the training and technical assistance, all of that available through the BJA website, which is bja.gov. And I just wanna thank our presenters today for participating in this, and with that I'll turn it over to you, Mike.

Michael Hatch: Awesome, thanks. Thank you, Cornelia. So, my name is Mike Hatch, I'll be your moderator today. I'm a senior project associate with Policy Research Associates. And I'm also a very proud team member to the Academic Training to Inform Police Responses. A couple housekeeping things that I need to go through. The preparation of this webinar was supported by Grant number 2020-NT-BX-K001, awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Department of Justice's Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the Office for Victims of Crime, and the SMART Office. Points of view or opinions in this document are those of the authors, and do not necessarily reflect the official positions or policies of the U.S. Department of Justice.

As a reminder, if you look in the bottom-right side of your WebEx page, you'll see a location there where you can submit your questions to the presenters in the Q & A pod. The presenters will address as many questions as time permits at the end of the presentation. I will ask that, because we have so many people on this, just keep in mind that we won't likely get to everybody's questions, but we'll get as many as we can. And if you have a question for a specific presenter, please put the presenter's name that you're addressing your question to. Or if it's a general question, we'll be glad to take care of that as well. We also have a sign language interpretation during this meeting. For the best visibility of the interpreters, we recommend the following changes to your WebEx layout. You'll see in the upper right-hand corner of the window, there will be a tab that says Layout. Follow the directions here. Layout, hide non-video participants. And then change your view to full screen. And the icon looks like opposing edges of a rectangle, if you do that or need that service. Additionally, we have live captioning for today's webinar. To view the live captioning, select the Accept the button in the multimedia pod located in the lower right-hand corner of your WebEx screen. The color contrast of the live caption pod can be arranged as needed. The high contrast style is recommended for best visibility. What I'm gonna now is I'm gonna go through and read introduction bios of all six of our presenters. And then we'll jump right in with the first presentation.

The first one is Ruth Simera. Ruth is the Executive Director of the Coordinating Centers of Excellence in the Department of Psychiatry at Northeast Ohio Medical University. Ruth was previously the director of the Ohio Criminal Justice Coordinating Center of Excellence, or CJ CCOE, and now oversees three centers of excellence, including the first one I mentioned, and the Best Practices in Schizophrenia Treatment Center, and the Ohio Program for Campus Safety and Mental Health. Under the CJ CCOE, Ruth oversaw the statewide CIT dissemination and technical assistance activities and the Ohio Sequential Intercept Mapping Initiative. Previously, Ruth worked for 26 years in community mental health, three years in juvenile justice, and 10 years as an instructor in applied conflict management at Kent State University.

Our next two instructors will be co-presenting. The first one is Peggy Heil, who works in the Office of Research and Statistics in the Colorado Division of Criminal Justice at the Department of Public Safety. Peggy is a licensed clinical social worker with over 35 years of experience in criminal justice, behavioral health administration, service delivery, and research. In her current position, she promotes effective interventions for justice-involved individuals with behavioral health needs by facilitating policy and research development through the coordination of behavioral health related grants and participation on multiple behavioral health-related boards and committees. Her co-presenter is Dr. Abigail Tucker. She's a licensed psychologist in Denver, Colorado. Dr. Tucker currently serves on the Colorado Commission Criminal and Juvenile Justice, the Colorado Department of Youth Services Community



Board Northeast Region, and supports local and state task force efforts on matters related to the nexus of the justice system and behavioral health. Dr. Tucker serves as an adjunct faculty at Nova Southeastern University in both their College of Psychology and for the Fischer College of Education and Criminal Justice. The focus of her ongoing research and practice includes emergency responders' psychology, the intersection of behavioral health and social justice, and suicide prevention.

Our next presenter is Detective Ben Melendrez. Ben has served with the Albuquerque Police Department since 2003 and is currently assigned as a detective in the Crisis Intervention Unit. He's spoken on the topic of mental health and officer wellness at several national conferences and works closely with the Behavioral Sciences Unit at APD. Before becoming a detective, Ben had served for 14 years as a police officer. And prior to joining the police department, Ben served in the U.S. military.

And then, our next two co-presenters are Robert Smuts, he's the deputy director of the San Francisco Department of Emergency Management, overseeing the city's PSAP. He has held this position for seven years. And prior to that, Robert was the chief administrative officer for the city of New Haven, Connecticut for seven years. Robert's co-presenter is Simon Pang, who's the section chief of community paramedicine for the San Francisco Fire Department. He's been in the fire service for 25 years as a firefighter, paramedic, and rescue captain. His interests are finding innovative cross-boundary, collaborative solutions to fill gaps in the system of care. Those are our presenters today. And with that, I'll turn it over to our first presenter, Ruth Simera.

Ruth H. Simera, M.Ed., LSW: Thank you, and thanks for the nice introduction. Thanks for having me today. I am going to talk about Ohio's statewide effort to train CIT dispatch trainers. So, the purpose of this effort is, of course, to increase the level of inclusion of 911 call-takers and dispatchers in CIT programming, which in Ohio is highly relevant to any type of crisis response. So first, let me set the stage for how our statewide CIT efforts are rolled out. The Northeast Ohio Medical University Department of Psychiatry is home to three coordinating centers of excellence, which you just heard listed off: The Criminal Justice Coordinating Center of Excellence, the Ohio Program for Campus Safety and Mental Health, and the Best Practices and Schizophrenia Treatment Center. All three of these centers work with a wide array of partners and community organizations to provide training, education, and technical assistance in order to improve local programs and practices for people living with serious mental illness throughout the state of Ohio. The centers also advocate at the local, state, and national levels for policies and funding to support the implementation of best practices and programs. The Ohio Criminal Justice Coordinating Center of Excellence, which is really what I'm gonna be highlighting today, works with communities to forge collaborative relationships between mental health and criminal justice systems in order to help communities develop effective programs in order to engage people with mental disorders in treatment and divert or deflect them from the justice system. This center, as such, is also the statewide CIT Technical Assistance Center for Ohio. The Ohio Program for Campus Safety and Mental Health, which was born out of the Criminal Justice CCOE, works to promote a comprehensive approach to mental health, campus safety, and academic success at colleges and universities. And lastly, the Best Practices in Schizophrenia Treatment, or Best Center, provides training, consultation, and technical assistance to accelerate the adoption of evidence-based and promising schizophrenia treatment practices in community settings.

