

**County of Santa Clara**  
**Behavioral Health Services Department**  
**MHSA INN-15: Community Mobile Response Program**

<b>COMPLETE APPLICATION CHECKLIST</b>	
<p>Innovation (INN) Project Application Packets submitted for approval by the MHSOAC should include the following prior to being scheduled before the Commission:</p>	
<p><input type="checkbox"/> Final INN Project Plan with any relevant supplemental documents and examples: program flow-chart or logic model. Budget should be consistent with what has (or will be) presented to Board of Supervisors.</p>	
<p><input type="checkbox"/> Local Mental Health Board approval*</p>	<p>Approval Date:</p>
<p>*Public Hearing with the County's Behavioral Health Board is scheduled on April 5, 2021</p>	
<p><input type="checkbox"/> Completed 30 day public comment period</p>	
<p>Comment Period: February 12, 2021 to March 14, 2021</p>	
<p><input type="checkbox"/> BOS approval date**</p>	<p>Approval Date:</p>
<p>If County has not presented before BOS, please indicate date when presentation to BOS will be scheduled: April 20, 2021</p>	
<p>Desired Presentation Date for Commission: May 27, 2021</p>	

**COUNTY NAME: SANTA CLARA COUNTY**

**DATE SUBMITTED:** Estimated Submission Date to the Mental Health Services Oversight Accountability Commission (MHSOAC) is slated in May 2021 after the completion of the local community planning and review process.

**PROJECT TITLE: COMMUNITY MOBILE RESPONSE (CMR) PROGRAM**

**TOTAL MHSA INN FUNDING REQUEST: \$27,949,227**

**DURATION OF PROJECT: 54 MONTHS**

**Section 1: Innovations Regulations Requirement Categories**

**CHOOSE A GENERAL REQUIREMENT:**

An Innovative Project must be defined by one of the following general criteria. The proposed project:

- Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention
- Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

**CHOOSE A PRIMARY PURPOSE:**

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

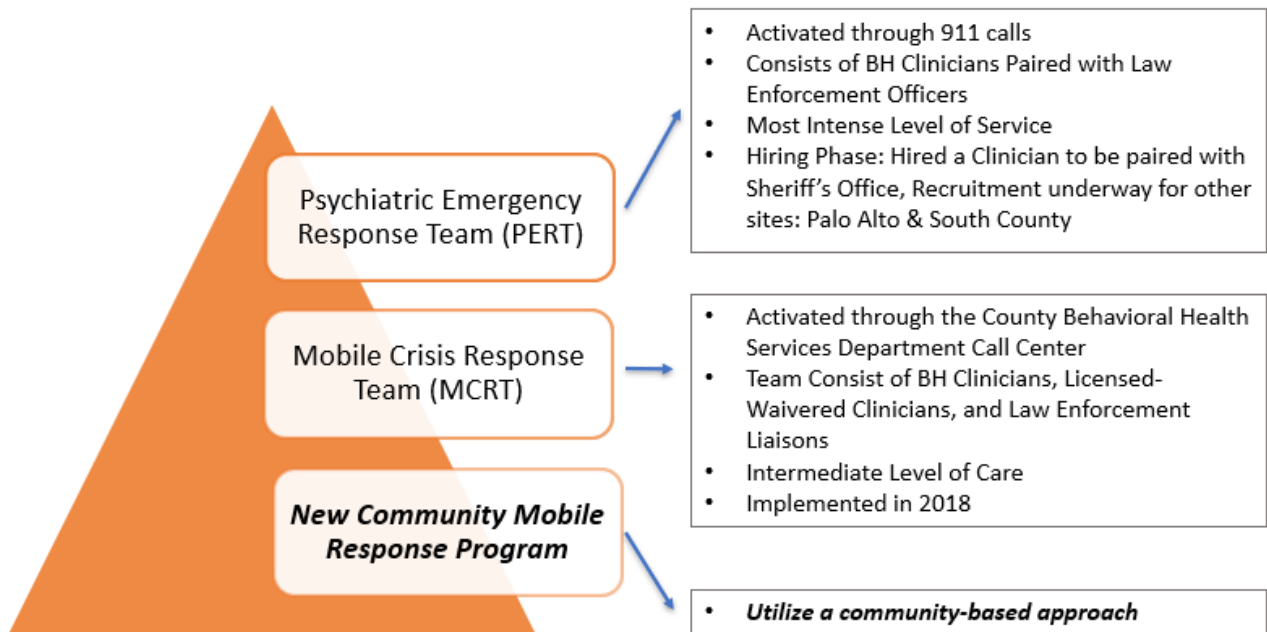
- Increases access to mental health services to underserved groups
- Increases the quality of mental health services, including measured outcomes
- Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

## Section 2: Project Overview

### **PRIMARY PROBLEM**

1. Individuals experiencing mental health crises often interact with police and emergency departments. For communities that are historically unserved, underserved, and inappropriately served, interacting with law enforcement can be a frightening, distressing, and even deadly experience.
2. Communities with historical trauma because of police brutality and negative interactions with other government authorities do not usually call for assistance when needed because calling for assistance may at times lead to involuntary hospitalization and unnecessary incarceration, both of which can be traumatic and life-changing.
3. Santa Clara County has developed a mental health crisis response system that is efficient and effective. However, community members have expressed concerns that these teams require the inclusion of law enforcement in response to individuals in a mental health crisis. During community input meetings, many community members noted negative interactions with law enforcement, which has prevented them from seeking assistance from these programs.

### **THE COUNTY'S BEHAVIORAL HEALTH (BH) MOBILE PROGRAMS**





4. Individuals who are assessed and deemed not needing a 5150 hold may not be linked to any supportive or therapeutic services post-crisis response. Data shows that this can lead to repeat calls for emergency services and lead to unnecessary transport to emergency rooms and other emergency psychiatric hospitals.

*“Due to a lack of access to appropriate quality care, African Americans are much more likely to have their first mental health treatment in an emergency room, or as the result of incarceration, with inadequate follow-up or referral for continuing care.” (CRDP, 2018)*

5. Santa Clara County’s current practice only utilizes an ambulance to transport individuals on a 5150 hold to a hospital. Furthermore, law enforcement can only transport individuals if they sit in the back of the police car, and many times it also means being handcuffed, which can be traumatizing.
6. In Santa Clara County, people of color have reported that there are discrepancies in treatment between racial and ethnic groups. Consumers who are people of color have reported during focus groups, a disparity in the caliber of treatment they receive from law enforcement when experiencing crisis compared to other racial groups, citing numerous negative experiences.
7. With the killing of George Floyd and other African/African Ancestry and Latin individuals, there is an increased need to refrain from utilizing law enforcement when responding to community behavioral health needs. Individuals representing these populations are less likely to seek help by calling 911 for fear of being mistreated or even killed.
8. Due to stigma related to seeking behavioral health services, community members who are people of color are less likely to seek assistance when needed.

## ***PROPOSED PROJECT***

The County of Santa Clara Behavioral Health Services Department (BHSD) provides an array of behavioral health services, including services for crisis, acute inpatient psychiatric care, subacute, residential care, full service partnerships, and outpatient services. Although various behavioral health services are available to the community, there is also an increased need to expand community-based crisis services to encompass a truly community-focused approach.

The new Community Mobile Response (CMR) Program seeks to maximize the ability to expand crisis response for individuals and families by adopting a community model that uses community residents, mental health workers, and emergency medical support to prevent crisis.

*“Communities of color have a number of assets that form the foundation for a community based system of services that meets the mental health needs of all Californians. Community resiliency is developed when families, friends, churches, schools, and community groups work together to strengthen both individuals and communities. Individuals with strong ties to their community are more likely to increase their resilience, develop a positive cultural identity, and form networks.”  
(CRDP, 2018)*

The scope of services will prioritize serving those who are deterred from calling 911 for assistance due to a history of negative experiences with law enforcement. The program will consider population size, geography, and trend/location usage, race and ethnicity, cultural and community representation, LGBTQ population, disability, and other aspects that affect how someone responds to a crisis.

The CMR program will provide a safe and welcoming environment in an effort to reduce the stigma associated with seeking mental health services by the aforementioned consumers. The project will ensure that all aspects of service delivery are inviting, by being linguistically appropriate and lead by culturally informed individuals with lived experiences from these communities. As indicated in the California’s Reducing Disparities Project (CRDP) report from 2018:

*“In order to effectively treat individuals with mental health needs, the system must provide safe and welcoming environments that encourage clients to ask for help. Culturally and linguistically appropriate outreach and education can help confront attitudes and beliefs about mental illness and cultural prohibitions against talking*



*about mental health.”*

The CMR Program intends to proactively help individuals in crisis: any situation where an individual needs assistance in resolving conflicts or stressful situations. The program team will help individuals experiencing an increased level of stress and anxiety by conducting assessments for medical and/or behavioral health needs to minimize and prevent further escalating the crisis and provide the individual the support they need during their time of need. This program intendeds to utilize a community-based approach, this program is intended to be used by the community as an alternative to a law enforcement response. This program aims to serve individuals who do not feel safe contacting law enforcement for unusual situations that require outside intervention for resolution.

In light of the killing of George Floyd and events that took place in 2020, the Mental Health Service Act (MHSA) Stakeholder Leadership Committee (SLC) endorsed this new MHSA INN project: CMR to address current needs through a race equity and social justice lens and make available a program that can help the unserved and underserved. The CMR program will include a process in the program’s workflow to include other resources as needed and, when appropriate, link to other teams and programs, such as the County’s Emergency Medical Services (EMS) team, other County Mobile Response programs like the Mobile Crisis Response Team (MCRT), and Psychiatric Emergency Response Team (PERT).

Community Mobile Response innovative approaches ideas:

- A) **Family involvement** – Utilize Assembly Bill (AB) 1424 which requires that all individuals making decisions about involuntary psychiatric treatment consider information supplied by family members, to encourage family involvement from the phone screening through the entire process, including follow-up.
  
- B) **Prevention focused** – Focus on lower acuity situations and diversion, by being culturally intuitive, utilizing compassion and de-escalation techniques to prevent high stress situations from becoming a crisis, and prevent future calls by providing resources pre and post response.
  
- C) **Access through a trusted community phonenumber** - a centralized 3-digit number that is not 911 or 311.



- D) **Transformed trauma-informed mobile response vehicle** - Designed by a local community artist and voted on by the community that can be utilized for field treatment or transport when needed.
  
- E) **Community Collaborators** - Utilize community members in all aspects of the design, implementation and evaluation process. Staff the program with individuals from the community, prioritizing people with lived experiences. A model detailing community collaborations can be found in the model titled “Community Collaborators” below.
  
- F) **Take a regional approach to learning by collaborating and communicating with other counties** with similar programs. Potentially create a county collaborative on mobile crisis programming.

### **SERVICE AREAS:**

The project will launch in three general geographic areas in Santa Clara County: San Jose, Gilroy, and North County, with a plan to expand to other sites in future years if successful.

According to the Center for Disease Control and Prevention (CDC), the social vulnerability index for Santa Clara County, shown in the next page, shows the highest level of vulnerability is concentrated in San Jose and South County, specifically in Gilroy.



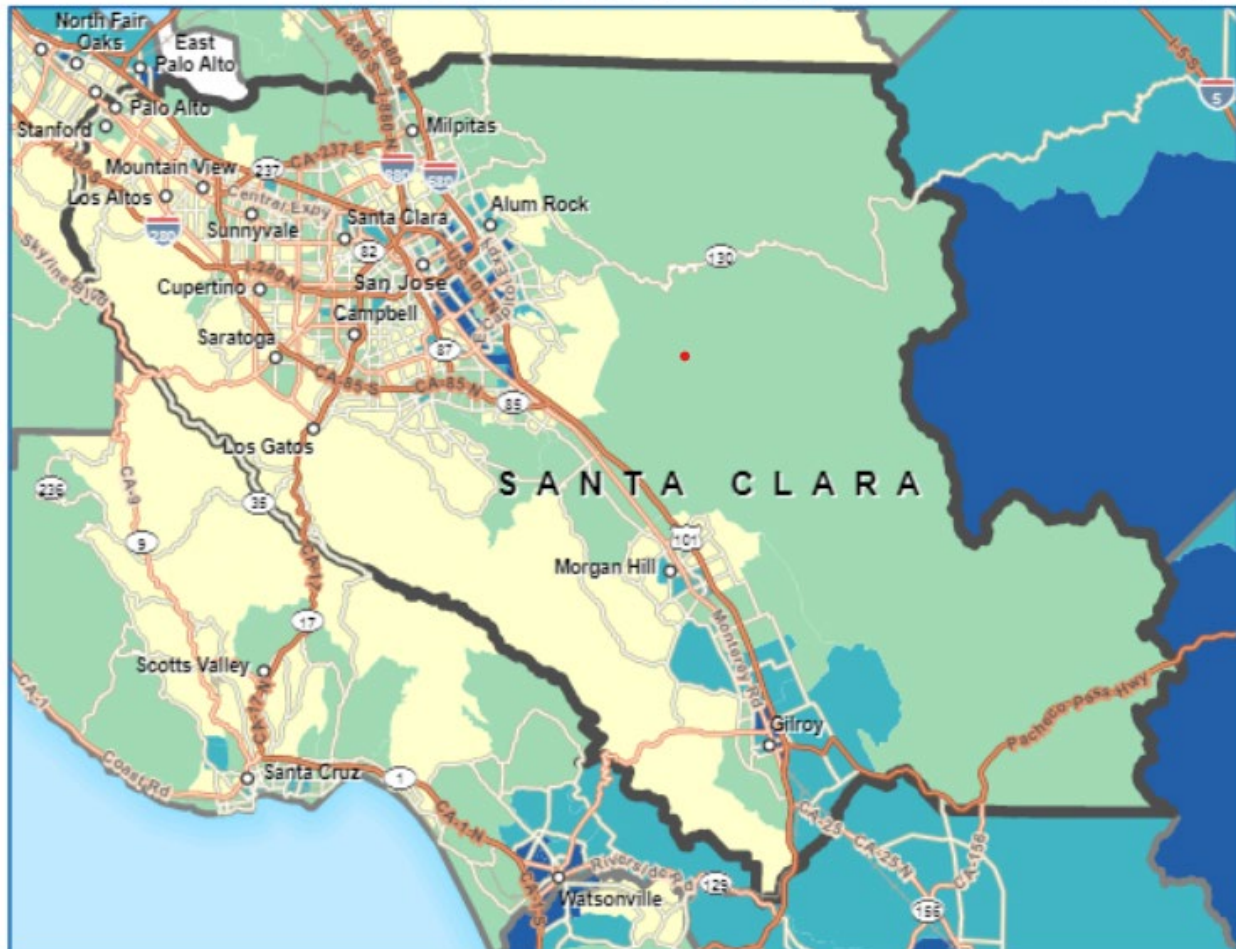
# CDC's Social Vulnerability Index 2016

Santa Clara County, California

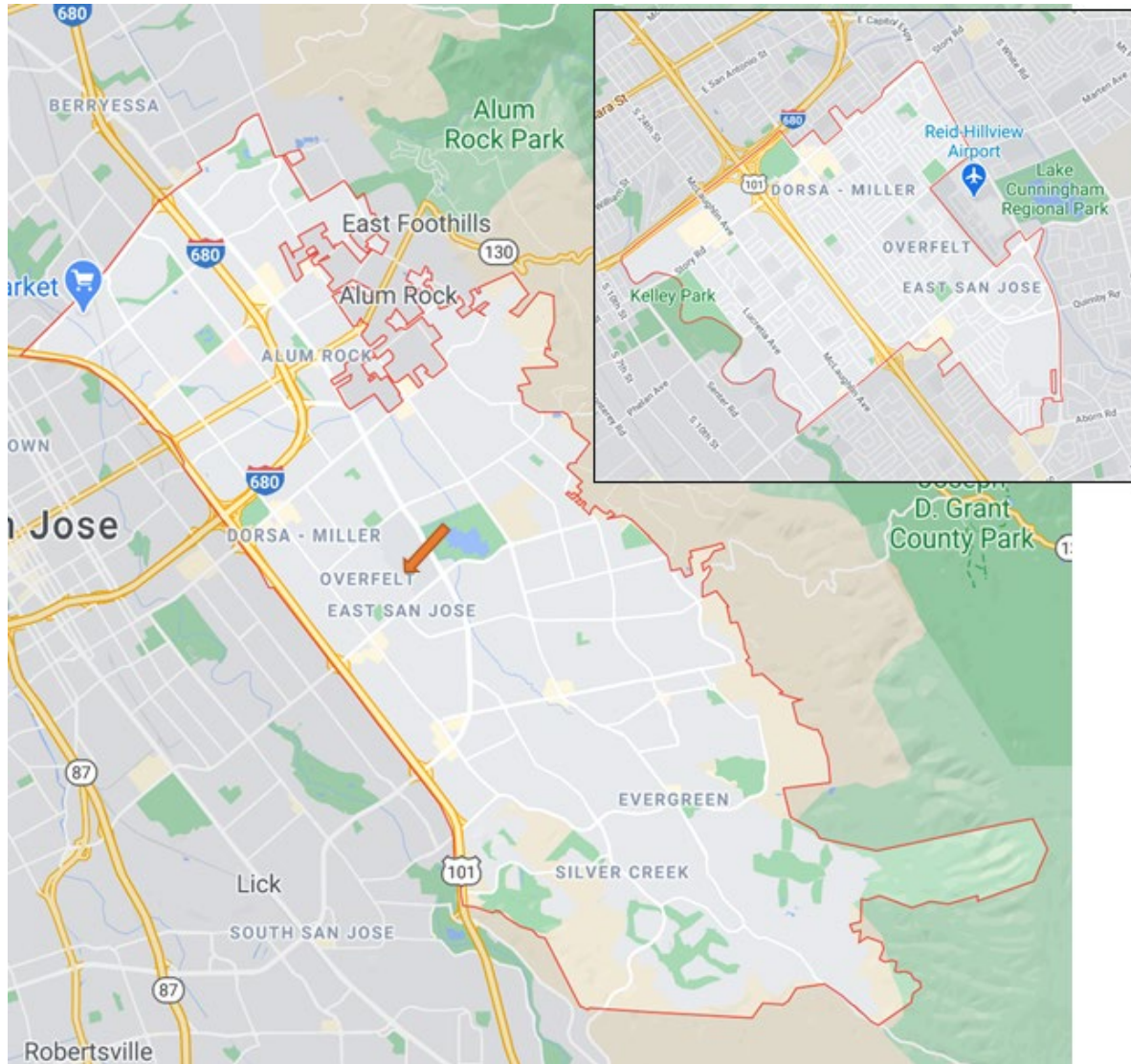
PART 1



## Overall Social Vulnerability<sup>1</sup>

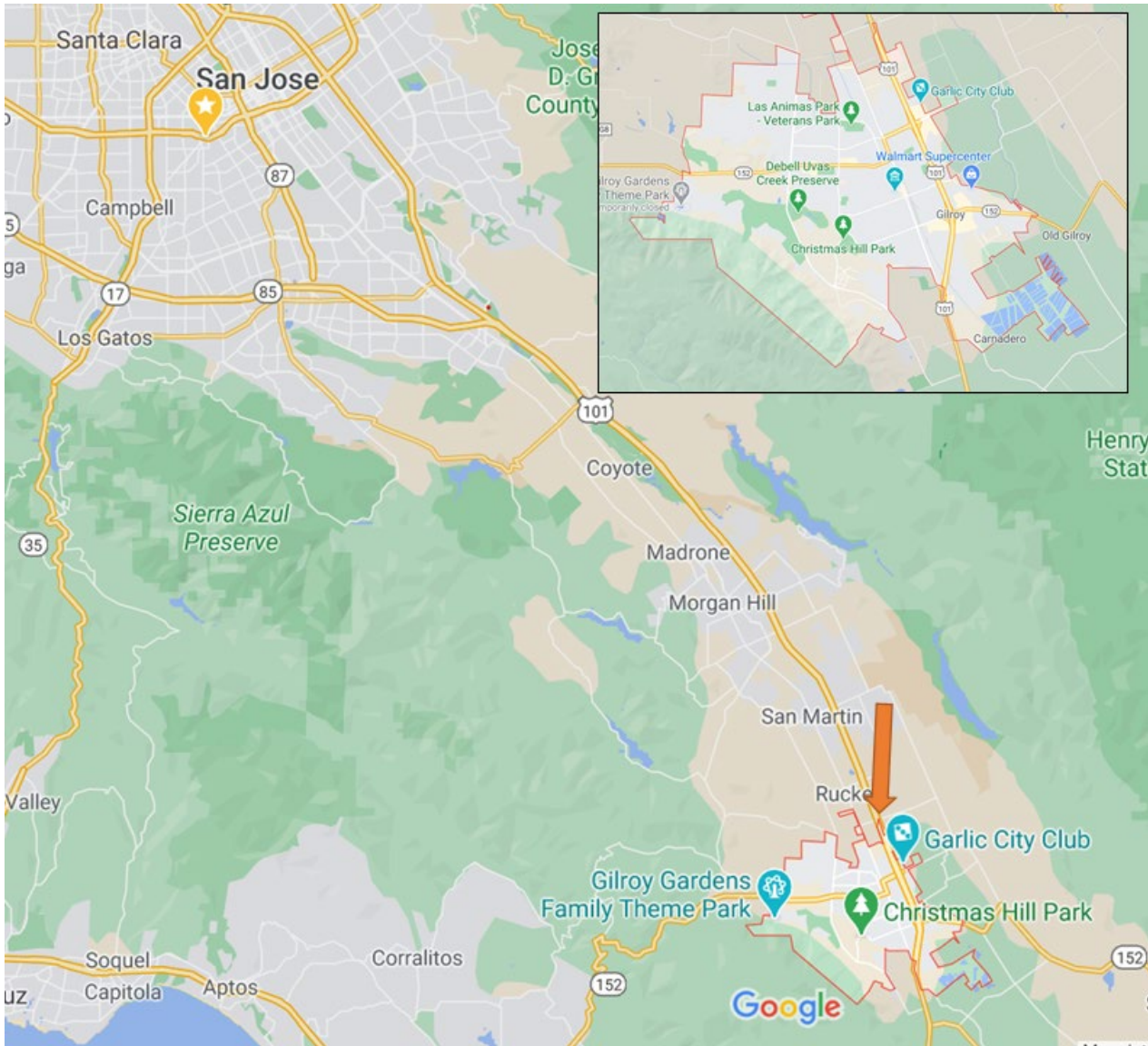






The program will serve all of San Jose. East San Jose and eastside has been identified as a priority area within the San Jose service area. Community and stakeholders expressed the desire to focus efforts on East San Jose due to the concentration of people of color and refugees who reside in this area and has had a history of being underserved and over-policed. Stakeholders expressed the desire to prioritize zip codes 95112 and 95122, and 95116 in East San Jose, based on research and information provided by CMR Workgroup Committee members who helped analyze and develop the program during the February 1 – 3, 2021 CMR Workgroup Committee sessions.

During the 30-day public comment period, comments were received requesting to include the zip code 95116 in the initial launch, to encompass Eastside San Jose, an often missed, underserved pocket in east San Jose.



The second location will prioritize South County, including Gilroy. The community chose this location due to the lack of services available in this area of the county, which is also supported by the CDC vulnerability index referenced above.



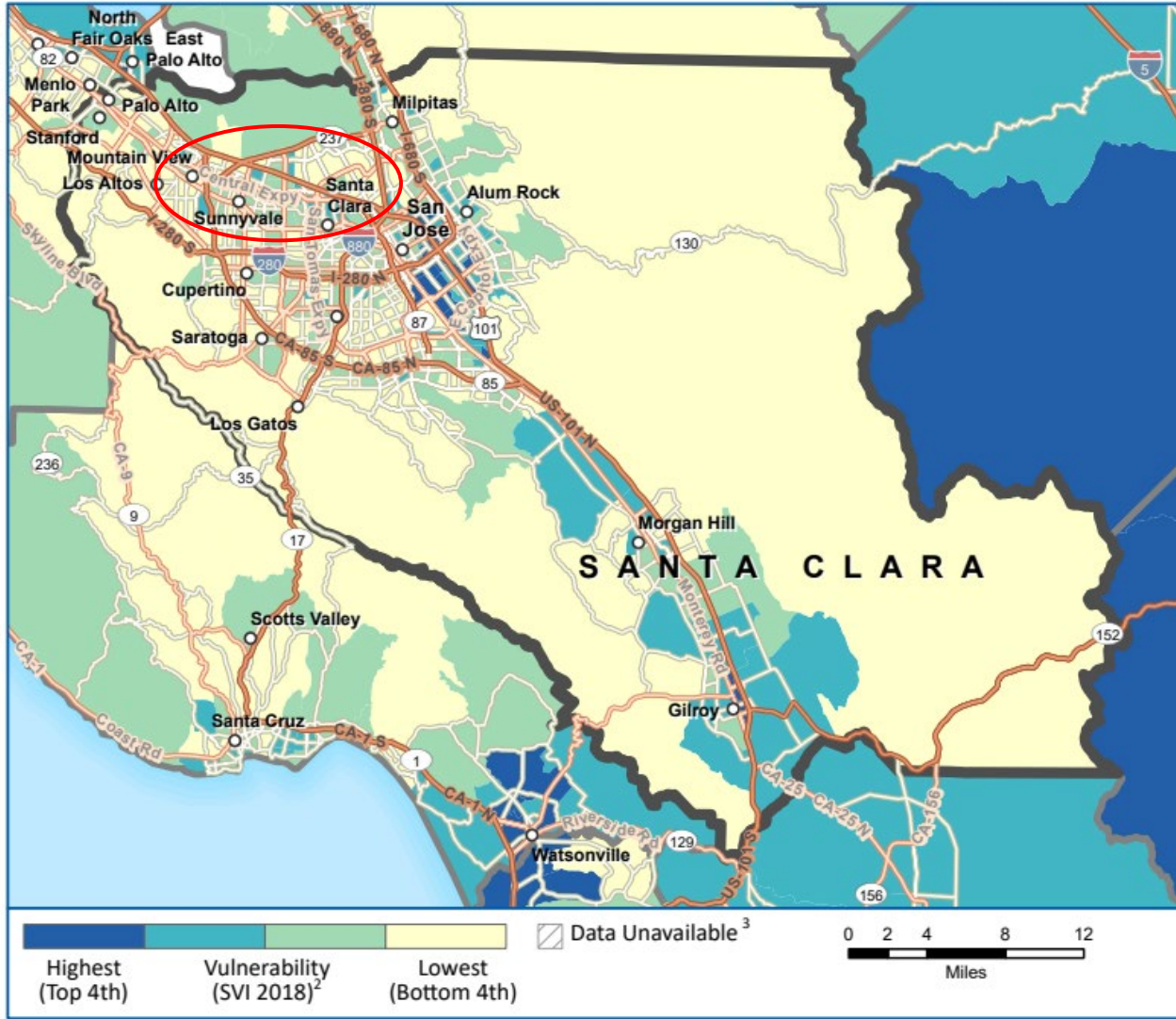
# CDC Social Vulnerability Index 2018

## Santa Clara County, California

PART 1



### Overall Social Vulnerability<sup>1</sup>





The original plan included only two sites: San Jose and Gilroy for the initial launch, with the potential to expand to a third site that includes Morgan Hill and North County if the program was successful and funding is available. However, during the 30-day public comment period, BHSD received comments about the need to expand the program to include North County immediately. BHSD convened meetings with the MHA SLC stakeholders and the public in March of 2021 to assess the comments received, during this time, the community determined that the program would include North County during the initial launch. The third site will serve all of North County with a focus on high need, priority areas using the 2018 CDC vulnerability index above: Mountain View, Sunnyvale, and Santa Clara.

## ESTIMATED NUMBER TO BE SERVED ANNUALLY

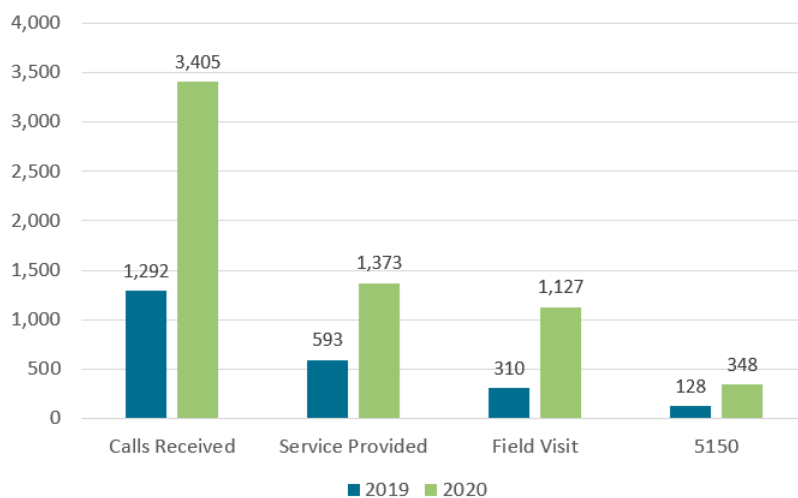
Given the CMR program will be operational 24/7, 365 days of the year, the aim is to serve as many individuals as possible. The program will prioritize serving individuals who are 18+, people of color, refugees, those who identify as LGBTQ, and others with a history of being unserved or underserved. The ultimate goal is to provide a safe and welcoming service for those with a history of negative experiences interacting with government officials and/or law enforcement.

As the stakeholders have shared throughout the planning input phase, this new program aims to help as many individuals as possible in a behavioral health crisis in the County.

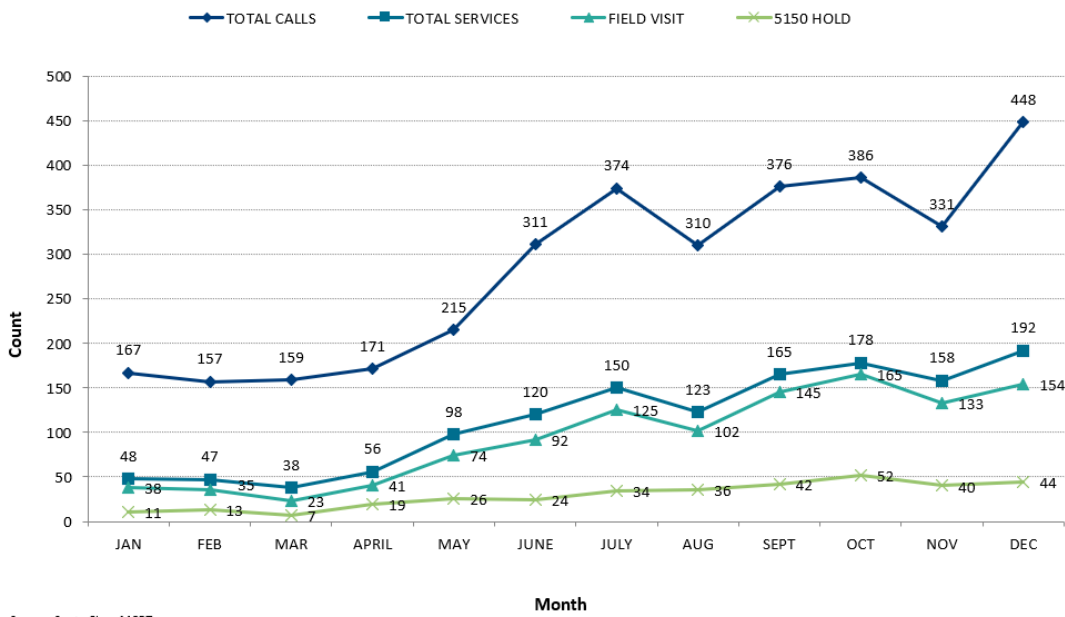
BHSD reviewed the County’s existing Mobile Crisis Response Team (MCRT), data from 2019 to 2020. The MCRT serves the San Jose and South County areas. In 2019, MCRT received 1,292 calls and in 2020, MCRT experienced a 163.5% increase with a 3,405 calls. In addition, the second graph shows the monthly utilization trend for 2020 and MCRT usage continues to increase. BHSD used the MCRT utilization information to help determine the minimum number to be served for this new program. Given this program will use a community-based approach to prevent law enforcement involvement whenever possible to crisis-related behavioral health calls, the CMR program may receive more calls from the public compared to the MCRT as it will be a safe place to call. With this new program, more community members may use this service, and people may be linked to behavioral health services for the first time with the use of this service through the follow-up component (via Call Center or CMR Onsite Field Teams). Again, the program aims to serve as many individuals as possible but, at a minimum, serve approximately 5,000 people annually.

### MCRT SERVICE DATA

Services	2019	2020	% Increase
Calls Received	1,292	3,405	163.5%
Service Provided	593	1,373	131.5%
Field Visit	310	1,127	263.6%
5150	128	348	171.9%



### JANUARY TO DECEMBER 2020 MCRT SERVICES DATA



Source: Santa Clara MCRT

## VEHICLE DESIGN

### Interior

The interior of the vehicle will harbor a safe, calming, therapeutic environment with encouraging images that are not overly stimulating and a bench/bed where individuals can lie down or sit. The community/stakeholders stressed the importance of the vehicle team being able to provide calming items such as fidget spinners, stress balls, food, and water, so the vehicle will be equipped with storage space for these items. The vehicle will also include equipment to provide basic medical treatment in the field and will also have the capability of transporting the patient plus a family member when needed.

### Exterior

To ensure that the vehicle does not potentially cause additional anxiety or stress, the exterior will not reflect law enforcement or other official looking vehicles. The community also stressed the importance of the CMR vehicle being a neutral color and including a discreet logo/design to ensure that it does not have a stigmatizing presence.

In an effort to promote community collaboration and a sense of ownership, BHSD will host a contest for local community artist to design the logo/design for the new program, please refer to section below titled “Community Collaborators and Outreach.”

## CALL CENTER

### *The Call Center Team*

Community members and stakeholders voiced the need for this program to be accessible through a trusted community phone line managed by a centralized Call Center, operated by a community-based organization (CBO). The Call Center will be operational 24 hours, 7 days a week, 365 days of the year.

*“24X7 help is missing. Weekends are very stressful for families. We had to wait until Monday to call into the MCRT in October, and by that time a CIT, ambulance and 5150/5250 were required.” - Community Member and Consumer*

The Call Center Team will include:

- 1.0 FTE Program Manager (Licensed or Licensed Waivered)\*
- 13.5 FTEs to staff the Call Center. The staff may include peer specialists/peer family, paraprofessionals (such as rehabilitation counselors, mental health community workers, and Community Workers) and volunteers\*\*

\*The program manager will be a licensed behavioral health or licensed waived behavioral health clinician (a clinician who is working towards obtaining their licensure). The primary role of the program manager is to provide program oversight and provide support to staff to triage and assist as needed when clinical experience/determination is required.

\*\*Volunteers may comprise up to 25% of the Call Center team.

Through the CMR planning input sessions, stakeholders and community members relayed how the call center team should be knowledgeable on triaging calls, picking up calls, and responding in a timely manner. They also noted the importance of including staff with lived experience who are culturally responsive and have mental health training.

It was important to stakeholders to have the Call Center team comprised of behavioral health trained, relatable staff, and when possible, be able to de-escalate situations over the phone as this was an important component that stakeholders want in place for the Call Center. Also, the Call Center team when appropriate will dispatch the CMR onsite field team to the client in need. The Call Center team will be able to assist clients in a variety of languages. Based on the workflow, described in the “Triage and Workflow” section of this document, if the crisis is de-escalated over the phone, the call center team will follow up with the individual within 24-72 hours.

### **Phone Number for the New CMR Program**

Early on in the planning process, in fall 2020, stakeholders voiced the need to create an accessible, trusted community phone line for the new CMR program. Many stakeholders commented on the need to have a phone number in place that is separate from existing systems such as 911, 311, or the BHSD Behavioral Health Call Center, numbers associated with law enforcement. During the planning input sessions held from December 2020 to January 2021, stakeholders were asked to provide feedback on the new CMR program's phone number: a new 3-digit phone number or a new 10-digit number. Out of the discussions, a vast number of stakeholders voiced that a new 3-digit phone number is best for this program. As one community members stated at one of the planning input sessions:

*“People with altered mental states can remember a 3-digit number better.”  
(Community Member, January 2021)*

Overall, there was consensus from stakeholders and a strong preference for a three-digit number as the phone number information will be consistent throughout the County, easy to remember, which is important to individuals who are in crisis. A three-digit number is “memorable” and can be helpful with program expansion to other areas in the County.

### **CMR ONSITE FIELD TEAM**

As described in the section above, titled “Service Areas,” there will be three service sites: San Jose, Gilroy and North County, there will be one CMR team per service area.

<b>SAN JOSE SERVICE AREA</b>	<b>GILROY SERVICE AREA</b>	<b>NORTH COUNTY SERVICE AREA</b>
<ul style="list-style-type: none"> <li>• 1.0 FTE Community Collaborator</li> <li>• 1.5 FTE Program Manager* (Licensed)</li> <li>• Onsite Field Team**               <ul style="list-style-type: none"> <li>• 4.5 FTEs Emergency Medical Technician</li> <li>• 4.5 FTEs Crisis Intervention Worker (similar to a Rehabilitation Counselor)</li> <li>• 4.5 FTEs Outreach Specialist</li> <li>• Subtotal 13.5 FTEs</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• 1.0 FTE Community Collaborator</li> <li>• 1.5 FTE Program Manager* (Licensed)</li> <li>• Onsite Field Team**               <ul style="list-style-type: none"> <li>• 4.5 FTEs Emergency Medical Technician</li> <li>• 4.5 FTEs Crisis Intervention Worker (similar to a Rehabilitation Counselor)</li> <li>• 4.5 FTEs Outreach Specialist</li> <li>• Subtotal 13.5 FTEs</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• 1.0 FTE Community Collaborator</li> <li>• 1.5 FTE Program Manager* (Licensed)</li> <li>• Onsite Field Team**               <ul style="list-style-type: none"> <li>• 4.5 FTEs Emergency Medical Technician</li> <li>• 4.5 FTEs Crisis Intervention Worker (similar to a Rehabilitation Counselor)</li> <li>• 4.5 FTEs Outreach Specialist</li> <li>• Subtotal 13.5 FTEs</li> </ul> </li> </ul>
<b>Total 16 FTEs</b>	<b>Total 16 FTEs</b>	<b>Total 16 FTEs</b>

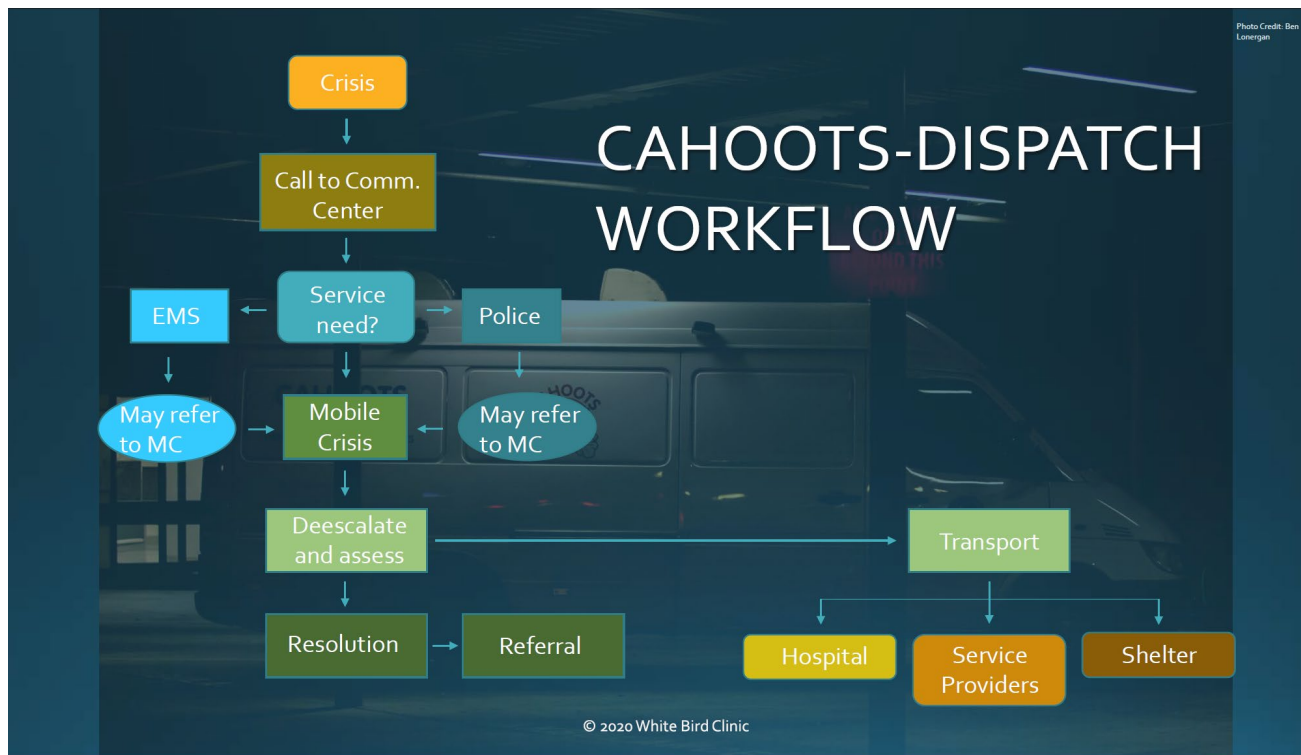


\*A program manager will be licensed, so the manager can do a 5150 hold if needed. The primary role is to provide program oversight.

