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Implementation of the Community Crisis Response Program in Richmond CA
JULY 2023

SOS Richmond Focus Group 5/17/23

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What Would Make Richmond's Emergency
What Would Make Richmond's Emergency Services Better?

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Acknowledgements

First and foremost, thank you to Richmond's residents, political leadership, city government staff, service providers, and community leaders. It is an honor to work on one aspect that reflects Richmond's commitment to public safety innovation envisioning a caring and violence-free city that advances community wellness, high quality and trust in government services, and support for all residents in need. We thank all of these residents for their thoughtful insights and wisdom, and willingness to share their aspirations and ideas for a new response initiative. We appreciate the City of Richmond's commitment to addressing equity, public input, transparency, and accountability.

Unfortunately, this report cannot provide full justice to the stories shared with us by residents narrating their lived experiences and impacts from a system/practice that too many times causes harm to individuals, places undue stress on police, and doesn't solve the root causes of the situations requiring intervention.

Attached is a list of stakeholder interviews and meetings with individuals and organizations who generously gave their time to support the research and community outreach upon which this report is based. We are grateful to everyone.

This report would not have been possible without the thoughtful and extensive research and advocacy by the Richmond Taskforce on Reimagining Public Safety, Chief French and the RPD staff, Chief Angel Montoya and the RFD staff, Communications Center Manager Michael Schlemmer and all the dispatchers who patiently answered questions and permitted us to watch their complex and fast-paced work. Suzanne Tavano, PhD, Director, Behavioral Health Services, Dr. Chad Pierce, PsyD, A3/Crisis Intervention Chief, and Debbie Thomas, LMFT, MH Program Manager ensured that we understand the wonderful work of the Anyone, Anywhere, Anytime (A3) Initiative and how to ensure integration and collaboration between the programs.

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Executive Summary

Urban Strategies Council (USC) works with public-sector jurisdictions in the United States (US) and Canada developing alternative emergency response program models and policy recommendations. Alternative emergency response programs address situations that drain public safety resources and benefit from a well-trained de-escalation and problem-solving team.

Beginning on August 1, 2022, USC was contracted by the City of Richmond to assess program model options and develop a pilot initiative for a non-police response to low-level 911 calls serving Richmond residents. USC engaged Richmond residents and community stakeholders in a community survey, focus groups, community meetings, organization presentations, and direct interviews to better understand their experiences with the 911 system, crisis resources, and aspirations for new response strategies. This report is intended as a comprehensive presentation of the program options.

The working name of the proposed program is the Community Crisis Response Program (CCRP). The goal is for a CCRP response to:

1. Reduce non-warrant arrests that may result during a 911 response.
2. Reduce the number of residents transported to the emergency department when another solution is possible.
3. Reduce the number of residents who frequently interact with the Richmond Police Department (RPD) and Richmond Fire Department (RFD).
4. Reduce the number of low-level calls that RPD and RFD currently respond to; and
5. Provide communities with a supportive response that helps connect residents to needed services.

CCRP is an opportunity to provide community-focused, trauma-informed, and healing-centered crisis responses by well-trained non-police staff and strengthen residents' connection to timely, appropriate, and safe services and resources. Everyone in Richmond stands to benefit from the CCRP program. Residents get a safer response and policing that is better able to focus on major crimes, emergency response and investigation - their core public safety responsibilities.

The basic service of the CCRP pilot is the deployment of well-trained teams that respond to a broad range of behavioral health or low-acuity calls and situations without police, fire, or other Emergency Management Services (EMS) personnel. At the center of the team are CCRP responders consisting of a Community Response Specialist and Emergency Medical Technician. The

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CCRP staff also includes a Project Director and a small clinical and support staff. The pilot program projects a total of 14 full-time positions required for a 24/7 citywide pilot implementation.

For the pilot, RPD Dispatch will dispatch calls to 911 or the non-emergency number that are low-priority and meet identified criteria that make them appropriate for the CCRP response. The specific types of calls will be developed by the key stakeholders (CCRP staff, RPD, RFD and 911 dispatchers). Situations that are commonly and successfully responded to by an alternative response program include:

- Person drunk in public
- Panhandling/Aggressive Panhandling
- Disorderly juveniles - group
- Auto Disturbance - noise, revving engine
- Loud music - Noise complaint
- Incorrigible juvenile
- Confused/senile person
- Family dispute
- Neighbor disputes
- Incomplete 911 call
- Trespasser/unwanted person
- Loitering
- Public urination/indecent exposure (without criminal intent)
- Wellness check
- Subject down (often resident asleep in public)
- Found syringe
- Person screaming
- Person needing referral to services
- People in vehicles/camping in public

CCRP's operational requirements include: a small office space (staff will largely operate in a mobile unit); access to RPD's radio dispatch system; specially designed protocols for CCRP service call referrals and follow up; necessary first-aid supplies; a strong data collection, monitoring, and evaluation system; referral relationships with community-based service providers; ongoing staff training and call reviews; and a pro-active and transparent community outreach and engagement effort. The report also identifies structures to ensure ongoing communication with and feedback from RPD officers and dispatchers, RFD staff, Richmond city staff, Contra Costa County staff, Richmond City Council, and residents.

Four phases are identified for program implementation, including an initial period for City Council decision-making about program implementation (phase 1) and startup planning (including staff hiring/training) (phase 2).

Five implementation options for City Council decision are discussed in this report: 1) selecting a non-profit program vendor from outside the City infrastructure; 2) CCRP implementation in an existing City department; 3) creation of a new City department; 4) a hybrid model involving starting up

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the program in a nonprofit, then moving it to the City; and 5) a hybrid program implemented in partnership with the County. Pilot program rollout timeline depends on the implementation decisions, as do the estimated pilot costs. The CCRP pilot should run for 18 months to two years.

USC participates in convenings, both formal and informal, of jurisdictions and practitioners sharing models and learning. As more communities have implemented models, USC engages in more discussions about the experiences, challenges, and needed modifications to programs. USC has deep familiarity with the various models and the initial experiences of jurisdictions with those models, the evaluation approaches, community oversight and engagement strategies and experiences. Although USC brings those experiences to the discussion, USC remains focused on understanding the specific local needs, resources, and goals of a municipality. Each city USC has assisted, either formally or informally, will report that USC shares the information and analysis USC have gained, while respecting the unique considerations and decision-making that each city must make for itself.

USC expects that once alternative emergency response programs are integrated into Richmond's communities, having established themselves as well-known and trusted messengers, they will be used as an effective, accessible community response to a broader range of community needs, such as weather, air quality emergencies, public health, and other emergencies. Once CCRP is established, USC encourages Richmond to engage in future regional discussions to share resources and learning among crisis response programs.

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Project Background/Community Need

The May 2020 murders of Breonna Taylor and George Floyd highlighted the level of distrust and problems that develop when police interact with Black and Brown communities, even for the most innocuous of reasons. It also ignited the largest mass protest movement in U.S. history, opening policy windows across the country for reforms and reinventions of policing systems, policies, and practices. Many jurisdictions have developed programs to respond to non-violent, non-medical-emergent situations where a gun and badge is not needed or helpful and where both the residents involved, and the police are better served by alternative non-police responses. This deep and complex community discussion is ongoing in Richmond.

In October 2020, the Richmond City Council appointed 21 residents to a newly constituted Reimagining Public Safety Community Task Force (RPSCTF) to identify public safety policy reforms and program innovations for the city. Unlike in many other jurisdictions where similar taskforces have ended, the RPSCTF remains active and involved in the development of a new alternative response program. Between October 2020 and now, the RPSCTF has met 39 times and hosted eight community round tables and conversations on issues including Mental/Behavioral Health, Homelessness, Police Policies/Alternative Methods, Youth Works, Unhoused interventions, RPD budget and call data, Community Crisis Response Team, and the Office of Neighborhood Safety. The taskforce issued a CCRP Proposal which is attached and discussed in this report (Attachment #1).

The extensive participation of Richmond residents and the Taskforce on Reimagining Public Safety and City Council (including extensive research, alternative models, community discussions) has provided a deep level of understanding, support, and engagement.

The Richmond Police Department (RPD) Dispatch processes over 4000 calls each week. A 2020 report by the Center for American Progress (CAP) and the Law Enforcement Action Partnership (LEAP)[1] looked at 911 calls for service in eight cities and found that 23 to 39 percent of calls were low priority or nonurgent and 18 to 34 percent of calls were for life-threatening emergencies. Similar data has been replicated in other studies. Through in-depth engagement with a broad range of stakeholders, USC has confirmed that there are numerous low-level calls and situations without a serious criminal or medical component that meet the criteria as benefiting from a well-trained community response in Richmond.

[1] https://www.americanprogress.org/article/community-responder-model/

Richmond is a diverse community of approximately 115,000 residents in 33 square miles. Rising housing costs have deep and ongoing impacts - a doubling of unhoused residents in the past five years and an ongoing diaspora of Black and low-income residents. With the largest proportion of immigrant residents of any city in the Bay area region, Richmond's cultural and linguistic diversity creates another challenge in providing services. Immigrant communities have multiple concerns in interacting with police - history of policing in their countries of origin, immigration status, or that they will have trouble communicating with officers who will have a language barrier or incomplete understanding of their community and culture. According to the latest Point-In-Time survey of homeless residents[2], Richmond is home to 27 percent of all unhoused Contra Costa County residents.

Unhoused individuals have additional reasons to avoid encounters with police. Unhoused residents may have an outstanding warrant or be on probation or parole and could be violated for any law enforcement interaction. An arrest of an unhoused person has multiple negative effects – they are likely to lose their tent, possessions, spot in an encampment, eligibility paperwork for services, and identification. Even without an arrest, there is a broad perception that the level and quality of response and service is lower for Black, Brown, and immigrant residents. It has never been clearer that there is deep community distrust of law enforcement which affects public safety in communities across Richmond. Many institutions and residents feel overwhelmed with the numbers and needs of the unhoused residents and are unsure of how best to engage and what resources are available. There was a widely held perception that there are insufficient resources for the substantial increase in unhoused Richmonders.

There has been a national trend of police departments becoming the default response for a broadening range of societal challenges, requiring new and sometimes conflicting knowledge, skills, and abilities. This expansion of police functions has not been well-planned or conceived but defaulted to police because there were no other existing public services that were so universally available and accessible.

Arrests have long-term impact through exposure to the criminal justice system. Police responding to mental health emergencies is stigmatizing, suggesting a crime rather than a health emergency. In some situations, non-criminal/non-violent calls can be escalated by the mere presence of armed officers. Police are trained to dominate, even using physical force, to manage situations or ensure compliance with orders, that can result in

[2] https://cchealth.org/h3/coc/reports.php#Annual

trauma for residents and damaged community relations. Even if a situation is handled perfectly, the long-standing distrust of police in many heavily policed communities limits many residents' willingness to call for police assistance or engage with police on scene. Data from national research of police departments from across the country shows that there is a greater likelihood that a police officer will use force on Black, Indigenous, disabled, unhoused and people of color. When residents distrust police, they are less likely to call for help and more likely to distrust policing efforts to investigate crimes or strengthen community policing.

These discussions are founded on an understanding that in non-violent situations without a medical emergency or serious crime both the individuals involved, and the police can be better served by a well-trained, non-police response. The greatest unintended consequences of armed police responses to low-level calls are trauma, injury and death to the individual(s) being responded to. Additionally, inefficient deployment of police resources results in other negative unintended consequences. Police are increasingly being requested to connect unhoused individuals to short- and long-term support services, respond to 911 calls for people experiencing mental health crises, respond to 911 calls from those during family or neighbor conflicts, and working with young people who may be in danger of getting swept up as trafficking victims or into the criminal justice system.

As is discussed in detail in the MATRIX report[3], Richmond's police staffing challenges reflect a national pattern. Recruiting and retaining police officers makes discussions of appropriate levels of staffing complex – many cities are unable to recruit to their identified needed staffing level. This contributes a practical reason to identify public safety functions that can be re-organized and performed outside of the system that has developed.

In many cases, officers do not have the time and training to address situations with underlying complex socio-economic problems, nor adequate access to community resources. This results in a delayed focus on serious criminal response, investigation, and priority safety issues; poor officer morale/increased officer stress; increased overtime expenses; and arrests of individuals where a non-carceral outcome is warranted.

This is a moment of rapid change and reimagining of public safety and services in many communities, with new and expanded outreach and response teams, many focused on mental health, substance use disorder, and unhoused residents. This is especially true in Contra Costa County

[3] https://www.ci.richmond.ca.us/DocumentCenter/View/65094/Richmond-Police-DFR-3-6-23
https://www.ci.richmond.ca.us/4324/Richmond-Emergency-Services-Study

where cities are developing new models to respond to expanding or unaddressed needs while facing understaffing in police departments. County voters approved a special levy, Measure X, to develop an alternative emergency response system for mental health emergencies. The County is implementing this wide ranging and ambitious effort to radically strengthen the response and support for residents with mental health challenges, A3 - Anywhere, Anyone, Anytime - coordinated through the Miles Hall Hub Crisis Call Hub. One of the challenges - and benefits - of addressing the options for Richmond's response program is this rapidly changing landscape.

USC has found that developing a successful program with broad acceptance across diverse community interests is uniquely possible with alternative emergency response. There are several obvious but crucial elements - ensuring that the broadest possible range of stakeholders have meaningful input, deep, diverse, and culturally competent community participation, and transparent, respectful, principled engagement and reporting. In our experience, model and program development can often find common ground and support from across a spectrum of stakeholders and residents, if people believe that their concerns are meaningfully addressed. USC hopes that the residents of Richmond have found that our work and this report meets those objectives.

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CCRP Essential Components

The primary goal of the proposed Richmond Community Crisis Program (CCRP) pilot program is to provide a non-police alternative response to a broad range of low-level emergency situations with well-trained teams who are deeply familiar with Richmond communities. The CCRP response focuses on de-escalation, mitigation and prevention of escalation or repeated emergency situations, and connecting residents to appropriate services/supports. CCRP will utilize best practices for harm reduction, street outreach, trauma-informed and culturally competent care. The secondary goal of CCRP is to enable the Richmond Police Department (RPD) officers to focus on more serious calls, crimes, and investigations. CCRP is expected to be separate and independent of the RPD.

Why A Non-Police Response

There are alternative response programs (nationally) that co-respond with police. While there is no available data that measures levels of community support for co-response program models, the trust and relationship issues between law enforcement and many communities is well documented. Co-response models may also reduce police time on a call if they leave after determining the situation is secure, but overall do little to save money or enable police to focus on more serious emergency situations. Models that respond without a police report no increase in safety concerns and infrequent requests for police backup. On those occasions when a team requests a police response, it is typically not because of concerns about the safety of the response team, but because of a situation that can only be addressed by police (such as a resident wishing to report a crime or a situation unsafe for residents). Non-police response programs also appear (anecdotally) to have high levels of community support.

The 34-year program community-based public health response in Eugene Oregon, Crisis Assistance Helping Out On The Streets' (CAHOOTS) foundational principles are a strong starting point for CCRP:

All services are free and voluntary.