So, to provide context to the CIT dissemination work of the Criminal Justice CCOE, our ability to have statewide impact on the growth and evolution of any of the core elements of CIT is grounded in 20 years of laying a foundation and strong partnerships. And we don't have time for the detailed history of our center, NCAT in Ohio, which is fun in itself. But this slide shows our beginnings. And dating back to 1999, when Michael Woody, who was then a training Lieutenant at Akron Police Department and later became the first president of CIT International, went to Memphis to be oriented and trained at CIT. He came back, and by May of the following year, the first training in Ohio took place in the city of Akron. And a month later, the second training took place in the city of Toledo. So those are Summit County and Lucas Counties, respectively, in Ohio. Right around the same time, conversations were being had regarding the development of the Criminal Justice Coordinating Center of Excellence, which came to fruition in May of 2001. And as luck would have it, right around the same time, then Ohio Supreme Court Justice Evelyn Lundburg-Stratton was developing the Advisory Committee on Mental Illness in the Court out of the Supreme Court of Ohio. And those three folks basically got together, so long story short, and championed the rollout of CIT in Ohio. In doing that, they also partnered with CIT coordinators, which I'll talk more about. And by 2004, had created the Ohio CIT Consensus Document which was the prelude to the National CIT Core Elements. And in 2005, Ohio hosted the first National CIT Conference in Columbus, Ohio. So, all of that being said, in all the work that we do, past, present, and future, we work with key partners throughout the state to support and enhance CIT programming. And this'll, I think, become clear why this is so important as we talk about the dispatch training. We take a three-



pronged approach at state coordinating, in terms of CIT, to try to mirror, basically, what we want to have happen at the local level. The Criminal Justice CCOE represents mental health through our department of psychiatry. The National Alliance of Mental Illness of Ohio represents consumers and advocates. And we have a law enforcement liaison CIT coordinator that we contract with to represent the law enforcement community. And all decisions and movements for CIT in Ohio are coordinated by these three entities in concert with one another. The Ohio Department of Mental Health and Addiction Services is the core funder for the Criminal Justice CCOE, and they now also support CIT very directly through state funds. The Ohio Department of Public Safety, which houses our Office of Criminal Justice Services, has provided a myriad of CIT grants and other related funding to both our Criminal Justice CCOE and NAMI Ohio. And also, under Department of Public Safety is our Ohio State Highway Patrol. And they rolled out CIT just this past year, statewide. They used to just, some of the officers would participate in training locally, but they decided to do it with fidelity across the state. So, they're currently in the process of that, and doing a very nice job of it, I might add. The Ohio Department of Rehabilitation and Correction is the department that oversees our prison system. And they also rolled out CIT statewide in the prison facilities across the state of Ohio, starting several years ago. And then, we are very fortunate to have a statewide stepping up initiative in Ohio, which is spearheaded by now retired Ohio Supreme Court Justice Stratton. And that brings with it Department of Mental Health support and infrastructure, as well as funding support from a private foundation, PEGS foundation, which, if some of you have participated in CIT international conferences, you know have sponsored those conferences in the past. So, a couple other additional partners and then I wanna move on from this, but I do want to highlight our CIT coordinators group. This is basically the group of CIT coordinators across the state of Ohio who are the program coordinators for any and all of our CIT programs. And I mentioned the three-prong approach we take to coordination, that coordination is based in the foundation of this CIT coordinators group. So, these folks work together as peers, they work as our advisory group, they are instrumental to everything we do in CIT in Ohio. They meet twice a year. We hold monthly learning opportunity and technical assistance sessions with them and at their request. They serve as planners, trainers for our statewide trainings. They develop that consensus document I talked about and they also developed the Ohio peer assessment and peer review process for CIT programs. The other thing I wanna mention here is the Ohio chapter of the Association of Public Safety communications officials, because when we started rolling out the training of dispatch trainers, they approached us about sponsoring the third training after we had done a couple of them. And this was really important because it lent credence to our 911 call centers, in terms of the training and being more connected to CIT. And then lastly, our Office of the Ohio Attorney General is really important to CIT structure in Ohio because they also oversee the Ohio Peace Officer Training Academy. And if anyone's familiar with the One Mind campaign, you know that it's really important for emerging recruits to get good training, CIT officers to get specialized training, and then any other officer kind of in-between to also be sufficiently trained in mental health response in the community. And we're lucky to have what's now, I believe we're up to 28 hours since this slide was created, in Academy training for our officers. And then we've got a robust CIT program and we're trying to encourage mental health first aid for other trainings in between for all other officers. And the Attorney General's Office is the oversight of that. And they also now sponsor the Task Force on Criminal Justice and Mental Illness, which is the current iteration of the ACMIC Committee that I mentioned earlier, under Justice Stratton.

So, with all of that, CIT in Ohio is organized by our Alcohol, Drug Addiction, and Mental Health Services Board, meaning that's how we look at program development. Memphis was based on an urban model, one big department and our urban departments also create programs. But programmatically, we structure ourselves by the mental health system. We have 50 such board areas in Ohio and they are responsible for coordination and funding of the local public mental health services system. 45 of those 50 board areas sponsor CIT programs and training to go with those programs. The five of the 50 that don't currently sponsor their own CIT programs and infrastructure, the officers in those communities are able to seek training in neighboring communities. So, there's good collaboration at that front. And you're gonna see that we like maps in our CIT program. It's just a good way for our center to monitor the progress that's occurring throughout the state. So, this map shows, first of all, the breadth of involvement of law enforcement officers in CIT training across the state. You can see, based on the fact that there are no white counties here that we have trained officers in all 88 counties of Ohio, which is amazing. And the red counties specifically indicate that that County has the equivalent of 21% or more of all officers in that county being trained. Now, this does not account for attrition. We've done some study of that, but that's a different presentation altogether. Once we got to a point of such good saturation of trained officers in Ohio, we thought it was important, though, to look at the depth of participation in each county. Because for instance, in a metro area like Cincinnati or Cleveland, you could train a good contingent of a very large department like that, and on this map, it would



appear that a good percentage of officers across the whole county were trained, when maybe it was just that one major department. So, looking at the depth of training was important. So, this map shows that. It shows the number or percentage of law enforcement jurisdictions within each county that are participating in CIT. Lots of good news on this map, because as you can see, no county has fewer than 20% of their law enforcement jurisdictions involved in CIT. 77 of 88 counties have half or more of their law enforcement jurisdictions involved in CIT, and 20 counties have all of their law enforcement jurisdictions involved in CIT.