\*\*Prioritize individuals with lived experience: consumers and family members of consumers.

Overall, based on community and stakeholder input, the CMR team at each service site location should include staff members that reflect the community that they are serving, have lived experience, be approachable, trauma sensitive informed and understand the importance of having empathy. Also, stakeholders shared the need to hire bilingual staff with cultural literacy, who are able to relate to the population they are serving.

### TRIAGE AND WORKFLOW



Source: White Bird Clinic – Dispatch Workflow

The workflow above was shared at community input sessions and the community provided information on how it should be modified for the program. BHSD used the feedback gathered from the community and stakeholders to develop the work flow shown below. What was adapted from the CAHOOTS modes is shown in blue and the adaptations are reflected in green. These changes include an opportunity to de-escalate

the situation over the phone whenever possible, which may not require dispatching the CMR Onsite Field Team.

Stakeholders and the community felt strongly about not involving law enforcement unless deemed absolutely necessary and including a robust training program to ensure that individuals are treated with respect and compassion when accessing services.

During the focus groups, a mother shared her experience of a psychiatrist telling her that her son will be hospitalized for a long time in a psychiatric hospital if she continued to call to report crisis related to him. She is now afraid to seek help and wishes professionals were more humane.

In an effort to ensure that law enforcement has limited involvement, the CMR field team will respond to the situation and assess if there is a need for law enforcement. When appropriate and the situation requires assistance from law enforcement due to safety concerns regarding a client, the CMR Onsite Field Team will have the option of dispatching the county's PERT or MCRT. Community members shared during planning input sessions, if safety concerns arise from any crisis situation that will require law enforcement, they advocated for law enforcement who are trained in Crisis Intervention Training (CIT) to be dispatched to the site.

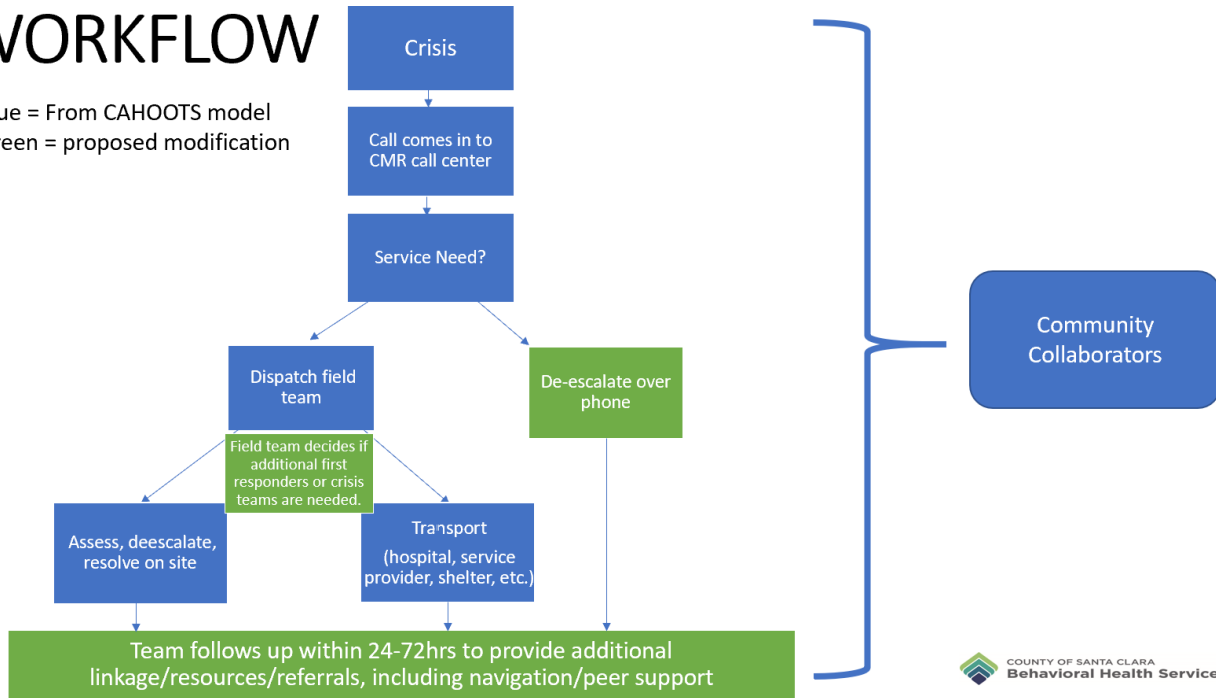
The community also noted the need to include timely follow up for anyone who receives services. To incorporate this, anyone who accesses the CMR program will receive follow up:

1. The Call Center Team will provide a follow-up call to the individual if the CMR Call Center Team can assist and de-escalate the situation with the caller, and the call did not require dispatching the CMR onsite team.
2. The CMR Onsite Field team will provide follow-up as required after providing services onsite to the client.

Follow-up with clients will be conducted within 24-72 hours to provide linkage and referrals to other resources for support.

# WORKFLOW

Blue = From CAHOOTS model  
Green = proposed modification



## PROGRAM OUTREACH AND EDUCATION

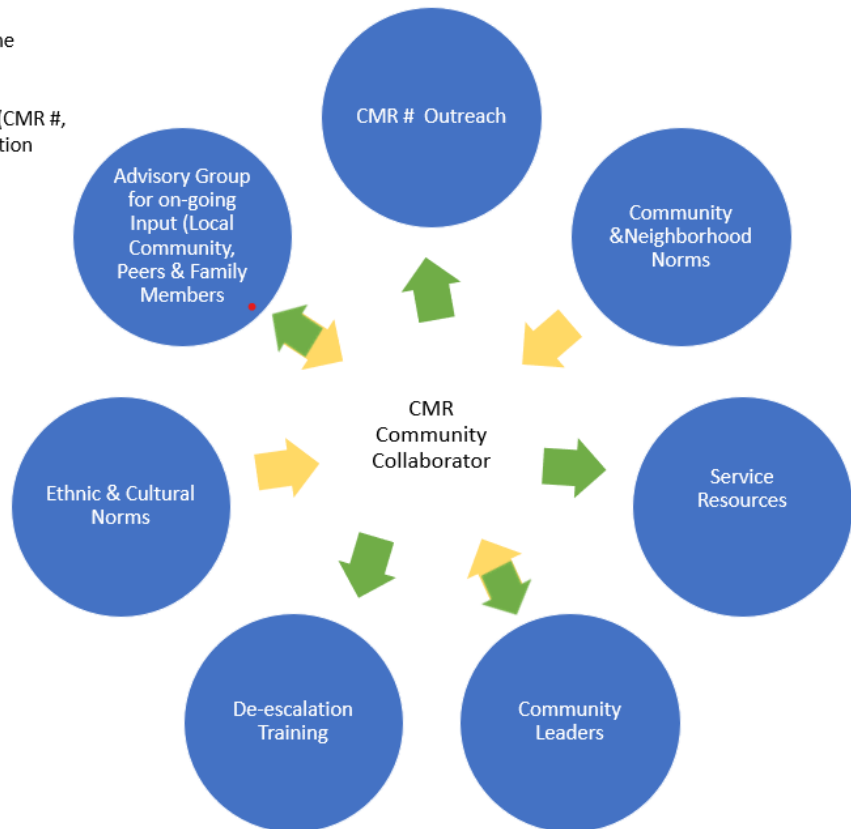
### COMMUNITY COLLABORATORS

During the community input meetings, community-based organizations, stakeholders and community members expressed a desire to include various aspect of community collaborations throughout the entire CMR process. An additional model was developed, shown below, to reflect the involvement of these “Community Collaborators.” The yellow arrows reflect the ongoing information that the community will provide to the CMR program, to inform the design and evaluation. The green arrows represent the information that the CMR program will share with the community, including sharing resources, facilitating trainings, attending community events, and collaborating with community leaders.

## COMMUNITY COLLABORATORS

**Yellow Arrow** = Community informing the design of program (ongoing)

**Green Arrow** = sharing information out (CMR #, Resources, Facilitate trainings, collaboration with shelters and CBOs)



In an effort to promote community collaboration in the design of the program, BHSD, in partnership with MHSa SLC and BHCA, will host a contest open to all community artists to design the logo for the new program. BHSD will develop the design contest with help from the MHSa SLC and BHCA members. Designs from this contest will be shared with the focus groups listed above and stakeholders, to vote on the top design. The winning artist will also receive a prize of \$5,000. The artist who wins the design contest will work with the design firm, selected through an Informal Competitive Procurement (ICP) process, to develop the winning design in a usable format for the new CMR program, to be displayed on the exterior of the van, uniforms, and any outreach items used to spread community awareness about the program. The design templates will also be shared with the CBO contracted providers for their use.

To aid in confronting stigma and negative attitudes about seeking assistance, the program will employ individuals who are culturally and linguistically aware of the community that they are serving. Additionally, all outreach and education materials and logos will be translated into the County’s five threshold languages: Spanish, Vietnamese, Chinese, Tagalog, and Farsi.



*“Without appropriate outreach and education, language barriers can deter many individuals from seeking treatment either because they do not know where to go or they feel they would not be able to adequately communicate with their providers.” (CRDP, 2018)*

## **COMMUNITY OUTREACH EVENTS**

In an effort to build relationships and become known in the community, the program will plan and attend various community events in San Jose and Gilroy. During these events, the CMR Onsite Field teams will bring the vehicle to allow community members an opportunity to tour the inside of the vehicle and meet the teams that are providing services. Attendance at these community events will also assist in building recognition of the CMR program.

During the community input session with transitional age youth, the youth suggested that the program develop a social media account to virtually engage the community and demystify the process of seeking services. To assist in the community becoming comfortable calling the new CMR program, the program will open a social media account to virtually showcase the vehicle and provide the public with a step by step process on what a person can expect when they contact the program for assistance.

*“Make sure to explain the process of what happens when you call. What does this mean for you? What would the resources be? Demystify the process: there should be a place to answer these questions to assuage fear, anxiety.” -  
Community Member*

When the CMR onsite teams are not responding to calls, they will make their presence and mission known throughout the community by driving through San Jose, Gilroy, and North County, seeking out opportunities to be of assistance. This could include assisting those who appear to be in need or by simply engaging community members in conversation and providing resources to detour potential behavioral health needs.

## **PROGRAM NAME**

The community was very vocal about wanting this program to have a positive therapeutic presence in the community. For this reason, the community suggested that the word crisis should not be used in the name of the program. During the workgroup session held on February 3, 2021, the following ideas were shared to utilize as the

name. The MHSA SLC and BHCA members will provide additional input on the name in the coming weeks. In the interim, the program will continue to be called the “Community Mobile Response” program.

- Community Assistance Response & Engagement (CARE)
- Community Wellness Support Team (CWS)
- Community Assessment Team (CAT)
- Community Support Team (CST)
- Community Care Team (CCT)
- Wellness Intervention Support and Help (WISH)

## What should the name be?

### **FAMILY INVOLVEMENT**

The program will leverage Assembly Bill (AB) 1424, which requires that all individuals making decisions about involuntary psychiatric treatment consider information supplied by family members. The CMR team will be directed to address the client first in order to ensure that the family member(s) is/are not a trigger to the crisis. If the family member is not the trigger, family involvement will be encouraged in every step of the process, from the initial phone call, to transport, if needed and through follow up.



*“In many unserved, underserved, and inappropriately served communities, family involvement is also key to improving mental health outcomes. Many people of color who have actively sought mental health treatment or had a family member looking for help have described the significant role that family plays in recovery.” (CRDP, 2018)*

*“Conversely, family rejection and rejection by communities of faith play a large role in the mental health challenges faced by LGBTQ youth and young adults.” (CRDP, 2018)*

To support individuals who identify as LGBTQ, stakeholders who participated in the December 2020 input sessions stressed the importance of including selected family as support persons. To accommodate this, the CMR program will allow the client to determine who their selected support person should be.

## **RESEARCH ON INN COMPONENT**

- The original project idea/concept for the new CMR program was drafted by the Behavioral Health Contractors’ Association of Santa Clara County (BHCA), an organization comprised of over thirty non-profit community-based organizations in Santa Clara County. BHCA’s idea, described in a White Paper, was modeled after the Crisis Assistance Helping Out in the Streets (CAHOOTS) Program from Eugene, Oregon. In August 2020, BHCA shared the White Paper with the Board of Supervisors (BOS) and BHSD, who supported it. The BOS went on to fully fund, utilizing County General Funds, a County Program Manager II position dedicated to the proposed CMR Program. During this time as well, BHCA brought this idea forward to the MHSA SLC group as a potential INN idea, which the MHSA SLC supported.
- BHSD researched the CAHOOTS Program referenced in the BHCA’s White Paper and discussed how the model could be implemented in Santa Clara County, with its unique geography and other differences that needed to be addressed.
- BHSD reached out to the MHSOAC in October 2020 and requested other counties’ project plans that included similar ideas to that being proposed by Santa Clara County. Provided by the MHSOAC, BHSD reviewed San Diego County’s Roaming Outpatient Access Mobile (ROAM) Project, Los Angeles County’s Therapeutic Transport (TT), and San Bernardino County’s Innovative Remote Onsite Assistance Delivery (InnRoads) Program.



Los Angeles: <https://mhsoc.ca.gov/document/2018-08/los-angeles-county-innovation-projecttherapeutic-transportation-tt-september-27>

On January 20, 2021, the BHSD team met with the Los Angeles County TT team to gather information on the development of their program, how it is going, lessons learned, and future plans, to help guide the development of the CMR program.

San Bernardino - Innovative Remote Onsite Assistance Delivery (InnRoads) Program: <https://wp.sbcounty.gov/dbh/wp-content/uploads/2018/10/InnROADs.pdf>

On January 13, 2021, the BHSD team met with the San Bernardino InnRoads team, to gather information on the development of their program, how it is going, lessons learned, and future plans, to help guide the development of the CMR program.

San Diego: <https://mhsoc.ca.gov/document/2017-05/san-diego-county-inn-plan-description-roaming-outpatient-access-mobile-roam>

On January 14, 2021, the BHSD team met with the San Diego County ROAM team, to gather information on the development of their program, how it is going, lessons learned, and future plans, to help guide the development of the CMR program.

- BHSD then expanded research to include other counties' MHSA and INN plans. Alameda County has a current Innovation Project called Community Assessment and Transport Team (CATT), which includes many of the same innovative components and plans as the other counties and served as another model.

Alameda: <http://www.acbhcs.org/wp-content/uploads/2018/04/Alameda-Co.-MHSA-INN-Plan-18-23F.pdf>

On January 29, 2021 BHSD conducted an interview with the Alameda County team, to gather information on the development of their program, how it is going, lessons learned, and future plans. BHSD will continue to collaborate with Alameda county throughout the development of the MCR program.

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- The California Behavioral Health Directors Association (CBHDA) provided information regarding San Francisco's new Street Crisis Response Teams, part of the City's strategic framework for improving the behavioral health response to people experiencing homelessness. The Street Crisis Response Team will be a collaboration between the San Francisco Department of Public Health and the San Francisco Fire Department, and each team will include a community paramedic from the Fire Department, and a behavioral health clinician and behavioral health peer worker from the Department of Public Health.





San Francisco: <https://sfmayor.org/article/mayor-london-breed-announces-plan-create-behavioral-health-street-crisis-response-team>

On February 1, 2021 BHSD conducted an interview with the San Francisco Department of Public Health’s team, to gather information on the development of their program, how it is going, lessons learned, and future plans. BHSD will continue to collaborate with San Francisco’s Mobile Crisis Response Team throughout the development of the MCR program.

- BHSD brought the numerous ideas researched and shared to multiple Stakeholder Leadership Committee meetings and gathered additional information about what community-based organizations were currently providing that were similar to the proposed project plan.
- Resource Development Associates: In the fall of 2016, BHSD hired Resource Development Associates (RDA) to assess the effectiveness, structure, quality, and impact of their MHA-funded Continuum of Care. This MHA Needs Assessment was commissioned by BHSD approximately ten years post MHA implementation. One of the goals of the project was to conduct a retrospective exploration to determine what had been accomplished with regards to MHA implementation. The Department was also interested in documenting the current landscape of MHA-funded services and what additional needs remain in order to target future efforts. The RDA Needs Assessment provided much of the background on the needs of Santa Clara County for this proposed plan document.
- California’s Reducing Disparities Project (CRDP) Report published in 2018.
- Research: The BHSD team conducted informational interviews with various County agencies, including the County EMS director and county counsel. These interviews helped guide the development of the program as it pertains to transportation and field treatment. The BHSD team will continue to collaborate with county counsel to ensure that family can be involved with the process and explore how the program can best collaborate with CBOs and shelters in the treatment and transportation of clients.



## LEARNING GOALS/PROJECT AIMS

1. By using de-escalation techniques, will this new program minimize the need for clients to be transported to the hospital or jail and instead when appropriate transport to other destinations such as housing shelters, sobering center, and other CBO programs?
2. Will this new program encourage community members to seek help when needed?
3. Will a collaborative approach involving community collaborators and other service providers (partner agencies, EMS, BHSD County Programs) help with increased use of the program?
4. Can the program lower the utilization rate of emergency services for behavioral health needs?
5. Can the stigma associated with seeking mental health assistance be lowered if services are provided in a safe, inviting, culturally informed, non-judgmental way?
6. Can the program lower the number of repeat callers for behavioral health crisis assistance by providing linkage and follow-up services to individuals post crisis?

## EVALUATION OR LEARNING PLAN

In an effort to maintain a neutral evaluation method, an independent evaluator will be contracted to conduct a comprehensive process and outcome evaluation of the project. BHSD will utilize the following data to inform the outcomes of this program:

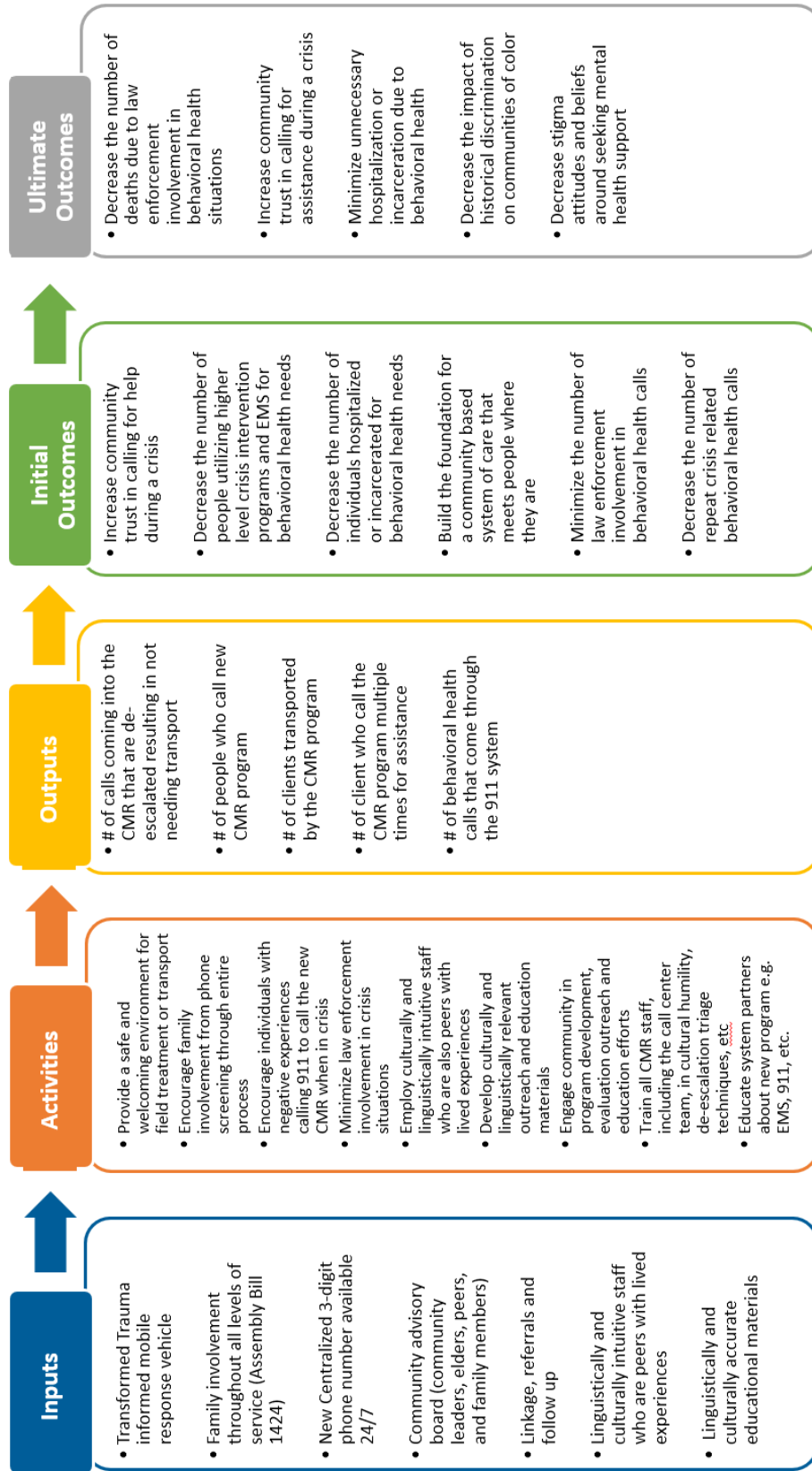
- CBOs will be contracted to manage the call center and three CMR onsite teams, these contracted providers will be asked to track the total number of calls received, and note the number of calls that are de-escalated over the phone or on site, resulting in the client not needing transport.
- For calls that result in a de-escalation over the phone, the Call Center staff will follow up with callers within the specified follow up timeframe.



- For calls that result in the client being transport by the new CMR program, CBO contracted provider(s) will be asked to track the destinations and final outcomes of all clients.
- To determine if the new CMR program assists in lowering the need to repeatedly use outside sources for behavioral health related situations, any person who contacts the CMR program will receive a follow up call from the Call Center team or CMR onsite team. During these follow up calls, CBO contracted provider(s) will ask about client's past use of behavioral health services.
- To evaluate if providing follow up assistance detours repeat calls to the CMR program, the CBO contracted provider(s) will be asked to track the number of individuals who call the program multiple times.
- To determine if the new CMR program results in a decrease in the number of calls and utilization rate of other emergency services, the program will gather baseline data for the following: rate of MCRT usage, ED/EPS admits due to behavioral health related issues, and 911 behavioral health related calls.
- To evaluate if the new CMR program can effectively build community trust and lower stigma related to seeking behavioral health services, the program will conduct regular customer satisfaction surveys.

Community Collaborators will establish a community advisory board made up of various community leaders, consumers, family members of consumers, peers and with partners: service providers, partner agencies, EMS and other County Programs, to help evaluate and inform the development and progression of the program. This group will meet quarterly to assess program progress and inform of changes or adjustments that need to be made.

See logic model in the next page, detailing the inputs, activities and outcomes of the new CMR program:



## Section 3: Additional Information for Regulatory Requirements

### **CONTRACTING**

For the CMR INN project, program services will be contracted out to a Community Based Organization (CBO) through the Request for Proposal (RFP) process. Evaluation services will be contracted out to a professional evaluator through a separate Informal Competitive Procurement (ICP) process. An ICP will also be conducted for the Design Firm that will be hired to assist with design/logo and work with BHSD and the artist who wins the Countywide Design Contest for the new program.

CBO contracted provider(s) selected to provide direct services, and the contracted evaluator will work closely with each other and BHSD to ensure the evaluation plan, data collection, and all technical processes are completed successfully for a robust evaluation. This will also enable BHSD to make a data-driven decision on whether the CMR program services should be sustained after the five years of the Innovation Project completion.

BHSD will review all contractor audit and financial information. The BHSD Contracts Unit, in collaboration with the BHSD Program Management team, will ensure quality as well as regulatory compliance in the contracting process. The independent evaluator contracted specifically for this Innovation Project will also be tasked with evaluating the quality of services.

### **COMMUNITY PROGRAM PLANNING**

In 2020, BHSD also commenced an Innovations (INN) planning process. The SLC membership endorsed to move forward two INN draft ideas: INN-15 Community Mobile Response Program and INN-16 Addressing Trauma and Stigma in Vietnamese and African/African Ancestry Communities. Here are the dates related to Innovation specific SLC meetings for the two new proposed projects.

Timeline of SLC planning meetings and processes - All meetings were open to the public and the meeting information was also available on [www.sccbhsd.org/mhsa](http://www.sccbhsd.org/mhsa).

- September 2, 2020: SLC Meeting including Innovation project prioritization
- September 9, 2020: SLC Meeting including Innovation project prioritization
- October 2, 2020: SLC Innovation Incubator Kick-Off Meeting
- October 17-November 16, 2020: Thirty-day public comment period



- October 26, 2020: SLC Subcommittee Meeting - Innovation Project Refinement
- November 2, 2020: SLC Subcommittee Meeting - Innovation Project Refinement
- November 6, 2020: SLC Subcommittee Meeting - Innovation Project Refinement
- November 17, 2020: SLC Subcommittee Meeting - Innovation Project Refinement.
- November 18, 2020: BHSD to post the updates to the draft plans for the two new INN projects, including INN-16, on the BHSD MHA site [www.sccbhsd.org/mhsa](http://www.sccbhsd.org/mhsa).

On October 17, 2020, BHSD initiated the public comment period, which was slated to end on November 16, 2020, but BHSD extended the public review comment period through November 24, 2020 to provide the public the latest update to the INN project based on the input received from the MHA SLC meetings conducted in October 2020 to November 2020 and also allow time for the community and stakeholders to share additional input and feedback on the two new INN projects. On November 30, 2020, BHSD presented a summary of changes based on input at an MHA SLC meeting that was also open to the public. At the meeting, stakeholders supported extending the planning process to allow a wider variety of consumers and stakeholders an opportunity to provide input for the INN-15 CMR program and have this work completed by BHSD in collaboration with BHCA.

From December 12, 2020 to January 15, 2021, in partnership with BHCA, BHSD convened planning input sessions to build upon the recommended innovative approaches generated in fall 2020. BHSD sought to obtain input on the programmatic elements of the new program, such as the call center design/team, phone number, composition of the CMR team, program workflow/triage, the design-interior/exterior of the trauma-informed response vehicles, and the extent of the family involvement/loved one's involvement for the new program.

These planning input sessions were open to the public and sought focused input from the following diverse groups:

- African/African Ancestry Community
- Chinese Community
- Clinicians with Mobile Crisis Experience
- Consumers
- Consumers/Family Members of Consumers
- Families who have lost loved ones
- Filipino Community
- Justice-Involved and the Re-entry Community
- Spanish Speaking Community
- Stakeholders in North County
- Transitional Age Youth (TAY)
- Vietnamese Community



In all, 13 planning input sessions were held. The meetings were conducted in collaboration with BHSD program areas: Cultural Communities Wellness Program (CCWP) and the Criminal Justice Service (CJS) program division as well as with partner organizations such as the National Alliance of Mental Illness (NAMI) of Santa Clara County, Black Leadership Kitchen Cabinet (BLKC), Silicon Valley De-Bug, and Stanford Center for Youth Mental Health and Wellbeing. Overall, various community members, from consumers, family members of consumers, community members that identify as LGBTQ, and many more as described above, participated in the planning process and development of this new program.

At the end of January 2021, BHSD presented the information gathered at the planning input sessions with the MHSA SLC members and BHCA partners and invited them to join the CMR Workgroup Committee whose tasked to help refine and finalize the CMR program by analyzing the gathered data from the community planning input sessions, see reference section “Planning Input Notes – December 2020 to January 2021.”

Sessions with the CMR Workgroup Committees were held on February 1 - 3, 2021, and the group analyzed and refined the programmatic elements of the CMR projects. The CMR workgroup committee members included:

- Ana Villarreal, NAMI Faith Collaborative, MHSA SLC Member: Faith-Based
- Armina Husic, Associate Director, Center for Survivors of Torture (CST), Asian Americans for Community Involvement (AACI), MHSA SLC Member: Adult/Refugee Health Advocate
- Cheryl Engelstad, MFT, Member of the Lumbee Tribe, Director of Intensive Outpatient Program, Starlight Community Services, MHSA SLC Member: Service Provider – Underserved Youth
- David Mineta, MSW, President and CEO, Momentum for Mental Health, BHCA Member
- Dolores Garcia, Coordinator, Parent Hub, and AB 109 Programs, ConXion to Community, MHSA SLC Member: Social Services
- Don Taylor, Executive Director, Bay Area Region, Uplift Family Services, BHCA Member
- Elisa Koff-Ginsborg, Executive Director, BHCA
- Gary Miles, MHSA SLC and Behavioral Health Board (BHB) Chairperson
- Kathy Forward, Consultant, NAMI of Santa Clara County, MHSA SLC Member: Family Member



- Lorraine Zeller, Retired - Mental Health Peer Support Worker, Office of Consumer Affairs, Ambassador, ACCESS for Mental Health MHSA SLC Member: Client/Consumer
- LouMeshia Brown, LMFT, Program Manager II, BHSD, MHSA SLC Member: Cultural Competence
- Mohamed Ali, Mental Health Peer Support Worker, BHSD, MHSA SLC Member: Family Member
- Peggy Cho, Mental Health Peer Support Worker, BHSD, MHSA SLC Member: Client/Consumer
- Sparky Harlan, CEO, Bill Wilson Center, MHSA SLC Member: Service Provider TAY
- Yvonne Maxwell, LCSW, Executive Director, Ujima, BHCA Member

On February 10, 2021, BHSD held an MHSA SLC meeting that was open to the public in which the BHSD team presented the updated CMR plan. The presentation included programmatic updates and budget information, which has also been included as an attachment to this plan document.

The CMR draft plan document was posted for 30-days from February 12, 2021 to March 14, 2021 on [www.sccbhsd.org/mhsa](http://www.sccbhsd.org/mhsa). A SurveyMonkey link was available on that site to provide individuals and the public an opportunity to submit their comments/feedback on the plan. During this time, a total of 15 comments were submitted by community members and the following organizations: BHCA, Bill Wilson Center, The City of Palo Alto, The Law Foundation of Silicon Valley, various non-profit organizations, Santa Clara University and Uplift. A summary of the comments received, and responses provided by BHSD is included in the Appendix section of this plan titled “MHSA INN#15 Community Mobile Response 30 day Public Comments.”

BHSD held a public meeting on March 15, 2021 to address the comments received during the 30-day posting period. During this meeting, the MHSA SLC members decided to revisit the budget portion of the plan, to ensure that the salary range for the positions proposed would be competitive enough for the service providers to staff the program. BHSD held another meeting with the MHSA SLC members that was also open to the public on March 23, 2021, to discuss potential revisions to the plan. During this time, BHSD shared additional budget options and timing scenarios for potential plan adjustment. The PowerPoint with these budget scenarios can be found in the appendix titled “March 23, 2021 MHSA SLC Meeting - Community Mobile Response (CMR) Program - Informational Update” and “March 25 2021 MHSA SLC Meeting - Community Mobile Response (CMR) Program Discussion and Next Steps.”





On March 25, 2021 a meeting was held with the MHSA SLC members and the public to decide on final revisions to the draft plan. The community decided to revise the following:

- Adjust plan based on salary/benefit analysis conducted by BHSD Finance and comparable info provided by BHCA, to include a 4.8% increase from the original draft plan. This would help ensure that service providers would be competitive enough to acquire staffing for the program.
- Update Project Duration from 5 years to 4 years and add a third onsite field team in North County.
- Change the project duration from 4 years to 4.5 years to be able to start the design contest related activities, purchase of vans/retrofitting activities for the first six months of the project.

BHSD will hold a public hearing with the Behavioral Health Board on April 5, 2021 and request the County's Board of Supervisors' approval of the plan on April 20, 2021.

This section will be updated as the community planning process is completed with this project.

## **MHSA GENERAL STANDARDS**

MHSA Innovation projects must be consistent with all potentially applicable MHSA General Standards listed below as set forth in Title 9 California Code of Regulations, Section 3320. This project meets the MHSA General Standards as described here:

- **Community Collaboration:** The BHCA initially brought forward the project idea through a white paper regarding the CAHOOTS model and the use of a community-based approach for crisis-related situations. BHCA shared this project idea/concept with the MHSA SLC group at a public meeting. The project idea was supported by MHSA SLC and advanced as an MHSA INN project in fall 2020. Since that time, BHSD, in collaboration with BHCA and other partner agencies, facilitated planning input sessions to garner broader participation from the community to obtain feedback on the new program. Please refer to the "Community Planning Process" described in the prior section for additional details on how many provided input in the development of this plan.
- **Cultural Competence:** By extending and including additional planning input sessions, BHSD engaged more individuals, community members to participate in the community planning process of the new community mobile response program. The



input gathered throughout the community planning process reflects the cultural, ethnic, and racial diversity representative of various communities in Santa Clara County.

- **Client Driven and Family Driven:** The community planning process included a broad range of community feedback, especially through the planning input sessions conducted in December 2020 – January 2021 that included participation from consumers, family members of consumers, families members who have lost loved ones that help provide input in the development of this project.
- **Wellness, Recovery, and Resilience Focused:** As a result of this Community Mobile Response Program and the improvements made through the expanded community planning process, clients of the crisis system, will have decreased levels of trauma and increased levels of support from the community, as well as their family members throughout the process of assessment, transport, and hospital admission, if needed and desired by the individual in crisis. Ultimately, through decreased wait times and the removal of most law enforcement response, the experience of the person in crisis will be transformed into one in which they get the services they need and emerge in a place more conducive to wellness, recovery, and resilience.
- **Service Integration:** The current design of the CMR Program seeks to reduce the number of providers and organizations involved in the crisis response from beginning to end, which will improve service integration by making the process more seamless and less drawn out and require the individual in crisis to repeat their information fewer times. The new program's linkage follow-up component, as described in the triage/workflow section of the document, will help clients gain access to a full range of needed behavioral services and post-crisis services will support both the individual, who was in crisis and the individual's family who were involved in the crisis situation.

## ***CULTURAL COMPETENCE AND STAKEHOLDER INVOLVEMENT IN EVALUATION***

BHSD will convene a community collaborative advisory board made up of community leaders, peers, family members, and consumers to help guide the development and continuous evaluation of the program. Additionally, all staff involved with the program will be trained in cultural humility.

## **INNOVATION PROJECT SUSTAINABILITY AND CONTINUITY OF CARE**

**Sustainability:** Based on the results of the independent evaluation of the Innovation Project, and the availability of other identified funding sources, the County will determine whether to continue the project as is or to keep particularly successful elements integrated into other programs already funded and being sustained. A year before the end of the project's INN funding, the evaluation contractor will present an evaluation project report to BHSD and MHSA SLC to provide information about the project's outcomes and the effectiveness of the project. The evaluator will also present an initial feasibility assessment for sustaining, integrating, or replicating project services or lessons learned to BHSD, the MHSA SLC group, and the County's Behavioral Health Board and discuss future plans for the CMR program in advance of the project end date as an MHSA INN project.

**Continuity of care:** Individuals with serious mental illness receive services from the proposed project. Well in advance of project completion, clients in the Innovation Funded programs will be assessed for transfer to other programs. If the Innovation Project is to be *sustained* and moved to a different funding source, clients will be notified of any changes that may impact them, such as a shift in what types of personal information or assessment data is being collected.

## **COMMUNICATION AND DISSEMINATION PLAN**

### ***Community Collaborators and Sharing of Info***

- Information on the results of the Innovation Project evaluation will be posted online, distributed via email, and reviewed at quarterly community advisory meetings. Please refer to the section above titled "Community Collaborators," as it describes how BHSD plans to include a community-driven approach by consulting with a community advisory board.

### ***CA County Collaborative: Share County Learnings***

- The CMR Program Manager II will engage with communities that have developed similar mobile response programs to develop a collaborative learning group to meet regularly throughout the project to share lessons learned and best practices.

### ***Ongoing Reporting Dissemination***

- BHSD will hold public meetings with the SLC to share learnings throughout the term of the project to assess progress and expand on project goals as needed.

## TIMELINE

**The goal is to obtain the County Board of Supervisor’s approval of the new Community Mobile Response program in April and request MHSOAC approval of the new INN program by May 2021 – June 2021, by the end of FY 2021.**

### ***Pre-MHSOAC Approval***

#### **BHSD RFP Development and Logo/Design Contest (March 2021 – June 2021):**

After the local community planning process has been completed with the County Board of Supervisors’ approval of the new INN-15 CMR program and while awaiting for MHSOAC review and approval of the plan, BHSD staff will conduct the following:

- Develop the scope of work(s) for the RFP that includes the programmatic details described in this Plan document, including the following components: Call Center, CMR Onsite Field Team for the San Jose Service area, and the CMR Onsite Field Team for Gilroy. The BHSD program team will work with the BHSD Contracts unit to prepare the RFP during this period.
- Plan and develop plans for the countywide design contest to create the logo/design of the County’s new CMR project, including the selection/award process. This process includes obtaining the County Board of Supervisors’ approval, which will be requested once BHSD receives approval of the new program from the MHSOAC.
- Develop the scope of work for the Informal Competitive Process for the Design Vendor who will be tasked with working with the winning artist to transpose the winning designs to usable formats, electronic images, create the design in the County’s threshold languages: Spanish, Vietnamese, Chinese, Tagalog, and Farsi.
- Develop the scope of work for the evaluation contract. The selected vendor will be tasked with program evaluation and working with community collaborators throughout the program implementation and evaluation process.