- *We rely on effective communication, trauma-informed care, harm reduction, and verbal de-escalation to maintain the safety of our staff and the community.*
- *We seek the most minimal intervention.*
- *It is our goal to remain client-centered, and to strive to provide all folks with unconditional positive regard, free of judgment or discrimination.*
- *We respect a client's right to privacy, dignity & confidentiality.*

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Program Components

Based on experience in the program development, implementation, and evaluation of alternative emergency response programs, reports from other programs, and the identified priorities in the city of Richmond, USC identifies the following essential components of a non-police alternative emergency response program:

Coverage

Ideally, the pilot will respond to calls 24 hours per day, 365 days per year, to ensure consistency, reliability, and scalability of response. Programs can fail to gain community and stakeholder awareness and confidence if the schedule is inconsistent or unavailable. If 24/7 service is not immediately possible, the goal should be the broadest possible schedule that can be consistently provided. There will be fewer resources available outside of business hours that enable warm handoffs but simultaneously make the need for a response greater; weekends and nights are repeatedly mentioned by stakeholders because no other resources are available.

Accessibility

Offering transportation to a safe location is often an essential factor in resolving or de-escalating a crisis or assisting a resident. Transportation is also essential to ensuring that a resident accesses a resource or referral to a warm and successful handoff. USC encourages Richmond to make a priority of creating a program that can transport people with disabilities. People with disabilities have an increased interaction with emergency services, greater likelihood of becoming homeless, and more negative outcomes in interactions with police. As Richmond creates an alternative response program, USC urges a program that can serve an inclusive population.

Community Presentation

CCRP cannot be used or viewed as an arm of enforcement. Building credibility and trust requires a non-authoritative, non-judgmental approach. This is especially important for people who have negative perceptions or prior experiences with law enforcement, health care, or government programs and may be hesitant to engage with responders. CCRP responders will carry a police radio and RPD dispatch will refer calls for CCRP response. It is important to clearly define CCRP roles and scopes of practice. It must be clear that CCRP has no enforcement function and its priority is the best interests of the resident so that the public understands that engaging with

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CCRP will not (except in extraordinary circumstances) result in police interaction.

Response & Communications

To get a CCRP response, Richmond residents will call 911 and the non-emergency line (510-233-1214) and appropriate situations will be dispatched to CCRP. CCRP is not solely a program that will be accessed by residents requesting the service for themselves. Some residents will call with a complaint or concern about someone who is unaware of the call. Some residents may want a police response. The selection of appropriate situations for a CCRP response rests with dispatch, following established protocols.

The program must have one access point and two-way communications, for the safety and efficiency of the team. Responders will carry a radio that enables them to receive dispatched calls and communicate their location and any other relevant information with RPD dispatch. Some programs have attempted to create multiple points to access their program. This creates a situation where the team is receiving multiple, uncoordinated communications. It also means that the team is expected to answer their phone or radio in the middle of a response, which is distracting and inappropriate. More than one access point also impedes collecting data and reporting. Teams can notify dispatch if they are responding to a situation not sent to them by RPD dispatch, such as "on-view," follow-up to a previous situation, or a community contact.

There is significant community interest in having another mechanism to reach CCRP without calling 911. There are programs that use other approaches, including separate dispatch and a separate number, educating the community to use a new number or existing number such as 311 for the new program, or (in its infancy) app-based contact and dispatch. There is little data on these approaches at this point, but the experience of hotlines generally is that it is very difficult to educate a community to use a new number or existing number for a new purpose. USC recommends a dedicated CCRP number that is answered by RPD dispatch, using a different script. Ideally, this number would be in place at the beginning of the pilot so that it is integrated into initial community education about CCRP but if delayed, should not delay pilot implementation.

The Taskforce's Community Crisis Response Program Proposal prefers that calls initially come through 311 and CCRP have a separate dispatcher. Directing Richmond residents to use 311 for low-level crisis situations would make it much more difficult to garner community engagement with CCRP and use of the response team. USC heard repeatedly that residents want a

response to the type of calls currently coming through the non-emergency number or 911 and responded to by RPD or RFD. USC suggests an ongoing effort to work with other referral networks (311, A3, 211) to identify and send to RPD dispatch situations that would benefit from CCRP support. There is a credible concern that if RPD dispatch is assessing and dispatching calls, it could have undue influence on CCRP, and the calls assigned to it. This has been an obstacle for some programs and should be evaluated over time by the CCRP Community Advisory Board and addressed in the program evaluation.

Establishing a new specialized number is straightforward operationally and has minimal additional cost if answered with a separate script by RPD dispatch. If the city determines that it wants to pursue a number that is not answered by RPD dispatch, it is possible to explore having 211 answer calls to a dedicated CCRP number, although with a higher cost and some additional technical issues, it would not be prohibitive. Calls through any system other than RPD dispatch would have to be patched back to RPD dispatch to send to the CCRP team.

Some initiatives narrowly target specific types of calls or communities to receive support, such as identified mental health calls or situations involving unhoused residents or people using drugs. This unnecessarily restricts addressing the types of situations that do not require police and undercounts the calls that should fall under the criteria. The initial types of calls and criteria will be developed in collaboration with CCRP, RPD, RPD dispatch, RFD, and stakeholders.

Examples of situations that CCRP may respond to include:

- Person drunk in public
- Panhandling/Aggressive Panhandling
- Disorderly juveniles - group
- Auto Disturbance - noise, revving engine
- Loud music - Noise complaint
- Incorrigible juvenile
- Confused/senile person
- Family dispute
- Neighbor dispute
- Incomplete 911 call
- Public urination/indecent exposure (without criminal intent)
- Wellness check
- Subject down (typically a resident asleep in public)
- Trespasser/unwanted person
- Loitering

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- Found syringe
- Person screaming
- Person needing referral to services w/o access to phone
- People sleeping in vehicles and/or camping in public

CCRP Staffing

The CCRP model has the team in the field for most of their shift, primarily responding to calls from RDP dispatch. The focus of the teams includes mediation, problem solving, crisis prevention and de-escalation, transportation, and connection to resources and referrals. If there is time between dispatched calls, responders will follow-up with residents from prior calls to encourage connection to services, check-in with residents who frequently call 911, visit areas of frequent calls for service, or make "on-view" (the team sees a situation developing and they stop to help) stops. Pilots and programs in other jurisdictions carry emergency medical supplies such as Narcan, EpiPen, Glucagon (diabetic emergency), O2 tank, Airway kit, wound care materials, and comfort and supportive items, like water, food, hand warmers, socks, etc.

CCRP responders must be well-trained and deeply familiar with the communities they serve. They do not perform clinical work and should not be clinicians or social workers. A model that does not use licensed mental health professionals or social workers as responders is less expensive and greatly expands and diversifies the pool of potential team members. Four years ago, subsequently, some Bay Area programs were already reporting that they could not expand services despite available funding because of challenges in recruiting and retaining clinical staff. Using well-trained non-clinicians removes the recruitment and retention problem faced by programs with licensed clinicians. Given the demographics of the US clinical workforce, non-licensed responders will better reflect the communities they work in. CCRP will be able to emphasize seeking staff with a deep understanding of impacted communities and lived experience. A common concern is that unlicensed responders could increase a jurisdiction's potential liability. Richmond should seek legal counsel on this matter, however other jurisdictions have concluded that responders acting within their scope of practice do not increase liability and that the function of the team may include connecting a resident with a licensed clinician but is not clinical.

Most US programs use licensed mental health clinicians and social workers on responder teams, although they consistently report difficulties in recruiting and retaining staff due to a national shortage and that their experience suggests that staff with lived experience should be utilized more. More programs are shifting to at least some teams without a clinical/social

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worker presence. This suggests that there has been an over-reliance on clinicians when responding to situations of lower acuity than identified serious mental health situations that require diagnosis, assessment, and long-term care planning.

Although the CCRP teams do not include a clinician responding to emergency calls, the model relies on a clinical position for developing and revising protocols, collaborating with the County and referral agencies, ensuring warm handoffs to services, appropriate clinical intervention, identifying training needs, case follow-up, when necessary, program oversight, analysis and evaluation of calls, and holding group team meetings to address clinical issues that arise. The other core function of the clinical position is to support the responder teams in their stressful work, including exposure to trauma and vicarious trauma. This is not a direct oversight role that is immediately available or on-call 24/7. Responders must have support for their field work and having a clinician or social worker as part of the program is an important component.

USC recommends a team of two, ideally a community responder with experience providing support to residents and an EMT. The Taskforce's CCRP Proposal calls for a three-person team - two mental health/harm reduction specialists and one medic. There are many programs responding successfully with two-person teams. In discussions about team size, those programs state that they are very comfortable with their teams and do not believe their work would be strengthened with a third team member. Programs with three-person teams tend to have very distinct job functions assigned to each team member. The CCRP model provides the teams members with the same training and expects them to function collaboratively.

A program that values a stable workforce must offer salaries that demonstrate commitment to the program and the value of the work. Paying equitable wages will be cost-effective in enabling CCRP responders to make the work their careers as they develop expertise and diminish the costs and program challenges associated with turnover.

CCRP Training

RFD dispatchers must have a deep understanding of the CCRP response, training, and capacity to have confidence in identifying appropriate situations to dispatch to the team. Dispatchers must also have confidence that they will be supported in making reasonable judgements, following their protocols and training. Initially, CCRP will respond to a smaller number of calls that are selected, working with dispatch, RPD, RFD, and utilizing the experiences

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of other programs. When dispatch has gained experience and comfort with CCRP, dispatchers will begin to identify appropriate situations without solely evaluating calls based on the categorization (call categories were designed for a system where only one type of response ever occurred). Ongoing and regular consultation between CCRP and dispatch is essential to maintaining communication and strengthening collaboration.

CCRP staff must receive comprehensive training, including field and driving safety. They must understand the scope of practice, policies, and procedures for RPD, CCFD, and the County response teams. USC recommends ride-alongs with RPD and A3 and a "sit-along" with RPD dispatch. Ongoing training is essential and must be integrated into the program planning, budgeting, and scheduling considerations, and a topic for evaluation. The training curriculum is discussed in the implementation section of this report.

CCRP Team Safety

The following requirements will help to ensure the safety of CCRP teams and community:

- RPD dispatch assesses the risks of each call with a series of questions and by reviewing the history of the caller and location.
- The CCRP responders must have extensive safety training in assessing and responding to a broad variety of situations.
- The teams will carry radios to communicate with RPD dispatch; in an emergency, they can request assistance. As programs across the country have begun implementation, initial data indicate that alternative response teams call for police to come to the scene very infrequently and typically for a non-emergency role (traffic control, relinquishing a gun, resident wants to report a crime, etc.).
- Teams are trained to use intuition and have decision-making autonomy for safety decisions.
- All resident interactions are voluntary. A component of CCRP safety is that community members are not worried about bad outcomes because they understand that all interactions with the team are voluntary, and residents will help to formulate and agree to any outcome.
- Ongoing communication, coordination, and engagement with partners – police, fire, dispatch, referral network, and community (including integration with the County, advocacy, and service provider networks).
- Ongoing community outreach to build trust, familiarity, and interchange so that residents understand CCRP, what to expect, and can offer feedback.

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CCRP Community Engagement

Community outreach, education, and engagement are essential to building a successful program and a strong, credible relationship with residents and stakeholders. CCRP must clearly communicate the parameters for a CCRP response. The goal is for all stakeholders and residents to understand when a CCRP response is appropriate and what to expect in the response. The pilot must prioritize engaging the community during the planning and implementation, demonstrate transparency in how CCRP engages with police and all stakeholders, and ensure ongoing community input and feedback. This ensures that the planning, implementation, and ongoing assessment of the program reflects the unique needs and experiences of Richmond's diverse communities. Ongoing community outreach and engagement are critical to the success of the program and to continuous improvement of the model to reflect the Richmond residents' experiences with the pilot. The outreach and engagement strategies must pay special attention to communities less likely to be connected to traditional media and outreach strategies.

Although it is rare to find anyone who does not agree with the importance of robust community engagement, it requires ongoing diligence and attention. Even the Crisis Assistance Helping Out On The Streets (CAHOOTS) program in Eugene, OR, with over 30 years of experience, has been making significant structural changes to address representation and community input and oversight. Several cities - Denver, San Francisco, and Oakland - are currently facing program hurdles that result from failing to maintain transparency and community engagement.

USC has been involved with program development that effectively sought out representative participation, including residents who are typically disconnected from city interactions, and meaningful and robust engagement from a broad range of perspectives. This report recommends several structural elements to create mechanisms for ongoing stakeholder and community outreach, engagement, and input into the program:

1. A community advisory board to provide oversight and support for the program.
2. Regular and structured meetings with service providers offering referrals and resources for CCRP.
3. A citywide outreach and public education campaign.
4. A regularly updated public facing CCRP website and a data dashboard.
5. A complaint and feedback mechanism and a process for the review of complaints.

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CCRP Support Networks

To facilitate connections to services, a robust network of referral resources and services that address community needs must exist. Building the network and identifying the parameters of each program should be in place before the pilot begins, although it will always be a work in progress. Regular meetings with service providers offering referrals and resources for CCRP should include reviews of referrals, answering both data and narrative questions (e.g., is the provider receiving appropriate referrals, are the warm handoffs supporting care, are there missing or overlapping elements to the CCRP support of the referral's clients, what are outcomes from referrals).

Along with structured and ongoing engagement and assessment with RPD leadership, the city must ensure that RPD and RFD staff are well-briefed on the pilot prior to implementation, including the scope and function of CCRP, how to interact beneficially, protocols, and how CCRP is an asset to Richmond's public safety mission. RPD leadership and officers must understand that CCRP has a separate and distinct scope of work and cannot be used as an arm or extension of law enforcement.

CCPHD Coordination/Collaboration

Contra Costa County's Behavioral Health Department and especially the Anyone, Anywhere, Anytime (A3) program and the Miles Hall Crisis Call Center are tremendous assets for Richmond and CCRP. The A3 call taking, and response teams provide a level of care for situations not appropriate for a CCRP response. A3's specially trained clinicians can assist with involuntary hospitalization (often referred to as '5150') for people who are a danger to themselves or others or are unable to manage basic needs. It is essential that any city program work closely with the County programs to best design a program that maximizes the relationship, addresses gaps in service, and continually evaluate and jointly identify modifications to develop better strategies and opportunities for integration, collaboration, and mutual support.

CCRP Evaluation

Program evaluation is an essential component to the success and sustainability of CCRP. To evaluate the program meaningfully and accurately, there needs to be an evaluation plan in place at the beginning of the pilot that identifies clear metrics and goals, data to collect, and how and when evaluation will occur. All stages of evaluation should be transparently communicated with the community.

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A non-police responder program in Richmond, developed in collaboration with community stakeholders and responsive to the needs and experiences of residents, with appropriate representation of impacted residents, training, and access to resources and referrals will benefit everyone. A community-based, resident-centered, trauma-informed response that promotes every resident's dignity, autonomy, self-determination, and resiliency will result in:

- reduction of police interactions with vulnerable populations.
- faster responses to lower priority calls, enabling mitigation and de-escalation of situations.
- lower-cost response to non-criminal, non-violent emergency calls.
- RPD officers and RFD firefighters freed up to respond to higher priority calls.
- a more appropriate response which connects residents with services to address underlying or root causes of the emergency issue.
- transport to services - removing a frequent barrier to services or crisis resolution.
- uncoupling health crises from unnecessary police contact.
- decriminalization of mental illness, alcoholism, and addiction.
- qualified and appropriate response for service providers, and families, and residents with mental health challenges.
- improved police/community relationships by reducing negative interactions.
- people impacted by the emergency response system gaining control of their social, emotional, and physical well-being through direct service, education, and increased access to community assets and resources.