So, this sets the foundation for the dispatch training, because as we consider rolling out kind of what's next in the core elements of CIT across the state, we do try to think about the readiness of our communities for this. So, to this end, in 2011, about two months after I arrived at the Criminal Justice CCOE, we held a statewide dispatchers training. That's the class pictured here. We recorded that training. We posted it on our website in one-hour increments. And we did so to provide an example of what a training might look like, to begin to encourage CIT programs across the state to think about or to begin developing dispatch trainings, or maybe, in some cases, if they couldn't do that, to at least have their dispatchers view this training to begin to get oriented to CIT because there wasn't a lot going on with dispatchers at the time. Fast-forward a few years from that, we weren't seeing a lot of rollout of dispatcher training. And in 2015, very fortuitously, we worked with all those key partners that you saw in the early slides to develop our first statewide CIT strategic plan. And this plan laid out goals for a five-year period. It was not only developed in collaboration with our partners, but I think in part done so that they had a greater sense of investment and were more well-informed and felt like they could support CIT in their own conversations and work as well. I think it's one of the best things that we ever did, quite frankly. But this provided specific objectives for our center. And of the four key strategies outlined in this plan, strategy number three was to prioritize training for 911 call-takers and dispatchers in all Ohio communities. This was not a small undertaking, but it made a lot of sense to us. And what you'll see on this slide are some of the things that we knew we needed to consider. We were aware that there were many models for CIT dispatch training across the country. It was a lot of hit and miss, though. We weren't seeing anything being done statewide. So, we contacted coordinators from various states and got input on this. We saw everything from four-hour models to 24-hour models, with some people saying they would love to see 40-hour models. We decided as a group, and this was in conjunction with the CIT coordinators and our partners, to model an eight-hour version in a dispatch training of trainers, while providing information and resources to allow local communities to basically develop whatever model they needed to, whether that was a four, eight, 16, or 24-hour model, or more. We knew we needed to meet local needs with this training. We really wanted participants to be experienced in local CIT programs, meaning we were marketing this to the coordinators, the trainers, the officers that were seasoned, the mental health providers involved in CIT programs, because we wanted the focus of the training to be on the content of what the training should look like and contain and provide resources to support that. We did not want to set out to claim to be training them on how to be good presenters, for example. And we knew we needed to address specific needs of 911 workers. Our express goal was for participants to go back and implement the training in their community.

So, I'm going to quickly walk through the agenda components that we decided upon for this training. We are currently reviewing this agenda and revising the training, with another June cycle to be planned. But these are the core baseline sections that were agreed upon by a steering committee of partners and CIT coordinators. And they're reviewed before each cycle. So, the agenda, I see it's very small for you, but I'll talk this through quickly. So, the first portion is just a welcome and introduction, it's done by our coordinating center. And we really talk through what is CIT and what does CIT mean in Ohio. And then we're lucky to have a wonderful video, the video that got developed by one of our local programs that actually contains a 911 call from a military veteran in crisis. And it's at a public event where this military veteran is now doing well and in recovery and he's thanking the dispatcher for the work that was done. And it sets a wonderful stage for the training and elevates the meaning of dispatchers and the crisis response system. The second section of this training is what does the CIT officer need from the dispatcher? This is presented by a seasoned CIT officer. He talks through identifying the mental health calls and what is needed in terms of collection of information and sharing of that information to the officers to set them up for success in the field. We learned something from this section after three times, and that's that we really should have it co-presented by law enforcement and a seasoned dispatcher who's well trained in CIT. The next section that we do is post-traumatic stress disorder, traumatic brain injury, and trauma kind of combined. And this is presented by an officer who used to be a dispatcher. And so, she brings a lot of credibility to the talk. She presents on brain development, defining trauma, the effects of trauma, and brings personal experience to it. And we strongly encourage our programs to include this topic in their training. The next section is probably the crux of the training, right? So, it's the Mental Illness 101, but you'll see that it includes mental illness, intellectual disabilities, and substance use disorders. We include intellectual disabilities in all



of our statewide trainings, and I believe that all of our 40-hour trainings across the state do as well. There's so many people living with coexisting or comorbid disorders that we really can't separate these out when it comes to preparing people to respond to crisis in the community. Plus, there's a high incidence of competency evaluation requests across the court systems that are related to the developmentally disabled population. So, we've got key partners in the boards of developmental disabilities that help to provide such trainings with us. So, this training really focuses on behaviors, cues the call taker can consider, take into account, better understand when interacting with somebody, what to expect, how it might present over the phone, how to explore, communicate, et cetera. As part of the resources, we provide a medications list that we have created by our medical director and psychiatrist at our Best Practices and Schizophrenia Treatment Center so that dispatch centers can have that in front of them. Cause once a dispatcher learns that somebody is living with a mental illness and they might begin to ask about medications, they can cross-reference that with the list and give them an indication of what they might be dealing with. Another lesson learned here is that this section needs a little bit more time. And then, the last or next to last section of the training is a consumer perspective. We encourage all of our training programs to include that. Meaning somebody with lived experience there at the training, talking to the would-be dispatchers or trainees so that they would understand what it's like to live with a mental illness and to meet somebody on a good day who can talk about their experiences. And then, a suicidal caller section, and I think that's a no-brainer. That is probably the most prevalent call that dispatchers get related to mental health and mental wellness. And we focus on the goals of the call taker, intervention strategies, et cetera. And then finally, scenario-based training, which is key to any CIT-related training. We have this co-facilitated by a law enforcement trainer and our mental health trainers. And we provide a variety of alternatives to how to approach this, because not all the trainings are 40 hours, clearly, so they don't always have as much time. So, there's a lot of alternatives in terms of how to get skill development and practice within the training. And then, tying back to the PTSD and TBI sections, we close out this training, and encourage our programs to do so as well, with self-care and resources for the dispatchers. So here, the officer comes back on and presents a section on this. And she's also a trained peer supporter around the state, so she provides a lot of resources for where the dispatchers and the trainers can refer dispatchers to for self-care. One of the big lessons learned from the whole training is that we need to add a policy component to this. So, we'll be looking at that in the next cycle. And I will close out by showing what we've accomplished so far with the three training cycles we've had between 2017 and 2018. We've had 82 participants, and these are trainers across 37 counties. And we are currently providing financial support for the implementation of these trainings. And we'll be monitoring over the coming months how many more trainings and dispatchers are being trained. Hundreds been trained so far, which is the good news, but there's more to come. So, thank you for your time.

Michael Hatch: Thank you so much, Ruth. If anybody has any questions for Ruth, make sure that you put them in the Q & A box and we'll get to those after all the presentations are complete. Next up are co-presenters, Peggy and Abigail, take it away.

Peggy Heil, LCSW, Behavioral Health Specialist: Hi, I'm Peggy Heil from the Colorado Division of Criminal Justice, and I'll be co-presenting with Dr. Abigail Tucker from SHE Consulting. And we wanna thank the conference organizers for inviting us to present today. We currently have a JMHP Planning Grant, and these webinars give us an opportunity to share what we're working on, but also to get additional ideas from participants and presenters. So, I'm very happy to be here. I'll be giving you some background on our grant, and then Abigail will spend more time on the tools we're trying to develop, since that might be more interesting to your jurisdiction.