**Once the MHSOAC approves the project, BHSD will request the County Board of Supervisor approval of an appropriation modification to recognize the MHSA INN funds in the BHSD budget for this new project. Assuming program and funding approval by the MHSOAC is obtained, and BHSD receives County Board of Supervisor approval of an appropriation modification by June 2021, the RFP and ICP process can start in July 2021.**

### ***Once MHSOAC Approval Is Obtained***

**Beginning in July 2021, The County will utilize the first six months of MHSA INN funding to execute the design contest as well as acquire, retrofit and prepare the vehicles needed for program implementation. This will initiate the 4.5-year drawdown of funding.**

#### **Design of a new logo of the new program (July 2021 – December 2021)**

- Initiate Countywide Design Contest of the new Program open to Santa Clara County residents (one month).
- Request the public to vote on submitted design ideas (two-three weeks).
- Announce winning design and artist.
- The winning artist to work with BHSD and the design firm to transpose the winning design to other media types such as electronic images and translate it to other languages (County's threshold languages) and share design/logo materials with selected CBO contract provider(s).
- Release an ICP for the Design Firm company that will work with the winning artist.

#### **Van Transport/Retrofit (July 2021 – December 2021)**

- BHSD will work with County's Facilities and Fleet (FAF) Management area to purchase two utility vans, including retrofitting the utility vans to include equipment and adjustments to the interior to allow for a comfortable, therapeutic space to help and provide care to clients. Lastly, complete the design wrapping to showcase the winning design/logo. Once completed, the van will be transferred to the CBO contracted provider selected to serve the San Jose area and one for the Gilroy area.

#### **Initiate RFP and ICP Process (July 2021 – December 2021)**

- Release an RFP that will include the following four components: Call Center, CMR Onsite Field Team for the San Jose Service area, CMR Onsite Field Team for Gilroy, and CMR Onsite Field Team for the North County service area. CBOs will have the options for applying for one or all four of the RFP components.
  - CBO provider(s) submit bid proposals.
  - Evaluate bidder proposals.
  - Select and award RFP contract(s) with a projected service contract start date of January 1, 2022.
  - Generally, the BHSD Contracting RFP process takes six to eight months, but BHSD will aim to complete the RFP process in six months.
- Release an ICP for the evaluation contract.



**If the RFP process is completed by December 2021, the program implementation will start in January 2022.**

**Program Implementation (January 2022 – December 2025)**

- Selected CBO provider(s) to implement the Call Center, CMR Onsite Field Team for San Jose, CMR Onsite Field Team for Gilroy, and CMR Onsite Field Team for North County. Six-month ramp-up to allow contracted CBO provider(s) to hire and train staff.
- Establish a Community Collaborative Committee facilitated by the community collaborator hired for each service area with the aim of having participants from local/partner agencies, community leaders, BHSD, and other service partners: County and CBOs, local jurisdictions to help educate about the new CMR program.
- Establish the evaluation contract with an independent evaluator.
- BHSD, CBO providers, and evaluator will provide periodic updates to the MHSA SLC member at MHSA SLC meetings that are open to the public.
- Convene community advisory board to assist selected service providers in developing program plan and help with community outreach and education.

**During the FY 2025 Annual Update Process, in preparation for the project end date of December 2025**

- Present draft evaluation project report with recommendations for inclusion of lessons learned.
- Present final project report with initial feasibility for sustaining, integrating, or replicating project services or lessons learned to BHSD, the MHSA SLC group, and the County's Behavioral Health Board and discuss future plans for the CMR program, in advance of the project end date as an MHSA INN project.

## Section 4: INN Project Budget and Source of Expenditures

### CURRENT REVERSION RISK

As of February 2021, the County has a total of three MHSA INN projects that are pending MHSOAC approval:

- INN-14: Independent Living Empowerment Project, a two-year project with a total INN funding request of \$990,000 for the entire term of the project.
- INN-15: CMR Program, a five-year project with a total INN funding request of \$27,949,227 for the entire term of the project.
- INN-16: Addressing Stigma and Trauma in the Vietnamese and African American/African Ancestry Communities INN Project, a three-year project, with a total INN funding request of \$1,753,140 for the entire term of the project.

Below is a table with the current information with MHSA INN funds at risk for reversion. The County aims to ensure the funds noted below will be used/applied to the three programs above to avoid reversion of County INN funds.

#### Estimates as of February 9, 2021

INN Funding Year (FY)	FY 2019	FY 2020	FY 2021
<b>Current Reversion Risk For Santa Clara County (Unallocated INN Balance)</b>	<b>\$2,007,859</b>	<b>\$4,292,150</b>	<b>\$5,568,909</b>
<b>Date of Reversion*:</b>	<b>6/30/2021</b>	<b>6/30/2022</b>	<b>6/30/2023</b>

*\*INN reversion dates may vary. Beginning with funds distributed in FY 2015-2016, a county must obtain approval from the MHSOAC for an Innovative Project Plan to spend INN funds. INN funds are encumbered up to the budget amount and the reversion period ends according to the terms of the approved INN Plan. If a county does not have an INN plan, funds will revert as of this date. A county may use a more recent available funding to encumber to future INN plans.*



## INN PROJECT BUDGET NARRATIVE, AND SOURCE OF EXPENDITURES

The budget includes four main components:

1. **One-time expenses:** van transport, equipment, logo/design.

Description	Annual Amount
Purchase of Utility Van (\$30K x 3)	\$90,000
Commercial Vehicle Wrapping (~\$5-7K x 3 = ~\$15-21K)	\$21,000
<u>Interior configuration/equipment: (~\$75K x 3 = ~\$225K)</u>	<u>\$225,000</u>
<b>Subtotal Vehicles cost*</b>	<b>\$336,000</b>
*To help start program implementation, one vehicle will be provided to each CBO provider: San Jose service area, Gilroy service area, and North County service area	
Design Contest	\$5,000
<u>Design Vendor: transpose winning design for use = ~\$10K</u>	<u>\$10,000</u>
<b>Subtotal Design/Logo</b>	<b>\$15,000</b>
<b>Total INN Funding Request</b>	<b>\$351,000</b>





- The **Call Center** will be operated by a community-based organization, which will be procured by BHSD through an RFP process.

<b>Call Center Budget Description</b>	<b>Annual Amount</b>	<b>Four and a Half-Year Project Total</b>
<b>Staffing for Each Service Area – Salaries/Benefits (Refer to Slide 16)</b> <ul style="list-style-type: none"> <li>1.0 FTE Program Manager (Behavioral Health Clinician: Licensed or Licensed Waivered)</li> <li>13.5 FTEs to staff the Call Center and the staff may include Peer specialists/peer family, paraprofessionals (e.g., Rehabilitation counselor, Mental Health Community Workers, and Community Workers) – may designate certain members of the team as program leads.</li> </ul> <b>Total 14.5 FTEs</b>	\$1,197,000	\$4,788,000
Training Budget	\$10,000	\$40,000
Volunteer Stipends	\$20,000	\$80,000
Operating Expense (Includes creation of a new 3-digit number, outreach, and other program expenses)	\$179,550	\$718,200
General Admin Overhead	\$210,083	\$840,330
<b>Total INN Funding*</b>	<b>\$1,616,633</b>	<b>\$6,466,530</b>

*\*Total does not include annual County expense of \$900 for 3-digit number. See budget component #4 for more information.*

BHSD reviewed comparable data of positions from prior CBO program bid responses, conducted salary/benefit analysis and reviewed comparable info provided by BHCA to determine the staffing budget.



- CMR Onsite Field Team** will be operated by a community-based organization(s), which will be procured by BHSD through an RFP process that includes two CMR Onsite Services teams, one for San Jose and one for the Gilroy service area.

**CMR FIELD TEAMS – OPERATIONAL 24/7, 365 DAYS  
THREE SERVICE AREAS: SAN JOSE, GILROY, & NORTH COUNTY – EACH ONE CBO-OPERATED**

Description	San Jose Service Area Annual Budget	Gilroy Service Area Annual Budget	North County Service Area Annual Budget	Annual Combined (SJ + Gilroy + North County) Budget	Four and a Half-Year Project Total
Staffing for Each Service Area – Salaries/Benefits (Refer to Slide 17) <ul style="list-style-type: none"> <li>1.0 FTE Community Collaborator</li> <li>1.5 FTE Program Manager* (BH Clinician Licensed)</li> <li>Onsite Field Team <ul style="list-style-type: none"> <li>4.5 FTEs Emergency Medical Technician</li> <li>4.5 FTEs Crisis Intervention Worker</li> <li>4.5 FTEs Outreach Specialist Subtotal</li> </ul> </li> </ul> Total 16 FTEs per Service Area	\$1,310,025 (16.0 FTEs)	\$1,310,025 (16.0 FTEs)	\$1,310,025 (16.0 FTEs)	<b>\$3,930,075</b> <b>(48.0 FTEs)</b>	<b>\$15,720,300</b>
Training Budget per Service Area	\$10,000	\$10,000	\$10,000	<b>\$30,000</b>	<b>\$120,000</b>
Operating Expense (Includes Outreach, Vehicle Maintenance, car insurance, purchase of additional vehicles as needed, other program related expenditures)	\$196,504	\$196,504	\$196,504	<b>\$589,511</b>	<b>\$2,358,045</b>
General Admin Overhead	\$227,479	\$227,479	\$227,479	<b>\$682,438</b>	<b>\$2,729,752</b>
<b>Total INN Funding Request</b>	<b>\$1,744,008</b>	<b>\$1,744,008</b>	<b>\$1,744,008</b>	<b>\$5,232,024</b>	<b>\$20,928,097</b>

BHSD reviewed comparable data of positions from prior CBO program bid responses, conducted salary/benefit analysis and reviewed comparable info provided by BHCA to determine the staffing budget.



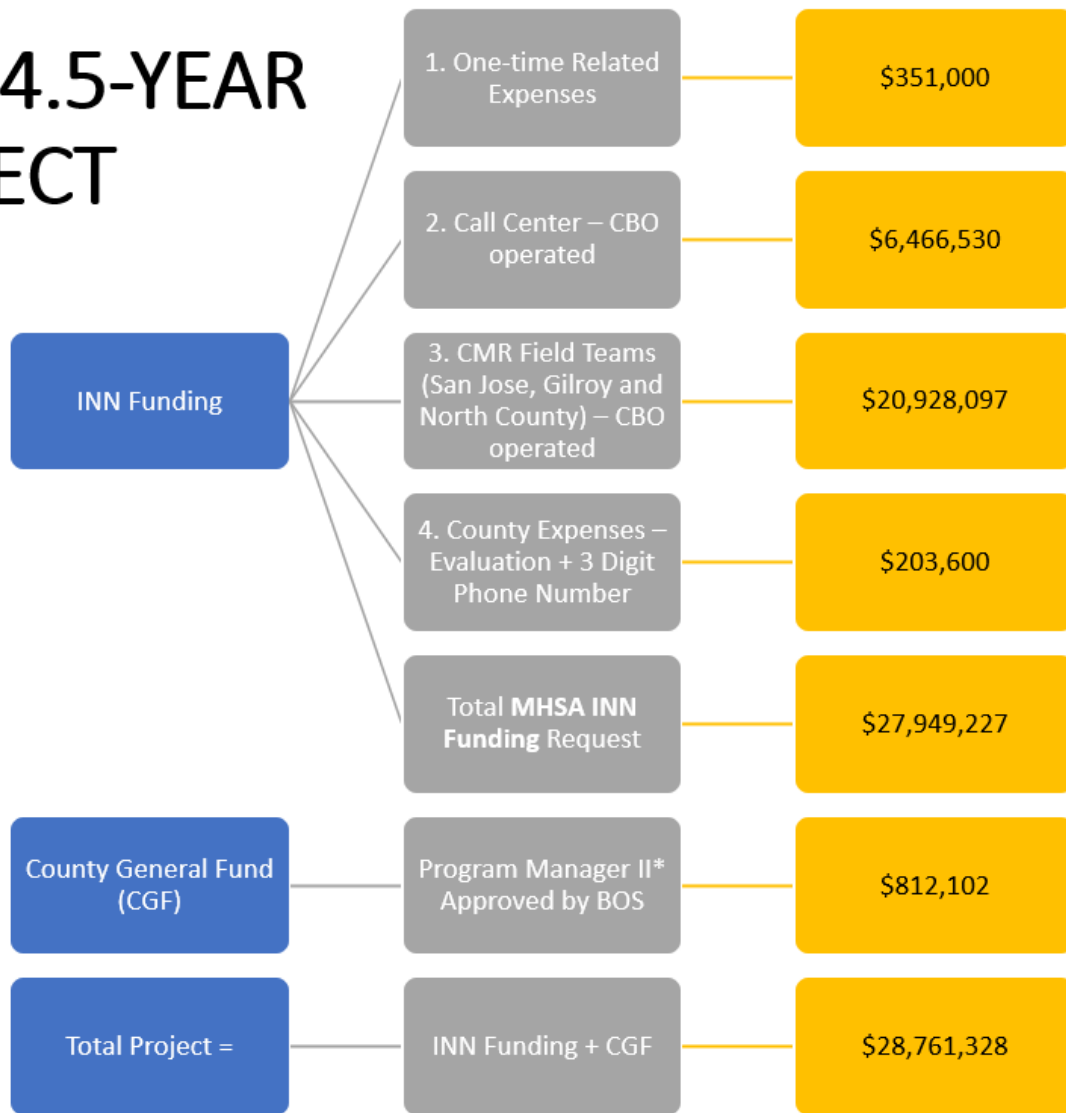
**4. Evaluation Contract and County-Related Expenses**

<b>MHSA INN County Expense Description</b>	<b>Annual Amount</b>	<b>Four and a Half-Year Project Total</b>
<ul style="list-style-type: none"> <li>• Evaluation Contract</li> <li>• 3-Digit Phone Number</li> </ul>	<p>\$50,000</p> <p>\$900</p>	<p>\$200,000</p> <p>\$3,600</p>
<b>Total INN Funding Request</b>	<b>\$50,900</b>	<b>\$203,600</b>

<b>Non-MHSA INN Funded County Expense Description</b>	<b>Annual Amount</b>	<b>Four and a Half-Year Project Total</b>
<p><b>Program Manager II</b>            Approved by BOS during August 2020 Budget Process, funded with County General Funds</p>	\$180,467	\$812,102
<b>Total County General Funding</b>	<b>\$180,467</b>	<b>\$812,102</b>

Here is an overall budget overview that reflects the information listed on pages 40-42.

# CMR 4.5-YEAR PROJECT



Here is the overall budget by fiscal year utilizing the MHSOAC budget template. However, please refer to the section above for details on the four main components of the budget.

<b>CMR – Community Mobile Response</b>							
<b>BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY*</b>							
<b>EXPENDITURES – Community Mobile Response Project – 4.5 year project (54 months)</b>							
	<b>PERSONNEL COSTS (salaries, wages, benefits)</b>	<b>Year 1 (12 months)</b>	<b>Year 2 (12 months)</b>	<b>Year 3 (12 months)</b>	<b>Year 4 (12 months)</b>	<b>Year 5 (6 months)</b>	<b>TOTAL</b>
1.	Salaries: Personnel expenditures, including salaries, wages, and benefits Staff will include: 1.0 FTE Program Manager II	\$180,467	\$180,467	\$180,467	\$180,467	\$90,234	\$812,102
2.	Direct Costs	\$0	\$0	\$0	\$0	\$0	\$0
3.	Indirect Costs	\$0	\$0	\$0	\$0	\$0	\$0
4.	<b>Total Personnel Costs</b>	<b>\$180,467</b>	<b>\$180,467</b>	<b>\$180,467</b>	<b>\$180,467</b>	<b>\$90,234</b>	<b>\$812,102</b>
<b>OPERATING COSTS*</b>							
5.	Direct Costs: Evaluation Contract (~\$50K per yr.) 3 Digit Call Center # (~0.9K per yr.)	\$25,450	\$50,900	\$50,900	\$50,900	\$25,450	\$203,600
6.	Indirect Cost	\$0	\$0	\$0	\$0	\$0	\$0
7.	<b>Total Operating Costs</b>	<b>\$25,450</b>	<b>\$50,900</b>	<b>\$50,900</b>	<b>\$50,900</b>	<b>\$25,450</b>	<b>\$203,600</b>
<b>NON-RECURRING COSTS (equipment, technology)</b>							
8.	<b>Purchase Vehicles:</b> Utility Van (~\$30K x 3 =~90K)	\$90,000	\$0	\$0	\$0	\$0	\$90,000
9.	<b>Retrofit:</b> Commercial Vehicle Wrapping (~\$5-7K x 3 = ~\$15-21K) Interior configuration/equipment (~\$75K x 3 = ~\$225K) Logo Design (~\$15K)	\$261,000	\$0	\$0	\$0	\$0	\$261,000
10.	<b>Total non-recurring costs</b>	<b>\$351,000</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$351,000</b>
<b>CMR CBO Service Contracts/ CONTRACTS (clinical, training, facilitator, evaluation)</b>							
11.	Direct Costs:	\$2,593,537	\$5,187,075	\$5,187,075	\$5,187,075	\$2,593,538	\$20,748,300



	<p>CMR Field Teams (Combination of San Jose, Gilroy, and North County) - Personnel expenditures, including salaries, wages, and benefits Staff will include:</p> <ul style="list-style-type: none"> <li>• 3.0 FTE Community Collaborator</li> <li>• 4.5 FTE Program Manager (Licensed Clinician)</li> <li>• 13.5 FTE Emergency Medical Technician</li> <li>• 13.5 FTE Crisis Intervention Worker</li> <li>• 13.5 FTE Outreach Specialist</li> <li>• Training: (~\$10K x 3 = ~\$30K)</li> </ul> <p>Call Center:</p> <ul style="list-style-type: none"> <li>• 1.5 FTE Program Manager (Licensed or Licensed Waivered Clinician)</li> <li>• 13.5 FTE Peer Specialists or Paraprofessionals</li> <li>• Volunteer Stipends: (~\$20K)</li> <li>• Training: (~\$10K)</li> </ul>						
12.	Indirect Costs: Operating expenditures at 15% of personnel costs and G&A overhead 15% of operating expenditures and personnel costs listed above	\$830,791	\$1,661,582	\$1,661,582	\$1,661,582	\$830,791	\$6,646,328
13.	<b>Total CMR Service Contracts</b>	<b>\$3,424,328</b>	<b>\$6,848,657</b>	<b>\$6,848,657</b>	<b>\$6,848,657</b>	<b>\$3,424,329</b>	<b>\$27,394,628</b>
	<b>OTHER EXPENDITURES (please explain in budget narrative)</b>						
14.		\$0	\$0	\$0	\$0	\$0	\$0
15.		\$0	\$0	\$0	\$0	\$0	\$0
16.	<b>Total Other Expenditures</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
	<b>BUDGET TOTALS</b>						
	<b>Personnel (total of line 1)</b>	<b>\$180,467</b>	<b>\$180,467</b>	<b>\$180,467</b>	<b>\$180,467</b>	<b>\$90,234</b>	<b>\$812,102</b>
	<b>Direct Costs (add lines 2, 5, and 11 from above)</b>	<b>\$2,618,987</b>	<b>\$5,237,975</b>	<b>\$5,237,975</b>	<b>\$5,237,975</b>	<b>\$2,618,988</b>	<b>\$20,951,900</b>
	<b>Indirect Costs (add lines 3, 6, and 12 from above)</b>	<b>\$830,791</b>	<b>\$1,661,582</b>	<b>\$1,661,582</b>	<b>\$1,661,582</b>	<b>\$830,791</b>	<b>\$6,646,328</b>
	<b>Non-recurring costs (total of line 10)</b>	<b>\$351,000</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$351,000</b>
	<b>Other Expenditures (total of line 16)</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
	<b>TOTAL INNOVATION BUDGET</b>	<b>\$3,981,245</b>	<b>\$7,080,024</b>	<b>\$7,080,024</b>	<b>\$7,080,024</b>	<b>\$3,540,013</b>	<b>\$28,761,330</b>

**CMR – Community Mobile Response**

**BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY\***

**EXPENDITURES – Community Mobile Response Project – 4.5 year project (54 months)**

	<b>PERSONNEL COSTS (salaries, wages, benefits)</b>	<b>Year 1 (12 months)</b>	<b>Year 2 (12 months)</b>	<b>Year 3 (12 months)</b>	<b>Year 4 (12 months)</b>	<b>Year 5 (6 months)</b>	<b>TOTAL</b>
1.	Salaries: Personnel expenditures, including salaries, wages, and benefits Staff will include: 1.0 FTE Program Manager II	\$180,467	\$180,467	\$180,467	\$180,467	\$90,234	\$812,102
2.	Direct Costs	\$0	\$0	\$0	\$0	\$0	\$0
3.	Indirect Costs	\$0	\$0	\$0	\$0	\$0	\$0
4.	<b>Total Personnel Costs</b>	<b>\$180,467</b>	<b>\$180,467</b>	<b>\$180,467</b>	<b>\$180,467</b>	<b>\$90,234</b>	<b>\$812,102</b>
	<b>OPERATING COSTS*</b>						
5.	Direct Costs: Evaluation Contract (~\$50K per yr.) 3 Digit Call Center # (~0.9K per yr.)	\$25,450	\$50,900	\$50,900	\$50,900	\$25,450	\$203,600
6.	Indirect Cost	\$0	\$0	\$0	\$0	\$0	\$0
7.	<b>Total Operating Costs</b>	<b>\$25,450</b>	<b>\$50,900</b>	<b>\$50,900</b>	<b>\$50,900</b>	<b>\$25,450</b>	<b>\$203,600</b>
	<b>NON-RECURRING COSTS (equipment, technology)</b>						
8.	<b>Purchase Vehicles:</b> Utility Van (~\$30K x 3 =~90K)	\$90,000	\$0	\$0	\$0	\$0	\$90,000
9.	<b>Retrofit:</b> Commercial Vehicle Wrapping (~\$5-7K x 3 = ~\$15-21K) Interior configuration/equipment (~\$75K x 3 = ~\$225K) Logo Design (~\$15K)	\$261,000	\$0	\$0	\$0	\$0	\$261,000
10.	<b>Total non-recurring costs</b>	<b>\$351,000</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$351,000</b>
	<b>CMR CBO Service Contracts/ CONTRACTS (clinical, training, facilitator, evaluation)</b>						
11.	Direct Costs: CMR Field Teams (Combination of San Jose, Gilroy, and North County) - Personnel expenditures, including salaries, wages, and benefits Staff will include:	\$2,593,537	\$5,187,075	\$5,187,075	\$5,187,075	\$2,593,538	\$20,748,300



	<ul style="list-style-type: none"> <li>• 3.0 FTE Community Collaborator</li> <li>• 4.5 FTE Program Manager (Licensed Clinician)</li> <li>• 13.5 FTE Emergency Medical Technician</li> <li>• 13.5 FTE Crisis Intervention Worker</li> <li>• 13.5 FTE Outreach Specialist</li> <li>• Training: (~\$10K x 3 = ~\$30K)</li> </ul> Call Center: <ul style="list-style-type: none"> <li>• 1.5 FTE Program Manager (Licensed or Licensed Waivered Clinician)</li> <li>• 13.5 FTE Peer Specialists or Paraprofessionals</li> <li>• Volunteer Stipends: (~\$20K)</li> <li>• Training: (~\$10K)</li> </ul>						
12.	Indirect Costs: Operating expenditures at 15% of personnel costs and G&A overhead 15% of operating expenditures and personnel costs listed above	\$830,791	\$1,661,582	\$1,661,582	\$1,661,582	\$830,791	<b>\$6,646,328</b>
13.	<b>Total CMR Service Contracts</b>	<b>\$3,424,328</b>	<b>\$6,848,657</b>	<b>\$6,848,657</b>	<b>\$6,848,657</b>	<b>\$3,424,329</b>	<b>\$27,394,628</b>
	<b>OTHER EXPENDITURES (please explain in budget narrative)</b>						
14.		\$0	\$0	\$0	\$0	\$0	\$0
15.		\$0	\$0	\$0	\$0	\$0	\$0
16.	<b>Total Other Expenditures</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
	<b>BUDGET TOTALS</b>						
	<b>Personnel (total of line 1)</b>	<b>\$180,467</b>	<b>\$180,467</b>	<b>\$180,467</b>	<b>\$180,467</b>	<b>\$90,234</b>	<b>\$812,102</b>
	<b>Direct Costs (add lines 2, 5, and 11 from above)</b>	<b>\$2,618,987</b>	<b>\$5,237,975</b>	<b>\$5,237,975</b>	<b>\$5,237,975</b>	<b>\$2,618,988</b>	<b>\$20,951,900</b>
	<b>Indirect Costs (add lines 3, 6, and 12 from above)</b>	<b>\$830,791</b>	<b>\$1,661,582</b>	<b>\$1,661,582</b>	<b>\$1,661,582</b>	<b>\$830,791</b>	<b>\$6,646,328</b>
	<b>Non-recurring costs (total of line 10)</b>	<b>\$351,000</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$351,000</b>
	<b>Other Expenditures (total of line 16)</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
	<b>TOTAL INNOVATION BUDGET</b>	<b>\$3,981,245</b>	<b>\$7,080,024</b>	<b>\$7,080,024</b>	<b>\$7,080,024</b>	<b>\$3,540,013</b>	<b>\$28,761,330</b>

\*For a complete definition of direct and indirect costs, please use DHCS Information Notice 14-033. This notice aligns with the federal definition for direct/indirect costs.



**BUDGET CONTEXT – EXPENDITURES BY FUNDING SOURCE AND FISCAL YEAR (FY)**

**ADMINISTRATION:**

A.	Estimated total mental health expenditures for administration for the entire duration of this INN Project by FY & the following funding sources:	Year 1 (12 months)	Year 2 (12 months)	Year 3 (12 months)	Year 4 (12 months)	Year 5 (6 months)	TOTAL
1.	Innovative MHSA Funds						
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding						
6.	<b>Total Proposed Administration</b>						

**EVALUATION:**

B.	Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:	Year 1 (12 months)	Year 2 (12 months)	Year 3 (12 months)	Year 4 (12 months)	Year 5 (6 months)	TOTAL
1.	Innovative MHSA Funds	\$25,000	\$50,000	\$50,000	\$50,000	\$25,000	\$200,000
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding						
6.	<b>Total Proposed Evaluation</b>	\$25,000	\$50,000	\$50,000	\$50,000	\$25,000	\$200,000

**TOTALS:**

C.	Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:	Year 1 (12 months)	Year 2 (12 months)	Year 3 (12 months)	Year 4 (12 months)	Year 5 (6 months)	TOTAL
1.	Innovative MHSA Funds*	\$3,800,778	\$6,899,557	\$6,899,557	\$6,899,557	\$3,449,778	\$27,949,227
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding – County General Fund	\$180,467	\$180,467	\$180,467	\$180,467	\$90,234	\$812,102
6.	<b>Total Proposed Expenditures</b>	\$3,981,245	\$7,080,024	\$7,080,024	\$7,080,024	\$3,540,012	\$28,761,329

\* INN MHSA funds reflected in total of line C1 should equal the INN amount County is requesting

\*\* If “other funding” is included, please explain within budget narrative.

**Note: The Year 1 start date begins when the County implements the Innovation Project (Innovation Project Regulation 3910.010)**



**Supplemental Documents:**

- December 2020 – January 2021 planning input session notes.PDF
- MHSA INN#15 Community Mobile Response Public Comments.PDF
- MHSA INN-15 CMR Program April 12 2021 BHB Hearing.PDF

# Community Mobile Response Program (CMRP) Community Input Session Notes: December 2020 – January 2021

Thank you to all our community partners for helping with the community planning process in the development of the CMRP and helping by hold the planning input sessions from December 12, 2020 to January 15, 2021 garnering input from diverse groups of people: consumers, family members of consumers, and various communities African/African Ancestry, Chinese, Families who have lost loved ones, Filipino, Justice-Involved /Re-Entry, Spanish-speaking, and Vietnamese. We appreciate your partnership and collaboration in this process as we work together to develop and finalize the County's new CMRP.



COUNTY OF SANTA CLARA  
**Behavioral Health Services**  
Supporting Wellness and Recovery

# COMMUNITY MOBILE RESPONSE PROGRAM COMMUNITY PLANNING MEETING NOTES

## AFRICAN/AFRICAN ANCESTRY COMMUNITY – DECEMBER 15, 2020

### Summary of Feedback

Topic	General ideas	General Findings
<b>Locations/Geographic Region</b>	<ul style="list-style-type: none"> <li>• Everywhere (North county)</li> <li>• City of Santa Clara</li> </ul>	<ul style="list-style-type: none"> <li>• Everywhere</li> <li>• North County (Santa Clara)</li> </ul>
<b>Call Center Team</b>	<ul style="list-style-type: none"> <li>• Will need to have intense training on how to triage.</li> </ul>	<ul style="list-style-type: none"> <li>• Should have good triage training</li> </ul>
<b>Phone Number</b>	<ul style="list-style-type: none"> <li>• Should not be 911</li> <li>• 3 digit number that's branded and easy to remember</li> <li>• Option* when called will automatically know location.</li> </ul>	<ul style="list-style-type: none"> <li>• Agreed on a 3-digit number</li> <li>• Not 911</li> <li>• Want option to GPS location when connected</li> </ul>
<b>Workflow and Triage</b>	<ul style="list-style-type: none"> <li>• Need to have detailed triage               <ul style="list-style-type: none"> <li>◦ What questions are they asking to clearly label/categorize the call as a mental health call?</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Must have detailed triage tree</li> </ul>
<b>Call center/phone assessment/triage</b>	<ul style="list-style-type: none"> <li>• Centralized</li> <li>• If decentralized, no wrong door, will still be assisted.</li> </ul>	<ul style="list-style-type: none"> <li>• Agreed to a Centralized Call Center Model</li> </ul>
<b>Law enforcement possible involvement</b>	<ul style="list-style-type: none"> <li>• Group noted negative experiences with law enforcement.</li> </ul>	<ul style="list-style-type: none"> <li>• Limit involvement due to past negative experiences</li> </ul>
<b>Transport Vehicle</b>	<ul style="list-style-type: none"> <li>• Flexibility – can people come sit in the van? Can worker go out and take a walk with the person in crisis?</li> <li>• Color and image that is inviting and neutral</li> </ul>	<ul style="list-style-type: none"> <li>• Flexible around where services are delivered</li> <li>• Neutral color and image</li> </ul>
<b>CMR Team Composition</b>	<ul style="list-style-type: none"> <li>• Uniform that doesn't look like police uniform</li> <li>• Someone from the neighborhood (community service in lieu of a professional degree).</li> <li>• Legal advocate (on call)</li> </ul>	<ul style="list-style-type: none"> <li>• No Police uniforms</li> <li>• Team should include community members</li> <li>• Should have a legal advocate on call</li> </ul>

# COMMUNITY MOBILE RESPONSE PROGRAM COMMUNITY PLANNING MEETING NOTES

Topic	General ideas	General Findings
<b>Family Involvement</b>	<ul style="list-style-type: none"> <li>Should be involved if not the trigger.</li> </ul>	<ul style="list-style-type: none"> <li>Involve if not trigger</li> </ul>
<b>Building trust/educating people to call the new CMRP</b>	<ul style="list-style-type: none"> <li>Build trust from the neighborhood out.</li> <li>Employ local people</li> </ul>	<ul style="list-style-type: none"> <li>Build from within community</li> <li>Employ local people</li> </ul>
<b>Other comments</b>	None	

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## CHINESE COMMUNITY – JANUARY 15, 2021

### Summary of Feedback

Topic	General ideas	General Findings
<b>Locations/Geographic Region</b>	<ul style="list-style-type: none"> <li>Milpitas and Palo Alto</li> </ul>	<ul style="list-style-type: none"> <li>Should include Milpitas and Palo Alto</li> </ul>
<b>Call Center Team</b>	<ul style="list-style-type: none"> <li>Clinicians</li> <li>Peer mentor someone who can relate to them</li> <li>Relieving to know that caller on other end has experienced what they are experiencing</li> </ul>	<ul style="list-style-type: none"> <li>Clinicians</li> <li>Peer mentors</li> <li>Should include people with lived experiences</li> </ul>
<b>Phone Number</b>	<ul style="list-style-type: none"> <li>3-digit – people can remember it easier</li> <li>Not always convenient to call the number, can we make it text accessible if people can't talk directly to someone on the phone</li> </ul>	<ul style="list-style-type: none"> <li>Prefer 3-digit number</li> <li>Asked to include a text option</li> </ul>
<b>Workflow and Triage</b>	<ul style="list-style-type: none"> <li>Have someone on this team who can do the 5150 without having to call another service</li> </ul>	<ul style="list-style-type: none"> <li>Team should include someone who can write a 5150 hold</li> </ul>

# COMMUNITY MOBILE RESPONSE PROGRAM COMMUNITY PLANNING MEETING NOTES

Topic	General ideas	General Findings
<b>Call center/phone assessment/triage</b>	<ul style="list-style-type: none"> <li>Centralized – easier to train and be able to have better coverage</li> </ul>	<ul style="list-style-type: none"> <li>Centralized model is preferred</li> </ul>
<b>Law enforcement possible involvement</b>	No Comments	
<b>Transport Vehicle</b>	<ul style="list-style-type: none"> <li>Snacks and water</li> <li>Bed or a chair so that they can be comfortable and have privacy if needed</li> <li>Warm clothes and maybe flip flops or shoes to give</li> <li>The more conspicuous the better – something more subtle</li> </ul>	<ul style="list-style-type: none"> <li>Should have snacks, water, and other comfort items</li> <li>Should be comfortable and discrete</li> </ul>
<b>CMR Team Composition</b>	<ul style="list-style-type: none"> <li>Would be good to have someone relatable on the team because they can connect in ways physicians can't</li> <li>Good to have someone licensed that can write a hold</li> <li>Would be good to have a clinician arrive</li> <li>Lighter colored uniforms (yellow) so it doesn't look like law enforcement</li> </ul>	<ul style="list-style-type: none"> <li>Should include someone clients can relate to.</li> <li>Should have someone that can write a 5150 hold</li> <li>Should have a clinician that is on call</li> <li>Uniforms should be light and not reflect law enforcement</li> </ul>
<b>Family Involvement</b>	<ul style="list-style-type: none"> <li>Anything to support the clients in an easier transition</li> <li>Consider transporting animals or any other support the client may want</li> <li>Sometimes minors would be in distress because of family. Need to explore how to handle situations when minors don't want their parents involved.</li> </ul>	<ul style="list-style-type: none"> <li>Should be on a case-by-case basis</li> <li>Consider transporting client's support animals</li> <li>Explore how to handle situations where minors don't want parents involved</li> </ul>
<b>Building trust/educating people to call the new CMRP</b>	<ul style="list-style-type: none"> <li>Work with people who speak the language and are trusted community leaders.</li> <li>Reach out to other service providers and CBOs who serve this community to help spread the word</li> <li>Make sure to have someone who speaks the language</li> </ul>	<ul style="list-style-type: none"> <li>Work with trusted community leaders</li> <li>Reach out to CBOs in the community</li> </ul>

# COMMUNITY MOBILE RESPONSE PROGRAM COMMUNITY PLANNING MEETING NOTES

Topic	General ideas	General Findings
		<ul style="list-style-type: none"> <li>Have someone who speaks the language</li> </ul>
Other comments	None	

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## CLINICIANS WITH MOBILE CRISIS EXPERIENCE – JANUARY 14, 2021

### Summary of Feedback

Topic	General ideas	General Findings
Locations/Geographic Region	<ul style="list-style-type: none"> <li>South County</li> <li>North County (Palo Alto, Mountain View (x2), Sunnyvale)</li> <li>Include San Martin in S County</li> <li>Alviso</li> </ul>	<ul style="list-style-type: none"> <li>Should include South County and North County (Mountain View)</li> </ul>
Call Center Team	<ul style="list-style-type: none"> <li>No Comment</li> </ul>	
Phone Number	<ul style="list-style-type: none"> <li>3-digit goes to a centralized call center</li> <li>Centralized w/ three digit number.</li> </ul> <p><i>“People who make the calls make them, themselves.”</i></p> <p><i>“People with altered mental states can remember a 3 digit number better.”</i></p>	<ul style="list-style-type: none"> <li>Agreed on a 3-digit number that goes to a centralized call center</li> </ul>

# COMMUNITY MOBILE RESPONSE PROGRAM COMMUNITY PLANNING MEETING NOTES

Topic	General ideas	General Findings
<b>Workflow and Triage</b>	<ul style="list-style-type: none"> <li>• Important that there is good training</li> <li>• Need for continuous ongoing education between agencies</li> </ul>	<ul style="list-style-type: none"> <li>• Stressed importance of good training for person doing triage</li> <li>• Important to have good communication between agencies</li> </ul>
<b>Call center/phone assessment/triage</b>	<ul style="list-style-type: none"> <li>• Make sure response time is fast</li> <li>• Centralized</li> </ul>	<ul style="list-style-type: none"> <li>• Agreed to a Centralized Call Center Model</li> <li>• Noted a need for fast response times</li> </ul>
<b>Law enforcement possible involvement</b>	<ul style="list-style-type: none"> <li>• May have a hard time finding MD to be on call for this               <ul style="list-style-type: none"> <li>○ MD's are afraid of safety when police aren't involved</li> </ul> </li> <li>• Need to work closely w/ law enforcement</li> <li>• Law enforcement needs to be trained and on board w/ mental health</li> </ul> <p>“We have had bad experiences when we have to call law enforcement out.”</p> <p><i>“My main concern is that even if we have trained mental health professionals, if the police assigned to the team isn't trained in de-escalation and doesn't have an understanding of mental health disorders and symptoms, then we risk further traumatizing clients and alienating community partners who do not want to use this resource because of the poor experience involving police.”</i></p>	<ul style="list-style-type: none"> <li>• May be hard to find an MD if police aren't involved</li> <li>• Law enforcement should be trained in mental health</li> <li>• Concern about past negative history with police deterring people from accessing services if police are involved</li> </ul>
<b>Transport Vehicle</b>	<ul style="list-style-type: none"> <li>• Not cluttered, not a lot of visual stimulation inside, make scent optional</li> <li>• No flashing lights</li> <li>• Neutral color, something like tan, brown and regular looking</li> <li>• Comfortable seats in the back</li> <li>• Sensory objects, playdoh, stress ball, fidgets</li> </ul>	<ul style="list-style-type: none"> <li>• Should be a calming comfortable environment</li> <li>• Should have sensory objects</li> <li>• Neutral color</li> </ul>
<b>CMR Team Composition</b>	<ul style="list-style-type: none"> <li>• May have a hard time finding MD to be on call for this</li> <li>• MD's are afraid of safety when police aren't involved</li> <li>• Without the ability to write a 5150 hold this will not be very useful</li> </ul>	<ul style="list-style-type: none"> <li>• Need to be able to write a 5150 hold</li> <li>• Peer support workers</li> </ul>