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Program Options

There are five structural options for how and who implements the CCRP. The primary factors impacting the choice of alternatives include: the speed of implementation, cost, sustainability, and community support. Implementation speed is the factor most valued by both the City's leadership and residents. City Council and Task Force members have expressed a strong desire for the program to start before the end of 2023. Program cost considerations are also an important factor. The City has included $1 million for the CCRP in its Fiscal Year 2023-2024 budget. While this is likely sufficient for initial pilot implementation, it will not cover the expenses for a full year 24/7 program (see Budget/Funding section). Sustainability refers to the fact that the CCRP needs to address systemic issues that cannot be resolved in a short-term time frame. Sustainability also requires that the program is insulated from changing City priorities and political influences. CCRP's sustainability will be insured by maintaining a strong level of community support. Different structural options for the CCRP may also have different levels of community support.

The five potential structural options for the City to consider are:

1. **Non-profit** - The City issues an RFP for an independent non-profit agency (vendor) to run the program. Lessons learned from Antioch's non-profit program implementation can inform the pros and cons of Richmond's decision-making.
2. **Existing City Office** – The City can choose to institute the CCRP within an existing municipal department. Potential candidates include the Richmond Fire Department, the Community Services Department, and the Office of Neighborhood Safety. Based on resident feedback, the CCRP should not be implemented under the Richmond Police Department.
3. **New City Department** – Another option, using the City's infrastructure as a foundation for the program, is to create a new City department that includes the CCRP and potentially other current initiatives (e.g., social service needs).
4. **Nonprofit Hybrid Model** – This option combines starting the CCRP in a non-profit (to implement the pilot) with the intention of the CCRP then being brought into the City.
5. **Richmond Partnership with Contra Costa County** - The city could negotiate with Contra Costa to provide the services the City of Richmond identifies.

The following table ranks each primary factor influencing the City's decision-making with the structural options proposed. The ranking is based on a 1-3

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scale, low to high ranking (with 1 being very low – more cons than pros, 2 being moderate – some pros and cons, and 3 being high – mainly pros).

	Implementation Speed	Cost	Sustainability	Community Support	TOTAL
Non-Profit	3	3	2	2	10
Existing City Department	2	1	3	3	9
New City Department	1	1	3	3	8
Non-Profit Hybrid	1	2	2	2	7
CCC Partnership	1	2	2	1	6

Based on this ranking, the non-profit option received the highest total and the partnership with Contra Costa County received the lowest total. It is likely that a non-profit could be best positioned to implement a program quickly and it may be easier to maintain fidelity to model with a contract in place. Programs implemented within a government agency seem to be more susceptible to political implications and pressures, however they have higher sustainability and community support rankings. Regardless of the structure chosen, sustainability will depend on the program demonstrating efficacy through data and evaluation. The non-profit hybrid option has risks. The non-profits USC has spoken to are not eager to develop an entirely new program and model only to turn it over to the City. One non-profit mentioned that they would also be losing staff they recruited or transferred to the program. For most non-profits, this is a significant undertaking, and they would be ramping up only to ramp back down after. Finally, collaborating with Contra Costa County has advantages, including that the program would be fully integrated with the County's Behavioral Health services and that the city would not have to create a new model, which the County already has in place. The County, however, has faced challenges recruiting and retaining responders, and feedback from residents indicates a strong preference for a Richmond-run program compared to a County-run program.

Another structural decision is how the Community Advisory Board will be constituted. This should be addressed quickly so that community voices are involved in the design and implementation and in developing and supporting community education and engagement (regardless of the implementation structure).

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Budget/Funding

Budget

The program budget cannot be finalized until many aspects of the pilot are determined, most significantly, where the program is housed, and operational decisions are made. Based on the structural options, the least costly is the non-profit option and implementing the CCRP within City government is, most likely, the costliest option.

Most of the program expenses will be allocated for program staff. The minimum total program staffing level envisioned, for a citywide 24 hours/day, 7 days/week program operation, is 14 FTEs. This includes: 1 Program Manager, .5 Program Data Analysts, 6 Community Crisis Responders, 6 Emergency Medical Technicians, and .5 Mental Health Clinician.

Following is an example of the work schedules for the CCRP core filed staff (Community Crisis Responders & Emergency Medical Technicians):

CCRP Team Schedule Example

Day of the Week	**Schedule (Teams 1-3)**	**Schedule (Teams 4-6)**
Sunday	Off	In the Field
Monday	Off	In the Field
Tuesday	In the Field	Off
Wednesday	In the Field	Off
Thursday	In the Field, Office Work, or Training	In the Field, Office Work, or Training
Friday	In the Field, Office Work, or Training	In the Field, Office Work, or Training
Saturday	In the Field, Office Work, or Training	In the Field, Office Work, or Training

Shift Name	**Shift Time Start**	**Shift Time End**
Day Shift (Teams 1 & 4)	7:00am	3:00pm
Swing Shift (Teams 2 & 5)	3:00pm	11:00pm
Night Shift (Teams 3 & 6)	11:00pm	7:00am

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Projected (average) annual salaries for each position (based on salary ranges for similar Richmond job classifications) are as follows:

Program Manager – $120,000
Administrative/Data Analyst – $80,000 ($40,000 for .5 FTE)
Community Crisis Responder – $70,000
Emergency Medical Technician – $80,000
Mental Health Clinician – $130,000 ($65,000 for .5 FTE)

The following table estimates CCRP personnel costs for a six-month (pilot) and full year (12 month) program implementation. Benefits projections vary based on nonprofit implementation (35%) versus City implementation (80%).

Position	Salary	# FTE	Salary Subtotal	Benefits (35%)	Total Comp. (12 Months)	Total Comp. (6 Months)
Program Manager	$120,000	1.0	$120,000	$42,000	$162,000	$81,000
Data/Admin Analyst	$80,000	.5	$40,000	$14,000	$54,000	$27,000
Community Crisis Responder	$70,000	6.0	$420,000	$147,000	$567,000	$283,500
EMT	$80,000	6.0	$480,000	$168,000	$648,000	$324,000
Mental Health Clinician	$130,000	.5	$65,000	$22,750	$87,750	$43,875
TOTAL		**14**	**$1,125,000**	**$393,750**	**$1,518,750**	**$759,375**
Position	**Salary**	**# FTE**	**Salary Subtotal**	**Benefits (80%)**	**Total Comp. (12 Months)**	**Total Comp. (6 Months)**
Program Manager	$120,000	1.0	$120,000	$96,000	$216,000	$108,000
Data/Admin Analyst	$80,000	.5	$40,000	$32,000	$72,000	$36,000
Community Crisis Responder	$70,000	6.0	$420,000	$336,000	$756,000	$378,000
EMT	$80,000	6.0	$480,000	$384,000	$864,000	$432,000
Mental Health Clinician	$130,000	.5	$65,000	$52,000	$117,000	$58,500
TOTAL		**14**	**$1,125,000**	**$900,000**	**$2,025,000**	**$1,012,500**

Estimates for CCRP personnel expenses range from approximately $759,000 (nonprofit implementation) to $1.013 million (City implementation) for the 6-month pilot startup, and $1.519 million (nonprofit implementation) to $2.025 million (City implementation) for the full-year program operation.

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In addition to personnel, the key program startup expenses include equipment purchases (including radio communications), staff training, transportation (vans), and office furniture. Additional expenses that need to be determined and incorporated include but are not limited to updated salary ranges based on the classification and compensation study and differential pay for night shifts and any other items subject to meet and confer with Richmond's unions. Additional analysis and conversations with Human Resources and Finance is needed to determine more refined budget numbers. This analysis can be done after City Council direction is provided.

The following is a sample 12-month program operating expense budget (including some narrative notes).

PROGRAM OPERATING COSTS	COST	NOTES
Equipment (Computers/Communications)	$55,000	Laptops & 6 Motorola police radios
Professional Services	$25,000	Technical assistance, program innovation, data services
Office Supplies/Furniture	$5,000	
Training/Staff Development	$25,000	Pre-startup and ongoing
Insurance	$15,000	To be researched.
Rent & Utilities	$5,000	1000 sq. ft. x $5 ft.
Repairs & Maintenance	$2,500	
Janitorial	$3,000	
First Aid Supplies	$10,000	
Non-First Aid Supplies	$10,000	PPE and comfort items such as warm clothes, snacks, water, etc.
Van Expenses (including maintenance & gas)	$100,000	2 Vans, ADA accessible
Travel	$1,000	
Emergency Housing	$5,000	

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Translation/Interpretation	$5,000	
Postage & Shipping	$1,000	
Telephone	$21,000	
Licenses	$2,500	
Electronic Health Records & Billing	$15,000	Medicare reimbursement processing
Community Outreach & Engagement	$20,000	Community meetings, social/print media
Program Evaluation	$25,000	
TOTAL OPERATING COSTS	**$351,000**	

Indirect expenses are not included in the total. Additional funds for indirect may need to be added if the program is contracted to a non-profit partner.

The pilot program implementation (1/2/24-6/30/24) is estimated to cost approximately $1.11 million (nonprofit implementation without indirect costs) to $1.36 million (City implementation). These expenses are estimated based on the program being able to be operational by the beginning of 2024.

Given these projections, it is estimated that a full year implementation for the program will cost approximately $1.82 million (nonprofit implementation without indirect costs) to $2.32 million (City implementation). (Please note – all these projections are subject to value-based budgeting analysis and team deployment scenarios based on emergency call data peak times/days.)

Funding

The City has budgeted initial pilot program funding ($1 million) from American Rescue Program Act (ARPA) reserves. Many response programs, across the country, in the past two years were able to use ARPA funds to support their new response programs. When these funds are exhausted, the City will need to identify additional resources for program operations.

There is an expanded focus of federal and state funding to support response programs, mental health and homeless programs, and "peer" or non-clinical programs. For example, the City of Oakland received $10 million from the CA Budget Act of 2021 to supplement local funding for the MACRO (Mobile

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Assistance Community Responders of Oakland) program. This is rapidly developing but is worth monitoring for future opportunities. Richmond should examine advocating for similar funding during the State's next legislative session.

At the federal level, localities have identified different ways to leverage federal funding for local response programs. For example, some jurisdictions have billed Medicaid for reimbursable services such as mobile crisis outreach, which can be offered by many community responder programs. Because Medicaid is a state-federal partnership program, localities must work within the restrictions specified by their state Medicaid agency and the U.S. Department of Health and Human Services to use these funds. Despite these restrictions, jurisdictions can access Medicaid funding to support community responder programs in multiple ways. For one, states considering this funding source can apply for a waiver of Medicaid program requirements, known as a Section 1115 waiver. This waiver provides jurisdictions with flexibility to direct Medicaid dollars toward innovative service delivery models like community responders.

One of the program decisions is whether to structure data and client information collection from the outset to enable MediCal billing. There are new billing modalities being developed that address billing based on the degree of the person providing services. Obviously, this is a complex issue, varying by County, but it should be researched to the extent possible, given the ongoing changes, in advance of the pilot. Many programs are relieved not to be required to collect billing information. California's new Peer Support Specialist Certification enables MediCal billing for support from responders without college degrees or licenses. Additionally, the structural program options could impact whether it is an option. For example, California laws address whether fire departments can bill insurance and government health programs.

The U.S. Department of Health and Human Services has several flexible funding sources that can also be used to support these programs. The Substance Abuse Prevention and Treatment or the Community Mental Health Services Block Grants are non-competitive federal formula grants distributed to all states. State Opioid Response grants are another funding source that have been used by states to develop substance use crisis response strategies that could include community responder programs.

Every year, the U.S. Department of Justice's (DOJ) Office of Justice Programs (OJP) also distributes roughly $5 billion in grants, much of which is awarded to state and local governments.

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Three grants Richmond may consider applying to are:

1. Byrne Justice Assistance Grant program**:** A formula grant that provides highly flexible funds that can support a wide range of safety and justice activities.
2. Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP): Competitive COSSAP grants can support first-responder models that divert people with substance use needs and co-occurring mental health disorders from the criminal justice system.
3. Justice and Mental Health Collaboration Program (JMHCP): JMHCP grants can be used to support a range of cross-system approaches for helping people with mental illnesses and co-occurring substance use disorders. It may not be a good fit for all community responder programs, however, as it requires a partnership with a criminal justice agency, which excludes programs that operate fully outside of the justice system. Under JMHCP a new grant opportunity called Connect and Protect launched in FY2021.

While federal funding, in many cases, is short-term, City and County funding may provide longer-term sustainable resources for ongoing program implementation. For example, although CCRP is not solely a program responding to unhoused residents, there will be a significant portion of the calls addressing issues arising from homelessness. With 72 percent of unhoused residents in all West Contra Costa County, Richmond could explore County funding to support a response team that will respond to a substantial number of situations that involve unhoused Richmonders and will connect residents with County services.

The County's A3 program is developing three tiers of response: clinicians co-responding with police for the most serious and potentially hazardous situations; a clinician-led team; and a team of "peers" - non-clinicians with training but no license or advanced education. Although A3 plans to remain focused on situations arising from mental health challenges, the third tier, a peer response, bears the strongest similarity to the CCRP team. Once CCRP and A3 are more developed, it may be possible to explore CCRP responding to calls appropriate for the A3 peer response or providing support if A3 responders are delayed in responding.

Philanthropic support should also be examined, specifically for program startup expenses (including ongoing program data collection/evaluation). There are some grants specifically for equipment and appropriate for response teams. Such a grant could enable the purchase of a wheelchair - accessible vehicle.

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Finally, the MATRIX report suggests "to increase utilization and potentially share costs, the department should examine opportunities to utilize the team regionally with other nearby municipalities." After the pilot, Richmond can assess, based on the data, if this is worth considering.

Pilot Program Implementation Planning

The pilot's goals are for rapid implementation, flexibility to tweak processes and learn during the pilot, and collaboration with RPD, RPD dispatch, referral agencies, the County's A3 program, and other stakeholders.

To be successful, the program must be able to take advantage of ongoing assessment and evaluation and expect changes based on what is learned during and after implementation. Many programs are hindered because they are unable to make changes. USC participates in meetings where alternative response program managers explain that they wish they could make a change but are hindered by a rigid organizational structure or immutable parameters.

The initial effort should provide the space to build relationships with the community, police, County, and a referral network and opportunities for program innovation and nimbleness in testing, knowledge-building, and continuous improvement.

Collaborations

CCRP will rely on building strong relationships and networks to connect residents with appropriate services and resources. The program will need to develop and maintain a comprehensive, continuously updated list of resources and referral programs based on availability, intake coordination, hours, rules, acceptance statistics, barriers to care, range of disposition options, ADA accessibility, and languages spoken. CCRP will need to track services based on some of the common obstacles to receiving services including how and whether programs accept pets, keep family units together, require sober living, require attendance of religious services, accept participants who are on court supervision, or permit people to store possessions. The success of the CCRP program will depend on the ability to transport residents to a safe location and have a "warm handoff" of clients to referral partners. The program manager and clinician will develop mechanisms, such as check-ins and meetings, for building and maintaining essential relationships with service providers in the city and County.

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The County is implementing a wide-ranging and ambitious effort to radically strengthen the response and support for residents with mental health challenges, Anyone, Anywhere, Anytime (A3). A3 is designed to receive calls at the Miles Hall Crisis Call Hub and, if necessary, dispatch a tiered response depending on the safety and acuity of each situation: a co-response with licensed clinician and police; a clinician-led team; and a team of well trained, unlicensed staff. One of the challenges of addressing the options for Richmond's response program is that the landscape is rapidly changing. What USC knows is that A3 will continue to focus on situations involving county residents with mental health challenges and that A3 does not transport residents. Even when A3 is fully implemented, they will not respond to situations that do not involve a person with a mental health challenge and there will continue to be more than enough situations to keep CCRP fully engaged. Discussions with RPD dispatch, RPD leaders, and Richmond stakeholders and residents indicate that, similar to the experiences of other cities that have implemented alternative response programs, there are a large number of low-level calls that do not involve a mental health situation, such as listed on page 14.