Our project initiated from a legislatively created multi-agency task force focused on justice-involved individuals with mental health disorders. A couple of years ago, the defense representatives started expressing concern that a growing number of 911 welfare checks ended in felony assault charges, primarily due to psychotic individuals resisting transport to a mental health hold. So, in essence, calls regarding non-criminal behavior were ending in criminal charges. We had identified information-sharing gaps by sequential intercepts in a prior BJA grant, and decided to focus on Intercepts Zero and One for this project. We felt these interventions held the greatest potential to prevent criminal justice involvement in the first place. We decided to reach out to several stakeholder groups to explore the issue. And the first thing we did was invite a group of PSAP, Public Safety Answering Point, or also known as 911 Emergency Communications Center directors to a lean-process mapping, with the goal of preventing default criminal justice involvement. The facilitator had the directors walk through the steps they take when they get a call involving behavioral health crisis. They documented those steps, as you can see in this slide, which I'm sure you can't read, and then obtained their ideas on system improvement opportunities. This helped us understand the PSAP process, which is a very demanding process,



as well as identifying their ideas on how it could change. I highly recommend lean-process mapping when you start an initiative like this, because it was really helpful to us. We then invited the Colorado Crisis Line director and regional crisis services administrators to the planning process to add their recommendations to the PSAP directors' system improvement ideas. Once we had developed goals and objectives, we applied for the grant to facilitate a statewide planning initiative. This initiative is planning protocols that can be used across Colorado's 83 primary PSAP agencies and seven crisis regions that cover a mix of urban, suburban, rural, and frontier areas of the state. So, we definitely have our work cut out for us.

Abigail S. Tucker, PsyD: Thank you, Peggy. So, with that history and foundation in place, we knew that we needed to add additional stakeholders. We wanted to make sure that we had a shared vision as we moved forward on the planning grant that Peggy discussed. Our first point and goal was to add behavioral health response as a fourth category. To clarify, what we wanted to ensure is that following the 911 call, in addition to having options such as law enforcement, fire, and emergency medical services, that whether that be a cultural shift, a resource shift, or a partner need, that PSAPs had the option to add behavioral health as a response. Second, with that response potentially being in place, we wanted to help support the integration of those services as part of the emergency response. This, as we'll get into in a moment, could include things such as creating standards, supporting specific trainings, or creating workflows that better help integrate behavioral health services at an emergency or crisis response. And finally, we've been very committed to finishing with a connection. What we're looking to do here is really redirect individuals who may be contacting the justice system at that Intercept Zero or One moment, and redirecting them back to the systems of care, if that was the primary driver. And this could include behavioral health or physical health or peer support services. And so, the stakeholders that we added included advocacy groups and individuals with lived experience who provided invaluable information about what it is, from different perspectives, to be a caller at 911 who has a primary behavioral health or intellectual disability needs, as the driver for that call. Our regional accountable entities in the state of Colorado are the agencies that broker the physical health and behavioral health Medicaid benefit for the state. They also partnered with the Colorado Consortium for Prescription Drug Abuse Prevention, the Office of Behavioral Health Co-responder Program, and most recently, although not on this slide, the Office of Suicide Prevention. So where are we now? We're staying true to the vision that we started with in the planning grant of creating a statewide justice and behavioral health collaboration. Unsurprisingly though, in a state such as Colorado, we know that our individual communities require the capacity to be creative. So, as we advance forward with creating the cultural shift and resources to add behavioral health as another category of emergency response, one of the tools that we are creating is a statewide map and menu, whereby agencies can statewide understand where communities may, for example, be already providing co-responder services. And that way, they can tap into planning, pilot, data sharing, and resource planning as well.

Peggy Hail, LCSW: So, this slide illustrates our initial PSAP triage model, on the left, that we started off with, that adds transfer to the Colorado Crisis Line, which is also going to be our future 988 provider, as a fourth type of first responder resource. Two PSAPs initially volunteered to pilot the model, one urban and one rural, but the rural PSAP covered several law enforcement agencies, one of which that currently uses their local crisis line and does not want to have their calls sent to the state crisis line. This helped us realize that a one-size-fits-all model would not work statewide. We readjusted our thinking to a process model, on the right of this slide, for determining a localized best practice model. The model involves forming a planning committee with key law enforcement, EMS, and mental health agency representatives, some of those Abigail already talked about, and identifying current specialized response options in that area, and selecting additional options the jurisdiction wants to add from a menu. Abigail will go into more detail about some of the options we're currently trying to develop.

Abigail S. Tucker, PsyD: Thank you, Peggy. So, starting at Sequential Intercept Zero, a lot of what the work that we realized in pooling our stakeholders and other interested parties is really to continue to support what is already in place. Colorado already has a robust crisis system. And how do we continue to support that system, as Peggy already stated, as one of our stakeholders? And while we believe that we have behavioral health care access in the state of Colorado, we know that there are still deficits. There are still gaps in funding and parity issues that need to be addressed in order to ensure that that access to care is universal. And then, to fight stigma. We've unfortunately heard of too many stories where, potentially, access to care and resources were available, but due to stigma or lack of awareness, individuals either did not feel comfortable accessing services or were directed incorrectly. As we move to Intercept Zero and One to highlight that this is a bit of a crossover, we were excited to work with Dr. Robert Valuck, who's developing the Opi-rescue Treatment Mapping, a very cool app whereby individuals can first be talked through how to administer



Naloxone, which is an overdose reversal medication. Colorado is fortunate enough to have a standing order, which increases access to Naloxone statewide. Now what they are looking at is adding a treatment mapping option to that, whereby an individual, perhaps who has recently been interacting with the justice system related to a Naloxone overdose, can find out where they can have treatment services that are substance use specific local to them. In addition, we're looking at helping to see where we can support our public safety telecommuters in creating standards and training. For example, we've heard many times that while our PSAPs are interested in how they might potentially redirect calls coming in to, say, our crisis line, they're concerned around liability. And so, we're digging in on standards and other options such as policy that can help support those concerns as we move forward. As Peggy certainly outlined in the previous slide, also looking at workflow. And we're also looking at potential ideas for integrating behavioral health at PSAP. Very interesting to learn about our partner in Ohio and their CIT training that could potentially be another great overlap in training with this Intercept. And if you'll remember that one of our goals was to finish with a connection. How do we ensure that individuals who have engaged in our justice system at the 911 intersect are redirected back to the systems of care or the drivers of that call in the first place? If you'll remember talking about the Opi-rescue treatment mapping options, we're curiously looking to see if there is a way that from a consumer-driven capacity, an individual could push a notification to either a treatment provider or potentially to a Medicaid broker with an interest to seek services so that they could tap in then to the resources and care managers that those agencies have, to engage them in services. Similarly, in working with individuals with lived experience who are working statewide to help create access for psychiatric advanced directives, again, psychiatric advanced directives are plans in which an individual who is living in recovery puts together a plan of care should they need a higher level of service at an unexpected time in the future. As they're developing how to create a statewide resource for this, we're looking to see how we can help, again, from a consumer-driven perspective, make sure that emergency health and behavioral health providers have access to those plans should, again, for example somebody be dropped off at an emergency room or a walk-in crisis center by a law enforcement officer. And, as you heard earlier, continuing to learn from pilots happening in the state that are specific to triaging our crisis line.