# COMMUNITY MOBILE RESPONSE PROGRAM COMMUNITY PLANNING MEETING NOTES

Topic	General ideas	General Findings
	<ul style="list-style-type: none"> <li>• Would be good to have peer support workers (senate bill 803) and to have a peer aspect</li> <li>• Consider licensed psych tech – can write a hold and do vitals</li> <li>• Good to have a licensed professional on the grant team for consultation</li> <li>• Should be diverse and include someone who speaks the language or are part of the culture they are going to.</li> </ul>	<ul style="list-style-type: none"> <li>• Licensed psych tech</li> <li>• Should be diverse and speak the language/reflect the community they are serving.</li> </ul>
<b>Family Involvement</b>	<ul style="list-style-type: none"> <li>• Try to minimize family involvement at onset so individual has opportunity to decide for themselves if they want family involved,</li> <li>• Let the people decide</li> </ul>	<ul style="list-style-type: none"> <li>• Allow individual in crisis to determine family involvement first</li> </ul>
<b>Building trust/educating people to call the new CMRP</b>	<ul style="list-style-type: none"> <li>• Important for people to have information on all the resources that are out there for them.</li> <li>• Good information for the community on what happens when you call</li> <li>• Work with ethnic leaders to raise awareness in community</li> </ul>	<ul style="list-style-type: none"> <li>• Stressed importance of community knowing about available resources</li> <li>• Work with leaders to raise community awareness</li> </ul>
<b>Other comments</b>	<ul style="list-style-type: none"> <li>• Need to recognize where people may be starting in terms of their use, refugees may not be familiar with using services</li> <li>• There has to be clarification about what constitutes a crisis vs an emergency.</li> </ul>	<ul style="list-style-type: none"> <li>• Important to consider refugees who may not be familiar with service</li> <li>• Define crisis v. emergency</li> </ul>

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## CONSUMERS – DECEMBER 16, 2020

### Summary of Feedback

Topic	General ideas	General Findings
<b>Locations/Geographic Region</b>	<ul style="list-style-type: none"> <li>• Include North County</li> <li>• Confirmed this includes Downtown San Jose, Eastside, Gilroy, Palo Alto</li> <li>• San Jose is huge; one location per city doesn't seem right</li> </ul>	<ul style="list-style-type: none"> <li>• Add North County</li> <li>• Confirm Downtown San Jose, Eastside,</li> </ul>

# COMMUNITY MOBILE RESPONSE PROGRAM COMMUNITY PLANNING MEETING NOTES

Topic	General ideas	General Findings
	<ul style="list-style-type: none"> <li>• Asked if San Martin and East Palo Alto would be included</li> </ul>	<p>Gilroy and Palo Alto are included</p> <ul style="list-style-type: none"> <li>• Noted that one location per city doesn't seem right</li> </ul>
<b>Call Center Team</b>	<ul style="list-style-type: none"> <li>• Need training for folks taking the calls as their judgement will triage the person into the flow process.</li> <li>• Need to be culturally responsive.</li> <li>• Suggested peer support; makes a difference on how the call and situation are perceived.</li> </ul>	<ul style="list-style-type: none"> <li>• Culturally responsive</li> <li>• Good training</li> <li>• Peer support</li> </ul>
<b>Phone Number</b>	<ul style="list-style-type: none"> <li>• 3-digit number</li> <li>• After hours line</li> <li>• Training for 911 operators; lack of trust with using 911</li> </ul>	<ul style="list-style-type: none"> <li>• Agreed on 3-digit number</li> <li>• Lack of trust with 911</li> <li>• Would like to have it operational 24/7</li> </ul>
<b>Workflow and Triage</b>	<ul style="list-style-type: none"> <li>• Suggest peer support; makes a difference on how the call and situation are perceived</li> <li>• Workflow includes police or no police; trust in law enforcement is low; is there oversight if police say</li> <li>• Workflow – assess if person has apparent/non-apparent disability; follow up service is lacking – to what extent follow up and timing of follow up?</li> <li>• Need communication across agencies Workflow and warm hand off.</li> </ul>	<ul style="list-style-type: none"> <li>• Peer support is important</li> <li>• Noted lack of trust in law enforcement, want to make sure there is oversight is police are involved.</li> <li>• Noted a need to include follow up in process</li> <li>• Noted need for communication across agencies and warm handoff</li> </ul>

# COMMUNITY MOBILE RESPONSE PROGRAM COMMUNITY PLANNING MEETING NOTES

Topic	General ideas	General Findings
<b>Call center/phone assessment/triage</b>	<ul style="list-style-type: none"> <li>Centralized call center</li> <li>Wait time is critical; wide map of Santa Clara County needs to be centralized (i.e. Cupertino, Campbell)</li> <li>Centralized - Santa Clara suicide hotline is 24/7 and receives many calls per week; licensed people who have been trained answer the call; 24/7 options works best, as the County line ends at 5pm (crisis occurs any time)</li> <li>Centralizes - people who call 911 are in crisis and are making the call themselves; it is easier to call a 3-digit number when in a manic state compared to a 10-digit number</li> <li>Centralized – can engage person on a crisis call; most people who have an emergency will call 911</li> <li>Centralized – train people to do a warm hand-off if caller wants to talk further</li> </ul>	<ul style="list-style-type: none"> <li>Agreed to a Centralized Call Center Model</li> </ul>
<b>Law enforcement possible involvement</b>	<ul style="list-style-type: none"> <li>Plainclothes officer w/o weapons or handcuffs but trained in physical restraint.</li> <li>Calling 911 – police aren't able to respond like they used to; if it is a domestic/violent need police.</li> </ul> <p><i>Experience</i></p> <p>“Person had a guest who needed support (was having a manic episode); 4 police cars pulled up with uniformed officers which caused anxiety for the guest and escalated the episode.”</p>	<ul style="list-style-type: none"> <li>If needed, should be plain clothes without weapons</li> <li>If domestic violence related, police need to be involved</li> </ul>
<b>Transport Vehicle</b>	<ul style="list-style-type: none"> <li>Safety Concerns</li> <li>No red van, prefer neutral colors (tan/brown)</li> <li>Drinks food refreshments</li> <li>Don't have stigmatizing presence; no markings on the van</li> <li>Chairs to meet outside, but how to keep confidential</li> <li>Make van welcoming</li> <li>Likes the non-emergency look</li> </ul>	<ul style="list-style-type: none"> <li>Inside should have comforting items</li> <li>Limit visual stimulation</li> <li>Should not have a stigmatizing presence</li> <li>No Red van, prefer neutral colors</li> </ul>

# COMMUNITY MOBILE RESPONSE PROGRAM COMMUNITY PLANNING MEETING NOTES

Topic	General ideas	General Findings
	<ul style="list-style-type: none"> <li>Some clients may have autism/sensory overload – don't have too much visual stimulation inside the van; scents can be soothing or overwhelming</li> <li>Have Playdough, squishy balls available to help calm a person</li> </ul>	
<b>CMR Team Composition</b>	<ul style="list-style-type: none"> <li>Staff trained in 5150 and/or lived peer support</li> <li>Important to have clinicians on the team to assess 5150 necessity</li> <li>Advocate for peer support worker involved in the follow up after the person returns from the hospital</li> <li>Bring in clinicians, social workers and peers (not just police), especially in communities of color</li> <li>Have folks with lived experience</li> <li>Noted it may be hard to fill "on-call" positions</li> <li>Comment from someone who worked 24/7 hotline: hire full-time employees and put them on-call; they're not there to provide therapy but to provide support (i.e. psychology field, teachers); highly trained people to work with the population</li> <li>Leverage SB 803; having a peer support person in crisis would have a great affect if used properly</li> <li>Consider licensed psych tech who is able to write holds and do vitals and have worked unusual shifts in hospitals; program managers with license may require mandating reporting</li> </ul>	<p>The team should be:</p> <ul style="list-style-type: none"> <li>Trained in 5150</li> <li>Provide Peer Support</li> <li>Have Lived experiences</li> <li>Trained professionals</li> <li>Clinicians, social workers and peers (not just police), especially in communities of color</li> <li>Licensed psych tech who is able to write holds and do vitals</li> <li>Consider leveraging SB 803</li> </ul>
<b>Family Involvement</b>	<ul style="list-style-type: none"> <li>Family can help or bring more distress; do on a case-by-case basis</li> <li>Family can be disruptive</li> <li>Up to the individual in crisis</li> <li>Try to minimize family involvement because clients in the criminal justice program don't have much say in their own lives; they are able to have open discussion when their family is not present; this builds better confidence in their own decision making</li> <li>Commenter has a nephew in prison who has schizophrenia – doesn't allow family to intervene but ho better to make decision than those who love them? A barrier is put up between family and the person</li> </ul>	<ul style="list-style-type: none"> <li>Case-by-case basis</li> <li>Should be determined by the individual in crisis</li> <li>Minimize family involvement, so clients are able to have open discussions with responders</li> </ul>

# COMMUNITY MOBILE RESPONSE PROGRAM COMMUNITY PLANNING MEETING NOTES

Topic	General ideas	General Findings
	<ul style="list-style-type: none"> <li>• Important to pay attention to the situation and client; determine if family and friends can offer support</li> <li>• Family involvement – individual and family counseling; need to train family so they know how to support their family member in crisis</li> </ul>	<ul style="list-style-type: none"> <li>• Train family on how to support person in crisis</li> </ul>
<b>Building trust/educating people to call the new CMRP</b>	<ul style="list-style-type: none"> <li>• Commenter – her clients trust her; can inform the client of the new CMR number and other resources; recognize where people are with their views</li> <li>• Commenter spoke on behalf of refugees &amp; immigrants – it’s a process to build trust; refugees new to the country learn that the police can come and take your kids; educate the people that the police won’t punish you and take your kids; there are services to help people in need</li> <li>• Commenter – works in homeless shelter; as staff rotates need for ongoing communication and collaboration; set clear expectations of what to expect when call the CMR number; collaboration with law enforcement important</li> <li>• Refugees exist in ethnic networks and get their information from there; there is a stigma in mental health so identify leaders in the community to encourage members to use resources</li> <li>• Important to understand the community and culture; is the person taking the call able to speak the language? Cultural training important</li> </ul>	<ul style="list-style-type: none"> <li>• Noted the need to build trust with refugee population</li> <li>• Inform public of what to expect when they call the CMRP</li> <li>• Identify leaders in refugee community to help raise awareness</li> <li>• Stressed importance of cultural training</li> </ul>
<b>Other comments</b>	<ul style="list-style-type: none"> <li>• Need to establish what is considered an Emergency vs. Crisis</li> <li>• How define Mobile Crisis</li> <li>• Need definition of Crisis clarified</li> <li>• Training needs to be informative</li> <li>• Treat those in crisis with dignity; maintain the dignity of the client</li> <li>• No handcuffs; leather restraints are more humane</li> </ul>	<ul style="list-style-type: none"> <li>• Establish what is an Emergency vs. Crisis</li> <li>• Define Crisis</li> <li>• Emphasis on need for informative training</li> <li>• No handcuffs, use leather restraints if needed</li> </ul>

# COMMUNITY MOBILE RESPONSE PROGRAM COMMUNITY PLANNING MEETING NOTES

## CONSUMERS AND FAMILY MEMBERS OF CONSUMERS – DECEMBER 12, 2020

### Summary of Feedback

Topic	General ideas	General Findings
<b>Locations/Geographic Region</b>	<ul style="list-style-type: none"> <li>No comment</li> </ul>	
<b>Call Center Team</b>	<ul style="list-style-type: none"> <li>Should be trained on psych evaluations, and how to best route the calls.</li> </ul>	<ul style="list-style-type: none"> <li>Should be trained on psych evaluation and triage</li> </ul>
<b>Phone Number</b>	<ul style="list-style-type: none"> <li>Something other than 911 but still want a 3 digit number to call instead of calling 911</li> <li>Call mental health call center instead of 911</li> </ul>	<ul style="list-style-type: none"> <li>Prefer a 3-digit number that is not 911</li> </ul>
<b>Workflow and Triage</b>	<ul style="list-style-type: none"> <li>Focus on psychiatric care, navigation, case management, and follow up</li> <li>Transition periods should be minimal</li> <li>Doctor available to assist w/ medications</li> <li>Would like to see resources and follow up (navigation/case management)</li> </ul>	<ul style="list-style-type: none"> <li>Focus on psychiatric care, navigations, case management and follow up</li> <li>Minimize transition periods</li> <li>Have doctor available for medication assistance</li> <li>Emphasis on resources and follow up</li> </ul>
<b>Call center/phone assessment/triage</b>	<ul style="list-style-type: none"> <li>Centralized 24/7 care</li> <li><i>“all my loved one’s crisis happen at night.”</i></li> <li>Resource/referral info should be centralized so it's consistent and not biased towards any one agency</li> <li>Special training for existing systems (fire/EMS)</li> <li><i>“24X7 help is missing. Weekends are very stressful for families. We had to wait until Monday to call in to the MCRT in October, and by that time a CIT, ambulance and 5150/5250 were required.”</i></li> </ul>	<ul style="list-style-type: none"> <li>Prefer a centralized call center with 24/7 care</li> <li>Referrals should be centralized and consistent</li> <li>Should have special training for existing systems</li> </ul>

# COMMUNITY MOBILE RESPONSE PROGRAM COMMUNITY PLANNING MEETING NOTES

Topic	General ideas	General Findings
<b>Law enforcement possible involvement</b>	<ul style="list-style-type: none"> <li>Negative interactions with police, traumatic.</li> </ul>	<ul style="list-style-type: none"> <li>Police should not be involved, citing negative traumatic interactions with police</li> </ul>
<b>Transport Vehicle</b>	<ul style="list-style-type: none"> <li>San Mateo smart cars where they use SUV instead of an ambulance</li> <li>Comfortable and accommodating</li> <li>Non intimidating, neutral color, low profile, no advertising</li> <li>No police or EMS colors,</li> <li>green, blues and light lavender, purple colors,</li> <li>Small logo if necessary on the door</li> <li>“There should be a PLACE to go that isn't a hospital and isn't traumatic since this is before crisis.”</li> </ul>	<ul style="list-style-type: none"> <li>Suggested using SUV instead of ambulance</li> <li>Should be comfortable and accommodating</li> <li>Neutral color, not associated with police or EMS</li> <li>Small logo if necessary</li> <li>Should transport to a place that isn't a hospital</li> </ul>
<b>CMR Team Composition</b>	<ul style="list-style-type: none"> <li>Overwhelmed w/ multiple agencies responding</li> <li>No uniforms</li> <li>Clinician and case manager – very big on case manager</li> <li>Potential liaison w/ a school</li> <li>Hire people from the community as part time, so it can be an additional job</li> <li>Lived experiences</li> <li><i>“Peer Support Specialists should be part of the CMCP, Family Support Specialists should also.”</i></li> </ul>	<ul style="list-style-type: none"> <li>Limit number of response personnel</li> <li>Prefer no uniforms</li> <li>Strong preference for a case manager</li> <li>Hire people from the community to work part time</li> <li>Include people with lived experience</li> </ul>
<b>Family Involvement</b>	<ul style="list-style-type: none"> <li>Love the idea of collaboration and involving the family members</li> <li>Large focus on family involvement and follow up</li> <li>Big on allowing family to help guide and facilitate mitigation.</li> <li>Concern: Gender affirming and LGBTQ individuals who may not want family involved.</li> <li>It would be helpful to have trained family members to help families that have similar experiences.</li> <li></li> </ul>	<ul style="list-style-type: none"> <li>Like the idea of family involvement</li> <li>Concern around LGBTQ individuals who may not want family involved</li> </ul>

# COMMUNITY MOBILE RESPONSE PROGRAM COMMUNITY PLANNING MEETING NOTES

Topic	General ideas	General Findings
<b>Building trust/educating people to call the new CMRP</b>	<ul style="list-style-type: none"> <li>• Make presence in and engage community</li> <li>• Clearly state who service is for, word of mouth, youth education, videos, etc.</li> </ul>	<ul style="list-style-type: none"> <li>• Make presence known in the community through community engagement</li> </ul>
<b>Other comments</b>	<ul style="list-style-type: none"> <li>• None</li> </ul>	

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## FAMILIES WHO HAVE LOST LOVED ONES – JANUARY 6, 2021

### Summary of Feedback

Topic	General ideas	General Findings
<b>Locations/Geographic Region</b>	<ul style="list-style-type: none"> <li>• No input</li> </ul>	<ul style="list-style-type: none"> <li>• No input</li> </ul>
<b>Call Center Team</b>	<ul style="list-style-type: none"> <li>• Someone who is trained in mental health and can assist.</li> <li>• Mental health specialist to staff call center</li> </ul>	<ul style="list-style-type: none"> <li>• Should include someone who is trained in mental health</li> <li>• Should include a mental health specialist</li> </ul>
<b>Phone Number</b>	<ul style="list-style-type: none"> <li>• Definitely think 3-digit is best</li> <li>• Have an avenue so that if someone does call 911 it can be routed to CMR</li> </ul>	<ul style="list-style-type: none"> <li>• A 3-digit number is best</li> <li>• If someone does call 911, should be directed to CMR</li> </ul>
<b>Workflow and Triage</b>	<ul style="list-style-type: none"> <li>• The proposed workflow and ideas are great</li> <li>• Suggested taking away the police block, and say the CMR team can assess if they need to make that call after arrival as some last resort given the inherent risk of police.</li> </ul>	<ul style="list-style-type: none"> <li>• Like proposed workflow</li> <li>• Suggest allowing CMR team to decide if police should be involved.</li> </ul>



# COMMUNITY MOBILE RESPONSE PROGRAM COMMUNITY PLANNING MEETING NOTES

Topic	General ideas	General Findings
<b>Call center/phone assessment/triage</b>	<ul style="list-style-type: none"> <li>• Centralized</li> <li>• Look at potentially using volunteers to staff the call center</li> <li>• Potentially partner with the college to employ social work students to staff call center.</li> <li>•</li> </ul>	<ul style="list-style-type: none"> <li>• Agreed to a Centralized Call Center Model</li> <li>• Consider using volunteers or college students to staff the call center</li> </ul>
<b>Law enforcement possible involvement</b>	<ul style="list-style-type: none"> <li>• <i>“I think it would be important for the mental health organizations to educate patients about how to interact with police.”</i></li> <li>• No police and if police involved, should not be the entity that controls the situation.</li> </ul> <p><i>“If armed police are called out, it will end up deadly due to their lack of training in trauma or de-escalation cause they never use their training skills.”</i></p> <p><i>“I would suggest if there’s already a model that involves police (outlined in the other slide), then this community response model should not involve police”</i></p>	<ul style="list-style-type: none"> <li>• If police are involved, they should not control the situation.</li> <li>• Model should not involve police because it could get deadly.</li> </ul>
<b>Transport Vehicle</b>	<ul style="list-style-type: none"> <li>• Should not look clinical or like other official vehicles.</li> <li>• Positive and comforting images and environment</li> <li>• Lighter colored van</li> <li>• Smaller discreet logo so there’s privacy</li> <li>• Should have Snacks/food/a place to chill/ therapy animal/weighted blankets/wifi</li> </ul>	<ul style="list-style-type: none"> <li>• Should be discreet and not look clinical or like other official vehicles</li> <li>• Should have a positive and comforting environment</li> </ul>
<b>CMR Team Composition</b>	<ul style="list-style-type: none"> <li>• Team should reflect the community they are serving, can relate understand and communicate</li> <li>• Needs to be people from the community</li> <li>• Should be diverse and bilingual</li> <li>• Trauma sensitive informed and understand the importance of having empathy</li> </ul>	<ul style="list-style-type: none"> <li>• Team should reflect and include people from the community</li> <li>• Team should be diverse and bilingual</li> <li>• Team should be trauma sensitive informed and have empathy</li> </ul>
<b>Family Involvement</b>	<ul style="list-style-type: none"> <li>• Should have option of family member involvement on a case by case basis.</li> <li>• Ensure that responder talks to person in crisis first and not family members</li> </ul>	<ul style="list-style-type: none"> <li>• Should be an option on a case-by-case basis</li> </ul>

# COMMUNITY MOBILE RESPONSE PROGRAM COMMUNITY PLANNING MEETING NOTES

Topic	General ideas	General Findings
		<ul style="list-style-type: none"> <li>Should talk to person in crisis before family members</li> </ul>
<b>Building trust/educating people to call the new CMRP</b>	<ul style="list-style-type: none"> <li>Change - mental health communication saying 'if you need help call 911, we need to make it so the non-police one is the response.</li> </ul>	<ul style="list-style-type: none"> <li>Educate public to call the CMR instead of police when help is needed.</li> </ul>
<b>Other comments</b>	<b>None</b>	

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## FILIPINO COMMUNITY – JANUARY 7, 2021

### Summary of Feedback

Topic	General ideas	General Findings
<b>Locations/Geographic Region</b>	<ul style="list-style-type: none"> <li>Milpitas in Santa Clara</li> </ul>	<ul style="list-style-type: none"> <li>Should include Milpitas in Santa Clara</li> </ul>
<b>Call Center Team</b>	<ul style="list-style-type: none"> <li>Counselor</li> <li>Someone that can relate to them, trained and relatable</li> </ul>	<ul style="list-style-type: none"> <li>Should be a counselor</li> <li>Important that person is trained and relatable</li> </ul>
<b>Phone Number</b>	<ul style="list-style-type: none"> <li>3-digit number (consensus)</li> </ul>	<ul style="list-style-type: none"> <li>Agreed on a 3-digit number</li> </ul>
<b>Workflow and Triage</b>	<ul style="list-style-type: none"> <li>Want to include family in the workflow</li> <li>Needs to be a critical part added that includes navigation to help triage and refer</li> </ul>	<ul style="list-style-type: none"> <li>Suggested including family in workflow</li> <li>Stressed the importance of navigation to help with triage and referrals</li> </ul>

# COMMUNITY MOBILE RESPONSE PROGRAM COMMUNITY PLANNING MEETING NOTES

Topic	General ideas	General Findings
<b>Call center/phone assessment/triage</b>	<ul style="list-style-type: none"> <li>Decentralized with the possibility of using the same number.</li> <li>Decentralized means that you can use the services anywhere would want to person to understand the community and be able to connect to local resources.</li> <li>Value in centralized, should have one number but have trusted community members to raise awareness. NEED COMMUNITY SUPPORT</li> </ul>	<ul style="list-style-type: none"> <li>Prefer decentralized but can be used everywhere, with the possibility of using the same number</li> <li>Noted value in centralized but need for community support</li> </ul>
<b>Law enforcement possible involvement</b>	<ul style="list-style-type: none"> <li>No Police, could be a deterrent</li> </ul>	<ul style="list-style-type: none"> <li>Prefer no police, could be a deterrent</li> </ul>
<b>Transport Vehicle</b>	<ul style="list-style-type: none"> <li>Make sure van and uniform does not look like police or ICE enforcement</li> <li>Like the more open look (plexiglass)</li> <li>Stay away from colors that identify w/ first responders</li> <li>Casual uniform, but uniformed (potentially different uniforms or identification for different levels of support)</li> <li>Potentially a different type of car than a utility van, SUV or something</li> <li>Want the van to reflect a happy place or a positive thing</li> <li>Don't want the van to be stigmatizing (don't include crisis response on the side)</li> <li>Would like for the unit to be able to treat people in the field but also transport if needed</li> </ul>	<ul style="list-style-type: none"> <li>Make sure van and uniform does not look like law enforcement</li> <li>Consider adding plexiglass for a more open look</li> <li>Want the vehicle to be non stigmatizing and reflect a happy place</li> <li>Should be able to treat people when in the field and transport</li> </ul>
<b>CMR Team Composition</b>	<ul style="list-style-type: none"> <li>Uniforms should not reflect police uniforms</li> <li>Someone who can come in, do an assessment and deliver the services that are needed</li> <li>Opportunity for mental health peer support: Likes the more intense approach that someone shows up they can talk to.</li> <li>Would rather not have licensed professionals for fear of stigma from talking to a "mental health" worker.</li> <li>Would like peer support worker to speak Tagalog – responders need to represent the community they are serving.</li> </ul>	<ul style="list-style-type: none"> <li>Uniforms should not reflect law enforcement</li> <li>Need someone who can do an assessment, but not someone that will be stigmatized as a mental health person</li> <li>Stressed need for peer support workers who can speak their language</li> </ul>

# COMMUNITY MOBILE RESPONSE PROGRAM COMMUNITY PLANNING MEETING NOTES

Topic	General ideas	General Findings
	<ul style="list-style-type: none"> <li>• Need to have someone well trained in crisis management who can direct where to go for assistance and help. Must be able to relate and de-escalate</li> </ul>	
<b>Family Involvement</b>	<ul style="list-style-type: none"> <li>• Family involvement important to not create additional problems in finding information.</li> <li>• Consider other support persons besides family</li> </ul>	<ul style="list-style-type: none"> <li>• Important to not create additional problems in finding information</li> <li>• Consider other support persons as well</li> </ul>
<b>Building trust/educating people to call the new CMRP</b>	<ul style="list-style-type: none"> <li>• Would hope that they do outreach and education in the community and normalizing mental health support.               <ul style="list-style-type: none"> <li>○ Use people from the community to let the community know the van is a safe place.</li> <li>○ Potentially faith based leaders</li> </ul> </li> </ul> <p><b>Advertising:</b></p> <ul style="list-style-type: none"> <li>• No flyers, mostly advertise through social media and community meetings</li> <li>• Churches, Prayer groups, small businesses, different generations and ages represented</li> <li>• Videos from people who represent the community to share (in different dialects)</li> </ul>	<ul style="list-style-type: none"> <li>• Must outreach to the community to help normalize mental health support</li> <li>• Use people from the community (faith based leaders) to reach the community</li> </ul>
<b>Other comments</b>	<ul style="list-style-type: none"> <li>• None</li> </ul>	

# COMMUNITY MOBILE RESPONSE PROGRAM COMMUNITY PLANNING MEETING NOTES

## JUSTICE INVOLVED AND RE-ENTRY COMMUNITY – JANUARY 15, 2021 (TWO SESSIONS)

### Summary of Feedback

Topic	General Ideas	Overall Findings
<b>Locations/Geographic Region</b>	<ul style="list-style-type: none"> <li>• Like proposed areas and can expand from there.</li> <li>• Target smaller areas to see how it goes. Then look to expand based on those learnings and the number of calls that are received.</li> <li>• Include: East San Jose, Gilroy and District 3, would be wise to have downtown San Jose.</li> </ul>	<ul style="list-style-type: none"> <li>• Like the two proposed locations: San Jose and South County</li> <li>• Start small and expand to additional areas</li> </ul>
<b>Call Center Team</b>	<ul style="list-style-type: none"> <li>• Trained mental health personnel.</li> <li>• Background in social work training.</li> <li>• Mental health clinician.</li> </ul>	<ul style="list-style-type: none"> <li>• Should be trained mental health personnel or clinician</li> <li>• Should have a background in social work.</li> </ul>
<b>Phone Number</b>	<ul style="list-style-type: none"> <li>• Three digit is best.</li> <li>• Not 911, triggers our clients</li> </ul>	<ul style="list-style-type: none"> <li>• All agreed on a 3-digit number</li> <li>• Not 911</li> </ul>
<b>Workflow and Triage</b>	<ul style="list-style-type: none"> <li>• 72hrs after crisis is very important for follow up, should incorporate follow up with all parties involved 24, 48, and 72hrs after.</li> <li>• Make sure that there's a place to track data and follow up with clients through the system.</li> <li>• Important to communicate with existing service providers.</li> <li>• Transport to other than hospital if client needs to go somewhere else.</li> <li>• Agencies noted the need for timely communication from the crisis response team to inform them if their clients called mobile crisis response.</li> <li>• Agencies noted that they have 24/hr services, so they could support if CMRP contacts them immediately.               <ul style="list-style-type: none"> <li>○ Currently, there is a delay before there is communication from mobile crisis programs that agencies' clients have been hospitalized.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Emphasis on needing to include a follow-up component in the workflow and triage</li> <li>• Agencies noted the desire to be involved in the workflow</li> </ul>

# COMMUNITY MOBILE RESPONSE PROGRAM COMMUNITY PLANNING MEETING NOTES

Topic	General Ideas	Overall Findings
<b>Call center/phone assessment/triage</b>	<ul style="list-style-type: none"> <li>• Centralized</li> <li>• Who will be triaging to determine if it is psychiatric or something else?</li> <li>• Specific staff with the expertise to determine which type of specialty staff should be dispatched.</li> </ul>	<ul style="list-style-type: none"> <li>• Agreed to a Centralized Call Center Model</li> <li>• Staff should be thoroughly trained to properly triage calls</li> </ul>
<b>Law enforcement possible involvement</b>	<ul style="list-style-type: none"> <li>• Police trigger our clients.</li> </ul>	<ul style="list-style-type: none"> <li>• Police can trigger clients, so limit involvement</li> </ul>
<b>Transport Vehicle</b>	<ul style="list-style-type: none"> <li>• White van</li> <li>• Blue logos are soothing</li> <li>• Medical insignia logo represents health</li> <li>• Have decorations/art inside so that it feels more like a home and less like an emergency van.</li> <li>• County of Santa Clara logos, windows.</li> </ul> <p><i>“Clients that are UTI of meth/MH paranoia are often very paranoid and if the van wasn’t clearly County, they may become aggressive due to feeling they were being lied to.”</i></p>	<ul style="list-style-type: none"> <li>• Van should be white logos that represent health</li> <li>• Interior should be decorated and feel comfortable</li> <li>• Consider adding Santa Clara County logo</li> </ul>
<b>CMR Team Composition</b>	<ul style="list-style-type: none"> <li>• A clinician who previously worked as a mobile crisis clinician feels it is very important to have expertise in serious mental illness, e.g. bi-polar.</li> </ul> <p><i>“They need additional training for these populations beyond what they receive in graduate school. Specific training would be more important than licensure.”</i></p> <ul style="list-style-type: none"> <li>• Licensure is important due to liability. Interns may not have the experience in placing 5150 holds or diverting elsewhere. Potentially there could be a structure of one licensed clinician could supervise and make the more complex decisions that the pre-licensed clinicians who consult them on.</li> </ul>	<p><b>Would like team to consist of:</b></p> <ul style="list-style-type: none"> <li>• Licensed mental health clinician with specific training.</li> <li>• RN with SUDS and/or Psych training</li> <li>• Pre-licensed clinician supervised by lead clinician</li> <li>• Noted the need for extensive training in: severe mental illness, substance</li> </ul>

# COMMUNITY MOBILE RESPONSE PROGRAM COMMUNITY PLANNING MEETING NOTES

Topic	General Ideas	Overall Findings
	<ul style="list-style-type: none"> <li>• Need someone trained in substance use so they can determine if a psychotic event is due to substance use instead of mental health issue, and how to address this instead of bipolar episode, etc.</li> <li>• RN with substance use training/specialty SUDS RN</li> <li>• Could be a pre-licensed clinician supervised by licensed clinician who are able to consult on more challenging crises.</li> <li>• Should not have too many people respond to call, may be difficult to dispatch multiple calls.</li> </ul>	<p>use, de-escalation techniques for all scenarios.</p> <ul style="list-style-type: none"> <li>• Noted need for someone trained in substance use, to determine if event is due to substance use or a mental health issue</li> <li>• Should limit the number of people responding to calls, in order to dispatch multiple calls.</li> </ul>
<b>Family Involvement</b>	<ul style="list-style-type: none"> <li>• Clients will need to give consent. If living with family, client might be released to family.</li> <li>• Should be decided by the client.</li> <li>• Caregivers/family should be provided with resources and how to handle the situations in the future.</li> </ul>	<ul style="list-style-type: none"> <li>• Family involvement should be determined by the client in crisis.</li> <li>• Noted the need for family to be provided with resources on how to handle situations in the future.</li> </ul>
<b>Building trust/educating people to call the new CMRP</b>	<ul style="list-style-type: none"> <li>• AARS and SCC SUTS hosts an IP (innovative partnership) meeting on the second Monday of the month at 1 pm. That would be a great place to reach all directors/managers of SUTS agencies in the county.</li> </ul>	<ul style="list-style-type: none"> <li>• Noted an opportunity to raise awareness.</li> </ul>
<b>Other comments</b>	<b>None</b>	

# COMMUNITY MOBILE RESPONSE PROGRAM COMMUNITY PLANNING MEETING NOTES

## SPANISH-PEAKING COMMUNITY – JANUARY 8, 2021

### Summary of Feedback

Topic	General ideas	General Findings
<b>Locations/Geographic Region</b>	<ul style="list-style-type: none"> <li>Expand services in South County                             <ul style="list-style-type: none"> <li>Especially in the Gilroy area.</li> </ul> </li> <li>Consider adding East San Jose</li> </ul>	<ul style="list-style-type: none"> <li>Should expand to South County</li> <li>Consider adding East San Jose</li> </ul>
<b>Call Center Team</b>	<ul style="list-style-type: none"> <li>People who are patient and can support the families when in need of help.</li> <li>Need to have people with lived experience answering the phone, or someone who has a relative with mental illness and can understand others, someone who can respond with support and avoid calling the police.</li> <li>They want the staff to be caring and able to de-escalate a crisis</li> <li>People who have life experience working with people suffering with mental illness</li> </ul>	<ul style="list-style-type: none"> <li>Important to have staff with lived experience or who can relate to person in crisis and responds without dispatching police</li> <li>Staff should be caring and able to deescalate situations.</li> </ul>
<b>Phone Number</b>	<ul style="list-style-type: none"> <li>The members preferred to use a three digits number</li> </ul>	<ul style="list-style-type: none"> <li>Prefer a 3-digit number</li> </ul>
<b>Workflow and Triage</b>	<ul style="list-style-type: none"> <li>The participants stated that it would be great to implement a model that has worked in other community or another state.</li> </ul>	<ul style="list-style-type: none"> <li>Should implement a model that has proven success</li> </ul>
<b>Call center/phone assessment/triage</b>	<ul style="list-style-type: none"> <li>All the participants agreed on a centralized model</li> </ul> <p><i>Experience</i></p> <p>A mother expressed her experience calling many times the call center when her son was in crisis and she did not get the help she needed. Her son's behavior</p>	<ul style="list-style-type: none"> <li>Agreed to a Centralized Call Center Model</li> </ul>



# COMMUNITY MOBILE RESPONSE PROGRAM COMMUNITY PLANNING MEETING NOTES

Topic	General ideas	General Findings
	<p>escalated to the point that he had to be hospitalized. She believed this experienced could have been prevented.</p>	
<p><b>Law enforcement possible involvement</b></p>	<ul style="list-style-type: none"> <li>• The participants liked the Cahoots model and agreed that it would be important to involve the police when others are in danger.</li> <li>• Members expressed the need for better training of the police on mental health crisis, and training them on effective communication when supporting a person or family during a crisis.</li> <li>• They wanted the police to be better trained doing on 5150 situations. <i>“When they lack this training, it is easy for them to send the family member to the hospital or to jail.”</i></li> </ul>	<ul style="list-style-type: none"> <li>• Important to involve police when people are in danger</li> <li>• Law enforcement should be thoroughly trained in mental health crisis response and how to respond to 5150 situations.</li> </ul>
<p><b>Transport Vehicle</b></p>	<ul style="list-style-type: none"> <li>• Members would like the vehicle to display a small logo, more discrete.</li> <li>• White color.</li> <li>• Should not be red.</li> </ul>	<ul style="list-style-type: none"> <li>• Discreet small logo</li> <li>• White</li> <li>• Should not be red</li> </ul>
<p><b>CMR Team Composition</b></p>	<ul style="list-style-type: none"> <li>• Family members, peer mentors</li> <li>• People that have life experience, paraprofessionals</li> <li>• Professionals that can evaluate for any 5150</li> <li>• Bilingual</li> <li>• Have a diverse group of staffing to appropriately respond to community needs (staff for varying levels of response)</li> <li>• Competency in language and culture</li> </ul>	<ul style="list-style-type: none"> <li>• Peer mentors</li> <li>• Individuals with Lived-experience</li> <li>• Competency in language and culture.</li> <li>• Diverse group of staffing that includes professionals who can evaluate for a 5150</li> </ul>
<p><b>Family Involvement</b></p>	<ul style="list-style-type: none"> <li>• Some members stated that we have to respect the desire of the person when being transport to the hospital, if she/he wants to go alone in the van, we have to let them go by themselves.</li> <li>• Other members stated when it comes to minors is very important that parents can accompany the child in the van.</li> <li>• 100% involvement of family members</li> </ul>	<ul style="list-style-type: none"> <li>• Should respect the desires of the client</li> <li>• Parents should accompany minors</li> <li>• Family should 100% be involved</li> </ul>
<p><b>Building trust/educating people to call the new CMRP</b></p>	<ul style="list-style-type: none"> <li>• Per participants own experience when reaching out for mental health support, they stated staff should demonstrate empathy and knowledge about persons living with mental illness.</li> </ul>	<ul style="list-style-type: none"> <li>• Staff should demonstrate empathy to make people feel</li> </ul>

# COMMUNITY MOBILE RESPONSE PROGRAM COMMUNITY PLANNING MEETING NOTES

Topic	General ideas	General Findings
	<ul style="list-style-type: none"> <li>Staff should also demonstrate knowledge about the family’s barriers and challenges relating to supporting a love one with mental illness.</li> </ul>	<p>comfortable accessing services</p> <ul style="list-style-type: none"> <li>Should have knowledge about mental illness</li> </ul>
<p><b>Other comments</b></p>	<ul style="list-style-type: none"> <li>Current language translations are too technical, use Spanish language that is more relatable.</li> </ul> <p><i>Experience</i> Another mother shared her experience of a psychiatrist telling her that her son will be hospitalized for long time in a psychiatric hospital if she would continue to call to report another crisis related to her son. She is afraid to seek help for her son. She wishes professionals were more humane.</p> <p><i>Experience</i> Members reported concerns about the services received in the emergency room such as lack of sensitivity, and not having staff that speak their language and understand their culture.</p> <ul style="list-style-type: none"> <li>Latinos (for the most part) call/reach out for help at the moment of <i>greatest, critical need</i></li> <li>Do not trust existing mobile crisis services</li> </ul> <p><i>Experience</i> A participant shared that the adult mobile crisis team has stopped taking their calls, 7 x she called, until her adult son committed a crime, he is now in jail (4 months), and cannot get in touch with him</p>	<ul style="list-style-type: none"> <li>Noted barrier in current Spanish language translations</li> <li>Shared negative experiences which resulted in a barrier to seeking services</li> <li>Shared negative experiences with current crisis response programs</li> </ul>

# COMMUNITY MOBILE RESPONSE PROGRAM COMMUNITY PLANNING MEETING NOTES

## STAKEHOLDERS IN NORTH COUNTY – DECEMBER 17, 2021

### Summary of Feedback

Topic	General ideas	General Findings
<b>Locations/Geographic Region</b>	<ul style="list-style-type: none"> <li>North County</li> <li>Consider accessibility. Can someone reach the location?</li> </ul>	<ul style="list-style-type: none"> <li>Should consider adding North County</li> </ul>
<b>Call Center Team</b>	<ul style="list-style-type: none"> <li>People trained with consistency</li> <li>Person receiving call should be mental health professionals</li> </ul>	<ul style="list-style-type: none"> <li>Team should have consistent training</li> <li>Should be a mental health professional</li> </ul>
<b>Phone Number</b>	<ul style="list-style-type: none"> <li>3-digit number preferred - consistent, memorable can be helpful when expanding.</li> </ul>	<ul style="list-style-type: none"> <li>3-digit number is preferred</li> </ul>
<b>Workflow and Triage</b>	<ul style="list-style-type: none"> <li>Who's going to be following up; who's going to be working with schools and clinics?</li> <li>Should prioritize de-escalation</li> </ul>	<ul style="list-style-type: none"> <li>Stressed importance of follow-up after a call is made.</li> <li>Should prioritize de-escalation</li> </ul>
<b>Call center/phone assessment/triage</b>	<ul style="list-style-type: none"> <li>People call into ONE number (youth and adolescent services for example) → go into system for someone to triage → dispatch in Morgan Hills or San Jose</li> <li>Key phrase to say when calling, like "I need the Mobile Crisis team."</li> <li>Would it be possible for a call center or triage team to come train or go over process with the community organizations?</li> </ul>	<ul style="list-style-type: none"> <li>Agreed on a centralized system that can be dispatched</li> <li>Potentially use key phrase when asking for services</li> <li>Asked that call center triage team train community organizations on process</li> </ul>
<b>Law enforcement possible involvement</b>	<ul style="list-style-type: none"> <li>Identifying which situations are clearly PD responses and CMR responses should be straightforward. Running through the "grey area" will be important so that each entity understands what protocol is most appropriate.</li> </ul>	<ul style="list-style-type: none"> <li>Need to clearly identify what does and does not require policy involvement.</li> </ul>

# COMMUNITY MOBILE RESPONSE PROGRAM COMMUNITY PLANNING MEETING NOTES

	<ul style="list-style-type: none"> <li>Including 911 Dispatchers will also be critical if they will be involved in triaging/assigning resources.</li> </ul>	<ul style="list-style-type: none"> <li>Need to include 911 dispatchers in training for triage and assigning resources</li> </ul>
<b>Transport Vehicle</b>	<ul style="list-style-type: none"> <li>Van should look more discrete.</li> <li>The one that takes calls should look like ordinary cars.</li> <li>Focus on safe therapeutic environment</li> </ul>	<ul style="list-style-type: none"> <li>Van should look discrete</li> <li>Suggested using ordinary cars</li> <li>Should be a safe therapeutic environment</li> </ul>
<b>CMR Team Composition</b>	<ul style="list-style-type: none"> <li>Diversity of levels of professionalism, credentials, and experience is good.</li> <li>Important to have someone on the team with a lived experience – a former consumer who can give back. Always good to have someone with lived experience who can relate.</li> <li>Nurse and clinicians are good</li> <li>Psych nurse – potentially retired and wanting to give back</li> <li>Consider Tele-psych</li> <li>Potential medical staff on call</li> <li>Comfortable and welcoming clothes but some type of uniform</li> <li>Would like less authority/undercover cop feel</li> <li>More ethnic diversity on the team.</li> <li>I think involving more folks with lived experience in the design is great! I also appreciate the team having a make up of individuals from peer support to clinical and being diverse in terms of racial/cultural background and gender.</li> </ul>	<ul style="list-style-type: none"> <li>Noted various levels of professionals that should be considered</li> <li>Stressed the need to have someone with lived experience</li> <li>Team should be diverse</li> <li>Should wear comfortable clothing</li> </ul>
<b>Family Involvement</b>	<ul style="list-style-type: none"> <li>Would need to be flexible on this, assess the situation and take on a case by case basis</li> </ul>	<ul style="list-style-type: none"> <li>Should be handled on a case by case basis</li> </ul>
<b>Building trust/educating people to call the new CMRP</b>	<ul style="list-style-type: none"> <li>Show up to community events</li> <li>Partner with trusted community leaders</li> <li>Making sure to explain the process of what happens when you call. What does this mean for you? What would the resources be? Demystify the process: there should be a place to answer these questions to assuage fear, anxiety.</li> </ul>	<ul style="list-style-type: none"> <li>Attend community events</li> <li>Partner with trusted community leaders</li> <li>Make sure community knows the process</li> </ul>
<b>Other comments</b>	No comments.	