Contra Costa Health Services' Coordinated Outreach Referral, Engagement (C.O.R.E.) program provides unhoused residents with connection to health, basic needs, and housing. C.O.R.E. is an entry point for the County coordinated entry system. C.O.R.E. is accessed through 211. C.O.R.E. is not a response program for crises. Not every call to Richmond dispatch is for an emergency or crisis. Some situations will be appropriate to either C.O.R.E. or CCRP, whichever team is available.

Consistent and responsive collaboration are vital to fully engage County resources, maintain excellent communication between programs, and ensure clarity of the scope and responsibility of each program.

Community Education & Engagement

Transparent and accessible community education, engagement, and oversight strengthens the program, permits program management to focus on implementation and management of the program, provides residents with a clear and useful mechanism for engagement and feedback, and results in continuous improvement of the model to reflect the Richmond residents' experiences with the program. USC has been following various approaches to ongoing community engagement. Although many jurisdictions have some form of a community advisory or oversight board, the forms vary. Selection, representation, authority, and transparency all vary. USC is prepared to share with the City models and examples, including best practices for advisory boards, transparency, and engagement of impacted communities, residents, and people with direct experience with the program.

Community Advisory Board (CAB)

An independent and committed community advisory board (CAB) is an essential factor in precluding unnecessary complications, maintaining community confidence, and early opportunities to address challenges. The CAB should provide oversight and support for the program, with access to program information and data (anonymized). Meetings, reports, complaints, and data should be public facing (except when it includes identifying information); transparency will help build confidence in the board and diminish any concerns about representation or the selection process for the board. It has proven important to create the board in advance of implementation so that there is a structured mechanism for community engagement in the decision-making leading up to the implementation.

As is emphasized in best practices for community engagement in-service programs, USC recommends that communities who will have extensive interaction with CCRP are represented on the CAB, for example, unhoused Richmonders and voices that might have a unique experience that should be reflected, such as young people, residents living with disabilities, and immigrant communities.

Transparency and Community Education and Engagement

Richmond is well-positioned on public reporting and transparency to provide accessible and useful public information both on the program, development, and planning. Effective community education on the program must include online and in-person outreach, social media, and traditional media to increase community knowledge and confidence, participation, and the formal and informal sharing of materials. All program information should include contact information for any member of the public wishing to provide feedback on reports and program development or make suggestions. USC recommends developing a plan for robust and ongoing community education and outreach including:

This report recommends several structural elements to create mechanisms for ongoing stakeholder and community outreach, engagement, and input into the program with special attention to communities less likely to connect through traditional media and outreach strategies.

1. Accessible educational and outreach materials, including social media posts, flyers, and FAQs.

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2. Translation of basic materials into languages, identified with input from community members. The city can consider which languages to translate more comprehensive materials and meetings.
3. Distribution and outreach plan -
    - Identify mechanisms for distribution of city materials such as existing city communications with residents and organizations' newsletters.
    - Media list
    - CCRP Updates/Newsletter distribution list - beginning with participants and attendees to the Taskforce events, if possible
    - Develop an outreach list of organizations for presentations and to share materials and announcements, starting with existing City lists.

4. A regularly updated public-facing reporting CCRP webpage including:
    - Data Dashboard - A dashboard on the CCRP web page or Transparent Richmond could provide aggregate data reporting (without identifying information) on types and numbers of calls, outcomes, response time, length of call, length of response, and data analysis. Including demographic breakdowns.
    - Regularly published newsletter
    - Community Advisory Board meetings and documents
    - Timeline
    - Reports
    - Educational material
    - Social media announcements
    - How to engage with CCRP
    - Sign-up for updates
    - Sign-up for hiring announcements
    - Upcoming meetings/events
    - CCRP History

5. A clear and independent complaint and feedback mechanism with several access points, including training response teams to facilitate the complaint process. A process for the review of complaints, providing the results of the process to the complainant, non-identifiable public reporting.

Program Functions

Primary goals of CCRP include addressing low-level situations as an opportunity to find a resolution before further escalation - whether through mediating a dispute, helping a resident with safety planning, or connecting residents with appropriate services. Through both proactive and self-initiated

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interactions, CCRP will follow-up on previous situations or with residents who have repeated interactions with emergency services. The team will have more opportunity for follow-up during periods with lower call volume.

All program staff, including both direct service and those in support roles, will follow all of California's mandated reporter requirements regarding known and suspected instances of child/elder abuse and neglect. Unique standards of care apply to responding to and treating children and adolescents under the age of 18. Additionally, all legal requirements and best practice standards for confidentiality and consent for treatment regarding children and their parents will apply to all program staff. Some Richmond residents have raised concerns about mandatory reporting and the history of government protective services' invasive and harmful interventions with residents of color and families in poverty. The city should obtain additional counsel on its options in addressing this concern, but USC has not seen a program that does not follow mandated reporting requirements. If necessary, CCRP can consult with CAHOOTS which follows reporting requirements while maintaining the trust and confidence of the community they serve.

It is important not to be overly prescriptive with the details of pilot implementation. The team developing the pilot will consider many factors in deciding whether, for example, to implement immediately with a 24/7 schedule or build to it or whether to initially limit their response to a smaller geographic area, typically with a sizable population of people at risk for negative police interaction and/or a sizable underserved mental health and unhoused populations. Considerations include those discussed in this section. Typically, pilots begin with a smaller set of call types and parameters that expands over time.

Some areas of the city (e.g., libraries, sections of the business district) have been resource-challenged with the substantial increase in the number of unhoused Richmonders and the dearth of resources and referrals. CCRP may decide to develop early relationships to provide additional attention in these areas.

Length of Pilot

This report recommends that the pilot last for at least 18 months and no longer than 2 years. This gives enough time for delays in some aspects of implementation (as have occurred in other programs) and enabling evaluation of a year of full implementation. It is sufficient time to establish the pilot, including responding to feedback, changing elements, and

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assessing the impact. If the city decides to issue an RFP/Q, two years is long enough for nonprofits to consider making the organizational commitment.

Scheduling of coverage and shifts should consider how to support RPD in high-volume periods and whether to create schedules that do not coincide with RPD shifts to support coverage during shift changes. Many services and referrals are less accessible outside of office hours. Shelter referrals are sometimes not available on weekend days. With fewer referrals available, the need for an alternative response is imperative during nights and weekends. One of the challenges that programs face is when residents and stakeholders find the services unavailable when needed. A 24/7 response helps ensure that all stakeholders and residents have confidence in the program and the ability to access its support.

Crisis Prevention

Another key prevention strategy is identifying cases that are likely to need or benefit from follow-up, including informal welfare checks and encouraging residents to connect to services and clinical interventions. This can be reviewed over time as additional data will provide valuable information in the types of situations that result in escalation, repeated interactions with emergency services, etc. The program team will adjust the balance responding to crisis calls and the time and resources available for follow-up on prior situations.

Residents who have repeated interactions with emergency response programs are not receiving the services they need to break the cycle of intervention and are a significant cost driver for emergency services. Olympia, Washington's specific clinical program for high utilizers of services, Familiar Faces, provides strategies and practices for engaging this population. Dispatchers and OFD will be able to help identify frequent callers. Calls dispatched to CCRP can include a focus on frequent callers to 911 that require frequent police officer response. An alternative response team is well-positioned to address the challenges. CCRP responders can displace police in the immediate call with a goal of building a relationship to divert future emergency calls and determine if other solutions or services could be implemented. Success is a significant decrease in the number of calls by the frequent users and receiving a more appropriate and less costly response. It is unlikely that the calls will be eliminated completely.

Prevention of crisis escalation would be greatly strengthened by a resource location available to residents who need a safe place to recover during a crisis and access to support and services, sometimes called a "warming" or "drop-in" center, "sobering center" (although this suggests a much more

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limited scope of services), or "living room" model. Typically, these programs offer support for up to 23 hours. The closest such facility is being opened by the County in Concord, although the referral and situation specifics are not yet available.

Facilities, Equipment, Supplies

CCRP teams will be in the field for most of their shift, primarily relying on the pilot facility at the beginning and end of the shift to manage paperwork, restock supplies, share information with the incoming shift, etc. Facility needs for the pilot program are: 24-hour access, secure parking, a place to complete and submit paperwork, supplies storage, meeting space, and restrooms. Minimally, the office size should be prepared to accommodate 3-4 people at one time with a plan for where to hold meetings and training courses.

The most challenging piece of equipment to identify and obtain will be the van(s). Some programs start without their permanent vehicle and use temporary equipment in the interim. USC recommends finalizing vehicle needs as early as possible because of backlogs in specialized vehicles, especially when requiring a wheelchair accessible vehicle.

Ideally, the vehicle will be able to transport several passengers with additional space for belongings or for CCRP responders to assist a resident in a warm, sanitary, and confidential location and will have a separate area to secure supplies.

USC has developed a comprehensive supply list, based on several programs, that can be a starting point for the CCRP team to curate their own list. The list will have seasonal differences and will change over time based on the experiences of the team.

Call Identification & Dispatch

It is important to recognize the centrality of dispatch in identifying calls that could benefit from an alternative response and determining the level of risk for the responder and residents. They use the address and caller history and a series of standard safety screening questions, following up to clarify and gain additional information. An example of dispatcher judgment and discretion would be in calls complaining about loud music. Dispatch might decide that an address with repeated noise complaints, other interactions with RPD, or reports of weapons might be less likely to be responsive to a non-enforcement intervention. Another noise complaint might suggest a situation where the complaining neighbor might be assuaged with

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information about when the child's birthday party is expected to end, and the party-throwers are likely to abide by an agreement of the ending time.

Protocol Development

CCRP and RPD Dispatch will need to work together to develop protocols to provide guidance to dispatchers on identifying, assessing, and documenting calls that are appropriate for CCRP dispatch response. CCRP will develop protocols for responding to situations, as well as outlining internal procedures. USC can provide samples used by other programs and facilitate conversations to learn from other programs about their experiences the protocols. After the development of the initial protocols, RPD, CCRP, and RPD dispatch will continue to collaborate to assess the outcomes and further review and refine protocols.

Training

RPD Dispatch

Training for dispatchers and the CCRP team on dispatch process and protocols, including scenario-based, must begin prior to implementation. Ideally, training would be integrated or coordinated among all resources and programs, including A3, C.O.R.E. and CCRP, so dispatchers understand the criteria and protocols, how the programs work together and how to assess calls for each program. Dispatching calls to CCRP will be most successful with the training and engagement of dispatchers and CCRP field staff, not solely at the management or supervisory level. Initial training should be followed with regular meetings to review calls, data analysis, and continuous dispatch and team assessments. Ongoing engagement of dispatchers, primarily during staff meetings will further their understanding of CCRP, receive their input, and identify and develop additional training as new scenarios, issues, and protocols arise.

Training the entire RPD dispatch staff will require two-hour sessions with morning and evening times, so that dispatchers can attend at the beginning or end of a shift, rather than being required to come in on a day off.

The MATRIX report recommends dispatch training for new Community Service Officer (CSO) methodology into call taking and dispatching protocols. (pg. 72) If this is implemented, the city should coordinate training, so dispatchers better understand the distinctions between the programs.

Collaborative Relationships

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Education and training must be developed for other emergency services to understand CCRP and how and when to engage them. This information sharing is only one aspect of developing the broader collaboration with these institutions including RFD, A3, CORE, 211, 311, and the Sheriff's Department.

CCRP staff can attend RPD roll call to briefly explain when CCRP can assist in a situation. Some programs receive up to 30 percent of their calls from officers who arrive in the field and conclude that the situation would be better handled by the alternative response team.

CCRP Staff Training

USC has gathered training curricula and outcomes and feedback from both program leadership and non-licensed responders in other alternative response programs. USC expects to share information on training as CCRP begins planning, including helping identify and select from the many resources available in the County and region, on top of trainers and materials that can be used on-line.

Most of the elements for the California Peer Support Specialist Certification will already be addressed in the CCRP training. CCRP should consider preparing for the Certification exam concurrently with training, if CCRP is considering pursuing MediCal reimbursement.

USC recommends training for de-escalation, trauma-informed care, responding to people in mental health crisis, addressing suicide and drug use. Additionally, self-care, maintaining boundaries, and vicarious trauma are important in supporting team members. Safety for teams and communities should include driving safety. Staff Development is an ongoing priority and should include reviewing calls as well as formal training of additional topics as they are identified. A list of potential topics to cover in training responders is included as Attachment #2.

The Taskforce proposal suggests training like Mental Health First, a hotline run by volunteers, and CAT911, a southern California program that trains residents to respond to community crisis and provide support without involving police. These curricula have much value as community education but are not based on the experience of responding to emergency calls and are not as extensive or comprehensive as recommended here. The Taskforce proposal also mentions the SPIRIT program which is a very impressive and valuable resource. It is important to note that SPIRIT only accepts people with lived experience with mental health, which is a much narrower span of lived experience than this report suggests for recruiting CCRP responders.

Staffing

Given the diversity and access challenges faced by community members (which was also identified by police and fire), program success depends on program staff that reflect and deeply understand the communities they serve.

Program/Implementation Manager - USC recommends the city consider a position who can be dedicated to the substantial work of developing a new program. USC has provided the City with some suggestions and the job descriptions of program and implementation managers that have been used in other programs. Richmond city staff have been supportive and responsive throughout this process, but it is very clear that they are stretched thin, often managing multiple assignments. It is not clear that there is anyone within the city with the capacity and bandwidth to dedicate their attention and time to shepherd the development and implementation of the program without delays.

Engagement of Immigrant Communities - Given the demographics of Richmond and the size and range of immigrant communities, USC recommends CCRP build staff capacity to engage with Richmond's immigrant communities to ensure engagement with CCRP and assisting to overcome differences in language and culture. This responsibility could be filled by the Program Manager or Community Crisis Responders.

Recruitment

Recruiting and prioritizing the hiring of committed and qualified people with lived experience and a deep understanding and knowledge of Richmond communities requires diligence and attention. CCRP can recruit from community resources and programs, with the help of advocacy groups and service providers connected to local networks of qualified people. Additionally, the Office of Neighborhood Safety has experience in recruiting and hiring using non-traditional priorities.

There are obstacles which must be overcome or avoided, such as giving undue weight to educational advancement. USC recommends ensuring that job requirements do not narrow the pool of applicants unnecessarily. CCRP can expand the pool of experienced applicants by addressing potential barriers to employing otherwise qualified people. Although there is a federal requirement that anyone using a police radio undergoes a lower-level, case-by-case background check, it typically does not need to preclude hiring

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formerly incarcerated residents who are otherwise qualified if managed thoughtfully.

Successful recruiting also requires ensuring that potential applicants are aware that they should consider a position that they have not typically been eligible for. USC recommends:

- Developing a recruitment list of people (both individual applicants and organizations who would share postings) who would like to be notified when team member jobs are posted.
- Creating an outreach and recruitment plan that engages community groups that could help identify a robust group of potential candidates that reflect the community they will serve.
- Ensuring that job requirements do not create barriers for otherwise qualified applicants.
- Promotional opportunities emphasize knowledge, skills, and abilities that are integral to the job, requiring advanced degrees only if necessary (such as for the licensed clinician/social worker).