So, what are our next steps? We're really excited to be in the process now of scheduling a virtual site visit to Houston to learn more about what they've been doing. We of course will continue to monitor the pilots that we have happening in the state of Colorado right now. We've already started some of the work on PSAP policies and workflows that would help support. We need to continue in that effort. We wanna increase treatment mapping and treatment engagement at Intercept Zero and One, again, to help support redirecting individuals from our justice systems back to the systems of care that were the drivers of the call in the first place. And in doing so, our goal is to create a statewide process and map whereby communities can learn from each other, share resources and data to continue to make the progress that is already in place in Colorado. And as has been stated earlier, if there are questions, feel free to put them in the question and answer, and hopefully we can get to them at the end of this webinar. Thank you very much.

Michael Hatch: Thank you, Abigail and Peggy. Before we get to the next presenter, I just wanna remind everybody that this training is being recorded and it will be available on the IACP website. Dr. Engel has put the website address, or the link to that, in the Q & A section, if you look up towards the top. At least in mine, it's towards the top, you will find that there. Next up presenter is Detective Melendrez. Ben, take it away.

Detective Ben Melendrez: Good afternoon, everybody. And thank you for having me. So, I'm gonna talk a little bit about what my department, the Albuquerque Police Department does, as far as developmental disability trainings for our telecommunicators. And when I used the term telecommunicators, I'm talking about our 911 call-takers and our police dispatchers. So here in New Mexico, we had a state law that passed that required mental health training for both our police officers and our dispatchers at the academy level. And so, our state law here in New Mexico requires our telecommunicators to get 20 hours of mental health training. And being a part of the CIT team here at APD, it is our job to develop and implement that training. And so, we did a pretty intensive needs assessment to talk about what was gonna be a part of that training and what our dispatchers needed and what they could use and what they found useful. And so, this is what we came up with for our 20-hour training for our telecommunicators.

The first eight hours, the first day is a curriculum called Mental Health First Aid, which is a national curriculum and really does a really good job of providing kind of a foundation for folks who maybe not have a lot of experience with people living with mental illness or an intellectual or developmental disability. So, we thought that was a good place to start. It's a great curriculum. Most of the instructors that that work in my unit are also trained in mental health first aid, so that's the first day. And then the next eight hours we created here at APD to include a number of different subjects. The ones that I'll talk about specifically is there's an hour of



specific intellectual and developmental disability and autism-spectrum instruction. I'll talk a little bit about what goes into that hour. And then we have a NAMI peer panel, NAMI being one of our partners here at APD, just a wonderful resource, a wonderful partner here that we use. So, we have a peer panel with individuals with lived experience. That panel kind of changes depending on who can make it and who can't, but it often includes a gentleman who lives with autism spectrum disorder. And so, they get a firsthand introduction to somebody who is living with an intellectual developmental disability. And then kind of our next four hours, the half day, we use scenario-based training. And we use trained actors for our scenarios. They are all trained actors and they've worked with law enforcement. One specific scenario includes a caller living with autism spectrum disorder because it's one of the more prevalent calls we get here in Albuquerque when it comes to folks living with intellectual developmental disabilities. And so, we'll kind of get a little bit more specific on what this training includes. So, for the one-hour intellectual developmental disability class that we created, we define what IDD is. And we provide examples of the different diagnoses that includes. We provide information on prevalence and the etymology of IDD. And then really kind of the meat and potatoes is what we want our dispatchers and 911 call-takers to realize, that there are going to be some communication difficulties sometimes when you're working with this population. And so, we go into what those difficulties might be like and strategies to kind of get better results from working with that population. And those strategies are really reinforced when we go to our scenarios. And of course, this is just one hour out of the eight. The other seven are mostly concentrated on the mental illness aspect of this kind of training. And then, when we work with our NAMI panel, one of the things that we noticed is, with both officers and our telecommunicators, I mean, just based on the fact that these folks are having to interact with police and dispatchers means that something is probably gone astray in their life. And so, what our officers and dispatchers were starting to think is that all folks in this population were having issues and were constantly involved with police, and we just know that that's not the case. So, we brought the NAMI panel in as kind of a refresher look at what folks who've lived in this population are actually like. And it's so wonderful to see our dispatchers get to ask these folks with lived experience questions like, as a dispatcher, how can I serve you better? What questions can I ask? What strategies can I use to make our communication better? And we found that the NAMI panel and interacting with folks with lived experience really does start to de-stigmatize both intellectual developmental disabilities and mental illness for our dispatchers, for our officers. And so, we really like the NAMI panel. It's often one of our highest, most liked portion of the class when we do our reviews of the class. And so, it really goes a long way in helping to de-stigmatize this population. And, I think, at the root of all successful police calls, it really starts at the dispatcher level. And being able to set the stage for the call and maybe realize that folks are in this population so that we can tailor our responses as police officers, when we finally make it to the call.