# COMMUNITY MOBILE RESPONSE PROGRAM COMMUNITY PLANNING MEETING NOTES

## TRANSITIONAL AGED YOUTH (TAY) – JANUARY 12, 2021

### Summary of Feedback

Topic	General ideas	General Findings
<b>Locations/Geographic Region</b>	<ul style="list-style-type: none"> <li>• Good w/ proposed locations</li> <li>• Consider traffic and response times</li> </ul>	<ul style="list-style-type: none"> <li>• Agree with proposed locations</li> <li>• Should consider traffic response times</li> </ul>
<b>Call Center Team</b>	<ul style="list-style-type: none"> <li>• Should not put people on hold, have some kind of que.</li> <li>• Need to be trauma informed</li> <li>• Be able to determine when extra help (police/medical) are needed</li> <li>• Some kind of therapy training so they can be more personable</li> </ul>	<ul style="list-style-type: none"> <li>• Should not put people on hold</li> <li>• Should have mental health training, be trauma informed, and be able to triage properly</li> </ul>
<b>Phone Number</b>	<ul style="list-style-type: none"> <li>• Consensus on 3 digit number – easy to remember</li> </ul>	<ul style="list-style-type: none"> <li>• Agreed on 3-digit number</li> </ul>
<b>Workflow and Triage</b>	<ul style="list-style-type: none"> <li>• Can people be transported without needing to be handcuffed?</li> </ul>	<ul style="list-style-type: none"> <li>• Want to ensure that people can be transferred without being handcuffed.</li> </ul>
<b>Call center/phone assessment/triage</b>	<ul style="list-style-type: none"> <li>• Centralized offers more opportunity for consistency</li> <li>• De-centralized may be more personal but may not offer services when they are needed</li> <li>• Centralized may seem more reliable</li> </ul>	<ul style="list-style-type: none"> <li>• Agreed to a Centralized Call Center Model</li> <li>• Noted de-centralized may be more personal, but may not offer services when needed</li> </ul>
<b>Law enforcement possible involvement</b>	<ul style="list-style-type: none"> <li>• When call mobile crisis line police officers show up in police uniforms and it is traumatizing to the youth.</li> </ul>	<ul style="list-style-type: none"> <li>• Prefer no law enforcement involvement</li> </ul>

# COMMUNITY MOBILE RESPONSE PROGRAM COMMUNITY PLANNING MEETING NOTES

Topic	General ideas	General Findings
<b>Transport Vehicle</b>	<ul style="list-style-type: none"> <li>• Plain white van would be creepy – need to have some kind of logo/design</li> <li>• Cushioned bench in truck or medical bed so people can lay down and pillows</li> <li>• Wording on the side of the van shouldn't have "crisis" in it. Should reflect what the service that is provided – we are here to help</li> <li>• Weighted blanket</li> <li>• Soothing smells</li> <li>• <i>Potential Idea:</i> hands open face up which is a universal sign for here to help</li> <li>• Pastel colors, something soothing not associated with law enforcement</li> <li>• Shouldn't be super bright</li> <li>• Have it be discreet so people don't know what it is</li> <li>• Yoga mat that people could lay on if they don't want to lay in the van</li> <li>• Magnets to cover up the logos if want to be discreet</li> </ul>	<ul style="list-style-type: none"> <li>• Should have a discrete logo or design that does not include the word "crisis"</li> <li>• Should be comfortable on the inside</li> <li>• Pastel or neutral colors that are not associated with law enforcement</li> </ul>
<b>CMR Team Composition</b>	<ul style="list-style-type: none"> <li>• Would be good to have a younger person that youth can connect to.</li> <li>• Want to have a peer support aspect</li> <li>• It can be overwhelming when there are a lot of people there. Try not to make the response team so big.</li> <li>• Should be at least one medical person – Someone in uniform that is identifiable</li> </ul>	<ul style="list-style-type: none"> <li>• Stress the importance of having a peers support aspect or someone younger that youth can connect with</li> <li>• Should be a small response team, to not be overwhelming</li> <li>• Should include an identifiable medical person</li> </ul>
<b>Family Involvement</b>	<ul style="list-style-type: none"> <li>• Parents can sometimes escalate the situation – this should be optional.</li> </ul>	<ul style="list-style-type: none"> <li>• Should be optional</li> </ul>
<b>Building trust/educating people to call the new CMRP</b>	<ul style="list-style-type: none"> <li>• Would help if people doing education should be youth</li> <li>• Have a social media account to show the van and inside so people know what it is</li> </ul>	<ul style="list-style-type: none"> <li>• People doing education should be youth</li> <li>• Should have a social media account to raise awareness</li> </ul>

# COMMUNITY MOBILE RESPONSE PROGRAM COMMUNITY PLANNING MEETING NOTES

Topic	General ideas	General Findings
<b>Other comments</b>	<p><i>Experience:</i> Paramedics asked how do I stop my child from doing something like this.</p> <ul style="list-style-type: none"> <li>The resources are out there it's important that we can connect them to them</li> </ul>	<ul style="list-style-type: none"> <li>First responders should be trained on how to be empathetic</li> <li>Stressed importance of connecting to resources</li> </ul>

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## VIETNAMESE COMMUNITY – DECEMBER 29, 2021

### Summary of Feedback

Topic	General ideas	General Findings
<b>Locations/Geographic Region</b>	<ul style="list-style-type: none"> <li>No comment</li> </ul>	<ul style="list-style-type: none"> <li>No comment</li> </ul>
<b>Call Center Team</b>	<ul style="list-style-type: none"> <li>Multilingual speaking staffs are needed</li> </ul>	<ul style="list-style-type: none"> <li>Include multilingual staff</li> </ul>
<b>Phone Number</b>	<ul style="list-style-type: none"> <li>100% reported wanting 3 digits phone numbers.</li> </ul> <p>Suggestions:</p> <ul style="list-style-type: none"> <li>3 same digits (i.e. 888) or 3-digits with two numbers (i.e. 898)</li> <li>3-digits plus the last letter for language specific (i.e. 888V for Vietnamese, 888E for English, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>Agree that 3-digit number is best</li> <li>Should include multi lingual staff</li> </ul>
<b>Workflow and Triage</b>	<ul style="list-style-type: none"> <li>No comment</li> </ul>	<ul style="list-style-type: none"> <li>No Comment</li> </ul>
<b>Call center/phone assessment/triage</b>	<ul style="list-style-type: none"> <li>They are 50/50. Some prefer a centralized call center for purpose of training and consistency in services. Some want different numbers for people in different region.</li> </ul>	<ul style="list-style-type: none"> <li>Half preferred centralized model</li> </ul>

# COMMUNITY MOBILE RESPONSE PROGRAM COMMUNITY PLANNING MEETING NOTES

Topic	General ideas	General Findings
		<ul style="list-style-type: none"> <li>• Half preferred different numbers for different regions</li> </ul>
<b>Law enforcement possible involvement</b>	<ul style="list-style-type: none"> <li>• Suggested to get help from the police</li> <li>• 1 person suggested pepper spray was suggested for safety purpose.</li> </ul>	<ul style="list-style-type: none"> <li>• Suggested getting help from law enforcement if needed</li> </ul>
<b>Transport Vehicle</b>	<ul style="list-style-type: none"> <li>• Suggested colors: yellow, light green and/or blue but light colors</li> <li>• Logo, name and phone # should be printed on the vehicle</li> <li>• Translation of the names/services should be printed on different vehicles (different vehicles will have different languages printed on them)</li> </ul>	<ul style="list-style-type: none"> <li>• Logo, name and phone # should be printed on vehicle some with translations</li> </ul>
<b>CMR Team Composition</b>	<ul style="list-style-type: none"> <li>• 2- or 3-persons team was suggested:</li> <li>• One of the staff with specialty in working with Vietnamese people is preferred. Suggested to have bilingual staff.</li> <li>• Manager of the program must be licensed</li> <li>• Team can consist of a nurse and Crisis Intervention Worker, no need for a licensed/Licensed-Waiver staff.</li> </ul>	<ul style="list-style-type: none"> <li>• Suggested 2-3 person team</li> <li>• Would like one Vietnamese staff member and someone that is bilingual</li> <li>• Can be nurse and crisis intervention worker</li> </ul>
<b>Family Involvement</b>	<ul style="list-style-type: none"> <li>• Ask individual for consent before allowing family or close ones to ride along. Try to obtain consent and involve family members or supportive members as much as possible.</li> </ul>	<ul style="list-style-type: none"> <li>• Should ask client for consent before involving family</li> </ul>
<b>Building trust/educating people to call the new CMRP</b>	<ul style="list-style-type: none"> <li>• Educational program to inform and educate the public about the program</li> </ul> <p>Suggestion:</p> <ul style="list-style-type: none"> <li>• Need to educate the public</li> </ul>	<ul style="list-style-type: none"> <li>• Have educational program to inform public</li> </ul>
<b>Other comments</b>	<ul style="list-style-type: none"> <li>• None</li> </ul>	





Submitted Comments*		Submission Method and Date	Submitted by	Participant Info	BHSD Response
1.	Since the integration of the three departments in LA County, there is more opportunities to recover from [mental illness] MI.	<i>Via SurveyMonkey link provided on 2/12 survey link</i>  Received: Thursday, February 18, 2021	Maria Tan	<b>What group do you represent:</b> Consumer, Provider, Community membership, Housing Coalition Member <b>What is your primary system transformation interest:</b> Integrated Service Experience (CCR § 3200.190) <b>Organization or Affiliation:</b> LACounty Out Patient Services, State Contracted through LA County	Thank you for your input. BHSD looks forward to providing additional opportunities and resources for County resident’s behavioral health needs.
2.	This is a good start to taking mental health out of the police department. This program needs to be funded, evaluated, and expanded if successful.	<i>Via SurveyMonkey link provided on 2/12 survey link</i>  Received: Monday, February 23, 2021	Heather Cleary	<b>What group do you represent:</b> Social Services Provider <b>What is your primary system transformation interest:</b> Consumer and Family Driven Mental Health Services (CCR § 3200.50, § 3200.120) <b>Organization or Affiliation:</b> Peninsula Family Service	Thank you for your input. BHSD looks forward to the launch of this new program and potential expansion in the future if it is successful and funding is available.
3.	Need for County contracted mental health providers to work/collaborate with social service agencies to provide support fo their clients especially the homeless population.	<i>Via SurveyMonkey link provided on 2/12 survey link</i>  Received: Friday, February 26, 2021	Benaifer Dastoor	<b>What group do you represent:</b> Social Services Provider <b>What is your primary system transformation interest:</b> Consumer and Family Driven Mental Health Services (CCR § 3200.50, § 3200.120); Wellness Focus: Recovery and Resilience (WIC § 5806, § 5813.5) <b>Organization or Affiliation:</b> West Valley Community Services	Thank you for your input. BHSD plans to work collaboratively with community organizations and other county departments to ensure that all clients, including the unhoused population, are served. Please see Draft plan pages 17-18, Section Titled: Community Collaborators program component of the CMR program for more information on the collaboration plan.
4.	The SJ target area should be expanded to have 95122 at the center but not restrict second zip code targeting 95112 which is really downtown San Jose not eastside. Eastside	<i>Via SurveyMonkey link provided on 2/12 survey link</i>	Sparky Harlan	<b>What group do you represent:</b> Social Services Provider <b>What is your primary system transformation interest:</b>	Thank you for your comment and feedback. As described on page 9 of the Draft CMR plan document, <i>“The program will serve all of San Jose.”</i> During the planning and workgroup sessions, east San Jose had been identified as a priority area within the San Jose service area. At the



	residents always feel left out because public officials misidentify where eastside is. 95112 ends east at Coyote Creek which is where eastside begins which is 95116. It is best to drop artificial zip code lines and broaden beyond to a general circle north, east, and west of 95122.	Received: Friday, March 11, 2021		Community Collaboration (CCR § 3200.060) <b>Stakeholder Affiliation:</b> Bill Wilson Center	workgroup sessions, east San Jose was identified as a priority area, and workgroup members also wanted priority areas for zip codes 95122 and 95112. However, the Draft Plan will be updated to include 95116 as an additional priority area to encompass the eastside of San Jose.
5.	Support Community Mobile Crisis Unit	<i>Via SurveyMonkey link provided on 2/12 survey link</i>  Received: Friday, March 11, 2021	Miguel Valencia	<b>What group do you represent:</b> Family/Consumer of MH services; MH and Substance use Provider; Cultural Competence and diversity; Health care <b>What is your primary system transformation interest:</b> Cultural Competency (CCR § 3200.100); Consumer and Family Driven Mental Health Services (CCR § 3200.50, § 3200.120); Integrated Service Experience (CCR § 3200.190) <b>Stakeholder Affiliation:</b> Gardner Health Services	Thank you for your support, we look forward to working with all of our community based providers.
6.	Hello, Palo Alto has expressed interest in being a part of the CMR pilot. Please consider including northern cities like Palo Alto to increase geographic diversity and outreach. If MHSA funding cannot cover it, please allow cities the opportunity to provide city funding. Thank You, Patricia	<i>Via SurveyMonkey link provided on 2/12 survey link</i>  Received: Friday, March 11, 2021	Patricia	<b>What group do you represent:</b> Community Member; Health care <b>What is your primary system transformation interest:</b> Community Collaboration (CCR § 3200.060); Consumer and Family Driven Mental Health Services (CCR § 3200.50, § 3200.120); Wellness Focus: Recovery and Resilience (WIC § 5806, § 5813.5) <b>Stakeholder Affiliation:</b> N/A	Thank you for your comment and feedback. During the community input sessions held in December 2020 and January 2021, stakeholders were asked what areas in the County should be prioritized for the initial launch. During these meetings, stakeholders advocated for piloting the CMR program in San Jose and Gilroy.  During the community input sessions, stakeholders also noted North county and Morgan Hill as potential CMR service sites if funding is available. As stated in the "Service Areas" section at the end of page 7 in the Draft Plan, the County plans to expand to include North county in the future, as funding allows.



7.	<p>The present Behavioral health system in SCC is NOT adequate, not collaborative, consequently, it relies heavily on police departments.</p>	<p><i>Via SurveyMonkey link provided on 2/12 survey link</i></p> <p>Received: Friday, March 11, 2021</p>	<p>Cybele LoVuolo-Bhushan</p>	<p><b>What group do you represent:</b> Family/Consumer of MH services; Community Member; Other (please specify): Affordable housing advocate</p> <p><b>What is your primary system transformation interest:</b> Community Collaboration (CCR § 3200.060); Consumer and Family Driven Mental Health Services (CCR § 3200.50, § 3200.120); Wellness Focus: Recovery and Resilience (WIC § 5806, § 5813.5); Integrated Service Experience (CCR § 3200.190)</p> <p><b>Stakeholder Affiliation:</b> CBO ACLU mid-peninsula</p>	<p>Thank you for your feedback. As stated in the “Draft Plan” on page 5, “The scope of services will prioritize serving those who are deterred from calling 911 for assistance due to a history of negative experiences with law enforcement.”</p>
8.	<p>Please refer to the attached letter, submitted by:</p> <p>Michelle Oberman, Professor, Santa Clara University School of Law Molly Brennan, Senior Attorney, Law Foundation of Silicon Valley Marlene Bennett, Affiliate, Santa Clara University School of Law Christina Iriart, Student, Santa Clara University School of Law Adena Ishii, Student, Santa Clara University School of Law Cydney Chilimidos, Students, Santa Clara University School of Law</p>	<p><i>Via SurveyMonkey link provided on 2/12 survey link</i></p> <p>Received: Friday, March 12, 2021</p>	<p>Michelle Oberman</p>	<p><b>What group do you represent:</b> Education; Community Member; Cultural Competence and diversity; Disabilities advocate</p> <p><b>What is your primary system transformation interest:</b> Cultural Competency (CCR § 3200.100)</p> <p><b>Stakeholder Affiliation:</b> Santa Clara University School of Law</p>	<p>Thank you for your feedback. During the community input sessions held in December 2020 and January 2021, stakeholders voiced the need to create an accessible, trusted community phone line for the new CMR program.</p> <p>In total, BHSD, in partnership and collaboration with BHCA and partner organizations, held 13 planning input sessions in collaboration and partnership with the Behavioral Health Contractors’ Association of Santa Clara County (BHCA) and partner organizations; garnering input from diverse groups of people: consumers, family members of consumers, families who have lost loved ones, Justice-Involved /Re-Entry individuals, and various ethnic-specific communities: African/African Ancestry, Chinese, Filipino, Spanish-speaking, and Vietnamese. The call center design, phone number, and evaluation were developed with stakeholder input.</p> <p>A vast number of stakeholders voiced the need to establish a new 3-digit phone number separate from 911, 311, and the County’s Behavioral Health Call Center. The aim of the new CMR program is to increase access to behavioral health services for those individuals who are deterred from calling 911 for assistance due to a history of negative experiences with law enforcement. As part of the new CMR program, Community Collaborators will establish a community advisory board,</p>



					<p>see page 18 of the Draft Plan, which will include EMS and other County Programs to help evaluate and inform the development and progression of the program. The Community Collaborators and the selected community based organization (CBO) Call Center will work collaboratively with the County’s current 911 dispatchers and ensure they are aware of the new CMR program and, as needed, link 911 callers with a mental health crisis to the CMR program.</p> <p>Also, during the planning input sessions held from December 2020 to January 2021, participants were shown the CAHOOTS model and were asked what they thought of it. As detailed on pages 15-17 of the Draft Plan, stakeholders provided suggestions/modifications to the CAHOOTS model. The triage/workflow was modified based on stakeholder input, as reflected on page 17 of the Draft Plan.</p> <p>Evaluation is a major component in all MHSA innovation programs. As noted on pages 24-25 of the draft plan, BHSD plans to contract with an independent evaluator to conduct a comprehensive process and outcome evaluation of the project. This evaluation will include assessing the impact of the new program as it relates to access to behavioral health services as it relates to the County’s current MCRT and PERT mobile programs as well to determine if the new CMR program results in increasing access to behavioral health services for the underserved. As reflected on page 24-25 of the Draft Plan, will evaluate “to determine if the new CMR program results in a decrease in the number of calls and utilization rate of other emergency services, the program will gather baseline data for the following: rate of MCRT usage, ED/EPs admits due to behavioral health-related issues, and 911 behavioral health-related calls.”</p>
9.	<p>Please see the attached letter that indicates support from over 40 organizations. Primary asks noted below:</p> <ul style="list-style-type: none"> <li>• Urge that the reference to specific zip codes be updated to zip code 95122 and surrounding areas.</li> <li>• We ask that the County review the current cost for hiring and retaining similar types of staff in refining the budget. The extreme delays in other</li> </ul>	<p><i>Via SurveyMonkey link provided on 2/12 survey link</i></p> <p>Received: Friday, March 12, 2021</p>	<p>Community Nonprofit Organizations</p>	<p><b>What group do you represent:</b> Family/Consumer of MH services; Social Services Provider; MH and Substance use Provider; Community Member; Cultural Competence and diversity; Disabilities advocate; Health care; Other (please specify): Community Nonprofit Organizations</p> <p><b>What is your primary system transformation interest:</b></p>	<p>Thank you for your feedback. BHSD truly values the support of the County’s community non-profit organizations. As described on page 9 of the Draft CMR plan document, “The program will serve all of San Jose.” During the planning and workgroup sessions, east San Jose was identified as a priority area within the San Jose service area. The two priority zip codes noted to serve east San Jose were 95122 and 95112, which were identified during the workgroup sessions.</p> <p>As for the proposed budget for the CMR Program staff positions, the BHSD finance team conducted extensive research to ensure that salary</p>



	<p>mobile crisis services stemmed from difficulty in recruiting staff. We believe that the innovative design will help address that issue but a realistic budget is imperative as the staff will be taking on very challenging work.</p> <ul style="list-style-type: none"> <li>We urge you to commence the County-wide design contest upon receiving MHSOAC approval. This can be done concurrently with initiating the RFP and identifying the design and evaluation contractors.</li> </ul>			<p>Community Collaboration (CCR § 3200.060)  <b>Stakeholder Affiliation:</b> Community Nonprofit Organizations</p>	<p>ranges allocated were comparable to salaries for similar positions throughout the County.</p> <p>According to Innovative Project Regulations:  Title 9 California Code of Regulations:  <b>Division 1, Chapter 14 MHSA, Section 3910.010.</b>  Time-Limited Pilot Project.  (a) An Innovative Project shall have an end date that is not more than five years from the start date of the Innovative Project.  (1) "Start date" means the date the County begins the implementation of the Innovative Project.  (2) "End date" means the date the County finalizes the decision whether to continue the Innovative Project.</p> <p>Per consultation with the Mental Health Services Oversight Accountability Commission (MHSOAC) staff, the "start date" of the project begins once implementation starts. Due to this, the County will be unable to execute the design contest upon receiving MHSOAC approval, as this will impact the total amount of time for the INN funding availability for the call center and CMR field teams. For example, suppose County completes the local approval process with the County Board of Supervisors of the Draft Plan and obtains MHSOAC-state approval by the end of FY2021 in June 2021 and starts the design contest/van related activities, and starts expending funds on July 1, 2021. In that case, July 1, 2021 will be the date the MHSOAC will consider as the five-year project's start date. Having a 7/1/2021 start date will impact the County's ability to draw down the complete INN funding for the Call Center and Onsite Field Teams, which are expected to be implemented early 2022, after the Request for Proposal for the CMR is completed from July 2021 to December 2021.</p>
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10.	Please refer to the attached letter, submitted by the City of Palo Alto, Office of the City Manager	Via SurveyMonkey link provided on 2/12 survey link  Received: Friday, March 12, 2021	Chantal C. Gaines	<p><b>What group do you represent:</b> Other (please specify): Municipal Government</p> <p><b>What is your primary system transformation interest:</b> Consumer and Family Driven Mental Health Services (CCR § 3200.50, § 3200.120);Wellness Focus: Recovery and Resilience (WIC § 5806, § 5813.5)</p> <p><b>Stakeholder Affiliation:</b> City of Palo Alto</p>	<p>Thank you for your feedback. The Mental Health Services Act (MHSA) Stakeholder Leadership Committee (SLC) is in place to provide input to BHSD in its MHSA planning and implementation activities. The MHSA SLC serves as the BHSD’s primary advisory committee for MHSA activities and consists of representatives of various stakeholder groups. In their role, the MHSA SLC members review, comment and provide input on MHSA plans and annual updates. MHSA SLC meetings serve as a forum to assure wide-ranging representation in the MHSA community planning process. All MHSA SLC meetings are open to the public and allow for public comment. The SLC stakeholder leadership committee includes two members: Mary Gloner, Executive Director, Project Safety Net and June Klein, VP and CFO, Palo Alto University, who represent North County. Additionally, all meetings are open to the public. Notices for MHSA meetings and information on upcoming MHSA projects and activities are available on our website: <a href="https://www.sccgov.org/sites/bhd/AboutUs/MHSA/Pages/default.aspx">https://www.sccgov.org/sites/bhd/AboutUs/MHSA/Pages/default.aspx</a></p> <p>The stakeholder process on this new project began in August 2020, and planning input sessions were conducted through January 2021. From December 2020 to January 2021, the County, in partnership and collaboration with BHCA and other partners, conducted additional planning meetings, in all 13 were held, and the County garnered input from diverse groups of people: consumers, family members of consumers, families who have lost loved ones, Justice-Involved /Re-Entry individuals, and various ethnic-specific communities: African/African Ancestry, Chinese, Filipino, Spanish-speaking, and Vietnamese. Please refer to the community planning session section of the Draft Plan.</p> <p>The call center design, phone number, and evaluation were developed with stakeholder input. Two meetings were held in partnership with two North County organizations: December 17, 2020, at 5:00 PM hosted by Project Safety Net (PSN) – City of Palo Alto and Tuesday, January 12, 2021, at 5:00 PM Session for the County’s Transitional Aged Youth (TAY), ages 18 – 25, hosted by BHSD and facilitated by Ana Lilia Soto, Stanford Psychiatry Center for Youth Mental Health and Wellbeing.</p>
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					<p>Per stakeholder feedback at the December 2020 – January 2021 planning input sessions, the County included a placeholder for a site in North county once funding is available, as reflected on page 7 of the Draft Plan.</p> <p>The BHSD maintains an MHSA email distribution list which we use to inform the public of upcoming MHSA meetings, activities, including annual updates and three-year plans and new Innovation projects. Any person with a desire to be added to the MHSA email distribution list can email us at <a href="mailto:MHSA@hhs.sccgov.org">MHSA@hhs.sccgov.org</a>. Please contact us if you would like to be included in the MHSA email distribution group list.</p>
11.	<p>Please refer to the attached letter, submitted by the Behavioral Health Contractor’s Association (BHCA)</p>	<p><i>Via SurveyMonkey link provided on 2/12 survey link</i></p> <p>Received: Friday, March 12, 2021</p>	<p>Elisa Koff-Ginsborg</p>	<p><b>What group do you represent:</b> Other (please specify): Municipal Government</p> <p><b>What is your primary system transformation interest:</b> Community Collaboration (CCR § 3200.060) Cultural Competency (CCR § 3200.100) Consumer and Family Driven Mental Health Services (CCR § 3200.50, § 3200.120) Wellness Focus: Recovery and Resilience (WIC § 5806, § 5813.5) Integrated Service Experience (CCR § 3200.190)</p> <p><b>Stakeholder Affiliation:</b> Behavioral Health Contractors' Association (BHCA)</p>	<p>Please refer to the response provided for comment #9, which addresses service location, budget, and project time limit.</p> <p>As for the budget for the CMR Call Center and Onsite Field Teams, the salary assumptions were prepared based on midpoint averages from</p> <ul style="list-style-type: none"> <li>• Past approved MHSA Innovation projects, as recent as INN-13: allcove</li> <li>• Previously submitted request for proposal (RFPs) bids – finance/budget portion submitted by bidders-community-based organizations.</li> <li>• Reviewed the salaries from the recently approved INN-16 budget: Addressing Stigma and Trauma in the Vietnamese and African-American/African Ancestry Communities (Approved by the MHSOAC in February 2020)</li> </ul>



12.	<p>Please see the attachment titled: " INN 15 feedback Uplift"</p>	<p><i>Via SurveyMonkey link provided on 2/12 survey link</i></p> <p>Received: Friday, March 12, 2021</p>	Don Taylor	<p><b>What group do you represent:</b> MH and Substance use Provider</p> <p><b>What is your primary system transformation interest:</b> Community Collaboration (CCR § 3200.060) Cultural Competency (CCR § 3200.100) Consumer and Family Driven Mental Health Services (CCR § 3200.50, § 3200.120) Wellness Focus: Recovery and Resilience (WIC § 5806, § 5813.5) Integrated Service Experience (CCR § 3200.190)</p> <p><b>Stakeholder Affiliation:</b> Uplift Family Services</p>	<p>As provided in BHSD’s response to BHCA’s submitted comment #11, the salary assumptions for the CMR Call Center and Onsite Field Team were prepared based on midpoint averages from</p> <ul style="list-style-type: none"> <li>• Past approved MHSA Innovation projects, as recent as INN-13: allcove</li> <li>• Previously submitted request for proposal (RFPs) bids – finance/budget portion submitted by bidders-community-based organizations.</li> <li>• Reviewed the salaries from the recently approved INN-16 budget: Addressing Stigma and Trauma in the Vietnamese and African-American/African Ancestry Communities (Approved by the MHSOAC in February 2020)</li> </ul> <p>MHSA Finance can model potential scenarios that address the recommendations and share the budget scenarios with stakeholders at an MHSA Stakeholder leadership Committee (SLC) that will be open to the public. Also, adjusting the CMR onsite field team, currently comprised of three members: emergency medical technician (EMT), crisis intervention worker (CIW), and peer outreach specialist to a two-member team of an EMT and a CIW, would require stakeholder review. Throughout the planning process, stakeholders and the public stated that they would like to have peers be part of the team. Changing the plan would require additional feedback from stakeholders. If this is the plan MHSA SLC members would like to take, then SLC members can elect to take a pause, provide the County MHSA Finance team to develop possible scenarios related to adjust staffing costs, and allow members to offer their input on the proposed staffing reduction from 3 members to 2 members as well.</p>
13.	<p>Please see the attachment titled: "LFSV CMR Comment Final"</p>	<p><i>Via SurveyMonkey link provided on 2/12 survey link</i></p> <p>Received: Friday, March 12, 2021</p>	Molly Brennan	<p><b>What group do you represent:</b> Other (please specify):: Legal Services for people with mental health illness</p> <p><b>What is your primary system transformation interest:</b> Community Collaboration (CCR § 3200.060)</p> <p><b>Stakeholder Affiliation:</b> Law Foundation of Silicon Valley</p>	<p>Thank you for your feedback and program recommendations.</p> <p>The stakeholder process on this new project began in August of 2020, and planning input sessions were conducted through January 2021. Meetings were conducted with members of the SLC and community members representing various target populations, including community members with diverse lived experiences, ethnicities, and various levels of mental health experience. In an effort to increase involvement, BHSD partnered with various community agencies and associations to assist in conducting community meetings that members of the public</p>





					<p>would be comfortable attending and participating in; and additional planning input sessions were held from December 2020 to January 2021. In partnership and collaboration with BHCA and other partner organizations. BHSD held 13 planning input sessions in collaboration and partnership with the Behavioral Health Contractors' Association of Santa Clara County (BHCA) and partner organizations and garnered input from diverse groups of people: consumers, family members of consumers, families who have lost loved ones, Justice-Involved /Re-Entry individuals, and various ethnic-specific communities: African/African Ancestry, Chinese, Filipino, Spanish-speaking, and Vietnamese. The new CMR program was developed with stakeholder input. BHSD partnered with include BHCA that represents 40 community based organizations in the County, National Alliance on Mental Illness (NAMI) of Santa Clara County, Black Leadership Kitchen Cabinet of Silicon Valley, California, De-Bug of Silicon Valley, Gardner Health Services, Project Safety Net, Stanford Psychiatry Center for Youth Mental Health and Wellbeing, and the County BHSD: Criminal Justice Services and the</p> <p>Further details on these community input sessions and notes that resulted are described in the Plan Document available on the BHSD website: <a href="https://www.sccgov.org/sites/bhd/AboutUs/MHSA/Pages/default.aspx">https://www.sccgov.org/sites/bhd/AboutUs/MHSA/Pages/default.aspx</a>, please refer to the "Community Planning Process," section of the plan, which starts on page 26.</p> <p>As for the 3-digit number, the intent is to use the same 3-digit number countywide, the community based organizations selected, through a County procurement process, will need to develop a public communication plan to publicize the new CMR Countywide and emphasize the availability of this new program to the prioritized service areas: San Jose and Gilroy. Also, as BHSD learned from the planning input session held with transitional-aged youth, ages 18-25, social media will be leveraged to promote this new program as recommended by the TAY participants.</p>
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					<p>During the CMR planning process, stakeholders indicated the need for peers to be part of the program. The CMR onsite field team includes three team members: EMT, crisis intervention worker, and peer support specialist. The peer support specialist is intended to be the peer support worker.</p> <p>In regards to family involvement, stakeholders commented, which is reflected in the Draft Plan, that the client’s preference is first and foremost, and they decide who they want to involve in the process when calling the CMR. Additionally, a person can choose to involve relatives or individuals who are not their “blood or legal relatives.”</p> <p>Your recommendations for outreach and community education are appreciated. The current budget allows for operating expenses, which includes an allowance for incentives to increase program awareness. More details on community collaboration and outreach can be found on pages 17-19 of the Draft Plan, detailing the amount of community involvement in the development of the program and a plan for outreach.</p> <p>The CMR Program was developed to encourage individuals with a history of negative experiences with law enforcement to seek help when needed. The program realizes that omitting law enforcement altogether may not be an attainable goal, as some situations may be dangerous for CMR field staff, requiring law enforcement intervention. During the December 2020 – January 2021 period, stakeholders also commented that if police officers need to be involved, they would prefer and recommend the dispatch of police officers trained on Crisis Intervention Training (CIT). To better mitigate law enforcement involvement, the workflow reflected on page 17 of the Draft Plan depicts the CMR onsite field team, through their assessment, will be able to determine if there is a need to dispatch law enforcement through the County’s current MCRT/PERT program, these two programs work with law enforcement officers who are CIT trained. The workflow allows a thorough assessment and not prematurely dispatch law enforcement if it is not warranted.</p>
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					<p>Evaluation is a major component in all MHSA innovation programs. As noted on page 24 of the draft plan, BHSD plans to contract with an independent evaluator to conduct a comprehensive process and outcome evaluation of the project. This evaluation will include assessing the impact of the new program as it relates to access to behavioral health services as it relates to the County’s current MCRT and PERT mobile programs as well to determine if the new CMR program results in increasing access to behavioral health services for the underserved. As reflected on page 26 of the Draft Plan, the independent contractor will evaluate “to determine if the new CMR program results in a decrease in the number of calls and utilization rate of other emergency services, the program will gather baseline data for the following: rate of MCRT usage, ED/EPs admits due to behavioral health related issues, and 911 behavioral health related calls.”</p>
14.	<p>Section 2 - Primary Problem-would like to expand to crisis connected to substance abuse and being unhoused.</p> <p>Page 6 - Training of 911 operators and dispatchers to this network is needed, particularly when an unrelated member of the public makes an emergency services call.</p> <p>Page 6, item C. Utilization of new emergency # must be widely publicized. See yellow cards used for Rapid Response Network.</p> <p>Page 18-Like specification of multiple threshold languages</p>	<p><i>Via SurveyMonkey link provided on 2/12 survey link</i></p> <p>Received: Saturday, March 13, 2021</p>	Harriet Wolf	<p><b>What group do you represent:</b> Community Member Faith Community Disabilities advocate</p> <p><b>What is your primary system transformation interest:</b> Integrated Service Experience (CCR § 3200.190)</p> <p><b>Stakeholder Affiliation:</b> PACT, Congregation Shir Hadash</p>	<p>Thank you for your feedback and program recommendations. BHSD plans to work collaboratively with community organizations and other county departments to ensure that all clients with a mental health condition and a co-occurring like substance use issue are served. Please see Draft plan pages 17-19, Section Titled: Community Collaborators program component of the CMR program for more information on the collaboration plan.</p> <p>Please note, due to the funding source of the new CMR program with MHSA Innovation (INN) funding, any new INN program must:</p> <p>Per the California Code of Regulations Section 3910. <b>Innovative Project General Requirements.</b> Section (d) <b>Focus on Mental Health and Mental Illness</b></p> <p>As part of the new CMR program, Community Collaborators will establish a community advisory board, see page 25 of the Draft Plan, which will include EMS and other County Programs to help evaluate and inform the development and progression of the program. Community Collaborators and the selected community based provider to provide Call Center services will work collaboratively with the</p>



					<p>County’s current 911 dispatchers and ensure they are aware of the new CMR program and, as needed, link 911 callers with a mental health crisis to the CMR program.</p> <p>Page 19 of the Draft Plan, the section titled “Community Outreach Events,” details the outreach and communication efforts that will be implemented to raise program awareness and ensure that the new 3-digit number is widely publicized for use.</p>
15.	<p>This social problem analysis was prepared for an undergraduate social work policy course at SJSU.</p> <p>The paper focuses on why the current model of co-response mobile crisis intervention services provided in Santa Clara County are not the best approach to providing crisis intervention services to historically marginalized communities; and presents an argument for why the proposed CMR program is a better designed service.</p> <p>Please see the attachment titled: “CMR Proposal Public Comment” for more information on this analysis.</p>	<p><i>Via SurveyMonkey link provided on 2/12 survey link</i></p> <p>Received: Saturday, March 13, 2021</p>	Tarab Ansari	<p><b>What group do you represent:</b> Consumer of Mental Health Services; Community Member</p> <p><b>What is your primary system transformation interest:</b> Consumer and Family Driven Mental Health Services (CCR § 3200.50, § 3200.120) Integrated Service Experience (CCR § 3200.190)</p> <p><b>Stakeholder Affiliation:</b> SJSU BASW Undergraduate Student</p>	<p>Thank you for your input. BHSD values this analysis of the current MCRT program and your support for the new CMR program.</p>

*\*Note: This document includes comments provided via SurveyMonkey links and email as of March 14, 2021. This section will be updated to incorporate additional comments received through the local review process, including public comments received at the public hearing with the Behavioral Health Board.*



## **MHSA INN-15 CMR Program Proposal Comments**

We are a group of Santa Clara County-based lawyers and Santa Clara University law students and professors who are engaged in an intensive study of Santa Clara County's current legal and policy responses to homelessness. We write to applaud the Behavioral Health Services Department's Community Mobile Response proposal, which correctly recognizes the many ways in which police presence undermines and even jeopardizes the ability to effectively respond to mental health crises in some of our community's most vulnerable members. We offer comments in three specific areas: the lack of training of 911 dispatchers; the missed opportunity to openly evaluate the current Mobile Crisis Response Team; and, the missed opportunity to capitalize on the cost-savings a non-law enforcement approach to crisis response can bring the County.