CCRP Response Staff

USC had originally expected to recommend a 2-person response team of a Community Response Specialist and an Emergency Medical Technician (EMT). This staffing is like the CAHOOTS model in Eugene OR. CAHOOTS has demonstrated 34 years of success in responding to emergency situations with non-clinical field staff, hiring people with experience delivering service in non-traditional environments, ability to engage diplomatically with partner agencies, and resiliency. Many programs find that basic emergency medical training on teams that respond to lower acuity situations than are responded to by Fire, EMS, or clinical mental health responders is helpful in supporting residents with less access to health care. While serving as integral team members, EMTs provide a valuable additional skill set to assist with non-invasive procedures such as wound care, swamp foot (also known as trench foot), assisting with instances of low blood sugar, and Basic Life Support.

Before making final decisions on the composition of the CCRP team, there is additional clarity needed in understanding the parameters and regulations as interpreted by the County Division of Emergency Medical Services. It is too soon to understand the options, but some considerations include CCRP EMTs hired and supervised by RFD while assigned to CCRP teams or contracting with an ambulance company to provide the EMTs who are assigned to the CCRP teams. Even if it is not possible to have EMTs in the CCRP response, the core mission of CCRP can be met, if less optimally.

There is sometimes an inclination to add requirements to the responder positions. USC encourages Richmond to keep the barriers to employment as minimal as possible to enable the largest pool of potential applicants for CCRP's consideration.

Both the EMT and a crisis worker with several years of experience with the required skills of serving the needs of a diverse community, de-escalation, and resident-centered problem-solving can staff ACT mobile units. These skills and experiences are increasingly sought-after in a tight job market, both because of the expansion of new efforts to address mental health and crisis response and because existing programs are recognizing the value and expanding jobs with these skills and backgrounds. For years, the people with these skills and experience were offered low salaries and turnover was high.

CCRP responders represent a new type of emergency response. Although one position may include an EMT license, it would not be a standard EMT job. A CCRP EMT would be a fully integrated team member with an additional license. EMT jobs in the Bay Area average a starting salary between $50,000 - $55,000 are undervalued and have high turnover. Recruiters often emphasize that the job is a stepping-stone to other health care jobs. A program that values a stable workforce must offer competitive salaries that demonstrate that it values the work and enables responders to become proficient and view CCRP as a career. USC recommends viewing the CCRP jobs as new emergency responder jobs, providing 24-hour field response in emergency situations. CCRP responders work alone in the field, responding to complex situations and relying heavily on independent judgment.

Oakland's wage scale is $65,700 - $80,000 for their alternative response team with comparable knowledge, skills, and abilities to what USC is recommending for CCRP. Antioch's new Angelo Quinto Community Response Team has a comparable wage. Antioch was able to fully staff the team on schedule; by comparison, Contra Costa's A3 recruiting, with substandard wages, has stalled. As more Bay Area jurisdictions create similar programs, recruiting and retaining responders will be essential to a stable program with excellent candidates. Well-paid staff will be cost-effective with low turnover, recruitment of highly qualified candidates, and a stable, dedicated, excellent workforce.

The program manager is a combined role who would be responsible for the day-to-day logistics, inter-departmental communication, data collection, recruiting and hiring, scheduling and supervising responder teams, record keeping, and coordinating training. This person should be familiar with the primary components of the program and effective and diplomatic in

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facilitating stakeholder communication and resident feedback. They could have additional duties in identifying and securing programmatic resources.

Core staffing levels based on providing Richmond services for 24 hours/day, 7 days/week during the pilot program implementation would require Program Manager (1 FTE) and Crisis Responders/EMTs (12 FTE) for teams of either 1 Crisis Responder and 1 EMT or 2 Crisis Responders.

This staffing meets industry standards for a position with appropriate time off and additional time to cover occasional training, meetings, community outreach, and consultation on clinical situations. Understaffing could undermine the ability to maintain consistent responses.

CCRP Support Staff (Clinical Coordination, Data Analyst, Administrative Support)

CCRP team must have adequate and ongoing support for the program to succeed. These positions enable adequate coordination for training, clinical support, and supervision. Both the Data/Administrative Assistant and Mental Health Clinician positions are part time. Whether the program resides in the city or in a nonprofit, there may be existing or shared positions that can manage these needs.

Coordinating Mental Health Clinician/Social Worker (.5 FTE)

Clinical coordination is integral to the CCRP model. The clinical role will develop, monitor, and evaluate protocols for calls and referrals. There are complex but manageable, multi-tiered considerations in determining appropriate referrals and resources - from health care coverage, if the resident is already receiving County services, obstacles to service access, and managing different constituencies with unique needs, requirements, and referral options (such as elderly, children and youth, intellectual disabilities, etc.). CCRP responders will meet regularly with the clinician to review issues, patient advocacy, and calls, as well as for their own counseling. The Coordinating Clinician will also manage case management, coordination with the County, and developing the referral and resource network.

Data/Administrative Analyst

Collecting baseline and subsequent data is key to measuring progress and improving the program. This includes review of types of calls, outcomes, response time, call characteristics, call origination, and follow-up. The analyst will also build the program’s data capacity and expand data collection. Data must be presented on the public-facing dashboard. The

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analyst must respond to data requests and present data in accessible, easily understood formats. Although most programs have responder teams filling out paperwork on tablets, some recordkeeping can be done by this position (it reduces the administrative burden on field staff, but by no means eliminates it). This position may also support reporting related to grant reporting requirements or health reimbursements.

Integration with RPD (Program introduction, Roll call engagement, Officer feedback)

RPD leadership has been very supportive of the research and development of an alternative response pilot. Interviews have consistently begun with RPD leaders and officers immediately identifying calls that they would like to see responded to by CCRP. CCRP responders will receive training on the scope of practice, policies, and procedures for RPD, RFD, EMS, and the County response teams.

RPD and RPD dispatch must be involved throughout the development and implementation of the pilot. To ensure that officers are well-briefed on the pilot prior to implementation, there should be presentations during daily rollcalls, including an opportunity to ask questions, and providing community education materials for officers to share with community members. The presentations will cover: the function of the CCRP, how to interact beneficially, protocols, and how CCRP is an asset to RPD's mission.

USC recommends structured and ongoing engagement and assessment with RPD leadership and looking for opportunities to receive input from line officers, including the survey that is discussed elsewhere.

Data and Evaluation Planning

Collecting baseline and subsequent data is key to measuring progress and improving the program. Data will help to understand the program, frequency of various types of calls, outcomes, response time, call characteristics, call origination, and follow-up. The data analyst should identify the best way to identify and track frequent users and the impact of CCRP response. Data collection and analysis can help target situations, locations, and residents for additional engagement and can inform refinement to call identification, prioritization, and dispatch.

USC can share the models used in other jurisdictions, including public dashboards of call data and regular reports with call data "snapshots."

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The pilot design supports innovation and testing of new practices and the structure includes continuous assessment of types of calls, areas of success and failure, relationships with stakeholders, and impact on community.

Specific goals of the CCRP pilot are:

1. Reduce the number of lower acuity behavioral health and community crises traditionally responded to by Police and Fire.
2. Reduce the number of non-warrant arrests that result during a 911 response.
3. Reduce the number of individuals transported to the emergency department for non-life-threatening medical-related issues because emergency services have limited options for response.
4. Reduce the number of RPD and RFD responses to residents who are frequent callers.

CCRP should be measured for success and evaluated on progress towards meeting these and any additional program goals, including:

- Identification of data to collect should be identified before the pilot is implemented (although during the pilot other data may be added or adjusted).
- Evaluation metrics should be identified before the pilot is implemented, including identifying data needs and gaps.
- An external consultant should be identified to conduct both a quantitative and qualitative evaluation of the pilot program.
- When possible, data should be disaggregated by race, gender, age, and language spoken.
- Use social math and data storytelling to transform data into user-friendly visuals and dashboards.
- Track findings, issues, requests, and actions requested by policymakers, stakeholders, and residents.
- The evaluation should include evaluation of the referral and resource network and stakeholder input.
- How to develop a better understanding of populations served. Despite the challenges in collecting this data, this will ensure that the program is culturally relevant and responsive and identifies potential gaps in service.
- The economic impact of the program. Exploring the cost-benefit analysis to the city and County will provide a clearer picture of the return on investment for the city, County, and community partners.
- Is the regular engagement, including case reviews, between CCRP and stakeholders functioning as the foundation for ongoing continuous improvement activities key to using expanded knowledge to refine the program.

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USC strongly suggests surveying police officers and dispatchers in advance of implementation and at regular intervals. First done in Olympia WA (only police), these surveys could provide actionable information on additional calls, call selection protocols, and how to support a mutually beneficial relationship between the existing emergency services and the new program. The USC Emergency Services Survey is Attachment #4.

Reporting

The pilot should collect and track adequate data on interactions with residents, outcomes, call responses, types of calls, and outcomes to ensure that analysis, including cost, is comprehensive. Determining what data to collect and what tools to use for input has been considered by multiple jurisdictions. Although Richmond may have specific considerations, looking at the process and results from other programs will be valuable. Some jurisdictions are creating public dashboards to display anonymized call response data, presenting data in comprehensible and accessible language. USC recommends a comprehensive annual report, a report at the end of the pilot, and in between three-month snapshot status reports during the pilot that include data, brief updates, and changes to parameters of calls dispatched to CCRP.

There is significant interest in alternative crisis response programs from academic researchers. Richmond can consider collaborating with researchers who are interested in a study that works with residents to assess impact through analysis of calls, outcomes, and data. Researchers would be especially helpful in finding ways to disaggregate RPD and CCRP data and find ways of quantifying call and outcome data that is not readily accessible.

USC Implementation Support

Under the contract with the city, USC will continue to provide support with the following areas:

1. After delivering the report to the City Council, USC expects to participate in further discussions to provide support for deeper conversations for Councilmembers to make the necessary program decisions.
2. Training - Identifying topics, developing curricula, finding trainers and programs. Having assisted in several training courses, USC is able to share our experiences in finding training programs, doing direct training, and the feedback of the team members of what was most useful in the field. It is important to identify training that is based on

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programs that have a depth of experience with a non-police field response and specific training to strengthen appropriate responses for specific communities and residents. Fortunately, Contra Costa and the broader Bay Area have some great resources and organizations with deep experience. The depth of experience of CAHOOTS cannot be overstated, and although they currently have capacity issues, there are some limited ways to bring in that experience in planning and training. Team members consistently rate it as the most impactful training. USC can also assist identifying as part of the training appropriate ride-alongs with other programs that serve Richmond or are similar in the Bay Area.

3. Dispatch - how to design training that is responsive to the needs of Richmond. Dispatch training and protocol resources are available.
4. Collaborating with the County's A3 program to ensure that CCRP enhances County resources. Explore documentation and integration with social service databases.
5. After the pilot is established, exploring integration of referrals from 211 and other hotlines including the NAMI Warm Line, domestic violence, sexual assault hotlines.
6. Identifying facility needs and potential program facilities.
7. Recruitment - people who have lived experience, eliminating barriers to employment, need to aggressively outreach, unaware of postings or assuming that they are not eligible for jobs. Enable the broadest pool of applicants to enable selecting the best team members.
8. Protocol development, including dispatch protocols. (Even if the program is contracted, the CBO may benefit from guidance on the elements of the protocols and job descriptions that reflect the city's model. USC can provide other jurisdictions approaches, feedback, and advise on drafting.)
   Protocol: The development of program protocols, including dispatch protocols, as well as clinical oversight, analysis and evaluation of calls, training, group team meetings, and support for responders are key components of any program.
9. Equipment and supplies. This is an area where the experience of other programs is very helpful. USC will provide information on supply lists and equipment considerations.
10. Assist in developing job descriptions/staff requirements, providing templates from other programs, advising on how to meet goals of removing employment barriers and other considerations.
11. Depending on which option the city selects, drafting RFP, publicizing RFP to ensure broad response, and vendor selection. (USC has participated in and observed multiple RFQ processes for new response models, can provide drafts, including suggestions around elements that created barriers to some CBOs applying.)

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12. Pre-implementation community awareness campaign - social media, meeting announcements, Community Advisory Board recruitment. Community education - outreach and engagement plan, timeline, and materials. Contest for program name & logo.
13. Developing the documentation system prior to rollout.

TIMELINE

Prior to the implementation of the pilot, the planning team will create initial administrative and clinical methods, identify logistical needs and considerations, and begin to build resource and referral networks. The Taskforce proposal timeline requires a longer time to build community awareness and use of the CCRP team because it is based on using 311 as the initial entry point to receive calls about crises from residents. This report assumes the diversion of appropriate calls to CCRP from 911 and the non-emergency number that residents already call.

The pilot program design can occur in four phases. How much time it takes depends on some of the decisions which have been outlined, including the length of pilot.

Phase 1 - The first decision, which informs almost all others, is where to house CCRP. If contracting the program to a non-profit, fast-tracking an RFP/Q and completing a competitive selection process will take at least three months. When placing the program within the city there are several decision points and steps depending on placing it in an existing department and how much it requires the development of new structures within the city.

- Program naming/branding (engage community, focus on youth participation)
- Identifying and convening an internal city planning/support team
- Identifying initial legal/insurance/compliance issues
- Funding research - opportunities and considerations
- Selecting a Program/Implementation Manager
- Staffing
- Identifying facility needs and potential program facilities.
- Identifying and ordering equipment
- Structure of Community Advisory Board (CAB)
- Recruiting/appointing CAB members
- Draft job descriptions (including approval by Civil Service, if within city)
- Create webpage - populate with initial materials

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Phase 2 - This will be a sprint to start up the pilot. City support external to the program will be needed for: RPD dispatch training, coordination with the County, and community outreach and engagement.

- Recruiting and hiring
- Opening an office
- Referral and resource network development
- Initial training - responders and dispatch
- Obtain equipment and supplies
- Identify initial parameters of situations to dispatch to CCRP
- Develop protocols
- Evaluation outline - metrics, selection process for evaluator
- Determine what data to collect and what tools to use for input; focusing on impact, outcomes, and efficacy.
- Develop documentation and process
- A citywide outreach and public education campaign, beginning several weeks before the pilot startup, including meetings with residents in neighborhoods most impacted by the emergency service system.
- Collaboration with County - how to share information/data/patient files; establish ongoing communication, explore developing data-sharing agreements, and MOUs to streamline information sharing.

Phase 3 - Initial implementation.

- Official roll-out - may wish to have several weeks of a soft launch
- Baseline Survey of RPD

Phase 4 - Pilot through competition

- Continuous assessment for expansion of parameters
- Selection of independent evaluator
- Evaluation during pilot

Sustainability

City leaders and residents appropriately focused on ensuring the long-term sustainability of the program. Data collection, assessment, and evaluation will demonstrate the impact and value of the program. Ongoing community engagement and oversight will not only ensure the support and confidence of Richmonders but the program will also be strengthened by integrating the information and feedback from residents who have received or observed the program. Mechanisms for ongoing analysis of partnerships will maintain and deepen collaborations. Once integrated into the community, CCRP should be used as an effective, accessible community response to a broader range of

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community needs. COVID, weather emergencies, etc. Eventually, Richmond will benefit from participation in regional and national discussions among alternative response programs.

Methodology

The level of community involvement in discussions, support, and research design options for a new community response program in Richmond has been remarkable, extensive, and continuing. Alternative response programs always have sweeping support across diverse communities. Richmond residents have demonstrated an even greater level of support.