And so, sort of my department's view on intellectual and developmental curriculum. Myself, along with several of the other detectives that work in my unit sort of started to believe that specialized IDD training was kind of the new horizon for specialized training in law enforcement. We've had CIT training since 1988, so well over 30 years. And what we started to see was that there were interactions across the country with officers and dispatchers involved in this group of people that started to go wrong. And we took note of that, and what could we do better, and what is needed? And so, we started to see a need for specialized IDD training for both our officers and dispatchers pretty early. And to my department's great credit, my chain of command all the way up to our chief of police has really been on board for getting this started and trying to get ahead of the game. And, our main goal is to just improve interactions with this population for when they need police services. And some of the stuff we aim to do better at is we really stress to our dispatchers and officers that patience is really key when you're working with this group of populations. And we go over some of the communications that they may or may not have. And then when officers would get on scene, we don't want stuff like, let's say, somebody living with autism spectrum disorder is stimming or self-soothing behaviors that might look to an officer as suspicious or violent. We really want them to slow down the call and recognize it for what it is. And if you have that information from the dispatchers prior to showing up on the call, it's just so pivotal when the officers can tailor their response to that. And then, some of the other things we needed to do better at, I think, at a national level is when you are interviewing or interrogating somebody from this population, there's such a high chance for a false confession. And I've been a cop for almost two decades. I've never met a cop who wanted to put the wrong person in jail. And so, we really needed to do better and be solid across the country. And even locally in Albuquerque, where folks in this population were admitting to crimes they did not commit because they thought that's what the officer wanted them to say. And so, some of our training specifically goes over that as far as what we need to accomplish when it comes to interviewing or interrogating folks. And again, this all starts at the dispatch level. If the dispatcher's able to kind of realize that this person might be part of the IDD or mental health population, it really can provide a lot of



directions for our officers. And again, we've had a support all the way up to our chief of police. And we work with the Special Olympics here in Albuquerque. We work with The Arc of New Mexico. And prior, certainly when I started as a police officer, police departments were kind of in this mode where it was us versus them when it came to training. We don't need any help, we're the experts. And I'm so glad that that has changed during my police career, where we're just, we wanna reach out to all of our local partners, our national partners, and they probably do it better than we do and we really need their input. And so, my department, again, to their great credit, has been absolutely supportive of us including folks like the Special Olympics, The Arc of New Mexico, and NAMI when it comes to helping us out, develop this training. This training is implemented in all phases of our officers and telecommunicators career. So, we do the 20-hour class at the beginning of their career. For officers, it's actually 40 hours. And then every year they get updated, what's called a Maintenance of Effort Training, which always includes mental health and intellectual developmental curriculum. So, the training is ongoing. Our department also runs what's called the CIT ECHO every week, which is a Zoom platform where we have experts from around Albuquerque and sometimes around the nation talk about subjects related to mental health or intellectual disability. And we have officers and dispatchers and other folks log in from all over the country, including Canada, to attend this 90-minute training that we hold on CIT ECHO every week. So, they get free training there. The CIT ECHO also involves a case debrief where, if somebody's having a particularly difficult case involving somebody with mental health issues or intellectual developmental disability, they can get feedback from several psychiatrists, detectives, and other folks in real time about how they might help that person, or link them to resources. I think that's all I had. But again, I will be around for the questions and answers. And thank you guys so much for this opportunity, I appreciate it.

Michael Hatch: Thank you, Detective Melendrez. The final presentation is Robert and Simon. Go ahead guys, take it away.

Robert Smuts: This is Section Chief of Community Paramedicine for the San Francisco Fire Department. We're talking today about San Francisco's Street Crisis Response Team which launched at the end of November. This is an effort to take what had been calls where the police department was the first responder, involving mental or behavioral health issues, and redirect them to a non-law enforcement response. We'll be touching base today quickly on the SCRT goals and structure. And then talking a little bit about how we're launching, particularly from the dispatcher perspective, from the PSAP perspective, going from where they had been law enforcement calls to the goal of having them completely non-law enforcement calls and that path in between point A and point B. And then wrapping up, talking a little bit about the full implementation vision of where we'll be after they're all no longer law enforcement calls.

So, some quick background. San Francisco is the second densest major U.S. city, with 880,000 people in 47 square miles. We're surrounded by water on three sides and mountain on the fourth. We're a unified city county. So, we don't have a lot of the jurisdictional issues some other agencies have. And my department is responsible for dispatching for police, fire, sheriff, and EMS. All of my staff are cross-trained for call-taking in all dispatcher roles among the different agencies. Annually, we have about 1.2 million incoming calls and dispatch calls for the different agencies. Just a note, fire department handles about 80% of our EMS incidents requiring a transport unit, and we have two other private ambulance companies to handle about the other 20%. I'm gonna turn it over now to Simon, who will talk a little bit about the program background and implementation. Simon?

Simon Pang: Thank you, Rob. This is Simon Pang. The need to improve the delivery of care to people in public spaces has been known for several years here in San Francisco. Way back in 2019, there were several mayoral level meetings talking about what we could do to improve the situation. There was mental health San Francisco legislation that included the creation of a street crisis response team, also in 2019. But it wasn't until the national events during the summer of 2020 that served as the catalyst that brought about a very ambitious timeline to get this done. And we really got the green light to start working on this on October 1st of last year. And I'm very proud to say that by November 30th, we got our first unit launched. It was a soft launch, but we did get that started in about two months' time. We knew going into this that, in addition to the work, the intense planning done between the Department of Public Health, the San Francisco Fire Department, and the Department of Emergency Management, we knew that we had to get the support of local stakeholders. So, there were many concurrent meetings and plans made. We involved interactions with community-based organizations, other programs within the department of public health, other city agencies such as the police department, the Department of Homelessness and Supportive Housing. There were two consumer focus groups that were convened to get the opinion of people who are actually living in the streets, to understand what kind of an engagement process would be most beneficial to them, as well as a number of city-wide community committees that were convened to work on alternatives to



policing. Next slide, Rob. So, we understood that there were four key elements of any crisis system. You needed someone to call, someone to respond, a place to go, and then ongoing linkages to care. We decided to... Oh, hang on. I want him to go back a little bit. For someone to call, we decided to use the 911 system, for a number of reasons. So, we early on thought, should we use the existing 911 system or should we have a secondary number, an independent number that people could call into? And although we may at some point have an independent number, we don't have one now, and we're focusing on 911. One reason is, if we really want to reduce law enforcement response to behavioral crises in the streets, then we really need to intercept the calls at the 911 level. Someone to respond, we have culturally... We have three members on each street crisis response team. It's an interdisciplinary team, culturally diverse. And I'll get more into who, the makeup of the engagement team is on the next slide. We recognize that we need a place to go. And in our city, I'm sure it's very similar in other cities, the city resources are quite siloed and it's very difficult to navigate the system or to understand how to access a certain resource. So, we know that part of our work is that we need streamlined referral processes so that we can access not only the referral process, but just to make sure that we have available access to the many resources available in the city. Also, part of this program is going to be the creation of the Office of Care Coordination. The Office of Care Coordination is going to have behavioral clinicians and healthcare workers that can meet people after the engagement of the Street Crisis Response Team to encourage them to continue in the process of care. And if some of the members, some of the clients remain in the community to do follow-up in the community and make sure that the consumer understands that there is always an offer for care and resources. Next slide, Rob.