### **The New 3-Digit Number**

To the extent that the proposal's goal is to ensure that behavioral health crises are met not by police, but rather by trained mental health responders, it is deeply flawed in one central aspect: rather than focusing on retraining 911 dispatchers, it proposes the development of a new 3-digit number. More troubling to us is the fact that the proposal contains no detailed plans for the deployment of this new system among key stakeholders. Instead, the proposal focuses on the ways in which responders will handle incoming calls.

When one stops to consider the structural challenges to deploying a new 3-digit mobile crisis number, it quickly becomes clear that, even with a public relations plan, the reality is that many will continue to call 911 in response to crises. It would take a massive public education campaign to alert the entire community to the new system, and even with billboards, radio ads, internet ads, etc., in a crisis, there is no doubt that many will continue to dial 911. This means that police will continue to be called upon to respond to crises that they are ill-equipped to handle. For all of the reasons the Community Mobile Response proposal so carefully documents, this outcome should be unacceptable.

The CAHOOTS program from Eugene, Oregon, upon which the Community Mobile Response proposal is based, differs in one critical respect: it relies on retraining 911 dispatchers. CAHOOTS calls are answered and dispatched via 911 or the non-emergency line. All calls made to the Eugene Police Department's service channel are filtered through the Central Lane Communications Center. At this Center, trained "Call-takers" answer the calls and quickly assess which resource would best serve the issue at hand. They then dispatch either the police department, fire department, Emergency Services, or CAHOOTS. Call-takers are trained to consider public and responder safety, presence of weapons, and the needs of citizens when dispatching one of the resources. Just as call-takers are traditionally trained to determine whether the police or fire department is needed (or both), Oregon's call-takers are trained to recognize when CAHOOTS would best fit a situation.

This model, training dispatchers rather than developing a parallel system, taps into existing resources and harnesses the expertise of dispatchers who are trained to respond calmly in crisis. By contrast, in order to successfully avoid police involvement in mental health crises, the current proposal rests on the hope that untrained members of the public will accurately identify the right response in the face of a crisis. More

daunting, it requires those same members of the public, in the face of a crisis, to recall a new 3-digit number. Even with a massive publicity campaign (which the current proposal omits), it seems implausible to expect widespread compliance.

Notably, other cities adopting the CAHOOTS model similarly trained their 911 staff rather than adopting a new number. For example, Denver implemented the Star program where crisis calls sort through the 911 call center. Dispatchers look for matters that are not a threat to public safety, and seem connected to unmet mental or physical needs. Like CAHOOTS, these dispatchers are trained in questioning and recognizing whether Star is a correct fit for the situation at hand. Similarly, in Phoenix, Arizona, 911 call-takers and dispatchers are trained to refer crisis-related calls to a crisis specialist who then either makes referrals via phone or deploys the mobile crisis team.

Choosing not to train 911 dispatchers leads to inefficiencies and all but guarantees continued law enforcement presence in behavioral health crisis situations. This is evidenced by the program implemented in Olympia, Washington. Olympia aims to follow the CAHOOTS model, but instead of training 911 dispatchers, behavioral health specialists monitor police radio to identify situations that may require their assistance. The result of this system is that law enforcement is always present with the behavioral health staff - the precise scenario the County aims to avoid.

In order to remove law enforcement from behavioral health crises calls, we must address the issue at the source of law enforcement involvement: the 911 call. On this basis, we recommend the County adopt the true CAHOOTS model and, rather than implement a new three-digit number, train 911 dispatchers to assess calls for crisis response.

### Assessing the Current Mobile Crisis System

In addition to overlooking the importance of training 911 dispatchers to the success of the CAHOOTS model, the County's proposal does not examine the ways in which the current Mobile Crisis Response Team (MCRT) falls short. If the County is to implement an improved and expanded Mobile Crisis program, it should take this opportunity to look at the system currently in place and identify areas for improvement. Although the proposed pilot tacitly remedies some of the obvious pitfalls of the current MCRT by uncoupling from law enforcement and operating 24 hours a day, it fails to directly acknowledge the shortcomings in the current Mobile Crisis program. Instead, it proposes a parallel program, which will leave us with two versions of Mobile Crisis operating in the County, one tied to law enforcement and the other staffed solely by mental health professionals and volunteers.

The irrationality of this approach is self-evident, but more alarming still is the existing plan to expand the current program--which is directly tied to law enforcement. While remedying flaws in the current MCRT may be outside the scope of the MHSA INN-15 grant, if the County is to truly commit to the protection of its citizens in crisis, it must account for the successes and failures of its existing programs designed to serve them. Therefore, we encourage the County to include in this pilot program an evaluation of the current MCRT program and incorporate lessons learned from its operation.

### Emphasizing Cost Savings

Last, the County's proposal does not include an explanation of the cost-savings a CAHOOTS-style program will likely achieve. For maximum public support of this new program, the County should

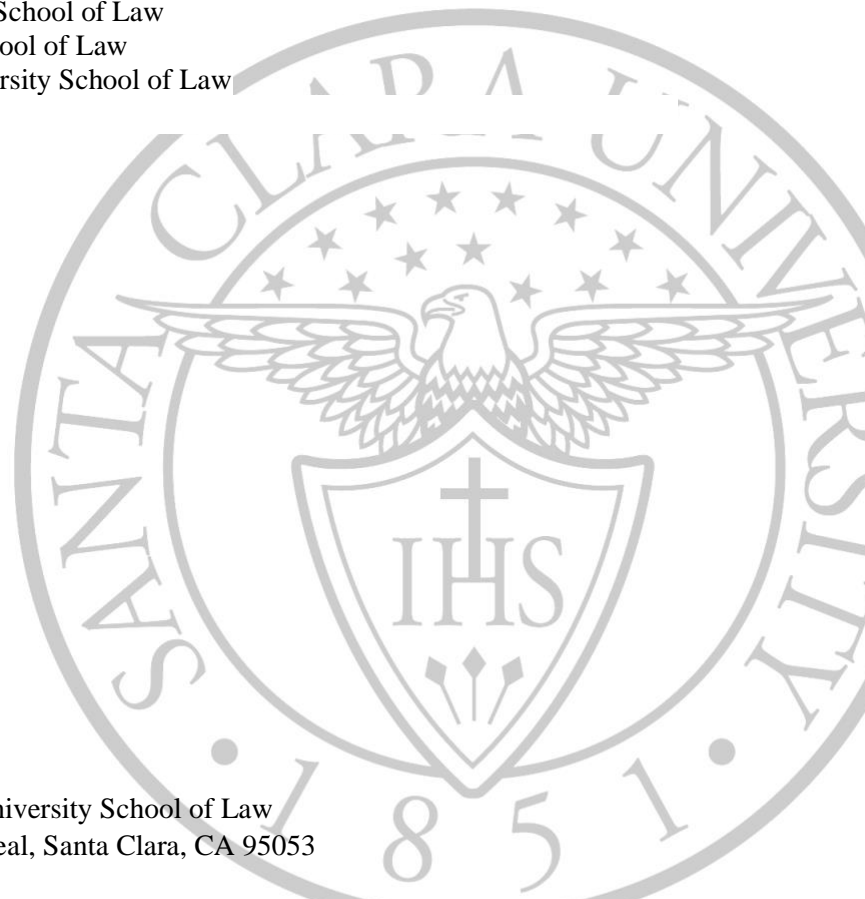
highlight the significant budgetary benefits of adopting a mobile crisis approach independent of law enforcement. In 2017, for example, the CAHOOTS team responded to 17% of the total Eugene Police Department call volume and saved the city an estimated \$8.5 million in law enforcement funds annually. Our county is a good deal larger than Eugene Oregon, and as such, the importance of the potential cost-savings for Santa Clara County ought not be understated, particularly in the current budget crisis. In light of these anticipated savings, the County and individual police departments within it could actively plan for alternative uses of the funds, including more robust mental health support services. We urge the County to add a cost-savings analysis in its proposal and project plan.

### Conclusion

Our top concern aligns with the County's: it is imperative that we remove police presence from behavioral health crisis calls. To effectively and efficiently do so, we must adopt a version of the CAHOOTS model that centers on training 911 dispatchers to assess crisis calls. Without contending with the failures of the present mobile crisis response system, which has left law enforcement in control, what we have here is a \$25 million plan that ultimately will keep police in the role of first responders to behavioral health crises. We thank the County for its efforts to provide appropriate and effective services to our County's vulnerable residents and for the opportunity to provide feedback on this proposal of such great potential.

Respectfully submitted,

Michelle Oberman, Professor, Santa Clara University School of Law  
Marlene Bennett, Affiliate, Santa Clara University School of Law  
Molly Brennan, Attorney at Law  
Christina Iriart, Student, Santa Clara University School of Law  
Adena Ishii, Student, Santa Clara University School of Law  
Cydney Chilimidos, Students, Santa Clara University School of Law



## **Organizational Signatories**

AACI  
African American Community Service Agency  
Asian American Recovery Services, a program of HealthRIGHT 360  
Asian Law Alliance  
Bay Area Community Health Behavioral Health Contractors' Association (BHCA)  
Bill Wilson Center  
Carry the Vision  
Catholic Charities of Santa Clara County  
City Year  
Community Health Partnership  
Community Solutions  
Gardner Health Services  
Jewish Silicon Valley  
LifeSTEPS  
MACLA/Movimiento de Arte y Cultura Latino Americana  
Mekong Community Center  
Momentum for Health  
NAMI Santa Clara County  
National Compadres Network  
Next Door Solutions to Domestic Violence  
Our City Forest  
Parisi House on the Hill  
PATH  
Peninsula Family Service  
Peninsula Healthcare Connection  
Project HIRED  
Project MORE  
Project Safety Net, Inc.  
Project Sentinel  
Recovery Café  
Sacred Heart Community Service  
San Jose Conservation Corps & Charter School  
Seneca Center  
Silicon Valley Council of Nonprofits  
Silicon Valley De-Bug  
Somos Mayfair  
St. Joseph's Family Center  
Ujima Adult and Family Services  
Uplift Family Services  
Veggielution  
Working Partnerships USA  
Youth Community Service

March 12, 2021

Evelyn Castillo Tirumalai, MPH  
Senior Mental Health Program Manager  
Mental Health Services Act (MHSA) Administration

To Ms. Tirumalai:

As community leaders in Santa Clara County we write to express our support for MHSA INN 15: Community Mobile Response Program. It takes an important step of putting the County's commitment to race equity into action.

A community mobile response without law enforcement involvement will be a welcome option to those who are historically under or inappropriately served for whom interacting with law enforcement can be a frightening, escalating or even deadly experience.

### **Program Design**

We strongly support these aspects of the proposed innovation project:

- A phone number to call separate from Police and Government
- Response by EMT, Crisis Intervention Worker and Outreach Specialist with lived experience.
- Ability for concerned family or friend to stay with the person in crisis (with client permission) if transport is necessary.
- Use of a Community Collaborator to engage community residents for both sharing of information about resources, training, etc. and on-going input into program design.

### **Priority Areas**

We agree with the priority area of Eastside San Jose and Gilroy and urge that the reference to specific zip codes be updated to zip code 95122 and surrounding areas.

### **Funding**

We commend the County for making a substantial commitment to standing up this innovative program with priority areas of East San Jose and Gilroy. We ask that the County review the current cost for hiring and retaining similar types of staff in refining the budget. The extreme delays in other mobile crisis services stemmed from difficulty in recruiting staff. We believe that the innovative design will help address that issue but a realistic budget is imperative as the staff will be taking on very challenging work.



## Timing

We urge you to commence the County-wide design contest upon receiving MHSOAC approval. This can be done concurrently with initiating the RFP and identifying the design and evaluation contractors. Doing so would allow for retrofitting of the two vans so they are ready to go in January 2022.

We are excited for the Community Mobile Crisis Model and pledge to assist in educating those in touch with our organization about this wonderful new resource.

Sincerely,

AACI

African American Community Service Agency

Asian American Recovery Services, a program of HealthRIGHT 360

Asian Law Alliance

Bay Area Community Health

Behavioral Health Contractors' Association (BHCA)

Bill Wilson Center

Carry the Vision

Catholic Charities of Santa Clara County

City Year

Community Health Partnership

community solutions

Gardner Family Health Network

Gardner Health Services

Jewish Silicon Valley

LifeSTEPS

MACLA/Movimiento de Arte y Cultura Latino Americana

Mekong Community Center

Momentum for Health

NAMI Santa Clara County

National Compadres Network

Next Door Solutions to Domestic Violence

Our City Forest

Parisi House on the Hill

PATH

Peninsula Family Service

Peninsula Healthcare Connection

Project HIRED

Project MORE

Project Safety Net, Inc.

Project Sentinel

Recovery Café

Sacred Heart Community Service

San Jose Conservation Corps & Charter School

Seneca Center

Silicon Valley Council of Nonprofits

Silicon Valley De-Bug

Somos Mayfair

St. Joseph's Family Center

Ujima Adult and Family Services

Uplift Family Services

Veggielution

Working Partnerships USA

Youth Community Service



CITY OF  
**PALO  
ALTO**

OFFICE OF THE CITY MANAGER

250 Hamilton Avenue, 7th Floor  
Palo Alto, CA 94301  
650.329.2392

March 12, 2021

Santa Clara County Behavioral Health Department  
Sherri Terao, Ed.D., IFECMH Specialist, RPFM  
828 S. Bascom Avenue  
San Jose, CA 95128

**RE: City of Palo Alto Comment Letter on the Innovation Project 15 (Community Mobile Response Program)**

Dear Director Terao and Team,

On behalf of the City of Palo Alto, I am writing to provide our official feedback on the Santa Clara County Community Mobile Response (CMR) Program funded by the Innovation Fund. Since first hearing about the program in 2020, Palo Alto has been very eager to see the program continue to take shape. The City of Palo Alto supports the creation of the CMR program, wishes to express our interest in participating in the CMR program, and requests consideration of a program site in the Northern part of Santa Clara County where there is a concentration of cities that could benefit from this unique program. Recognizing the limitations currently in place regarding funding, the City of Palo Alto requests that a placeholder be included in the program design documentation for expansion of the program into an area further north in the County should funding become available.

The CMR program provides an alternative response to mental health crisis situations rather than the current law enforcement response. The program is loosely based on the Eugene, Oregon CAHOOTS program and is intended to honor and value lived experience as critical experience needed to provide authenticity to this work in addition to the licensed professionals. Through Palo Alto's focused work on Race and Equity, our community has expressed an interest in this type of model to provide a more appropriate response to the mental health calls for service we often receive. We have been working with your County of Santa Clara staff to get a PERT resource clinician in Palo Alto for many years, but we have not yet been assigned a clinician. While we continue to seek a PERT resource, working towards a more northern site for the CMR program would be advantageous not only for Palo Alto and other nearby communities. Once PERT begins in Palo Alto, it would be very useful to see how it is used in relation to, and partnership with, a program like CMR.



[CityOfPaloAlto.org](http://CityOfPaloAlto.org)

Palo Alto, or a more northern location, is a logical CMR program site because of the volume of people who could be served, the need shown through calls for service, and because the northern part of the County has a slower response time through the existing Mobile Crisis Response Teams (MCRT) program due to distance. A northern county CMR site could provide service to many communities including Palo Alto, Mountain View, Los Altos, Sunnyvale and others. Although there is not a concentrated 'hot spot' of need within our collective communities, many people would benefit from the CMR services in the north County cities.

Palo Alto's calls for service include more than 1,300 welfare checks each year. At the moment, sworn and armed police officers are the only resource that the City can deploy for these welfare checks. Such calls are prime examples of the types of calls that the CMR program would be able to address in a way which addresses all the needs of an individual instead of having a law enforcement response.

Additionally, a northern CMR site would be beneficial because the aforementioned communities have a longer response time for the existing MCRT program. Since the MCRT program is based in San Jose, there is sometimes up to an hour delay from the time of the call before the resource teams arrive. Our community is accustomed to a more responsive customer service experience and often opts to just call 9-1-1 for assistance instead of calling the MCRT program simply because they are aware that law enforcement will arrive sooner. This significantly undercuts the effectiveness of MCRT in north county jurisdictions.

The City of Palo Alto would also like to express feedback regarding the metrics used to determine the preliminary siting for the two locations resourced through innovation funding. County staff shared that the two sites were chosen based on data, need, and stakeholder engagement. We would like to request for planning purposes, incorporation of additional data beyond the MCRT call data and the U.S. CDC social vulnerability index.

As discussed above, the MCRT call data cannot show that communities further away may not be calling because of the expected response time delays and thus, the data does not present a clear picture of needs for the CMR program. The City of Palo Alto would appreciate including the percentage of mental health-related law enforcement calls for service as a metric for determining siting of the CMR program.

In summary, the City of Palo Alto requests the following:

- A placeholder in the program design for a CMR site in Palo Alto or, failing that, in the Northern part of Santa Clara County.
- Participation by the City of Palo Alto on the planned Community Advisory Board or other advisory group; we feel it is imperative that the group intentionally geographically represents the entire County.
- Inclusion of the relationship between the CMR and the existing PERT and MCRT programs in the evaluation of the new CMR program; if a site had all three programs serving the population it would be very useful to understanding the collective, and individual, program impacts.

- County Advocacy, with the City of Palo Alto and other interested jurisdictions, to the State Assembly for the passage of bills like Assembly Bill 118 which proposes funding for mental health support programs through nonprofits.
- Creation of a distribution list where interested community members and city staff can easily get notified as interested parties about upcoming hearing dates, Stakeholder Leadership Council meetings, program progress, and other relevant information. This will enhance the ability of the community to stay involved and engaged as we seek to expand the program.
- Lastly, continued partnership with us as a city as we continue exploring these alternative models to law enforcement response that can be tailored to specific calls for service to ensure the best possible outcomes.

We look forward to seeing this program implemented in the County and to further discussions. Please do not hesitate to contact us in the process. My staff to connect with are Chantal Cotton Gaines, Deputy City Manager, at [Chantal.gaines@cityofpaloalto.org](mailto:Chantal.gaines@cityofpaloalto.org), and Zach Perron, Police Captain, at [Zachary.perron@cityofpaloalto.org](mailto:Zachary.perron@cityofpaloalto.org).

Sincerely,

DocuSigned by:

*Ed Shikada*

Ed Shikada

City Manager

Cc:

Palo Alto City Council

Santa Clara County Supervisor Joe Simitian District 5

# Behavioral Health Contractors' Association

of Santa Clara County  
1530 The Alameda, Suite 301  
San Jose, CA 95126  
Phone: (408) 579-6033 ▪ [elisak@bhcascc.org](mailto:elisak@bhcascc.org)



March 3, 2021

Evelyn Castillo Tirumalai, MPH  
Senior Mental Health Program Manager  
Mental Health Services Act (MHSA) Administration

To Ms. Tirumalai:

We are grateful to have had the opportunity to collaborate with the Behavioral Health Services Department as our proposal for a Community Mobile Response Program went from concept paper through stakeholder input to draft proposal. Upon review of the draft, we provide the following comment.

## Program Design

We join other community organizations in our strong community support for these aspects of the proposed innovation project and commend the Department for including these critical elements.

1. A phone number to call separate from Police and Government.
2. Response by EMT, Crisis Intervention Worker and Outreach Specialist with lived experience.
3. Ability for concerned family or friend to stay with person in crisis (with client permission) if transport is necessary.
4. Use of a Community Collaborator to engage community residents for both sharing of information about resources, training, etc. and on-going input into program design.

## Priority Areas

After consulting with community leaders and service providers, we recommend the San Jose priority areas center on zip code 95122 and the contiguous surrounding areas some of which are in 95112 and some in 95116.

## Member Agencies

AACI  
Abode Services  
Advent Group Ministries  
Alum Rock Counseling Center  
Bill Wilson Center  
Caminar  
Catholic Charities  
Children's Health Council  
Community Solutions  
Fred Finch Youth Center  
Gardner Family Care Corporation  
HealthRight 360  
HealthTrust  
Home First  
Hope Services  
Horizon Services  
Indian Health Center  
Kidango  
LifeMoves  
Mekong Community Center  
Mental Health Advocacy Project  
Mental Health Systems  
Momentum for Mental Health  
National Alliance on Mental Illness  
Parisi House on the Hill  
PATH  
Pathway Society  
Peninsula Healthcare Connection  
Rebekah Children's Services  
Seneca Kinship Center  
Ujima Adult & Family Services  
Uplift Family Services

## **Budget**

We are concerned that the annual salary and operating budgets are too low to result in a successful program. For example, on page 37 #2, it shows \$982,500 for 14.5 FTEs. If you simply divide it equally (which it would not be) this would be \$67,758.62/FTE. Generally, benefits run 25-30% of wages, leaving the employee salaries at \$47,431, which is below market rates for the call center staff in this area, and also leaves no room to shift some funds to a manager position and impossible for a licensed/licensed waived clinician. We ask that the County review the current cost for hiring and retaining similar types of staff and adjust the budget accordingly and recommend a minimum base pay of \$65,000 plus benefits for these positions, and a minimum base pay of \$125,000 plus benefits for a licensed manager.

The operating budget does not adequately take into account the cost of the technology both hardware and software that will be required for the call center and both the San Jose and Gilroy teams or the cost of insurance, maintenance of and fuel costs for the vans. We recommend raising the operating expenses from 15% to 25%.

A realistic budget is the cornerstone of all successful programs. We ask the County to identify a way to support a realistic budget such as increasing funding, decreasing the length of the pilot for the existing budget or adding other sources of funding.

## **Timing**

We urge you to commence the County-wide design contest upon receiving MHSOAC approval. This can be done concurrently with initiating the RFP and identifying the design and evaluation contractors. Doing so would allow for retrofitting of the two vans so they are ready to go in January 2022.

Thank you for your consideration of this feedback.

Sincerely,



Elisa Koff-Ginsborg  
Executive Director

March 12, 2021

Evelyn Castillo Tirumalai, MPH  
Senior Mental Health Program Manager  
Mental Health Services Act (MHSA) Administration

To Ms. Tirumalai:

Thank you to the Behavioral Health Services Department for leading the Community Mobile Response Program proposal process. The INN 15 proposal is very well put together, including the critical areas of: including a unique phone number run by trusted community organization; committing to non law-enforcement response; including a medical (EMT) and mental health blended response; including community collaborators; and remaining focused on a smaller geographic areas which will help this service truly become part of the identified community (and not stretched across the full County).

There is an area of program design and budget that we do have concerns and recommendations on. The salaries budgeted are below salary market rates, and Operating Expenses are lower than standard:

- Call Center. When breaking down the 14.5 FTEs, numbers reflect a \$67,758 average (or \$47,431 plus 30% benefits), which is approximately 70% of an average position salary. This average salary amount also does not take into account the higher licensed manager rate.
- Field Teams. When breaking down the 16 FTEs, numbers reflect a \$82,906 average (or \$58,034 plus 30% benefits), which is approximately 70% of an average position salary. This average salary amount also does not take into account the higher licensed manager rate.
- Operating Expense. Operating Expenses for programs like this are closer to 25%, versus the 15% allocated in the budget. This is due to insurance, hardware/software, call center maintenance, car maintenance, transportation/gas cost, client funding, etc.

We believe the INN project can maintain the current funded amounts by considering one of the following recommendations:

- Shift from a three staff response model to a two staff response model. There are very few models that have three responders, with two responders typically meeting safety and de-escalation needs. By creating teams with an EMT and a crisis intervention worker that also has lived experience, this can meet the response needs. Fiscally, this provides room for salaries and operating expense to be right sized.
- Another approach would be to maintain the total INN amount, but reduce the INN proposal from a 5 year to a 4 year project, increasing the salaries and operating expenses within the 4 years.
- Another approach would be to maintain the current structures and timeline, and increase the INN amounts to reflect market rate salaries and operating expense.

As a current crisis services provider, we know the importance of this INN proposal, and believe this will further support meeting the communities needs in earlier phases of crisis and pre-crisis, as well as reduce community law-enforcement responses. Thank you for your consideration of this feedback.

Sincerely,

Don Taylor  
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**Advancing Justice**  
Housing | Health | Children & Youth

March 12, 2021

Evelyn Castillo Tirumalai, MPH  
Senior Mental Health Program Manager  
County of Santa Clara  
Behavioral Health Services Department  
Mental Health Services Act (MHSA) Administration

**RE: Law Foundation of Silicon Valley Comments on Mental Health Services Act (MHSA) Innovation (INN) Project-15: Community Mobile Response.**

Dear Ms. Tirumalai:

The Law Foundation of Silicon Valley provides the comments below in response to the MHSA INN Project-15: Community Mobile Response. The Law Foundation supports a new and innovative Crisis Mobile Response (CMR), but encourage the Behavioral Health Department and Board of Supervisors to be thorough and thoughtful in creating a pilot that puts our communities experiencing mental health crises first, particularly paying close attention to the impacts of police response to our Black, Brown, and other communities of color.

**I. Introduction**

The Law Foundation of Silicon Valley, a nonprofit, nonpartisan legal services and social justice organization, was founded over 40 years ago and is based in Santa Clara County dedicated to advancing the rights of historically excluded and marginalized individuals and families across Santa Clara County and beyond through legal services, strategic advocacy, and educational outreach. The Law Foundation's Health program has an abiding interest in ensuring fair and due process and the promotion of the guaranteed rights of residents of Santa Clara County and California. Since its inception, the Health program has represented individuals in inpatient psychiatric facilities at due process and capacity hearings to protect their civil rights. Additionally, the Law Foundation has long fought to provides holistic legal services to people with mental health disabilities, including eviction defense and public benefits appeals. We serve communities who are historically excluded from health systems including Black, Indigenous, Latinx, Asian American and Pacific Islander, other people of color, LGBTQIA individuals and people experiencing homelessness. Our legal and policy advocacy is focused on supporting and advancing health equity for all.

We provide the following comments and suggestions to the Community Mobile Response proposal addressing community input, community collaboration, outreach, family involvement, best practices, and law enforcement involvement.



## II. Community Input

For the CMR program to work, it's imperative that it have community buy in. Based on the written plan, multiple focus groups were held with a variety of stakeholders. What is unclear is how many people were involved in each of these focus groups and the breakdown of their racial, ethnic, gender identity, sexual orientation, national origin, and disability demographics.<sup>1</sup> It is unclear how many people with lived experience with mental health symptoms participated in the process.<sup>2</sup> For many people with childcare responsibilities, inflexible work hours, or disabilities that impact participation, they may not be able to participate in focus groups. Additionally, trust and public education are normally foundational components regarding increased participation for surveys of this manner and outlining how that was built clarifies context. Even within a focus group setting, some individuals may feel less comfortable speaking up. Were there any efforts made to solicit community input in other ways, such as asking health care providers or schools to send anonymous surveys?

To increase community input to assess the efficacy of the program using satisfaction surveys and a community advisory board we recommend using incentives to increase response rates and participation.<sup>3</sup> Absent meaningful incentives, it is unlikely these satisfaction surveys will yield much meaningful feedback. The current makeup of the CMR Workgroup Committee is predominantly people who work or volunteer in the mental health field.<sup>4</sup> To get more input from mental health consumers who are not as connected to the current system of care, the County may wish to consider some sort of incentive for community members to participate in quarterly meetings. Such incentives may help increase representation from historically excluded groups to ensure that their perspectives are being heard. Additionally, working directly with and taking direction from Black, Indigenous, Latinx, and other people of color community organizers who are skilled with building trust and power within communities is likely a helpful addition to considering next steps.

## III. Community Education and Outreach

We support the CMR Program's plan of using Community Collaborators throughout the program process. Diverse community collaborators with lived experiences are critical for sharing program resources, facilitating training, and attending community events.

We have several recommendations regarding the Program's Outreach/Community Education Plans: (1) conduct outreach with diverse community groups and disseminate educational materials throughout the community, (2) partner with neighboring counties and cities to ensure

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<sup>1</sup> While some of the breakdowns suggest that at least one person from a certain community was consulted ie "Chinese Community," we are concerned that these groupings are too broad and are not nuanced enough to fully grasp what is happening within different communities. It also is important to explore these issues further to confirm that the research did not assume each community is monolithic and can be represented by a few voices.

<sup>2</sup> CMR Report Page 18.

<sup>3</sup> See CMR Page 25; see also "Research suggests three main reasons [people participate in surveys]: altruism (e.g., the survey furthers some purpose important to the respondent, or the respondent is fulfilling a social obligation); survey-related reasons (e.g., respondents are interested in the survey topic, or find the interviewer appealing); and egoistic reasons (e.g., I like it; the money). . . .The role of incentives in motivating survey participation has been widely documented. . . money is more effective than non-cash incentives. . . . Incentives are also more effective in surveys where the response rate without an incentive is low." (See Singer, Eleanor and Mick P. Couper, *Do Incentives Exert Undue Influence on Survey Participation? Experimental Evidence*, J Empir Res Hum Res Ethics. 2008 Sep; 3(3): 49–56, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2600442/>).

<sup>4</sup> CMR pp 29-30.

consistent messaging, (3) develop a social media strategy to target youth, and (4) translate all educational materials into the most common languages spoken in the areas where the program will be piloted.

First, the CMR program should conduct outreach and distribute educational materials with diverse groups throughout the county. Groups from different races, ethnicities, cultures, socioeconomic, sexual orientations and religious backgrounds must be included. While the CMR Program plans for two pilot sites in San Jose and Gilroy, the Program should consider broadening outreach as many individuals live and work in different areas of the County.<sup>5</sup> The CMR Program should also distribute educational materials and host events at local homeless shelters, homeless encampments, colleges, board and care facilities, food banks, legal aid organizations, and other social services agencies. We recommend that community outreach publicize the new 3-digit crisis mental health phone number on billboards, bus stops, radio and television ads. Community outreach needs to be welcoming to individuals who may not traditionally seek mental health services. Again, we also recommend enlisting help of community organizers within different communities to help with this strategy.

Second, the program should partner with crisis mental health services in neighboring counties such as San Mateo and San Francisco to share strategies and resources on community outreach. Currently, several city police departments (e.g. San Jose<sup>6</sup> and Palo Alto<sup>7</sup>) are also considering pilot crisis mental health response programs. The CMR Program must ensure that community members are not confused about the different crisis response programs throughout the Bay Area. Using a consistent 3-digit number for mobile crisis throughout the region (e.g. 998) could help build community awareness. Even with a clear communication and public relations plan, the reality is, the community knows and will inevitably call 911 out of instinct and familiarity with the number. For that reason, it is imperative that our county's 911 operators are also properly trained to re-route these calls to the new crisis mental health number or can dispatch the CMR Team.

Third, the CMR Program must also develop a social media strategy and use a variety of platforms including Facebook, Twitter, TikTok, and Instagram to spread awareness about the program. Youth are less likely than adults to seek mental health treatment despite high levels of mental health diagnoses.<sup>8</sup> Ninety-seven percent of teens use a social media program.<sup>9</sup> Using social media can help reduce stigma and educate youth about the services offered in the CMR program.

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<sup>5</sup> It is our understanding that these areas were chosen as the pilot. We still have some concerns regarding whether a broader survey would demonstrate a difference in where the pilot should happen. Creating a program in an area that is likely already overly policed without integrating it into a broader policing strategy is likely something that community members would want to discuss.

<sup>6</sup> SJPd Begins Reimagining Mental Health Crisis Response, San Jose Police Dept., Oct. 15, 2020  
<https://www.sjpd.org/Home/Components/News/News/125/262>.

<sup>7</sup> Sue Dreman, Palo Alto police to pilot psychiatric-emergency team  
<https://www.paloaltoonline.com/news/2017/01/12/palo-alto-police-to-pilot-psychiatric-emergency-team>

<sup>8</sup> Adams, S. H., Knopf, D. K., & Park, M. J. (2014). Prevalence and treatment of mental health and substance use problems in the early emerging adult years in the United States: Findings from the 2010 National Survey on Drug Use and Health. *Emerging Adulthood*, 2(3), 163-172.

<sup>9</sup> Mayo Clinic Staff, Teens and social media use: What's the impact?, <https://www.mayoclinic.org/healthy-lifestyle/tween-and-teen-health/in-depth/teens-and-social-media-use/art-20474437>

Finally, the program should translate all educational materials into the most common languages in the area where the program will be piloted. Currently, the program plans to translate all outreach and education materials and logos into the County's five threshold languages (p.18): Spanish, Vietnamese, Chinese, Tagalog, and Farsi. It is possible that the language needs in Gilroy differ from those in East San Jose and may include other languages than those needed county-wide. The Program team should research the most common languages in the pilot regions. The Santa Clara County Board of Supervisors has adopted a policy that seeks to ensure that all residents have meaningful access to County services and programs regardless of their English language proficiency.<sup>10</sup>

#### **IV. Suggested Best Practices / Peer Involvement / Peer Support Workers**

Peers can understand mental illness from experience and relate to mental health consumers in ways not duplicated in other clinical relationships. The experience gap between someone who has, for instance, experienced hearing voices, versus those who have not, is enormous. Peers may have insights into what to say and how to communicate with someone in a mental health crisis that is not available to those who lack this critical experience. The proposal lists titles of the mobile team members but does not specifically state whether any of these team members will be Peers.<sup>11</sup> Peer Support Workers should be included in the mobile teams and every effort should be made to determine what mental health symptoms the client is experiencing and to match the client with a mobile Peer Support Worker who has experienced similar symptoms. Efforts should also be made to match clients with Peers who are similarly demographically: age, gender identity, and ethnicity.

Particularly in the case of untreated, serious mental illness, the consumer's symptomology frequently taxes their familiar relationships and friendships, leaving the consumers isolated when they most need support. Mental health consumers need long-term, personal, supportive relationships within the mental health system that model and foster recovery. In addition to Peers being included on mobile teams, CMR should ensure referrals to organizations offering Peer Support will do so on a long-term basis.<sup>12</sup>

There are two additional reasons why integrating Peers into the system to the greatest extent possible is critical. First, mental health consumers often have mixed feelings about the mental health system as many have had negative experiences with involuntary hospitalization, seclusion, restraints and involuntary medication. These experiences break trust between the consumer and the system and cause consumers to avoid treatment. Peer Support Workers have frequently experienced the involuntary aspects of the system as well and are able to uniquely validate the consumer's feelings while remaining pro-treatment. Finally, Peers should be integrated into this new model to the greatest extent possible because Peer Support is effective. Studies show Peer Support greatly reduces rates of hospitalization; reduces number of inpatient days; increases utilization of outpatient services; and, lowers overall costs of care.<sup>13</sup>

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<sup>10</sup> County of Santa Clara, Language Access Guidelines and Procedures, <https://www.sccgov.org/sites/oir/Documents/Language-Access-Guidelines-and-Procedures.pdf>

<sup>11</sup> CMR page 14.

<sup>12</sup> CMR page 17.

<sup>13</sup> Evidence for Peer Support, Mental Health America, (Feb. 2017), <https://www.mhanational.org/sites/default/files/Evidence%20for%20Peer%20Support%20January%202017.pdf>

## V. Family Involvement

We appreciate that the plan recognizes that in many cases family members can help to make people experiencing crises feel more comfortable and supported. At the same time we recognize that for some people their family members could be triggering. Even in cases where the family is not the source of the problem, people with mental health conditions should be given autonomy to make their own decisions about their treatment. We want to flag that the individual who is experiencing the crisis should be given the opportunity to decide whether they want family involvement in a private conversation outside of their family's earshot. Additionally, we would like to ensure that the individual in crisis can select support people to be involved who are not blood or legal relatives.<sup>14</sup>

## VI. Law Enforcement Involvement

The proposed plan suggests "limited involvement" from law enforcement, however we recommend removing law enforcement altogether.<sup>15</sup> The purported purpose of the CMR plan is to reimagine how to address the mental and physical safety of those who are frequently put in danger by insufficiently trained officers. Having improperly trained law enforcement officers as a built-in "back-up" at the responder's discretion will inevitably lead to situations that are dangerous and life threatening to our community. Since 2015, law enforcement officers have shot more than 1,400 people with mental illness.<sup>16</sup> Additionally, studies do not show that bias training leads to changed behavior within law enforcement agencies.<sup>17</sup> We are especially concerned that Black and Latinx individuals with mental illness will be disproportionately impacted and the due to the lack of cultural competency, any interaction will be escalated.<sup>18</sup>

Having a mental illness is not a crime. Experiencing suicidal ideation is not a crime. Having a substance use diagnosis is not a crime, yet, too often police officers are the first responders to mental health emergency calls – a response that criminalizes mental illness and increases fear, trauma, stigma, shame, and mistrust. A system that allows law enforcement officers to appear on the scene will likely do nothing other than increase the risk of an altercation and a tragic outcome. If the CMR plan is to work effectively, there can be no police involvement. Relatedly, are the currently budgeted amount and staff allocations adequate to offer full services twenty-four hours-a-day, seven days-a-week? If there is only one licensed program manager for the team who can write 5150s, will this lead to more police calls after standard business hours?<sup>19</sup>

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<sup>14</sup> For example, many LGBTQ individuals create chosen families whose support can be vital in addressing healthcare emergencies. (See *"We Just Take Care of Each Other": Navigating 'Chosen Family' in the Context of Health, Illness, and the Mutual Provision of Care amongst Queer and Transgender Young Adults*, Nina Jackson Levin, Shanna K. Kattari, Emily K. Piellusch, and Erica Watson, *Department International Journal of Environmental Research and Public Health* (Oct. 2020) <https://www.mdpi.com/1660-4601/17/19/7346>)

<sup>15</sup> CMR page 16.