Specific methods informing the pilot program development included:

1) reviewing documentation related to existing and newly developed alternative response program models and alternative-response model best practices and evaluations.
2) reviewing documents and recorded meetings for a comprehensive understanding of the issues and resources affecting the Richmond landscape as it relates to emergency response and community crises.
2) conducting interviews with key Richmond community leaders/stakeholders; outreach to Richmond residents, focusing on communities most impacted by 911 calls and those communities with unique barriers to engaging with official city and County resources.
3) convening focus groups of Richmond residents and presenting at community meetings.
4) surveying Richmond residents digitally and on paper.

USC's initial proposal was to recruit fellows who would be trained to do community engagement and survey distribution and collection. Through discussions with city representatives, given some delays in beginning the research, the plan was changed to use those resources directly with Richmond community organizations that assisted with recruiting and organizing outreach in communities with unique perspectives and lived experiences.

Community and Stakeholder Engagement Approach

USC's community outreach and engagement methodology focused on engaging Richmond residents about their interaction with the 911 emergency call system; assessing support for the City's leadership objectives and expectations for a pilot program; engaging stakeholders to identify objectives in the development of a pilot that addresses the concerns of the public; and, collecting residents' experiences with Richmond's 911

system and local/Contra Costa County law enforcement, emergency response systems, and Contra Costa County services that assist residents in crisis. There was a special focus on gathering input and data from neighborhoods with the highest level of 911 calls and engaging specific constituent groups that have been historically disconnected from planning processes.

USC conducted in-depth virtual and in-person interviews with leaders from Richmond and Contra Costa's municipal and County governments, community-based and civic organizations, service providers, local businesses, and individuals directly impacted by an experience with the emergency call system. All interviews and meetings sought to learn about experiences with the 911 response system, community needs, crisis resources, and to receive feedback on what alternative response models and options would best serve Richmond. These interviews were essential to understanding the landscape, receiving valuable input that helped co-create these findings and recommendations, and identifying program opportunities, potential challenges, and resources for implementation. The list of interviews and meetings is Attachment 3.

Review of Documents and Existing Information

USC reviewed existing data, research, plans, and other relevant documents and recordings regarding community crisis response program development conducted by internal and external entities including:

- Youth Community Needs Assessment and Strategic Investment Plan 2020
- Community Needs Assessment for ARPA
- Health in All Policies 2020 progress report
- North Richmond Quality of Life Plan 2019, Healthy Richmond
- Community Engagement and Crime Prevention: RPD Strategic Planning Focus Group Results (February 2019)
- Richmond General Plan
- Taskforce research and planning
- 911 call data analysis by the MATRIX Consulting Group
- Contra Costa A3 program planning and meetings
- Recordings of community roundtables, meetings on public safety, and Taskforce Community Conversations between Oct 2021 - Jan 2022 on the subjects of Youthworks, Unhoused Interventions, Community Crisis Response Team, and the Office of Neighborhood were informative avenues for learning about community opinions and perspectives.

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USC analyzed the status of current and proposed models from Eugene and Portland, OR; Olympia, WA; Cambridge, MA; Albuquerque, NM; Denver, CO; Houston, TX, and Antioch, Oakland, and San Francisco, CA that provided insight into planning issues, proposed models, outcomes, and challenges faced by the different cities working to implement alternative response programs. USC also reviewed analysis and proposals of best practices for alternative response and crisis call management which continues to develop and emerge.

This information informed the development of the survey, questions, and topics pursued with stakeholder and resident interviews and focus groups.

Call Data and Analysis

Both the MATRIX Consulting Group and the Social Movement Support Lab, contracted by the Richmond Progressive Alliance, analyzed Richmond 911 call data. USC met with both groups which assisted in our understanding of the data and their analyses. Because the MATRIX analysis was part of a larger emergency services review, there is a gap between the call data analysis and information about calls needed to inform the planning for CCRP. This report relies on integrating the MATRIX analysis with the data analysis and experiences of other cities in developing and implementing alternative response programs.

This report reflects the findings from the MATRIX report, including summaries of a series of community meetings. The key issues identified were concerns about:

- the impacts of homelessness and persons in mental health crises on crime and
- the current approaches to policing marginalized populations.

MATRIX identified the following solutions which overlap the focus of this report. The solutions identified include:

- Provide resources inside and/or outside of police to support marginalized communities (e.g., homeless and persons in need of mental health services).
- Implement multi-lingual support throughout the Department.
- A recommendation for an emergency response team.

The report offers specific recommendations for a two-person emergency response team to respond to calls related to mental health and homelessness, with a field clinician and an EMT. 2 shifts. There is no information on FTEs or other details. Because MATRIX limited the analysis to a narrow number of mental health situations, it is important to consider the

continued implementation of the County's A3 program. MATRIX suggests that it is likely that five calls per day, or around 3.9 percent of calls handled by RPD could be dispatched to a mental health response team. Although call data analysis is valuable, in practice, each call is dispatched depending on specific parameters, not the call classification.

At least several of these calls likely fall under the scope of A3, if available. Their analysis of appropriate shifts very likely reflects the highest call volume for a broader range of low-level calls. With a broader range of calls for CCRP and the greater need for support in situations when other resources are unavailable, USC believes that CCRP will receive sufficient dispatches during an overnight shift.

MATRIX also recommended diverting some "non-emergency" calls to newly created Community Service Officers (CSOs). The calls recommended for CSOs are a mix of more bureaucratic types (such as filing crime reports) and some types of calls discussed in this report as potentially being responded to by the CCRP team, including Juvenile Out of Control/Runaway, Juvenile Out of Control, and Runaway Juvenile Return. The recommendation for CSOs to respond to "non-emergency" calls leaves for CCRP those situations that are both an emergency or requiring an immediate response AND not appropriate for a police response. This is not a concerning overlap since the actual number of calls is too small to affect the overall analysis or the planning of either program. If Richmond implements both CCRP and the CSO proposal, we recommend attention to aligning the protocols so there is broad understanding among stakeholders (especially dispatch) on the work that is assigned to each program.

It is noteworthy that the core findings and recommendations of the MATRIX and USC research are similar. USC found similar concerns of residents, agree on the three recommendations that address similar issues, and reflect the experiences of other jurisdictions. The MATRIX report parallels this report in finding that most of the situations proposed do not require a police backup.

Community & Stakeholder

USC has found that conducting surveys can be effective in understanding residents' unique experiences and perspectives with emergency services, service providers, informal support, and barriers to care.

513 people were surveyed between February and May 2023 using on-line and paper surveys. Paper surveys were filled out at meetings, tabling events, and distributed - approaching people and asking them to fill it out with the interviewer. 340 were completed on-line and 115 were filled out on paper. 455 respondents were Richmond residents and 58 were non-residents who work or go to school in Richmond (a majority of whom either used to live in Richmond or have family in Richmond). Gift card incentives were offered in communities that are less likely to engage with a city survey or focus group. Demographic questions were optional. USC monitored the anonymized demographic data of participants in the survey and focus groups to ensure that representation of voices of Richmond residents whose input could be overlooked.

Areas explored in the survey and focus groups included:

- Interactions with emergency services
- Accessing emergency and non-emergency services
- Barriers to access
- Outcomes
- Community Assets
- Unrecognized, under-developed, under-funded community resources
- Informal and community support during crisis
- Where residents receive information about resources and services

The survey was designed to collect qualitative and quantitative data. The opportunities for comment (qualitative) in the survey were very helpful in discovering issues and ideas that were not previously identified.

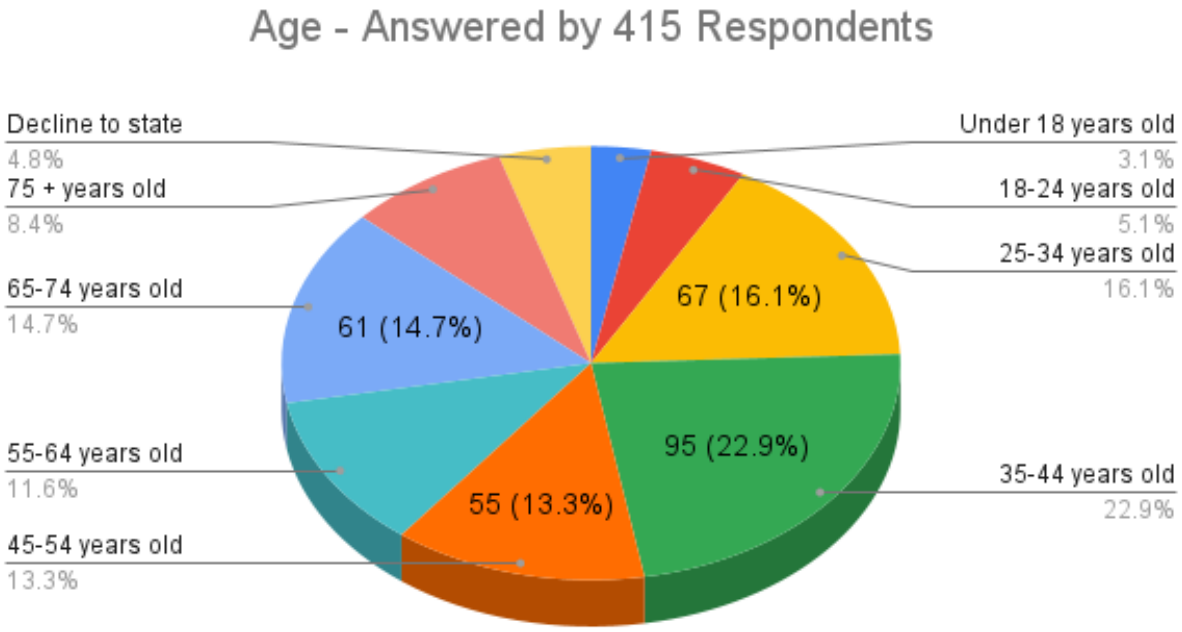
The survey was issued in English (396), Spanish (25), Mandarin (2), Hindi (28), and Portuguese (5). These languages were identified during interviews with city staff, stakeholders, and residents. Use of a particular survey language does not correlate with the demographic groups represented, since participants may be English speakers or bilingual.

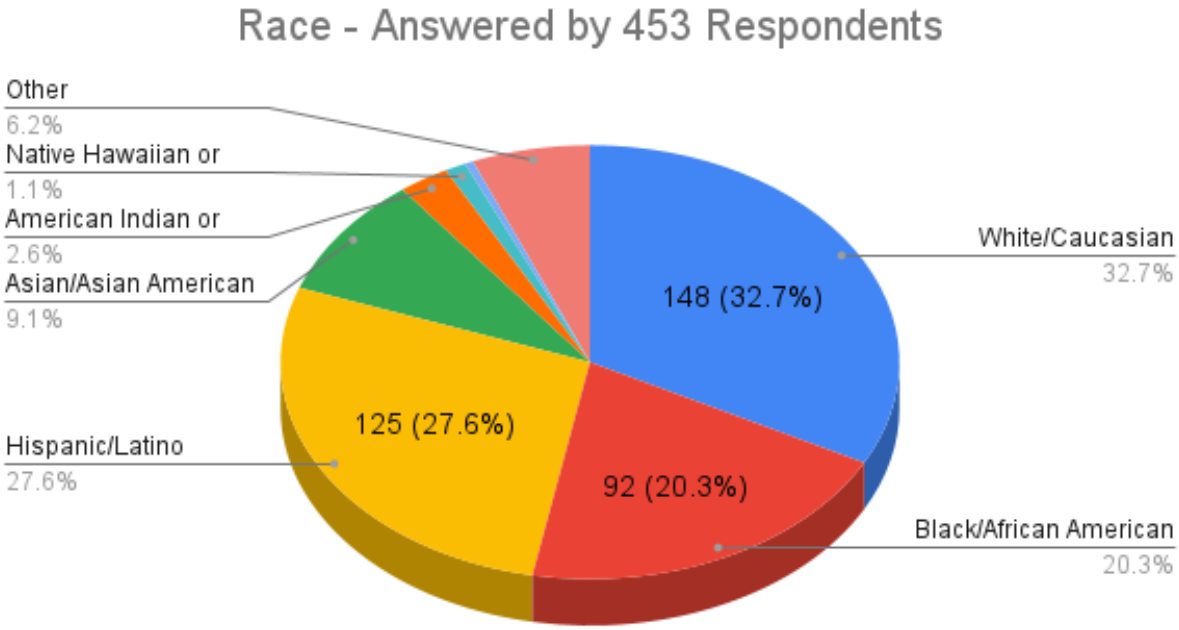
Alternative crisis teams are always wildly popular. One notable outcome of the Richmond survey was a significantly higher level of support for creating an alternative response program than in similar surveys of other cities' residents. Although it's not possible to adjust for the many variables to draw a direct correlation, the ongoing discussions and the work of the Taskforce

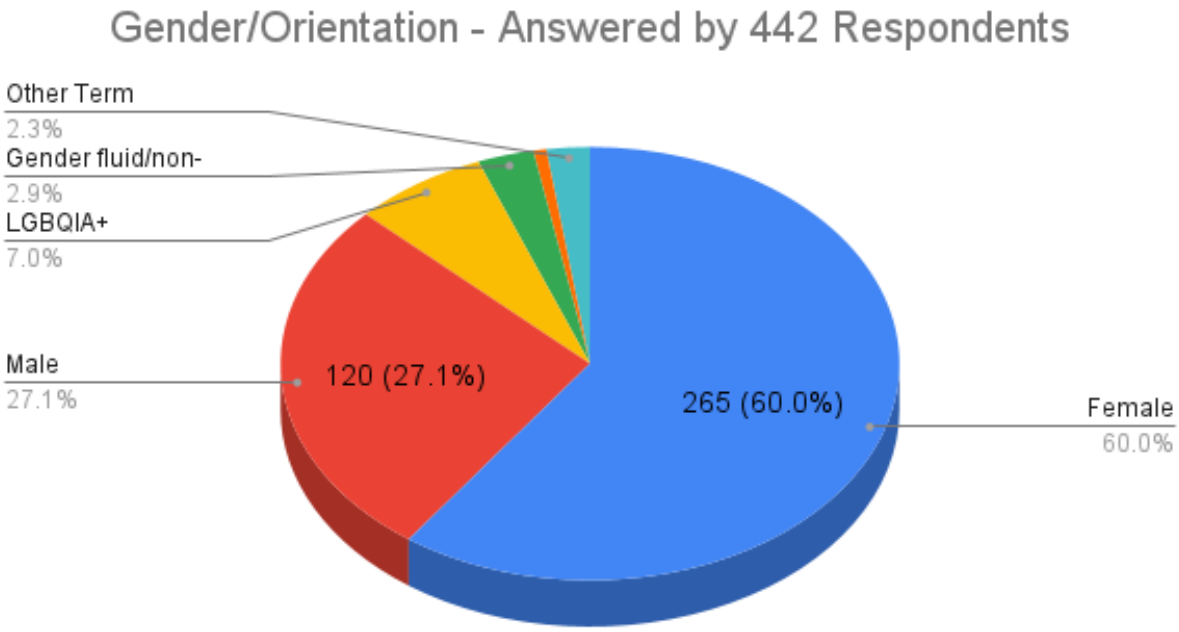
for the past two years appear to have increased awareness and knowledge about alternative response and appears likely to explain the significant increase.