So, Rob already mentioned some of our goals. I see it as three main goals. One is we really want to improve the delivery of care to people experiencing problem behavior, with a focus in public spaces, with a focus on adults, the people who are non-violent and who have not committed a crime. The second goal is we want to reduce or eliminate law enforcement responses to such behavioral crises. And then thirdly, to reduce unnecessary ER visits. We're focusing on, we decided... We looked at the 2019 data, 2020 data. First of all, we started planning in 2020. So, we're looking at 2019 data, but we had an understanding that 2020 data was very skewed because of the pandemic. So, from 2019 data, we decided to focus on police code 800, which is a report of a person with a mental disturbance. And I acknowledge that that is a non-trauma-informed phrase but it is how the code is actually defined. And furthermore, we want Priority B police code 800, which would be individuals that are non-violent and without a report of a weapon. I believe, Rob correct me if I'm wrong, but I believe there's just over 10,000 of such calls in 2019. So, we're focusing on those calls and we plan on having a patient-centered approach, an anything-it-takes attitude utilizing time and full competence to get people to the care that they need. And again, we understand that... We also want to get these individuals to definitive care. And definitive care could be an ambulance transport to an emergency room. It could be transport to a non-emergent resource, such as shelter, mental health care, or a substance use treatment program. And we also recognize that that all of our efforts, it's all voluntary on the part of the client. So, in spite of everything we have to offer, we understand that many individuals will choose to remain in the community. But also, with the recognition that even though clients may choose to remain in the community, it doesn't mean that the crisis was not successfully resolved. In many cases, people remain in the community and the crisis was resolved with a degree of success. Next slide.

So, a little bit more about the actual team. It's a three-person team on every vehicle. And by the way, our vehicle is going to be a Ford transit van that has a capacity for up to 12 people. We're not gonna ever anticipate having 12 people in our vehicle, but it is code three capable with lights and sirens. We are gonna have a community paramedic on the rig. A community paramedic is a traditional paramedic with extra training and an expanded role. And we think that a paramedic is very useful on this team because, first of all, we wanna have an all-hazard response and approach. So, having a paramedic there enables us to immediately identify people who actually might be having an acute illness and that requires immediate care. The paramedic can start care right there on the scene and can rapidly access an ambulance or transport to a hospital. In addition to that, the paramedics are all seasoned, urban 911 paramedics. And they're used to working in a chaotic environment. They have well-defined and practiced safety protocols. They have a radio at their hip and they can contact health, including law enforcement, if necessary. The behavioral health clinician could be one of three categories. It could be a marriage and family therapist, it could be a licensed clinical social worker, or a psychologist. And it is very important having them on board because a lot of the people we see on the street have a history of complex traumas, and the behavioral health clinicians are able to engage such individuals in a very nuanced and appropriate way. The peer health worker, I see it really as the gold standard of trauma-informed care. A peer health worker is someone who has lived experience. They may have formerly experienced homelessness. They may be in recovery. And they really provide us a higher degree of street



credibility. So, I think I covered just about everything on this slide. Next slide.

Robert Smuts: And maybe I'll take it up from here. So, the effort for SCRT is really to have a fourth response. Non-behavioral health issues, will continue to go where they always had, police, fire, EMS. We have CIT here in San Francisco. And so, a behavioral health incident that involves violence, weapon-involved, barricaded suspect, something like that would continue to have a SFPD response with the CIP team called out. But for behavioral health incidents, in particular in phase one in a public setting, who are non-violent we have the Street Crisis Response Team, the SCRT, as Simon described. So, the challenge that Simon and the planning team brought to me at the PSAP, when putting this together, was how do we take what had been placed calls and redirect them? And I'm not gonna walk through this flow chart, but this flow chart illustrates what we eventually worked out to train the dispatchers on. So, we were taking sort of mid-level acuity calls, so higher level acuity calls than what you might have heard of in programs like CAHOOTS or some other similar efforts in other cities. We did have a paramedic as part of the team, so that... The effort was to respond to issues sort of right below what our CIT engages on. And so, time was of the essence. Our goal in implementation really was to make sure that while we were ramping up this SCRT team we didn't have any reduction in services, no reduction in response time to responding to the issue in the field. And so, we worked it out that we'd send up two calls simultaneously, one was the traditional police response call, one was to the SCRT. And we cancel the one that didn't respond. And so, that was really our strategy from getting from point A to point B. In doing this, a lot of the sort of decision-making about whether the call fit the criteria specifically was within zone, because to start off, SCRT could only cover part of the city. We pushed to the SCRT team to have more manageable training for the dispatchers as things were changing frequently. Going on.

So, phase one launched at the end of November. And we've been working to add SCRT units. And we are hoping to launch phase two, it's actually been pushed back a little bit from what this slide says, in May or June at the latest. We plan on having six teams operational 24/7. And when we get to that full implementation, the goal is to remove the police calls as a backstop and to have all of the calls be able to be fielded by the SCRT teams, or if absolutely necessary, a regular medic unit as the backstop to take it if all the teams are engaged on calls. One of the other big changes that we'll get to for phase two is, for phase one, we continue to process the calls using our emergency police dispatch protocol, which is not a structured product, it's something we train our dispatchers or our call-takers to over many months, and switch it over to using a very structured product that we use for emergency medical dispatch, by ProQA, those of you familiar with that. And there are pluses and minuses to both the more flexible way that we handle police calls and the more structured way that we handle medical calls. And we're engaging how to make that changeover on these calls in a way that, again, doesn't reduce service to any of these calls and allows us to use this sort of fourth response, the SCRT team.

I'll mention a couple challenges and Simon can chime in on some of these. First challenge that we had is that, a data baseline. We had some existing data, but there were also challenges to the data that we had. And so, sometimes we were planning with best guesses about what we were likely to see. There are always implementation bumps, and I'll actually talk about flexibility versus clarity first. Flexibility, this is what I was talking about in terms of structured versus more flexible way of processing calls. The flexibility, we felt, was very essential in the implementation phase, but then wanted to, for phase two and full implementation, have a much more structured flow of how these calls would go. And eventually get to the point where my call-takers in the 911 center would know exactly how a call will flow and have the call-taking procedures to handle that. Whereas now, in implementation, we're tweaking things. We're tweaking the hours of operations, we're tweaking exactly where the units are responding to, and some other details like that as we try to hone in on this concept. Simon, do you wanna take over and just touch on any implementation bumps we've had?