<sup>16</sup> <https://www.washingtonpost.com/graphics/investigations/police-shootings-database/>

<sup>17</sup> "NYPD Study: Implicit Bias Training Changes Minds, Not Necessarily Behavior" NPR, Sept 10, 2020, available at <https://www.npr.org/2020/09/10/909380525/nypd-study-implicit-bias-training-changes-minds-not-necessarily-behavior>.

<sup>18</sup> Black, Disabled and at Risk: The Overlooked Problem of Police Violence Against Americans with Disabilities, TIME, June 25, 2020, available at <https://time.com/5857438/police-violence-black-disabled/>. The article outlines that it is important to understand disability framing specifically from Black and other people of color by stating "Disability is commonly understood through a white and wealth privileged lens," says Lewis, the lawyer with HEARD, who helps disabled people facing violence and incarceration across the country."

<sup>19</sup> CMR page 15.

Additionally, the plan proposes emergency medical technicians (EMTs) as part of the response team.<sup>20</sup> Often EMTs are trained to call police in crisis situations and do not have proper crisis training. Having responders who may be associated as a usual first responder often associated with the police, may lead to further escalation of the crisis and the client's mistrust of the CMR team.

Instead, as we've suggested, the use of purposeful, deliberate, patient, empathic interventions in a crisis is needed, and is a complex skill that takes years not hours of training and practice. None of which means the necessary inclusion of law enforcement. The proposal suggests that if law enforcement is needed, officers trained in Crisis Intervention Training (CIT) be dispatched.<sup>21</sup> A master's degree in social work, for example, requires at least 900 hours of supervised field experience in addition to two years of course work, whereas CIT training is considered complete in a matter of hours. No law enforcement officer responding to a mental health crisis will be better equipped to handle that situation than a trained mental health professional. Just this fall, on October 26, 2020 two Philadelphia police officers responded to a call of a man experiencing a mental health crisis. Instead of engaging in any form of crisis stabilization, or de-escalation, the officers fired multiple shots killing Walter Wallace, Jr.<sup>22</sup> The police responding to Mr. Wallace's family's call likely escalated the situation leading to Mr. Wallace's death. And this murderous history is deeply entrenched in policing Black communities as Eleanor Bumpers, a Black womxn with a history of mental illness, was shot and killed by NYPD officer Sullivan while attempting to assist the marshals in her eviction.<sup>23</sup>

Most upsetting among the general population is the incorrect perception that people with mental illness are so dangerous and out of control that only police are equipped for the job. This is far from accurate, according to the American Psychiatric Association, most people with mental illness are not violent, not criminal and not dangerous.<sup>24</sup> In fact, people with mental illness are more likely to be victims of crime, and "rhetoric that argues otherwise will further stigmatize and interfere with people accessing needed treatment."<sup>25</sup> If this program is to be truly innovative we need to take a radical step away from law enforcement and other public first responders including EMT/paramedics and fire departments.

## **VII. Additional Recommendations**

### **a. Critique and Analysis of the Current Mobile Crisis Response Team**

The CMR pilot proposal provided no critique of the current Mobile Crisis Response Team (MCRT) in Santa Clara County. How much has been spent on the current program? How successful was the program? As the County looks to spend twenty-five million dollars on this proposal an evaluation and assessment on what worked and didn't work, as well as the cost of prior attempts at Mobile crisis. Was there any cost savings associated with MCRT? Has there

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<sup>20</sup> CMR page 14.

<sup>21</sup> CMR page 16.

<sup>22</sup> <https://www.nytimes.com/article/walter-wallace-jr-philadelphia.html>

<sup>23</sup> A short history of Black women and police violence, Generocity, June 12, 2020, available at <https://generocity.org/philly/2020/06/12/a-short-history-of-black-women-and-police-violence/>.

<sup>24</sup> <https://www.psychiatry.org/newsroom/news-releases/apa-condemns-loss-of-life-from-gun-violence-disputes-link-to-mental-illness>

<sup>25</sup> *Id.*

been an analysis of how the CMR program can create cost-savings from the county budget through treatment over hospitalization and incarceration?

#### **b. Program Assessment**

When assessing the success of the program, we hope that the county will compare the rates of use and reduction in use of jail and hospitalizations to both pre-COVID and post-COVID rates. As the proposal explains, there was a significant increase in MCRT calls and 5150s in 2020.<sup>26</sup> However, 2020 posed unique challenges for our community including job loss, financial insecurity, loss of loved ones, fear of a pandemic, and social isolation. The level of need for CMR services may vary depending on the trajectory of the COVID emergency and our economy. As a result, we hope that any assessment of the need for and efficacy of the program factors in these environmental issues.

#### **c. The CMR Team Must be Culturally Responsive and Representative**

We appreciate the plan's aims to have members of the call center and CMR team who are representative of the communities being served, are culturally responsive, include mental health consumers, and include multiple language capabilities. To achieve these goals, we recommend compensating all members of the team for their services and expertise, even in planning. Given significant disparities in income for Black, Indigenous, and other People of Color (BIPOC) communities and the fact that the neighborhoods this project is targeting are largely lower income, many people from these communities would be unable to volunteer their time to assist with the call center or as part of the CMR team.<sup>27</sup> Moreover, regardless of their income, the expertise that BIPOC people bring to this effort is invaluable. If compensated, these roles would be more likely to get well-qualified applicants who fulfill the program's goals of reflecting the communities served.

Research shows that high-quality mobile crisis response teams can result in significant cost savings.<sup>28</sup> Should the county wish to maximize these cost savings, it should invest in having enough paid staff on the CMR team who meet its aims of being culturally and linguistically responsive and including peer support.

#### **d. Follow-Up to Provide Linkages to Services.**

We commend the plan to follow up with clients twenty-four to seventy-two hours after CMR interventions to link them to follow up services. One thing to consider is whether, "face-to-face engagement may be warranted or even necessary when the individual cannot be reached by phone."<sup>29</sup>

In conclusion, we appreciate the initial efforts to create a space that starts to reimagine less policing for crisis intervention. However, for the reasons outlined above, we believe there is

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<sup>26</sup> CMR page 11.

<sup>27</sup> CMR page 13.

<sup>28</sup> SAMHSA's *National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit* cites research showing that "mobile crisis intervention services can reduce costs associated with inpatient hospitalization by approximately 79 percent." p. 19 <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>.

<sup>29</sup> (See <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf> p. 21).

more to be done to truly create a space where the most vulnerable members of the community feel safe and seen during crisis interventions. We are available to discuss any of the points made and encourage you to work with BIPOC organizers for next steps in additional outreach to the community.

Respectfully Submitted,

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**Social Problem Analysis: Mobile Crisis Services in Santa Clara County**

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SCWK121: Social Welfare Institutions and Policies II

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March 4, 2021



## **Mobile Crisis Services in Santa Clara County**

Persons with mental illness (PMI) experiencing a behavioral health crisis in Santa Clara County (SCC), should have access to a 24/7 community based mobile crisis program with a 3 digit number that is optimized for linkage and follow ups. PMI and their families have identified continued police presence and methods of transportation to be barriers to using existing mobile crisis services, and these can be addressed by policy changes to the county service delivery system. Recognizing the need for a program that responds to an individual having a behavioral health crisis with professionals trained in crisis intervention and de-escalation, Santa Clara County created a Mobile Crisis Response Team (MCRT).

The MCRT—a part of the County’s Behavioral Health Services Department (BHSD)—has a 10 digit phone number and is available from 8 AM to 8 PM, Monday through Friday. The call center is staffed by a licensed, or license waived clinician, who can attempt to de-escalate the individual in distress over the phone. When necessary, a field team made up of a behavioral health specialist, an emergency medicine technician, and a law enforcement liaison are deployed to stabilize the individual and evaluate them for psychiatric hospitalization (BHSD, 2019). As noted in Appendix A, in 2020 the MCRT provided services to 1,373 cases; resulting in 1,127 field visits conducted and 348 “5150” holds issued (Moral & Hackett, 2021). The field team uses an ambulance for transportation when the person is placed under a hold, which can be an issue for PMI who live in communities where stigma around mental health exists. In focus groups held by County BHSD, consumers have stated that the presence of an ambulance or police vehicle brings unwanted attention which can further stigmatize a PMI and their family (Moral & Hackett, 2021).

Although the MCRT is an important resource in linking PMI experiencing a moderate crisis with psychiatric hospital services, thereby avoiding unnecessary arrest, the program is not designed to link consumers with direct service providers if they are not placed under involuntary hold (Moral & Hackett, 2021). An analysis comparing mobile crisis services that refer consumers to community based providers with those that refer consumers to emergency rooms (ER) found that consumers of ER based services, similar to the MCRT, were “1.5 times more likely to be hospitalized within 30 days after the initial crisis service” than consumers of community based mobile crisis services (Guo et al., 2001; as cited in Kim, Seokjoo, & Kim, HyunSoo. 2017). In the MCRT model, consumers who are not placed under a 5150 hold may not be adequately linked to community service providers and provided additional support post crisis response as no follow up is conducted. The issue in particular here is structural, because there is a gap in services for persons experiencing a behavioral health crisis. If a person is experiencing a crisis that is not severe enough for the services provided by the MCRT, they are in need of a service that provides them referrals to community based providers of social services and follows up afterwards to ensure linkage (Moral & Hackett, 2021). Such a program would also reduce the burden on law enforcement and the criminal justice system by further reducing the volume of police interactions with PMI.

From December 2020 through January 2021 the SCC BHSD, in collaboration with community organizations, held 12 virtual focus groups to gather input for a new Community Mobile Response (CMR) program. During these meetings, consumers of MCRT, PMI and their family members, behavioral health professionals, and other community members identified the MCRT’s 10-digit phone number, and limited service hours, as a barrier to using the service. They argued that a 10-digit number was difficult to remember during a crisis, and

overwhelmingly supported a 3-digit alternative similar to 911. In addition, many who were present at these meetings expressed desire for a crisis call center that was community based, available at all hours of the day, and staffed with persons with lived experience and family members (Moral & Hackett, 2021. pp. 45-71). A systematic review of mobile crisis programs in the U.S. by Shapiro et al., (2015) found that limited hours of service and inadequate linkage were some of the most salient barriers to the successful implementation of co-responding mobile crisis programs. Not only does the CMR program fix existing service gaps in Santa Clara County's mobile crisis services, but it also tailors its services to reflect community input.

The presence of police liaisons on the MCRT was another topic of concern brought up at every focus group held by the BHSD, and in similar focus groups held in counties across California (Moral & Hackett, 2021; DMH, 2018; City & County of San Francisco. (2020)). PMI and their family members stated that interactions with law enforcement can be traumatizing, especially if the person having a crisis is placed in handcuffs or in the back of a police cruiser (Krameddine & Silverstone, 2016). It is also important to note that as a result of prior negative interactions with law enforcement many People of Color hold a deep mistrust of law enforcement, which can deter them from accessing resources that involve police officers (California Reducing Disparities Project, 2018). The social problem is rooted in a history of systemic racism within police departments and the use of excessive force against members of marginalized communities and those experiencing a behavioral health crisis.

In light of the murder of George Floyd at the hands of police officer, and the ensuing peaceful protests for racial equity, the Santa Clara County Behavioral Health Services Department is developing a community based mobile crisis program to address gaps in mobile crisis services and make them more accessible to underserved communities, with input from

community members, professionals, and stakeholders. The CMR program is modeled after the successful CAHOOTS workflow model used by crisis response teams in Eugene, Oregon (Whitebird Clinic, 2020). The program, as currently proposed, would be piloted in two locations: a team located in South county, and another in East San Jose. These locations have been chosen due to high volume of calls to 911 relating to individuals experiencing a behavioral health crisis. Each location will have a call center staffed by a clinician, persons with lived experience, and family volunteers. People will be able to call a center at any time of day using a three digit number that is not 911 or 311. Unlike the MCRT, the CMR field team will not have a law enforcement liaison, and will instead have a peer support specialist with lived experience, along with an EMT and a behavioral health specialist. This comes after strong expressions from PMI and family members to refrain from police involvement until absolutely necessary (Moral & Hackett, 2021; DMH, 2018). In response to this input, the CMR workflow model was modified so that the field team can make the decision to call PERT or MCRT once they have arrived at the client's location (Moral & Hackett, 2021).

In order to provide transportation that is discrete and therapeutic, rather than stigmatizing, the proposal has opted for a white van with a therapeutic design for the interior, which is modeled after a similar service implemented by Los Angeles County in 2018 (DMH, 2018). The exterior of the CMR van will be painted white, with a simple logo, as not to attract unwanted attention when making a visit in the field. Community members attending focus groups advocated for the transport van to function as a safe space where a person experiencing a crisis can de-escalate. Recommendations for interior of the van included having water, snacks, and sensory toys like fidget spinners (Moral & Hackett, 2021).

Unlike the MCRT, the CMR workflow is designed to link consumers and their family with community based service providers, and, most importantly, conduct a follow up within a few days of the initial meeting to ensure the individual is referred to appropriate services. Linkage with service providers rather than psychiatric hospitals will give PMI and others in crisis access to a wider range of social services that may not be available through the MCRT (Moral & Hackett, 2021). Moreover, following up with the individual post crisis is a critical step in ensuring that the service provided achieves the intended outcome of reducing costs for, and burden on, the hospital and criminal justice systems (Bailey et al., 2018; Shapiro et al., 2015).

In addition, the program's intended use of community collaborators and outreach specialists is perhaps the most innovative facet of this proposed program. Collaborators and outreach specialists embedded in both locations will work to educate members of the community about services available to them in order to reduce stigma surrounding accessing such services. Furthermore, the CMR is designed to gather input from the community on an ongoing basis to aid in the design and evaluation of the program. Community collaborators will assist the CMR team in identifying and respecting the ethical and cultural norms of their client population (Moral & Hackett, 2021). This addition to the workflow should aid in overcoming cultural barriers to program implementation, which studies have identified to be a prominent barrier to implementing mobile crisis programs (Bailey et al., 2018).

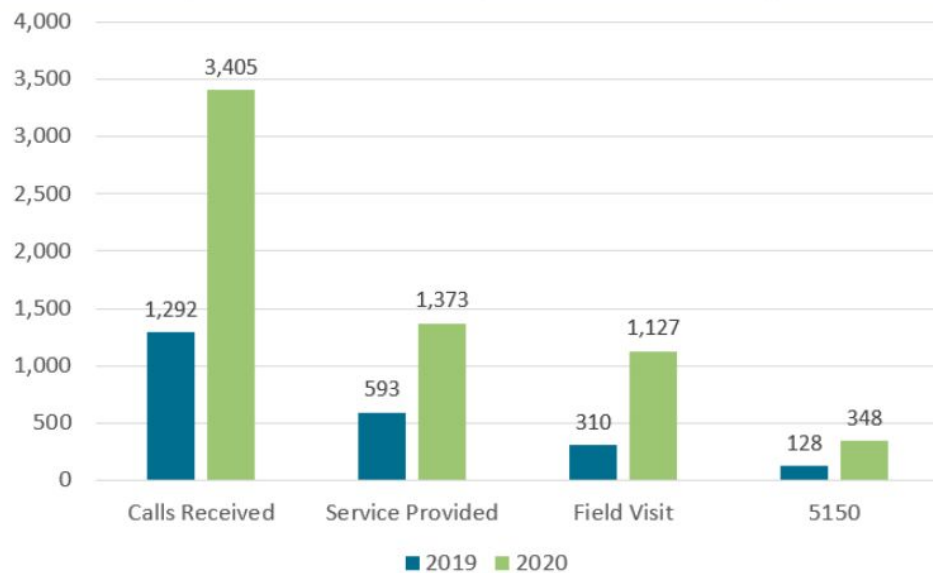
The protests for racial equity and systematic change that gripped the country in the summer of 2020, and the subsequent calls to defund police and fund social services, are symptoms of a deeply rooted social and systemic issue in the U.S.: the use of law enforcement and unwarranted force against persons suffering from a behavioral health crisis. It is time that this social problem be treated as the public health crisis that it is, and programs be put in place

that send behavioral health specialists and peer support specialists as first responders rather than law enforcement.

## Appendix A

### MCRT SERVICE DATA

Services	2019	2020	% Increase
Calls Received	1,292	3,405	163.5%
Service Provided	593	1,373	131.5%
Field Visit	310	1,127	263.6%
5150	128	348	171.9%



## References

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COUNTY OF SANTA CLARA

# Behavioral Health Services

Supporting Wellness and Recovery

**APRIL 12, 2021**

**2:15 – 3:00 PM**

**BEHAVIORAL HEALTH BOARD/MHSA PUBLIC HEARING  
INN-15 COMMUNITY MOBILE RESPONSE (CMR) PROGRAM**

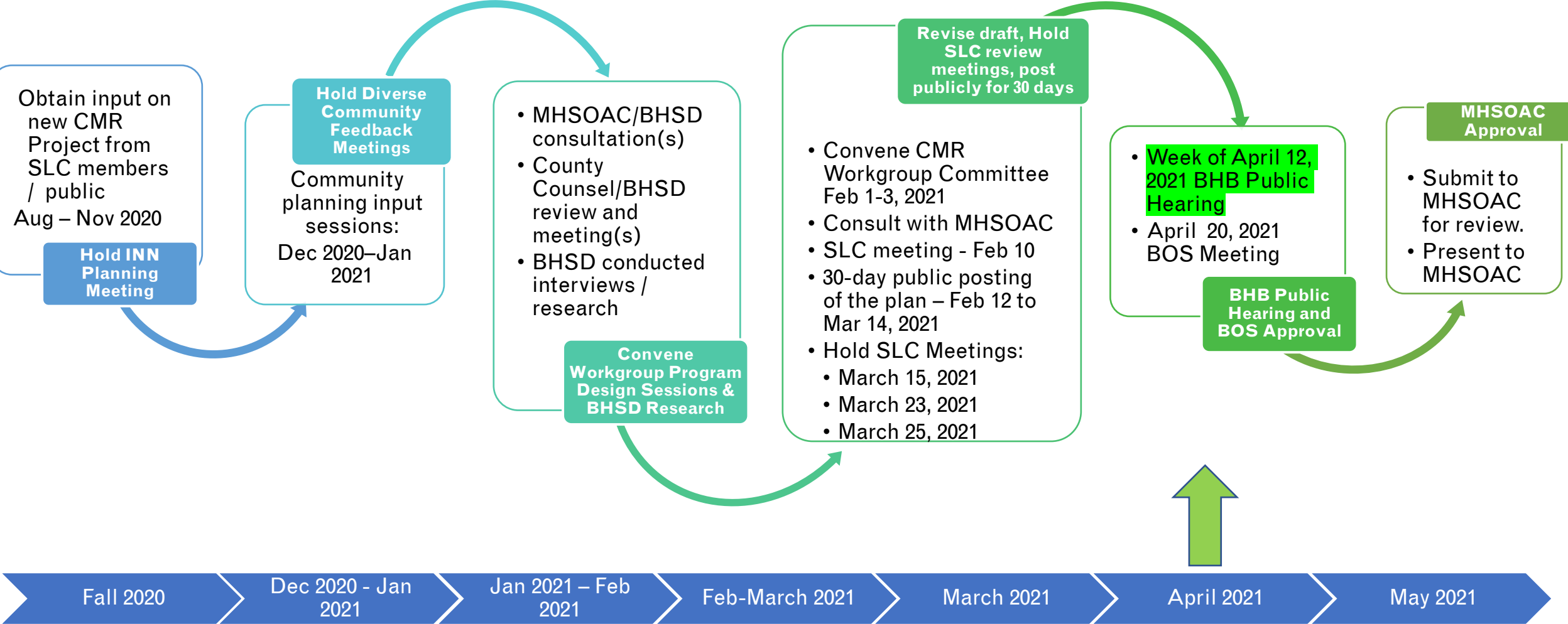
**BHB/MHSA PUBLIC  
HEARING  
ON INN-15 PROJECT:  
COMMUNITY MOBILE  
RESPONSE (CMR)  
PROGRAM**

**APRIL 12, 2021  
2:15PM – 3:00PM**

**TOPIC**

- 1. Introductions (Jeanne Moral)**
- 2. CMR Timeline and Latest Updates (Jeanne)**
- 3. Overview of Current CMR Plans (Jeanne, Jamina Hackett)**
- 4. Budget Overview (Jeanne)**
- 5. Next Steps (Jeanne)**
- 6. Comments & Questions (All)**

# COMMUNITY MOBILE RESPONSE (CMR) PROGRAM COMMUNITY PLANNING AND PROGRAM DESIGN TIMELINE 2020-2021



# Who participated in the CMR Planning Process

## Target Populations

- African/African Ancestry Community
- Chinese Community
- Clinicians with Mobile Crisis Experience
- Consumers
- Consumers/Family Members of Consumers
- Families who have lost loved ones
- Filipino Community
- Justice-Involved and the Re-entry Community
- Spanish Speaking Community
- Stakeholders in North County
- Transitional Age Youth (TAY), ages 18-25
- Vietnamese Community

- 13 planning input sessions held from December 2020 – January 2021
- Meetings conducted in collaboration with:
  - Behavioral Health Contractors' Association of Santa Clara County (BHCA)
  - BHSD Cultural Communities Wellness Program (CCWP)
  - BHSD Criminal Justice Service (CJS)
  - Black Leadership Kitchen Cabinet (BLKC)
  - Gardner Health Services
  - National Alliance of Mental Illness of Santa Clara County (NAMI)
  - Project Safety Net (PSN)
  - Silicon Valley De-Bug
  - Stanford Center for Youth Mental Health and Wellbeing

# CMR Workgroup Committee Sessions February 1 – 3, 2021

## CMR Workgroup Committee Members:

- **Synthesized** feedback – Reviewed Planning Input Notes from the December 2020 to January 2021
- **Identified** common themes
- **Refined** model elements
- **Identified** any outstanding questions
- **Helped inform** on the presentation for the MHSA SLC meeting on the CMR – February 10, 2021 prior to the 30-day public posting of the Draft Plan from February 12 - March 14, 2021

## Topics

- Locations
- Phone Number
- Define Crisis
- Workflow & Triage
- Call Center
- CMR Team
- Mobile Response Vehicle
- Family Involvement
- Outreach
- Program Name & Other Ideas
- Wrap up & Final thoughts

**THANK YOU!  
CMR WORKGROUP  
COMMITTEE MEMBERS  
COMPRISED OF MHSA SLC AND  
BHCA MEMBERS**

- **Ana Villarreal** MHSA SLC  
Member: Faith-Based
- **Armina Husic** MHSA SLC  
Member: Adult/Refugee  
Health Advocate
- **Cheryl Engelstad, MFT**  
MHSA SLC Member: Service  
Provider – Underserved  
Youth
- **David Mineta** BHCA  
Member
- **Dolores Garcia** MHSA SLC  
Member: Social Services
- **Don Taylor** BHCA Member
- **Elisa Koff-Ginsborg** BHCA
- **Gary Miles**, MHSA SLC and  
Behavioral Health Board  
(BHB) Chairperson
- **Kathy Forward** MHSA SLC  
Member: Family Member
- **Lorraine Zeller** MHSA SLC  
Member: Client/Consumer
- **LouMeshia Brown, LMFT**  
MHSA SLC Member: Cultural  
Competence
- **Mohamed Ali** BHSD, MHSA  
SLC Member: Family Member
- **Peggy Cho** MHSA SLC  
Member: Client/Consumer
- **Sparky Harlan** MHSA SLC  
Member: Service Provider  
TAY
- **Yvonne Maxwell** BHCA  
Member

# 30-DAY PUBLIC REVIEW OF THE CMR PLAN

## FEBRUARY 12 – MARCH 14, 2021

### Total of 15 Comments Submitted by:

- Community Members
- Stakeholder Affiliation:
  - BHCA
  - Bill Wilson Center
  - CBO ACLU Mid-Peninsula
  - City of Palo Alto
  - Gardner Health Services
  - Law Foundation of Silicon Valley
  - Non-profit organizations
  - PACT
  - Peninsula Family Services
  - San Jose State University
  - Santa Clara University School of Law
  - Uplift Family Services
  - West Valley Community Services

### Held MHSA SLC Meetings: March 15, 23, and 25

- Shared info regarding public comments/provided information
- Held an informational meeting on March 23 to provide options for MHSA SLC Members' consideration
- March 25: MHSA SLC voted to endorse option F
  1. Adjust the CMR Draft Plan based on salary/benefit analysis conducted by Finance and comparable info provided by BHCA,
  2. Updated the CMR project duration to 4.5 years
  3. Added a third service area/onsite CMR field team in North County



# INN-15 CMR PROGRAM



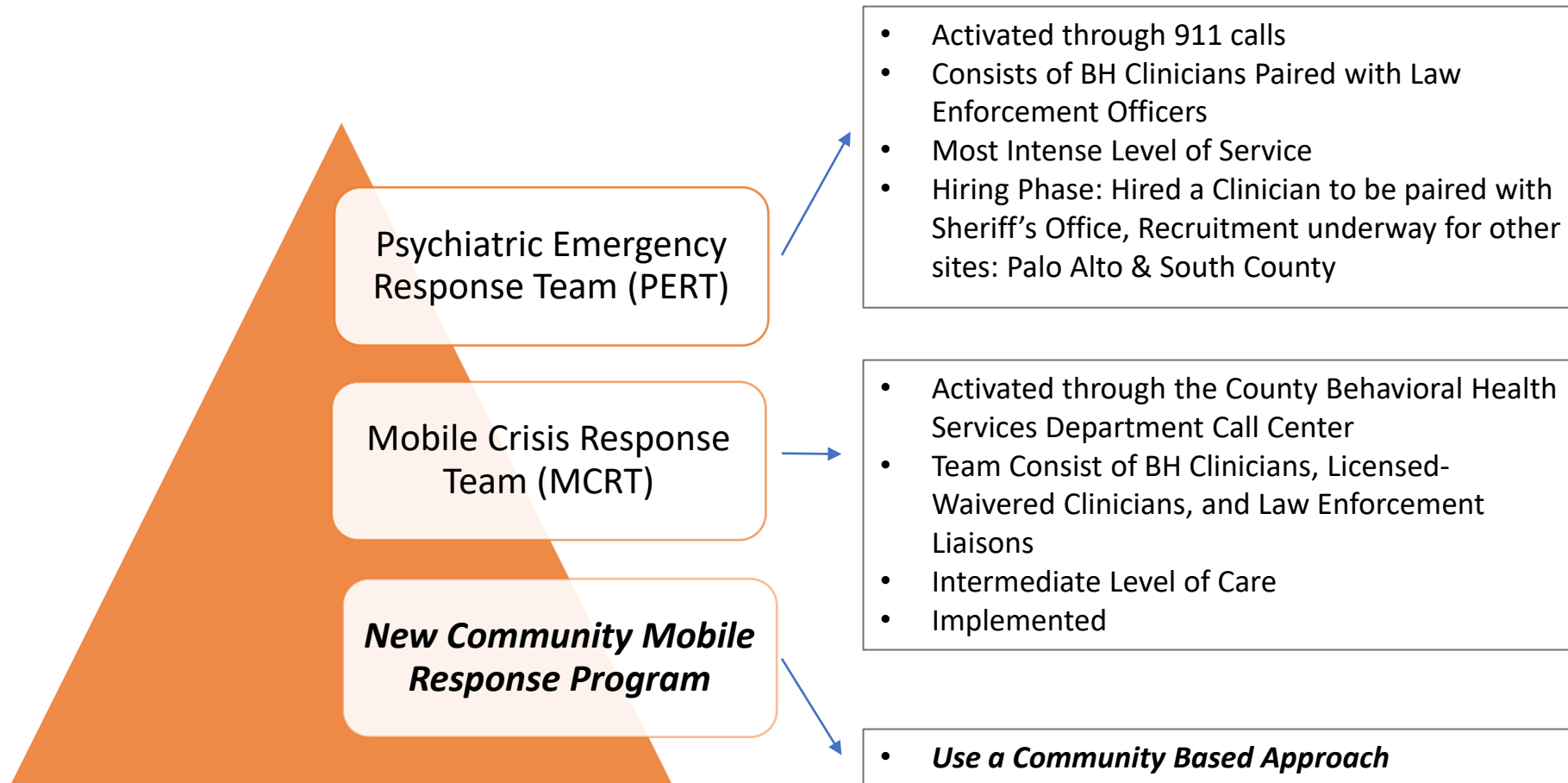
**Proposed Project Name**

**Community Mobile Response (CMR) Program**

Proposed Innovative Approach Ideas  
(From Fall 2020 and Shared During Planning Input Sessions in Dec 2020 – Jan 2021)

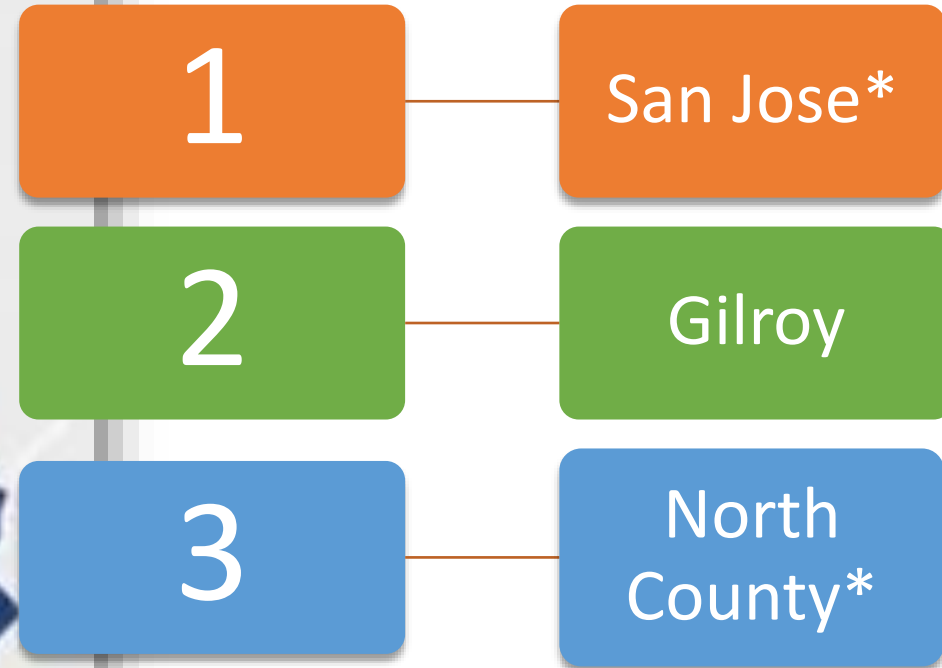
- **Family involvement** – Encouraging family in all aspects of the process, from the phone screening, to riding along, to the hospital admission.
- **Prevention focused** – Focus on lower acuity situations and diversion, as well as providing resources pre- and post-crisis response.
- **Access through a trusted community phonenumber:** a centralized 3-digit number that is not 911 or 311.
- **Transformed trauma-informed mobile response vehicle,** designed through community input, including those with lived experience with the assistance of a professional design and marketing firm.
- **Community Collaborators,** build a mechanism to receive continuing feedback from the community on the project.

# THE COUNTY'S BEHAVIORAL HEALTH (BH) MOBILE PROGRAMS



# CMR LOCATIONS

Start with three service sites with plan to expand Countywide in the future years, if successful.



**\*Focus on high-need/priority areas – Centers for Disease Control and Prevention (CDC) Social Vulnerability Index**

- For the San Jose service location: serve all of San Jose but with a focus on East San Jose/Eastside
- For the North County service location: serve North County with a focus on Sunnyvale, Mountain View, Santa Clara

Image Source: <https://citiesassociation.org>

# CDC Social Vulnerability Index 2018

Santa Clara County, California

PART 1



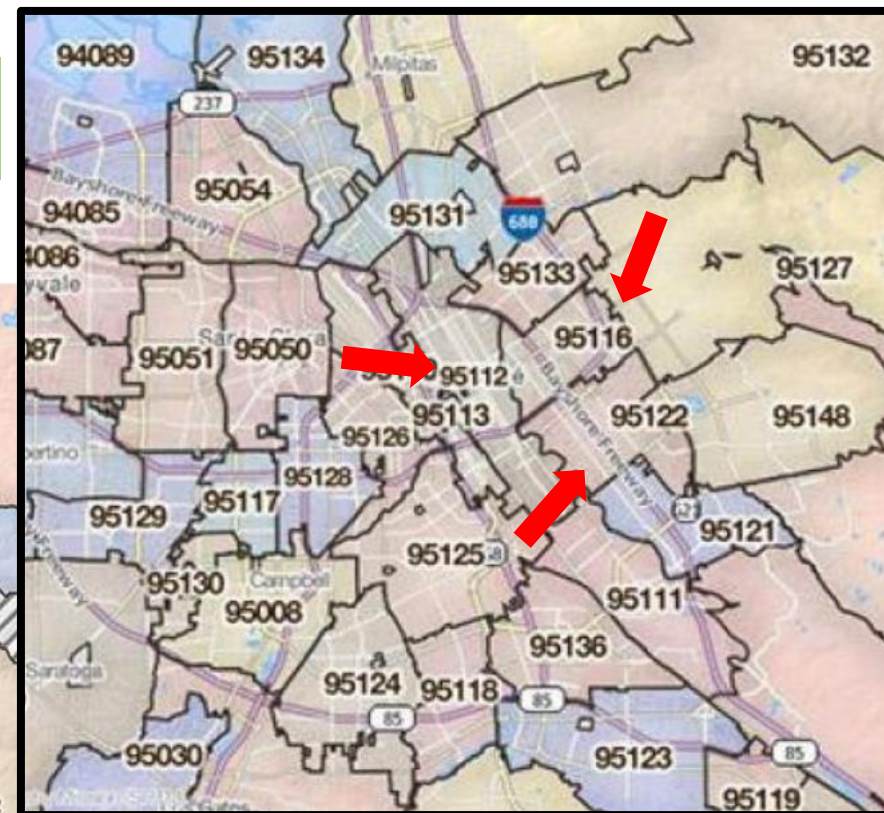
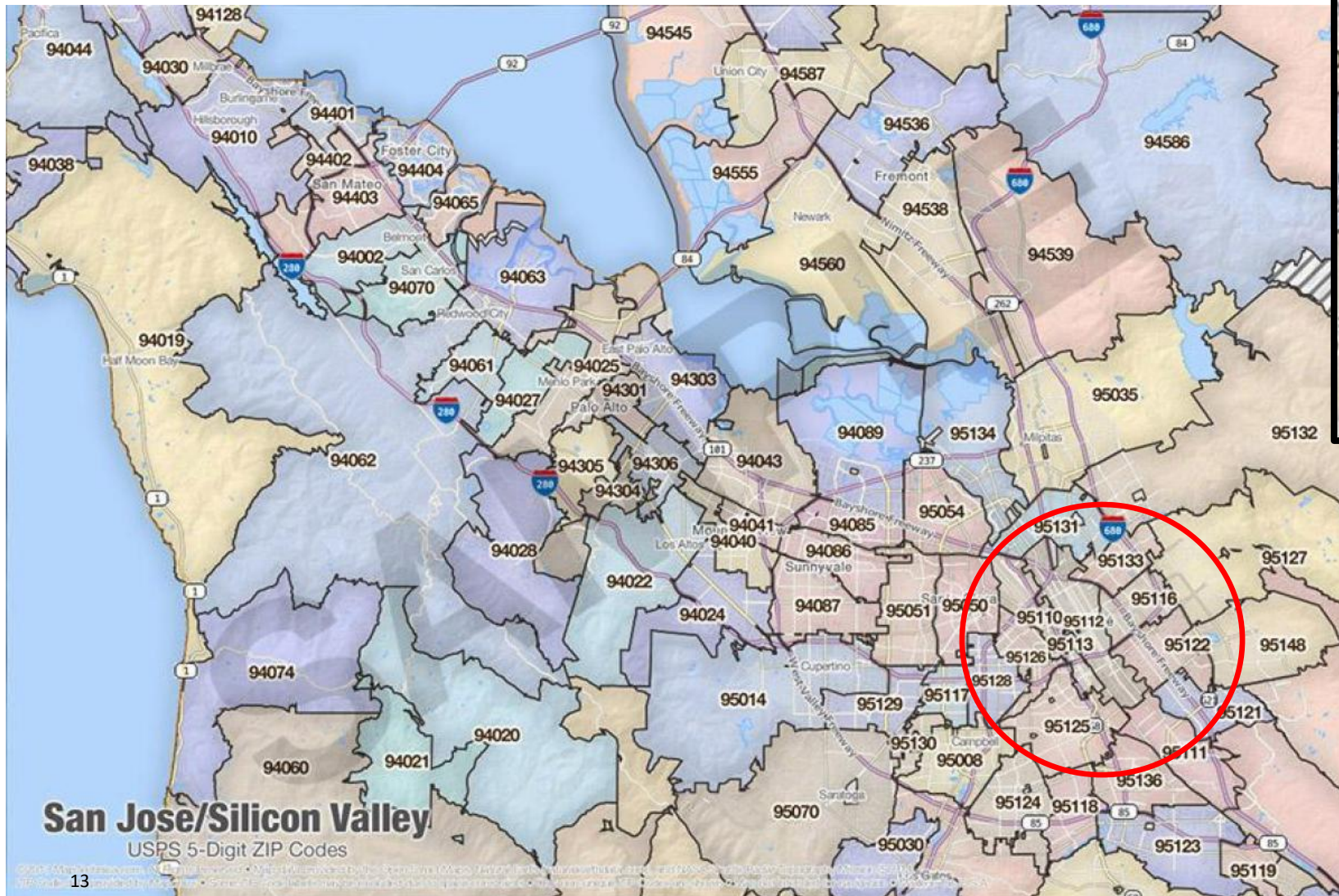
## Overall Social Vulnerability<sup>1</sup>



Source:

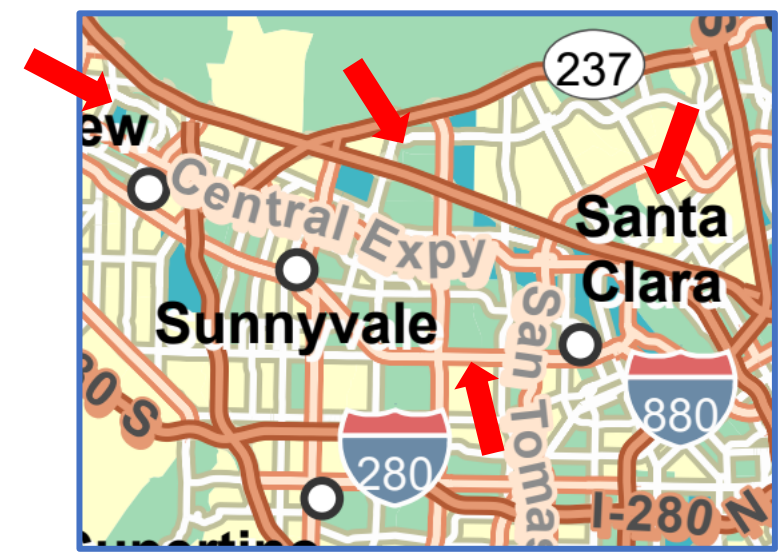
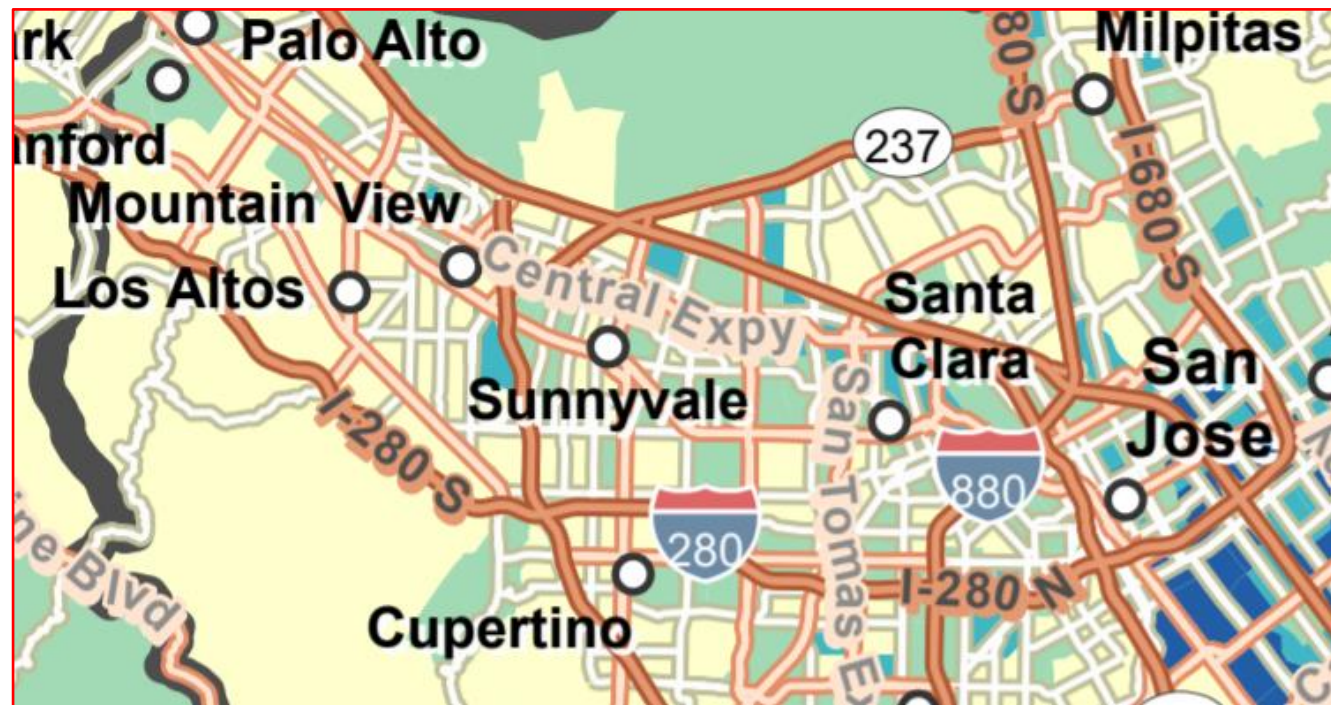
[https://svi.cdc.gov/Documents/CountyMaps/2018/California/California2018\\_Santa%20Clara.pdf](https://svi.cdc.gov/Documents/CountyMaps/2018/California/California2018_Santa%20Clara.pdf)

# Service Area Includes all of San Jose



- Prioritize Zip Codes:**
- 95112
  - 95122
  - 95116

# North County Service Area



## DEFINITION OF A CRISIS

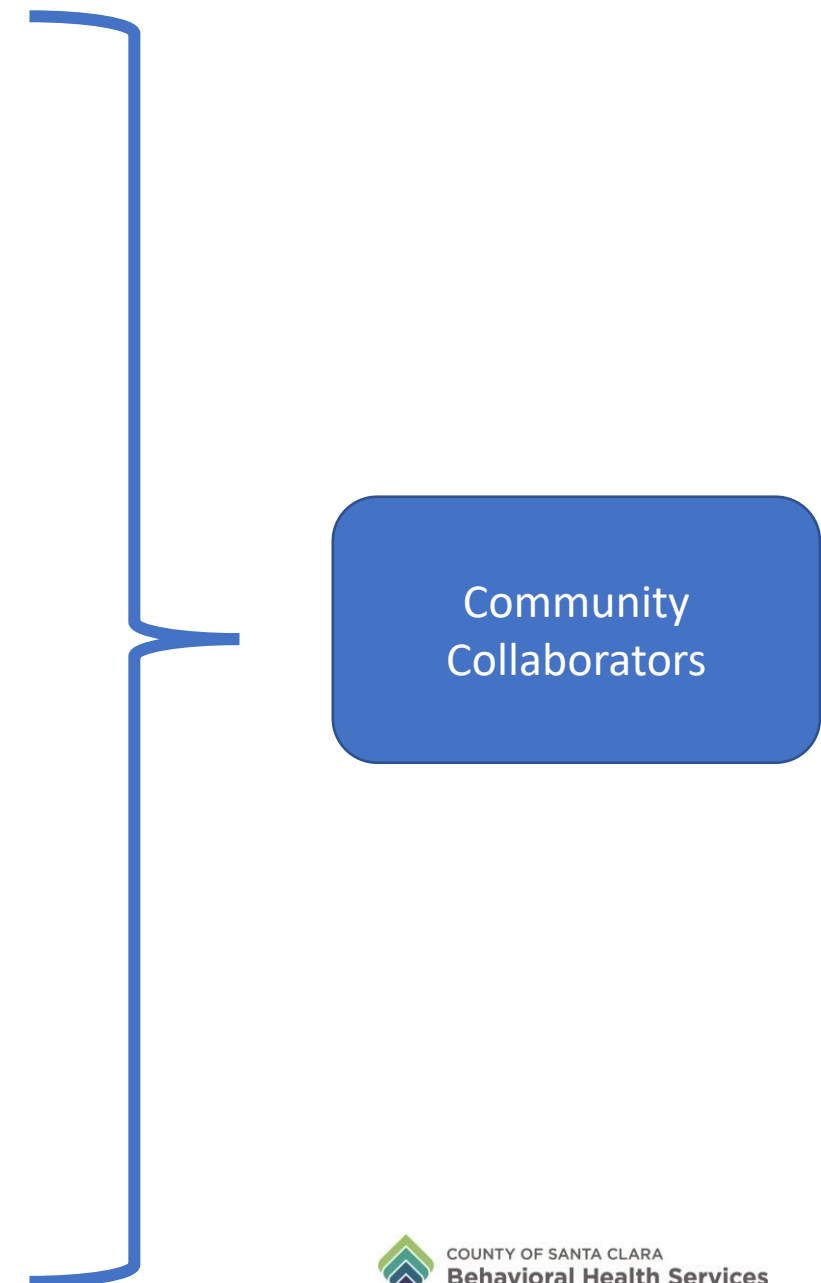
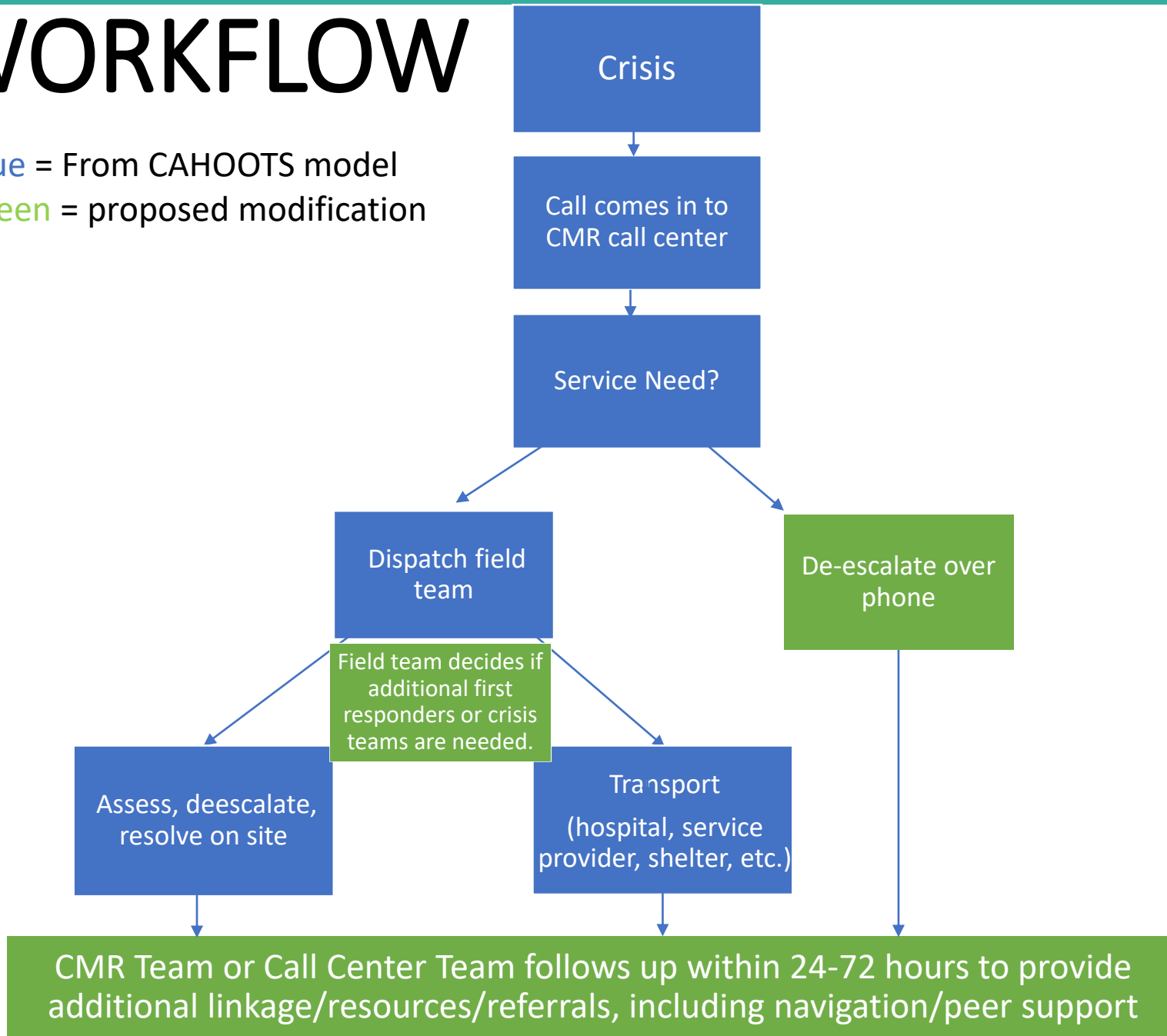
The new Community Mobile Response (CMR) Program intends to **proactively** help individuals in crisis: any behavioral-health related situation where an individual needs assistance in resolving conflicts or stressful situations. The **program team will help individuals experiencing an increased level of stress and anxiety by conducting assessments for medical and/or behavioral health needs to minimize and prevent further escalating the crisis and provide the individual the support they need during their time of need.** As this program is intended to utilize a community-based approach, the intent is to have this program broadly used by the community as an alternative to a law enforcement response and have this program in place for individuals to feel safe accessing when calling to get help for themselves and others during a crisis without law enforcement involvement.

In light of the killing of George Floyd and events that took place in 2020, the Mental Health Service Act (MHSA) Stakeholder Leadership Committee (SLC) endorsed this new MHSA INN project: CMR to address current needs through a race equity and social justice lens and make available a program that can help the unserved and underserved. The CMR program will include a process in the program's workflow to include other resources as needed and, when appropriate, link to other teams and programs, such as the County's Emergency Medical Services (EMS) team, other County Mobile Response programs like the Mobile Crisis Response Team (MCRT), and Psychiatric Emergency Response Team (PERT).



# WORKFLOW

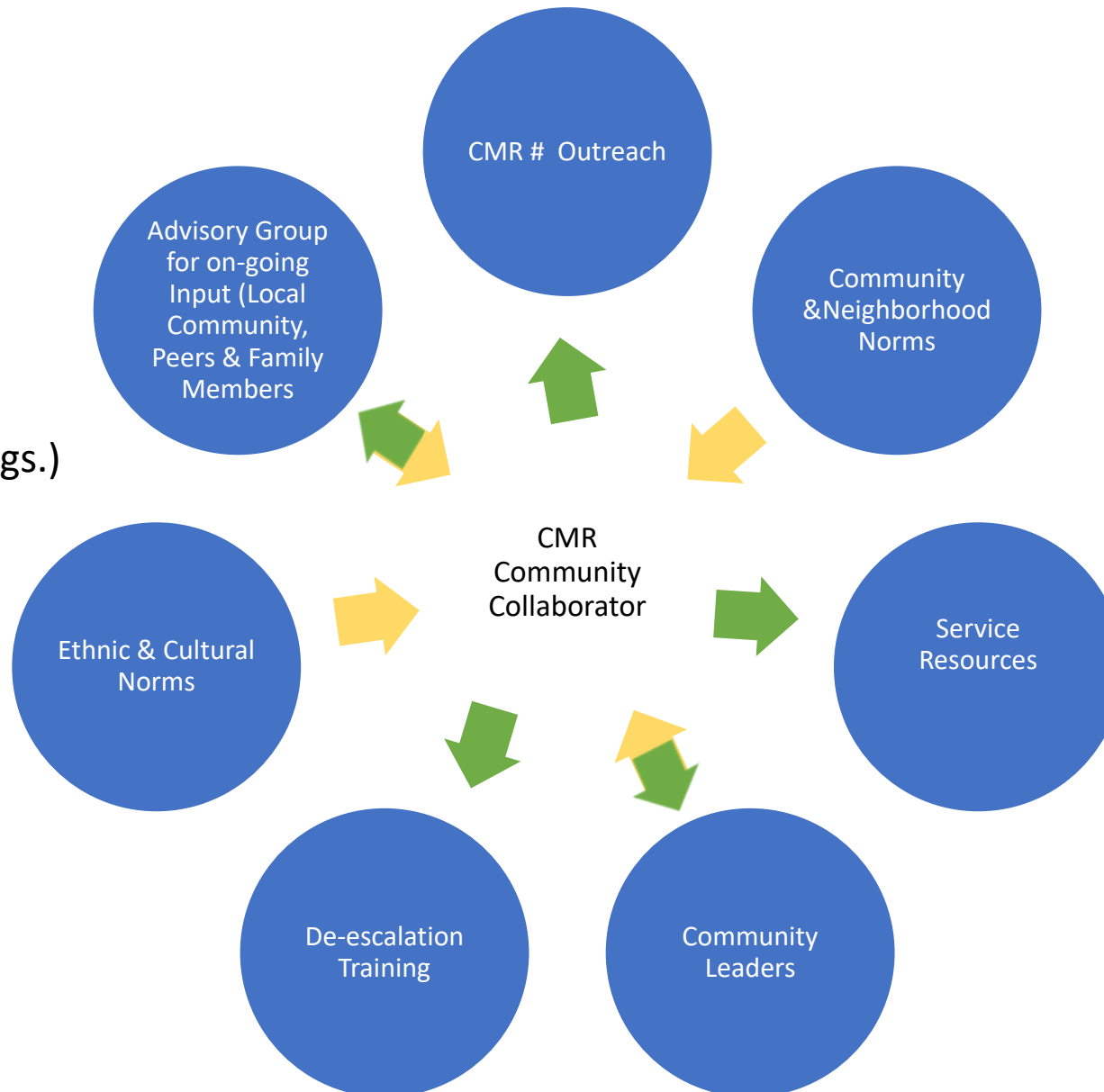
Blue = From CAHOOTS model  
Green = proposed modification



# COMMUNITY COLLABORATORS

**Yellow** Arrow = Community informing the design of program (ongoing)

**Green** Arrow = sharing information out (CMR #, Resources, Facilitate trainings.)



Community Collaborators will be focused on "prevention activities"



## Call Center

- Will be operational 24/7, 365 days of the year
- The Call Center Team\* (CBO-Operated) will include:
  - 1.0 FTE Program Manager (Behavioral Health Clinician: Licensed or Licensed Waivered)
  - 13.5 FTEs to staff the Call Center and the staff will include Peer specialists/peer family, paraprofessionals (e.g., Rehabilitation counselor, Mental Health Community Workers, and Community Workers) and volunteers\*\*

Note:

\*Prioritize Individuals with lived experience: consumers and family members of consumers.

\*\*Volunteers may comprise up to 25% of the Call Center team

# CMR Team

## Operational 24/7 in three service areas

### SAN JOSE SERVICE AREA

#### (CBO-Operated)

- 1.0 FTE Community Collaborator
- 1.5 FTE Program Manager\* (Licensed)
- Onsite Field Team (3-Member Team)\*\*
  - 4.5 FTEs Emergency Medical Technician
  - 4.5 FTEs Crisis Intervention Worker (similar to a Rehabilitation Counselor)
  - 4.5 FTEs Peer Outreach Specialist
  - Subtotal 13.5 FTEs

Total 16 FTEs

### GILROY SERVICE AREA

#### (CBO-Operated)

- 1.0 FTE Community Collaborator
- 1.5 FTE Program Manager\* (Licensed)
- Onsite Field Team (3-Member Team)\*\*
  - 4.5 FTEs Emergency Medical Technician
  - 4.5 FTEs Crisis Intervention Worker (similar to a Rehabilitation Counselor)
  - 4.5 FTEs Peer Outreach Specialist
  - Subtotal 13.5 FTEs

Total 16 FTEs

### NORTH COUNTY SERVICE AREA

#### (CBO-Operated)

- 1.0 FTE Community Collaborator
- 1.5 FTE Program Manager\* (Licensed)
- Onsite Field Team (3-Member Team)\*\*
  - 4.5 FTEs Emergency Medical Technician
  - 4.5 FTEs Crisis Intervention Worker (similar to a Rehabilitation Counselor)
  - 4.5 FTEs Peer Outreach Specialist
  - Subtotal 13.5 FTEs

Total 16 FTEs

\*A program manager will be licensed behavioral health clinician, so the manager can do a 5150 hold if needed. The primary role is to provide program oversight.

\*\* Prioritize Individuals with lived experience: consumers and family members of consumers.

## Interior

- Should be discreet and not look clinical or like other official vehicles
- Small logo in various languages
- Should not be red, should be a neutral color
- Should not have a stigmatizing presence

## Exterior Design

- Interior should be decorated and feel comfortable
- Should be a calming comfortable safe and therapeutic environment
- Limit visual stimulation
- Should not have a stigmatizing presence
- Calming objects, food, water
- Bed somewhere to sit and relax if needed
  - Also, an option to sit outside

# VEHICLE

# Program Name

## Community Mobile Response Program

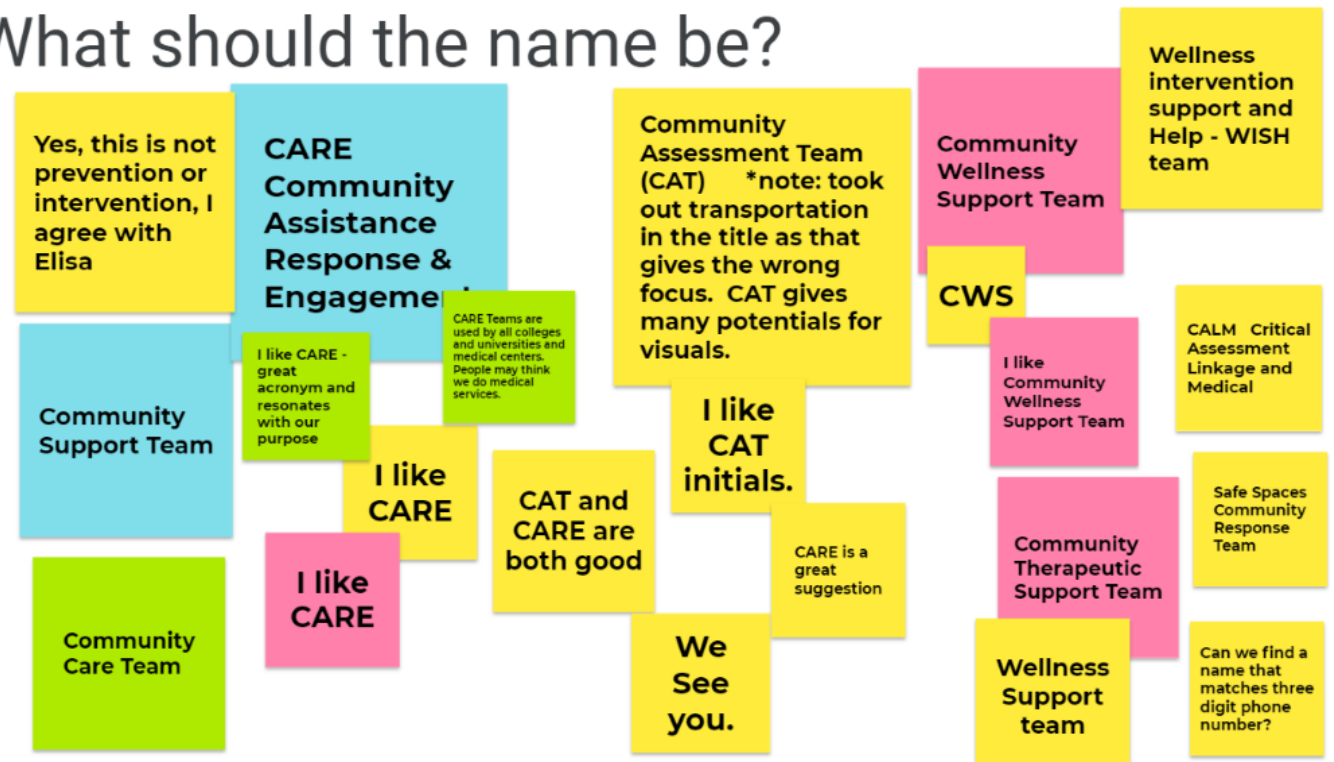
Interim Name

### Potential Names Generated by the CMR Workgroup Committee Members:

- Community Assistance Response & Engagement [CARE]
- Community Wellness Support Team [CWST]
- Community Care Team [CCT]
- Wellness Intervention Support and Help [WISH]
- Critical Assessment Linkage and Medical [CALM]

**BHSD will reconvene CMR Workgroup Committee to finalize program name prior to the start of the Design Contest.**

### What should the name be?





## FAMILY INVOLVEMENT

---

- Client first
- Supportive of the idea to include the family component piece in the program from beginning through follow up
- Should not be limited to just family members
- Leverage AB1424 for family involvement –  
AB 1424 Form: Information Provided by a Family Member or Other Support Person



# OUTREACH





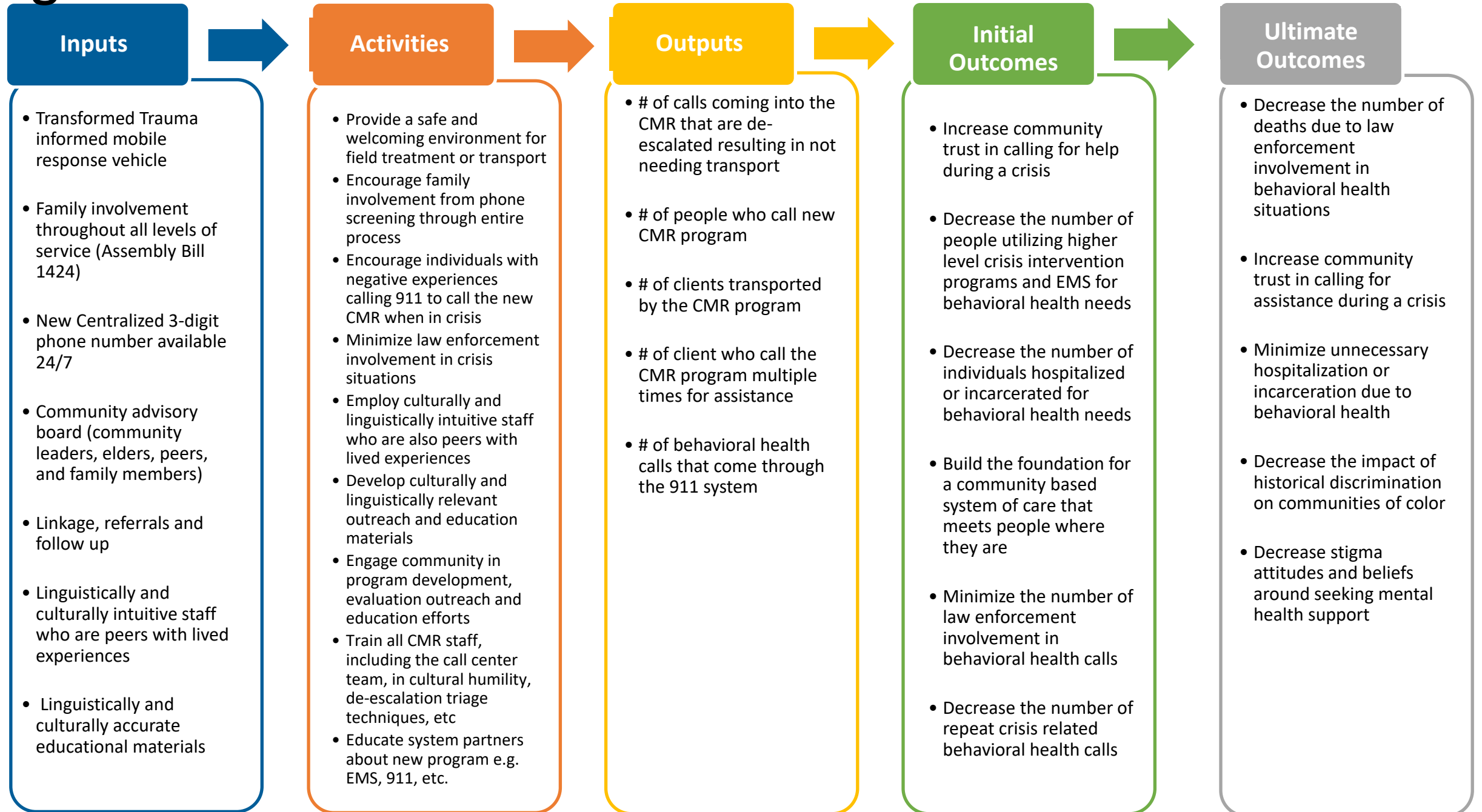
# LEARNING GOALS AND EVALUATION PLAN



Contract with an independent evaluator to assess the following program goals/outcomes are achieved:

- Will this new program lower the incidence of clients being transported to the hospital or jail?
- Will this new program encourage community members to seek help when needed?
- Will a collaborative approach help with increased use of the program?

# Logic Model



# OVERVIEW OF INN-15 CMR PROGRAM BUDGET



## MAIN COMPONENTS OF THE CMR PROGRAM BUDGET

1. One-time Related Expenses
2. Call Center – CBO operated
3. CMR Field Teams (San Jose Gilroy and North County) – CBO operated
4. County Expenses

# ONE-TIME EXPENSES 1<sup>ST</sup> YEAR OF PROGRAM IMPLEMENTATION

First Budget Component

Description	Annual Amount
Purchase of Utility Van (\$30K x 3)	\$90,000
Commercial Vehicle Wrapping (~\$5-7K x 3 = ~\$15-21K)	\$21,000
<u>Interior configuration/equipment: (~\$75K x 3 = ~\$225K)</u>	<u>\$225,000</u>
<b>Subtotal Vehicles cost*</b>	<b>\$336,000</b>
<p>*To help start program implementation, one vehicle will be provided to each CBO provider: San Jose service area, Gilroy service area, and North County service area</p>	
Design Contest	\$5,000
<u>Design Vendor: transpose winning design for use = ~\$10K</u>	<u>\$10,000</u>
<b>Subtotal Design/Logo</b>	<b>\$15,000</b>
<b>Total INN Funding Request</b>	<b>\$351,000</b>



Second Budget Component

Call Center Budget Description	Annual Amount	Four and a Half-Year Project Total
Staffing for Each Service Area – Salaries/Benefits (Refer to Slide 16) <ul style="list-style-type: none"> <li>1.0 FTE Program Manager (Behavioral Health Clinician: Licensed or Licensed Waivered)</li> <li>13.5 FTEs to staff the Call Center and the staff may include Peer specialists/peer family, paraprofessionals (e.g., Rehabilitation counselor, Mental Health Community Workers, and Community Workers) – may designate certain members of the team as program leads.</li> </ul> Total 14.5 FTEs	\$1,197,000	\$4,788,000
Training Budget	\$10,000	\$40,000
Volunteer Stipends	\$20,000	\$80,000
Operating Expense (Includes creation of a new 3-digit number, outreach, and other program expenses)	\$179,550	\$718,200
General Admin Overhead	\$210,083	\$840,330
<b>Total INN Funding*</b>	<b>\$1,616,633</b>	<b>\$6,466,530</b>

*\*Total does not include annual County expense of \$900 for 3-digit number. See slide 31 for more information.*

# Budget Assumptions

## Salaries/Benefits

- Program Manager (Licensed) \$110,250
- Community Collaborator \$102,900
- Crisis Intervention Worker and Peer Outreach Specialist \$80,500
- Emergency Medical Technician \$70,500

## Other Budget Calculation

- Operating Expense = 15% of staffing budget (salaries/benefits)
- General Admin Overhead = 15% of staffing budget + (Volunteer Stipends and/or Training) + Operating Expense

# CMR FIELD TEAMS – OPERATIONAL 24/7, 365 DAYS

Third Budget Component

## THREE SERVICE AREAS: SAN JOSE, GILROY, & NORTH COUNTY – EACH ONE CBO-OPERATED

Description	San Jose Service Area Annual Budget	Gilroy Service Area Annual Budget	North County Service Area Annual Budget	Annual Combined (SJ + Gilroy + North County) Budget	Four and a Half-Year Project Total
Staffing for Each Service Area – Salaries/Benefits (Refer to Slide 17) <ul style="list-style-type: none"> <li>• 1.0 FTE Community Collaborator</li> <li>• 1.5 FTE Program Manager* (BH Clinician Licensed)</li> <li>• Onsite Field Team                             <ul style="list-style-type: none"> <li>○ 4.5 FTEs Emergency Medical Technician</li> <li>○ 4.5 FTEs Crisis Intervention Worker</li> <li>○ 4.5 FTEs Outreach Specialist Subtotal</li> </ul> </li> </ul> Total 16 FTEs per Service Area	\$1,310,025 (16.0 FTEs)	\$1,310,025 (16.0 FTEs)	\$1,310,025 (16.0 FTEs)	<b>\$3,930,075</b> <b>(48.0 FTEs)</b>	<b>\$15,720,300</b>
Training Budget per Service Area	\$10,000	\$10,000	\$10,000	<b>\$30,000</b>	<b>\$120,000</b>
Operating Expense (Includes Outreach, Vehicle Maintenance, car insurance, purchase of additional vehicles as needed, other program related expenditures)	\$196,504	\$196,504	\$196,504	<b>\$589,511</b>	<b>\$2,358,045</b>
General Admin Overhead	\$227,479	\$227,479	\$227,479	<b>\$682,438</b>	<b>\$2,729,752</b>
<b>Total INN Funding Request</b>	<b>\$1,744,008</b>	<b>\$1,744,008</b>	<b>\$1,744,008</b>	<b>\$5,232,024</b>	<b>\$20,928,097</b>



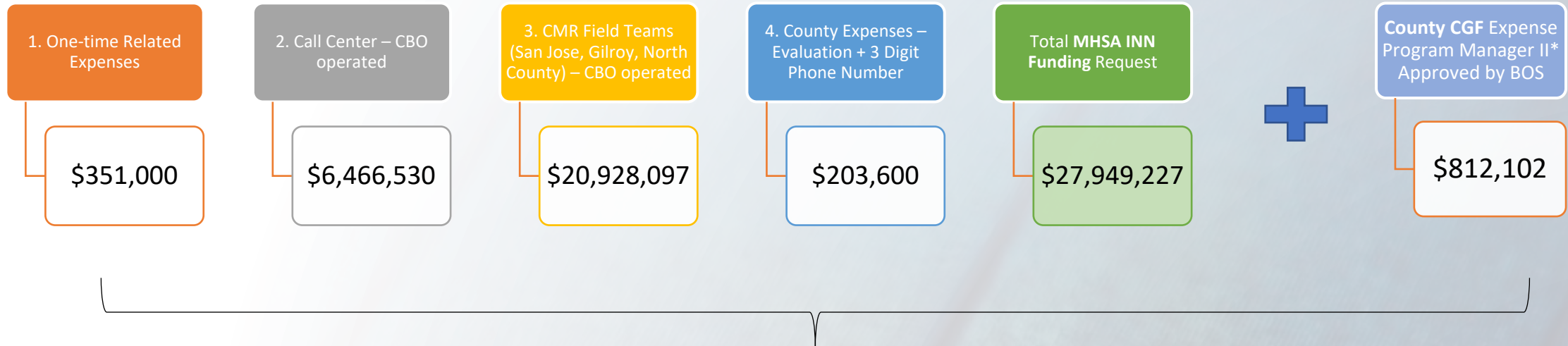
# COUNTY EXPENSES

Fourth Budget Component

MHSA INN County Expense Description	Annual Amount	Four and a Half-Year Project Total
<ul style="list-style-type: none"> <li>Evaluation Contract</li> <li>3-Digit Phone Number</li> </ul>	\$50,000 \$900	\$200,000 \$3,600
<b>Total INN Funding Request</b>	<b>\$50,900</b>	<b>\$203,600</b>

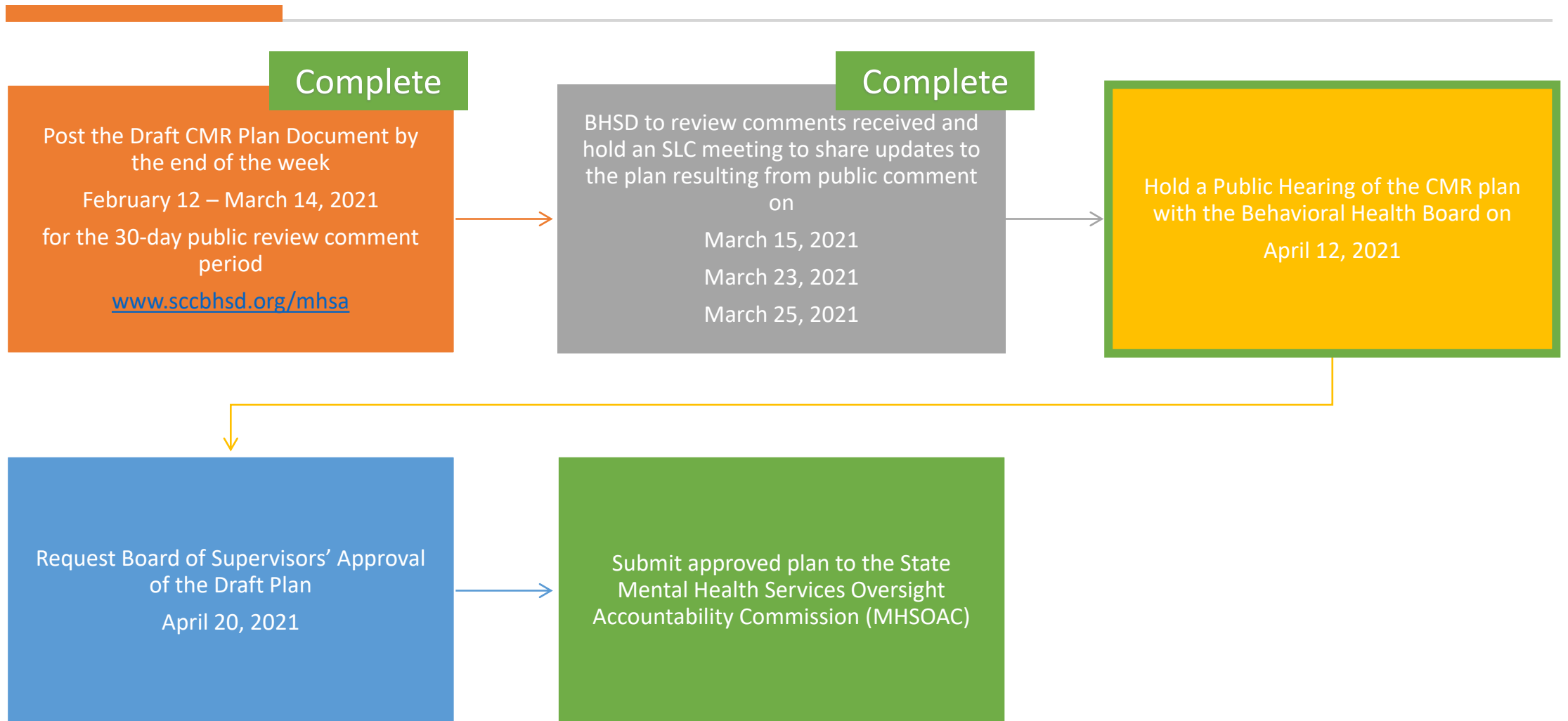
Non-MHSA INN Funded County Expense Description	Annual Amount	Four and a Half-Year Project Total
<b>Program Manager II</b> Approved by BOS during August 2020 Budget Process, funded with County General Funds	\$180,467	\$812,102
<b>Total County General Funding</b>	<b>\$180,467</b>	<b>\$812,102</b>

# 4.5-YEAR MHSA INN FUNDING REQUEST



**Overall Five-year funding (MHSA INN + CGF) = \$28,761,328**

# Next Steps - CMR Community Planning Process





# Comments & Questions

**THANK YOU!**

**For questions or if you would like additional information about the INN-15 CMR Program please contact the team:**

**Jeanne Moral, Program Manager III**  
[Jeanne.Moral@hhs.sccgov.org](mailto:Jeanne.Moral@hhs.sccgov.org)

**Jamina Hackett, Program Manager II**  
[Jamina.Hackett@hhs.sccgov.org](mailto:Jamina.Hackett@hhs.sccgov.org)