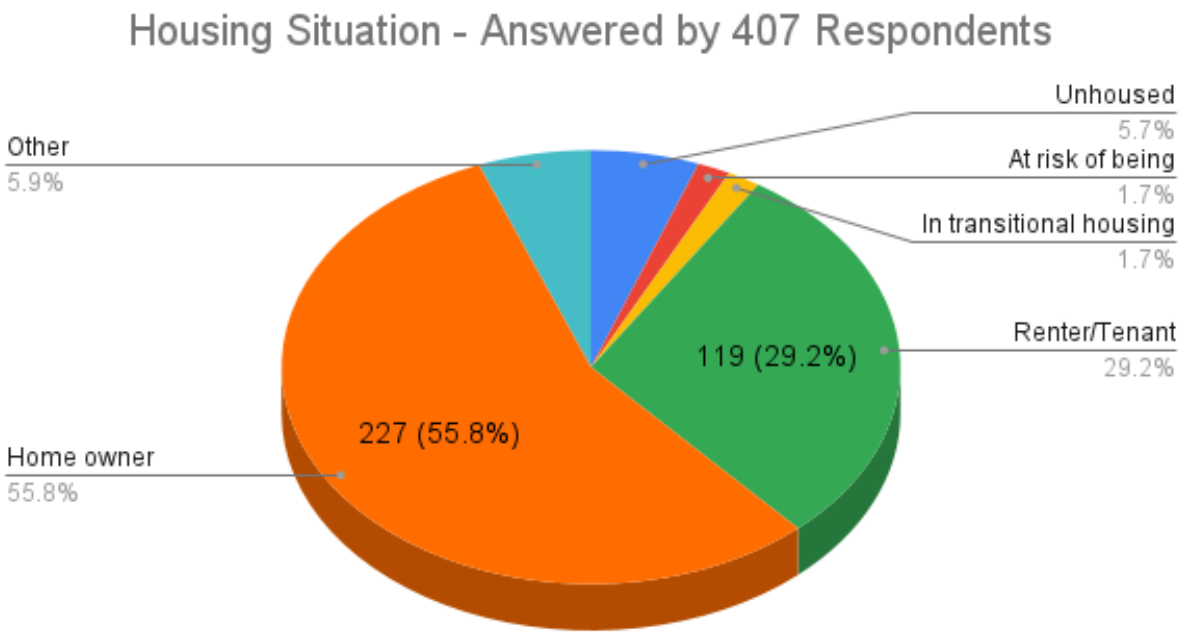
The data for each question is in Attachment #4. The answers that were individually written in by respondents are not included, due to length, but are available and were integrated into the findings presented in this report.

Who Took the Survey?




Race - Answered by 453 Respondents
Other
6.2%
Native Hawaiian or
1.1%
American Indian or
2.6%
Asian/Asian American
9.1%
Hispanic/Latino
27.6%
White/Caucasian
32.7%
Black/African American
20.3%
148 (32.7%)
125 (27.6%)
92 (20.3%)


Gender/Orientation - Answered by 442 Respondents
Other Term
2.3%
Gender fluid/non-
2.9%
LGBQIA+
7.0%
Male
27.1%
Female
60.0%
120 (27.1%)
265 (60.0%)



Interacting with Richmond Emergency Services

218 respondents said that they **had not** called or interacted with Richmond emergency services (police, firefighters, paramedics, etc.) in the past three years.

278 respondents said that they **had called or interacted** with Richmond emergency services (police, firefighters, paramedics, etc.) in the past three years.

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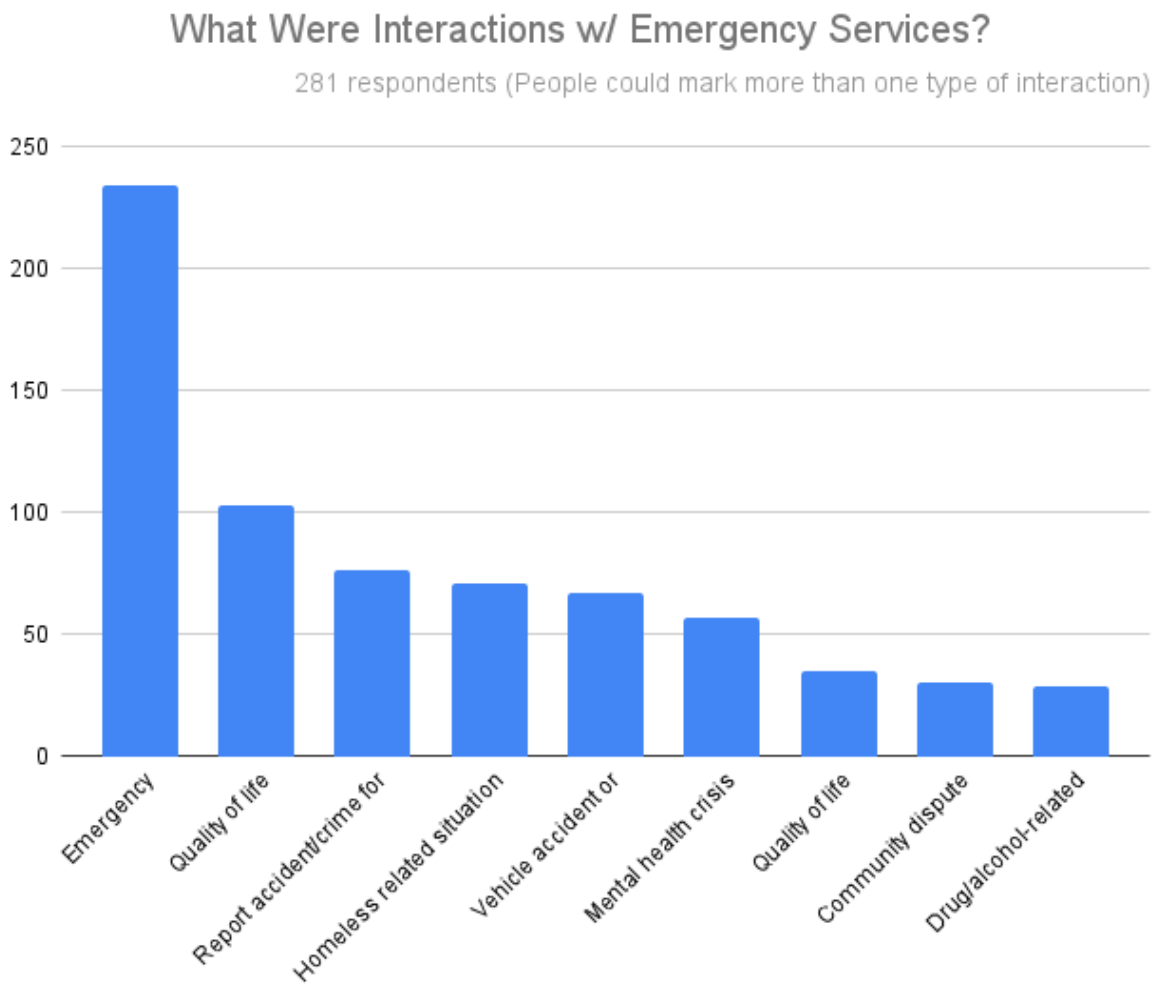
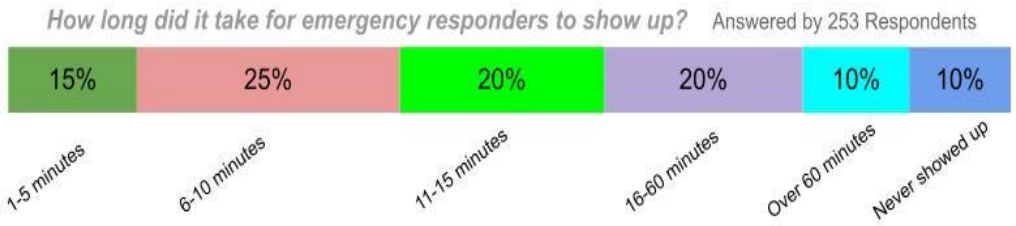
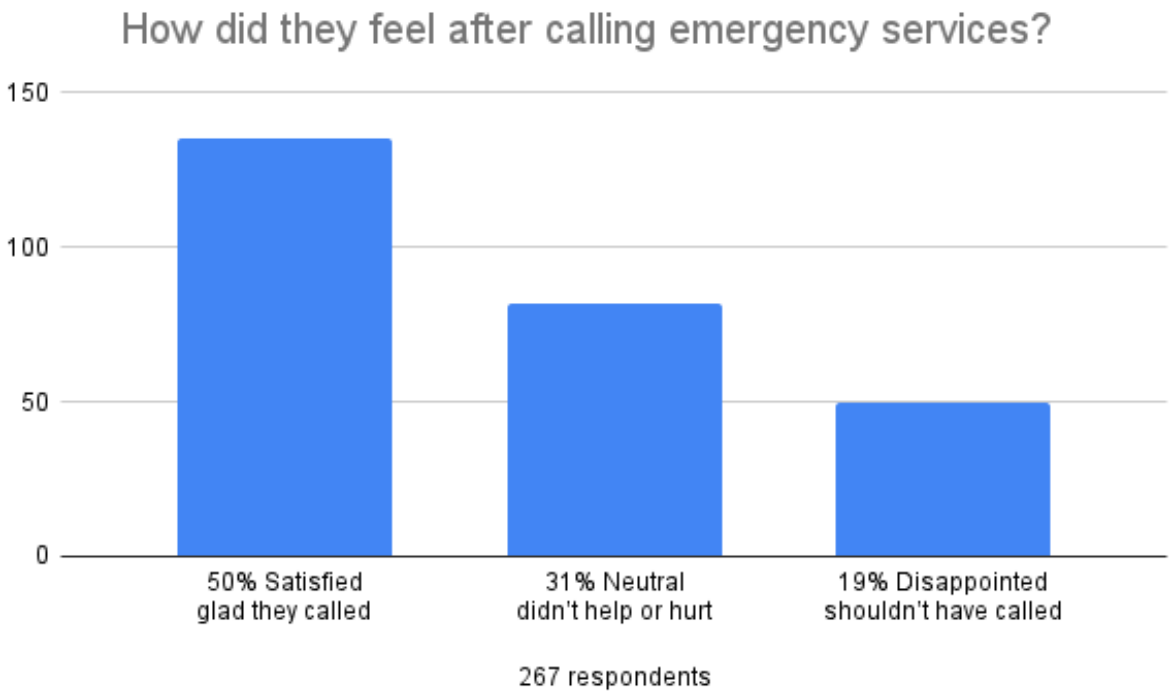


Emergency is defined as fire, crime in progress, threat to safety, medical crisis. **Quality of life** is a parking problem, noise complaint, dumping, etc. **Wellness check** is when a responder is asked to check on someone.



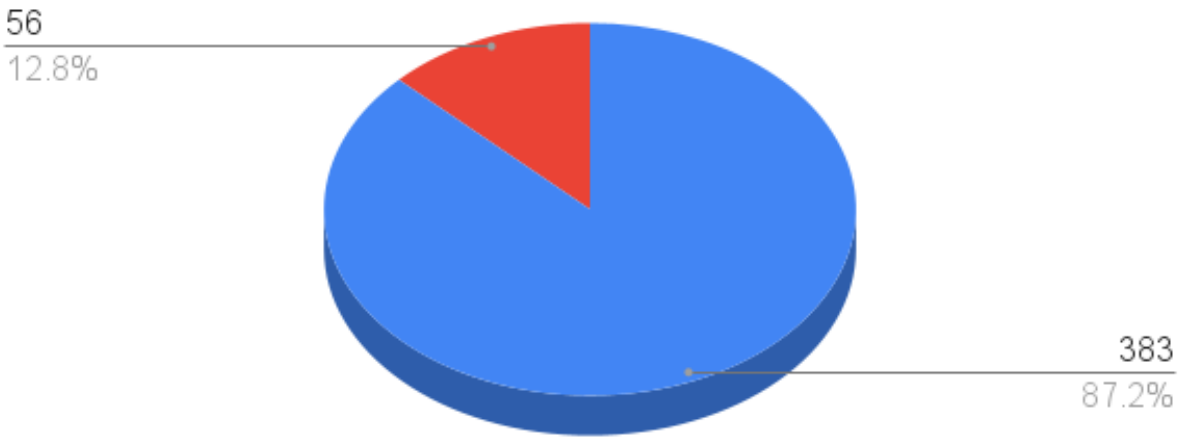

How did they feel after calling emergency services?
150
100
50
0
50% Satisfied
glad they called
31% Neutral
didn't help or hurt
19% Disappointed
shouldn't have called
267 respondents

DRAFT

Why Don't They Call?

Do you support a program where well-trained community members respond to some appropriate situations instead of police?

439 respondents



ATTACHMENTS

City of Richmond Community Crisis Response Program
Proposal

Program Description
The Community Crisis Response Program is a community-led program to address crises that are not appropriate for police response. To start, the program will address mental health crises and substance use issues, eventually expanding to support additional community based issues such as domestic conflict, street based conflict, and noise complaints. The program will respond to crises by dispatching a team of community responders (2 mental health/harm reduction specialists and 1 medic) to the scene, where the responders will engage with the participant empathetically and supportively, with a focus on de-escalation. The team will be dispatched by an in-house dispatcher, and calls will be directed to the number 311. All program staff will receive extensive training in de-escalation, mental health first aid, harm reduction, the biological impacts of substance use, and conflict resolution.

Dispatch
- The program will use the number 311 to receive calls
- Plan includes a public outreach campaign to educate public about the existence of the program, how to call, and what kinds of situations the program can support
- Over time, 911 dispatchers will be trained to refer calls to this program. To start, they will simply let callers know about the existence of the program. Eventually, they will be able to directly transfer calls to the 311 line, so community members will be able to access the line through 911. This program must always remain independent from the police, and residents must be able to access the program without involving police dispatch, even if police dispatch is fully trained. At no point will the 311 line disappear.

Staffing (total: 18.8 FTE)
- Office staff (total: 6.2 FTE)
    - Program Director (1 FTE, $85K/year)
        - Duties: manage staff, evaluate program, make program design decisions
    - 1 Dispatcher available 24/7 (4.2 FTE, $75K/year)
        - Duties: receive calls, conduct intake, assess appropriateness for the program, determine response (In person? Phone support?), send response team to the site
        - As call volume increases, more dispatchers may be added
    - 1 Community Liaison (1 FTE, $75K/year)
        - Duties: execute outreach campaign, connect with other service providers, community based organizations, potential participants, follow up on participants who interfaced with response team, provide connections to ongoing care. NOT case management - follow up does not continue beyond referral call(s).
    - At the beginning of the program, there will be few calls and the community will need to be given information about the program. Office staff will conduct outreach campaigns, then transition to full time service delivery as call volume increases.