Simon Pangs: Sure, I would just add to what you already mentioned, Rob, the first benchmark that we are not going to meet is full implementation on March 31st. And, it's because there's been a lot of difficulty in hiring behavioral clinicians. And I myself have not expected that. But I think that community paramedics are used to working nights, weekends, holidays, and other professionals are not. And so that's been the bottleneck. And I believe we should have enough clinicians to be a ready to go in maybe four to eight weeks after March 31st, that's my hope anyways. So that has been a big challenge. Another one is, I expected, I guess I knew that a lot of the clients would choose to remain in the community, but yet I was secretly hopeful that we would be wildly successful and get a lot of folks to accept our offer of shelter or whatever resource it was. But I think, the last date that I saw, I think 74% of the people we meet have chosen to remain in the community. And so, I myself would like to improve that number, but I recognize that



that is standard for other jurisdictions that are doing similar things. I think that number is within expected range, but still a personal disappointment. That's about it, Rob, for me on this slide.

Robert Smuts: Yep, I think we touched on the future implementation, just beyond what I described as full implementation. We're also looking at what other call codes that police respond to that perhaps we could carve out for SCRT responsibility in future phases, as well as how the SCRT team will interact with other parallel efforts San Francisco's engaged on to come up with alternatives to policing. San Francisco is looking at an alternative, non-law enforcement response to take some calls, mainly related to low acuity, low priority issues related to homelessness. And so, we will have to work out how SCRT relates with that effort, as well as how SCRT relates with the higher priority level calls that our police CIT response goes on. So those are some things that are on our plate to continue to work on. Thank you very much.

Michael Hatch: Thank you, guys. We're just a little bit behind. So, I'm gonna buzz right into questions here. I'll call out some questions. If they're specific to a person, I will ask that person to respond. Otherwise, they're open to the floor for the presenters. I will ask that you keep your answers as short as possible so we can get as many questions in as we can. Detective Melendrez did have to jump out. He had an emergency, he had to leave. But we did put his email address in the chat. If you have specific questions for Albuquerque and the detective, his email address is in that chat. I'll start with the first question. How do you handle training for more rural police departments? Do you offer replacement officers at no cost to take the place of the officer's training? I would assume that's probably overtime coverage or pay for that.

Ruth H. Simera, M.Ed., LSW: So, this is Ruth from Ohio, and while it wasn't really pertinent to my presentation, since there's silence, I'll offer this. In Ohio, with some grant and state funds through our Criminal Justice Coordinating Center of Excellence and NAMI Ohio, we do provide dollars for what we call scholarships that a law enforcement agency can request in order to backfill. And that can be based on financial need or our attempt to get new law enforcement agencies involved. We are seeing fewer and fewer of them utilize that today, but that has been part of our infrastructure.

Michael Hatch: Okay, thanks, Ruth. The next question is actually specific to you, Ruth, for the project in Ohio. Has there been any impact in levels of psych ED hospitalizations in counties with greater presence of CIT trainings?

Ruth H. Simera, M.Ed., LSW: That's a really good question. And we are just really getting to a point where we're getting more robust data in Ohio. So, I can't answer that yet, but that is certainly something we're going to be looking at, is just the dispositions resulting from CIT contacts. I think normally what we do see is just an uptick in any referral to mental health. And in some communities, the only option is an ED, but in other communities it may be other providers. But I don't have firm data for you just yet.

Michael Hatch: Okay, thank you. Next question, I'll throw this to our friends in Colorado. How does the implementation plan approved by the FCC establish a two-year timeline to make 988 operational nationwide, with calls routing through National Suicide Prevention Lifeline?

Peggy Heil, LCSW: So, in Colorado, the Colorado Crisis Line is also the provider that the Suicide Hotline calls get routed to. And we assume that they will be the 988 provider in our state. In fact, there's groups meeting on that right now, and potentially legislation will be introduced this year in the state legislature. So, we assume any planning that we do with the Colorado Crisis Line will also fold in 988. And if a lot of the mental health calls end up going to 988, great, and there's no need to try and transfer calls that are 911 calls, then that's fabulous. But we still anticipate that a lot of calls will go to 911. And there'll be a lot of calls that involve mental health crisis that will need law enforcement co-responder or EMS co-responder responses, as well. So, the model we're developing triages to get the appropriate resource out, based on the call.

Michael Hatch: Okay, thank you. And another question for Peggy and Abigail, how is Medicaid involved in the process for you?

Abigail S. Tucker, PsyD: Sure, this is Abigail. And originally, actually HCPF, which is Health Care Policy and Finance with state single agency in the state of Colorado oversees the Medicaid benefits. They were one of the stakeholders in the group that launched this forward. And more recently, we've been outreaching to our regional Medicaid entities asking them how we might be able to help support engagement post that 911 call. I hope that answers the question.

Michael Hatch: Yes. Here's just a general question for the group. I'm wondering if there's been consideration of expanding beyond



IDD to include other disabilities in the CIT training. I ask this because data reports that comorbidity is not limited to the IDD subset of the disability community.

Abigail S. Tucker, PsyD: Well, this is Abigail, I'll certainly share on behalf of Colorado. We really appreciated both learning today and hearing from a lot of the audience for the question to answer. And in addition to engaging that community specifically, I think indeed that will be a focus of ours, is expanding that outreach for those stakeholder groups as well as including that in definitions as we look at policy, standards of care, and training. So, thank you so much for the questions.

Michael Hatch: Okay. And I will just close with just one final question here. I know there's so many, and we just unfortunately just can't get to all of them, we ran out of time. Has there been any training discussion on how to handle a person with IDD who possibly may be under the influence of substances?

Ruth H. Simera, M.Ed., LSW: Hi, this is Ruth from Ohio. I'm sure everybody's silent because that's a really difficult question to answer. And partly because we could paint so many possible scenarios in terms of coexisting behaviors, coexisting disorders, and really get into the weeds in training. And one of the more important things of training law enforcement officers is giving them the skills and the resources that they need to manage what they're seeing and to get people to the right help. So, to answer that question directly, I would say I've not seen direct scenarios based on an intellectual disability combined with substances, but on the other hand, we do talk about, in our CIT trainings, any combination of these things and how they might present and how an officer can manage that.

Michael Hatch: Thanks, Ruth. I appreciate you answering that. That is a very difficult question. That's gonna close out our Q & A for now. Yep, there we go. So, also with this webinar today, we're offering a downloadable resource, a 911 Distressed Caller Diversion Program in Broome County, New York. This is a supporting document that was written for this webinar. You can see that the download is available on your screen for the participants, and you should be able to download that document. And it'll also be available on the IACP website at the address that we did post in the chat. And that closes us out. I wanna thank everyone for attending, and on behalf of the Academic Training to Inform Police Responses, which is the University of Cincinnati, Policy Research Associates, IACP, and The Arc, thank you so much for listening and being on with us today. If you'd like to learn more information about the Academic Training to Inform Police Responses, it is on the IACP website, and you can see that right here on this slide. Thank you, everybody. Be safe, have a great day.

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