- Response team (total: 12.6 FTE)
    - 2 community responders available 24/7 (8.4 FTE, $80K/year)
        - Duties: engage thoughtfully with program participants, focusing on de-escalation, mental health first aid, harm reduction, and supportive care. Provide care for any dependents of person in crisis at the scene, as necessary.
        - Community responders will not need to have specific credentials, education, or work experience; instead, they will need to demonstrate success in community engagement and specific core competencies. Some local programs (such as SPIRIT at Contra Costa College) will qualify graduates for the position, but any community member may have their application considered.
            - Based on *Mental Health First* model (Oakland and Sacramento): community based responders are best equipped to handle crises in their own community. Focus should be on preventing further harm and preventing coerced entry into the pre-existing system. Community responders have greater flexibility in their range of responses.
    - 1 Medic available 24/7 (4.2 FTE, $85K/year)
        - Duties: provide basic first aid to participants, focused on harm reduction and supportive care
    - As call volume increases, more response teams may be added

Training topics (to be given by a successful community based organization such as SPIRIT, MH First, CAT-911, etc):

- De-escalation, including creating plans for how the team will respond to violent behavior from person in crisis
- Self-defense training (that does not harm the other person)
- PPE and how to protect oneself from COVID and other airborne illness
- Non-stigmatizing mental health information
- Mental health first aid
- Conflict resolution
- Impacts of common controlled substances on the human body
- Harm reduction principles and techniques
- Trauma informed approach to assessment and care
- Existing relevant services in the community
- Historical context: why do we need a program like this? What needs is this program meeting that have not been met before? What is the danger of police response to people in mental health crisis.
- Child development/working with youth?
- Impact of secondary trauma/self-care/how to prevent burnout
- Know your rights re: police interactions, immigration enforcement
- Common crisis situations in Richmond

- Public Safety personnel training: First aid and basic lifesaving measures (CPR etc). Additional training for medic.

Phasing/Scaling

- Year 1
    - Community Oversight Committee forms, develops protocols around police contact with program
    - Training development
    - Staff hiring and training
    - 311 line setup
    - Call types: mental health and substance use
    - 1 Program Director, 1 dispatcher, 1 linkage to care specialist, 1 response team
    - Begin providing service to all of Richmond
    - Outreach (ongoing)
- Year 2
    - Ongoing service provision
    - Call types: mental health and substance use
    - Opportunity to add additional response team(s) based on call volume (as assessed by program staff and frequency of overlapping response needs)
    - Training of 911 dispatchers to refer community members to the program
- Year 3
    - Ongoing service provision
    - Call types: mental health and substance use, with the possibility to add call types based on community need (as assessed by program staff)
    - Opportunity to add additional response team(s) based on call volume (as assessed by program staff and frequency of overlapping response needs)
    - Ongoing training of and connection with 911 dispatch for increased call diversion

Call flow

- Community member calls 311
- Dispatch staff answers phone, listens to participant concerns, asks relevant questions, and determines best response.
- Dispatch staff communicates response plan to response team
- Response team executes response plan
- If in-person response: response team drives to scene in city vehicle. Community responders engage with person in crisis, de-escalates the situation, assess needs, and provide compassionate care and problem solving support. If necessary, medic performs basic first aid. If necessary, provide care for dependents at the scene.
- If phone response: Community responder engages with person in crisis over the phone, potentially transferring to linkage to care specialist for referral
- Response team completes response, returns to office, and submits reports about the response
- Community liaison reviews reports, identifies potential ongoing supports, and follows up with person in crisis.

Community Oversight Committee

- Composition of the committee: the committee will include representatives of Office of Neighborhood Safety and CBO mental health, harm reduction, and youth service providers, and will include a majority of members who are residents who have experience with receiving the services.
- Nomination and selection of committee members: each city council member will nominate two members and the city council will select committee members with overall composition that meets the criteria above.
- Members will serve two year terms, and will be able to serve additional terms upon approval by city council.
- The Community Oversight Committee will be responsible for:
    - Approving annual program budget
    - Reviewing quarterly reports on programs and monitoring program implementation and expenditures
    - Input on and approval of training goals and requirements
    - Participate in hiring decisions, development of job descriptions, and program implementation plans
    - Work with Community Outreach staff to receive and respond to resident feedback on the program

Engagement with Law Enforcement

- The program should call on law enforcement only in specific situations:
    - If the person in crisis requests it
    - If someone is actively brandishing a weapon towards program staff
    - If program staff have exhausted all available de-escalation methods and still fear for their safety

USC Training Outline for Alternative Response

I. SUPPORTING COMMUNITIES THAT HAVE BEEN MARGINALIZED

How gender, race, class, and ablism have impacted communities' health and interaction with health care and carceral systems.
Cultural competency - Cultural Humility and Anti-Racism
Stigma & Discrimination
Intersectionality, Culture, Diversity, and Worldview
Social Determinants of Health and Advocacy
Self-Determination and Stages of Change
Barriers to access in traditional health care, mental health care, and emergency response.

Specific training and tools for communities:
LGBTQI & trans, veteran, immigrant, BIPOC, Asian Pacific Islander, Latino/Latinx, houseless, Native, elders, children and youth, sex workers, residents who are disabled and/or face serious mental health challenges, residents who are in the crisis of poverty, people who use substances or are in recovery.

Areas of focus:
Impact of poverty, specific needs and experiences of children and youth and transition-aged youth; religious customs and beliefs, gender identity and inclusivity.

II. COMMUNITY-CENTERED RESPONSE

Concepts and methods for crisis and community response
Crisis prevention, intervention, and de-escalation;
Principles of wellness & recovery model;
Principles of trauma-informed care, response, and practices - understanding the impact of trauma on the individual & community;
Building supportive relationships;
The process of recovery and change;
Fostering self-determination and resilience; self-care and wellness plans;
Peer support - values, ethics, and principles of practice and effectiveness;
Diversion - from carceral systems, mental health systems;
Restorative justice;
Advocating for residents in institutional and enforcement settings.
Language used to describe residents - negative descriptors, appropriate langauge

Crisis situations and strategies

Communication, de-escalation, intervention, and mediation
De-escalation, disengagement, and conflict mediation;

Communication principles and methods; connecting through our experiences;
Motivational interviewing; resilience; active listening, problem-solving, decision-making;
Physical and verbal responder presentation;
Consent and agency of residents - centering their decision-making, supporting their planning;
Identifying behavior impacted by trauma and support mechanisms;
Wellness Recovery Action Plan (WRAP) & crisis safety planning tools;
Questions to understand the situation: physical needs, problem-solving questions, care.

Barriers to Communication
Language
Processing, including stress
Hearing
Cultural interpretations
Identifying and overcoming communication barriers

Specific situations and types of trauma -
Issue awareness and screening
Protocols for rapid response
Considerations and response: PTSD; suicide identification, risk screening, and intervention skills; sexual assault; child abuse; self-harm; intimate partner violence; grief; intellectual disability; autism; dementia, brain injury and stroke; panic attack; substance use and overdose; dual diagnosis; wellness checks.

Community health education & support
Healing practices
Coping strategies
Relaxation techniques
Resiliency skills
Practical and emotional support for residents & families during crisis and death

Follow-up and community resources
Case Management & Community Mental Health Work
Connecting with community resources
Case management and advocacy
Wrap-around care, follow-up support, wellness planning
Restorative Justice - circles, etc

III. MENTAL HEALTH FIRST AID -

Common mental illnesses
Psychiatric medications, withdrawal, and side effects
Dual diagnosis
Supporting residents experiencing symptoms

Considerations and tools when supporting youth, elders, and other vulnerable communities
Safety planning and advanced directives for mental health episodes
Risk management and crisis planning (including WRAP and crisis safety planning tools)

IV. SUBSTANCE USE & HARM REDUCTION

Substance use, symptoms, and withdrawal; principles of harm reduction and approach to care; safer use strategies; managing possible overdose situations, naloxone; medical detox; people who may be experiencing diverse mental states caused by substance use; relapse prevention; psychopharmacology 10; common medications & drugs; how to support people who are using substances; specific issues for people who use crystal meth; harm reduction resources within communities, building engagement and relationships through harm reduction.

V. RESOURCES & REFERRALS

What services exist, what they do, who is eligible, and how they are accessed. Referral process.

- City and county emergency response programs
- City and county resources
- Community-based and mutual aid services
- Identifying peer, family, and community support

Referral considerations:
Culturally and linguistically appropriate services and providers
Empowerment includes a menu of options - including doing nothing.
Warm handoffs are especially important for people who have previously experienced poor treatment and denial of appropriate care from established systems.
Inventorying and utilizing a person's own coping strategies and individual support network prior to engaging outside resources.

City geography
Database training - accessing and utilizing the resource database, submitting additions and changes.

VI. TEAM & COMMUNITY SAFETY

Planning and positioning for safety; scene assessment and situational awareness; intuition; verbal, nonverbal, and defensive interventions; working with agitation, violence, and violence/risk assessments; animal control; preventing slips, trips, and falls; defensive driving; infection control & prevention; standard precautions and bloodborne pathogens, incl. HIV & HepC. EMS, police, and fire training, scope of practice, and protocols; how to collaborate and manage situations w/ other first responders, ensuring that residents feel safe during an

interaction with police, how to advocate for residents. Communicating w/ team member during call.

VII. FIELD & SCENARIO-BASED TRAINING

Scenario and role-play-based learning will be used both within specific modules and to review and incorporate multiple areas of learning;
Presentations and discussions with residents w/ lived experience of health care and carceral systems, using drugs, being unhoused, being undocumented and immigrants;
Ride-alongs with experienced responders;
Shadowing service provider-partners;
Participate at events to build relationships with community members & leaders;
Participate with mutual aid events;
Sit-along at Cambridge dispatch

VIII. OPERATIONS & LOGISTICS

Defensive driving, vehicle maintenance; transport of residents; parking considerations.
Instruction and practice with dispatch radio.
Use of data management systems, record keeping, report writing.
Documentation policies.
Dispatch process and protocols.

IX. PRIVACY, RESIDENTS' RIGHTS, & RELATED ISSUES

Residents' privacy, rights to confidentiality and respect, including Health Insurance Portability and Accountability Act (HIPAA) compliance.
Mandated reporting - community issues and obstacles.
Scope of practice and care.
Laws and issues on public records, advocacy, and mental health/substance use, and schools.
Rights of residents regarding involuntary hospitalization and accessing health care.
Filing a complaint - medical center, referral agency, providers, police, complaints about the response team.
Becoming a witness - avoiding gathering information that makes a responders a witness in an investigation.
Speaking to the media.
Public recording of the teams while engaging w/ residents

X. TEAM ROLES & RESPONSIBILITIES

Structure, roles, and responsibilities
Principles of accountability, ethics, consent;
Staff standards & expectations (and what staff should expect);
Clinical oversight and review;
Personnel policies;
Sexual harassment and discrimination;
Team building and the science of team dynamics.

Staff Wellness
Compassion fatigue, vicarious trauma, triggering past trauma;
Addressing trauma for staff;
Counseling and mental health support for staff;
Self-care and building responder resilience;
Limits and Boundaries.

Stakeholder Interviews, Organizational Meetings, and Focus Groups

Below is a list of the meetings and presentations to ensure broad and deep community engagement in the development of the CCRP report. USC was also invited to do a “sit-along” to observe RPD dispatch and to visit the Contra Costa County Anyone, Anywhere, Anytime (A3) Miles Hall Crisis Hub.

Focus Groups & Survey Distribution

Greater Richmond Interfaith Program (GRIP)
Nepali Health Advocates
Richmond Latina Center (2 focus groups)
Richmond Progressive Alliance
Ryse Youth Center (2 focus groups)
Shields Reid Community Center
SOS Richmond

Meetings

Richmond Police Department
- Police Chief Bisa French
- Assistant Chief Tim Simmons
- Captain M. Stonebraker, Patrol Operations Commander
- Lt. Ernest Loucas, patrol division, Homeless Outreach manager
- Officer J. Sousa, Mental Health Evaluation Officer
- Michelle Milam, Crime Prevention Manager and Homeless Resource Coordinator

Richmond Fire Department
- Fire Chief Angel Montoya
- Fire Marshall Eric Govan
- Fire Battalion Chief Victor Bontempo

RPD Dispatch, Michael Schlemmer, Communications Center Manager

Richmond City Council, CM Robinson, CM Soheila Bana, CM Claudia Jimenez, CM Gayle McLaughlin

Richmond Neighborhood Coordinating Council
Richmond Office of Neighborhood Safety, Sam Vaughn
Richmond Office of Neighborhood Safety, violence interrupters
Richmond Commission on Aging
Richmond Taskforce CCRP Working Group, Steve Bischoff and Laura Mangeles,
Richmond Library Services - Diana Lopez, Library Director
Richmond Taskforce on Reimagining Public Safety

Richmond Community Services Dept, Eren Samano
Richmond Multi-Dept Unhoused Working Group

Contra Costa County Supervisor John Gioia
Contra Costa County Anyone, Anywhere, Anytime (A3) Initiative - Suzanne Tavano, PhD, Director, Behavioral Health Services, Dr. Chad Pierce, PsyD, A3/Crisis Intervention Chief, and Debbie Thomas, LMFT, MH Program Manager
Contra Costa County CORE team - Robert Preston, Michael Callanan
Contra Costa Office of The Public Defender, Social Workers, Angelene Musawwir, LCSW

Brighter Beginnings, Dr. Barbara McCullogh
Contra Costa Asian American Pacific Islander Coalition, Vy Vo
Easter Hill United Methodist Church, Rev. Dr. Dale Weatherspoon, Pastor
Family Justice Center
Felton Institute (implementing the crisis response in Antioch)
Health Care for the Homeless
HEPPAC, Braunz Courtney
Just Cities Institute - Margareta Lin and Xavier Johnson (background on Richmond outreach)
Latina Center, Miriam Wong
MATRIX Consulting Group - Richard Brady
Nepali Health Advocates, Anupama Chapagai Parajuli
Reimagine Richmond, Emily Ross and Eli Moore
Richmond Latina Center, Miriam Wong
Richmond Progressive Alliance, Marisol Cantu - survey distribuiton
Richmond Promise, Anjanine Bonet, Miguel Molina, Christopher Whitmore
Richmond Rotary Club, Darlene Rios Drapkin
Ryse Youth Center
Rich Minds & NAMI West County, Eddie Morris
Safe Return Project, Tamisha Torres-Walker
Social Movement Support Lab, Jim Freeman (data analysis)
SOS, Daniel Barth
Sara Cantor
Haruka Kelley, NP
Kristin Killian Lobos
Deborah Small
BK Williams

USC Richmond Emergency Responder Survey

We want to make sure that the experiences and knowledge from other emergency responders are reflected in the implementation of the new alternative crisis response program. Your responses will be confidential. Please answer according to your best estimate, based on your experiences. The survey will take 5-10 minutes. Thank you for participating!

1. ***I work for:***
   - Dispatch
   - Police
   - Fire
2. ***I am:***
   - Civilian
   - Sworn/commissioned

3. ***What shifts do you typically work?*** *(check all that apply)*
   - Day shift
   - Swing shift
   - Graveyard shift

4. ***In a typical week, how often do you encounter residents in some sort of crisis without a criminal or public safety element that requires police, fire, or EMS?***
   - None
   - 1-5
   - 6-10
   - 11-15
   - More than 16

5. ***What are the most common causes of crises that you encounter?*** *(check all that apply)*
   - Mental health
   - Substance use disorder
   - Poverty
   - Homelessness
   - Community/family/tenant conflict
   - Other: _____

6. ***Of the residents in crisis who you encounter, what percentage are currently homeless?***
   - None
   - Up to 25%
   - Up to 50%
   - Up to 75%

100%

7. ***What resource is the greatest IMMEDIATE needs of individuals that you encounter in crisis?*** *(check all that apply)*
   - Immediate shelter
   - Detox bed
   - De-escalation
   - Mental health counseling
   - Food
   - Non-emergency, low-level medical care
   - Transportation
   - A safe, supportive place to go during the day
   - Other: _____

8. ***Of the residents in crisis, how many have a non-emergency, low-level medical issue (needing wound or foot care, low blood sugar, etc)?***
   - None
   - Up to 25%
   - Up to 50%
   - Up to 75%
   - 100%

9. ***What calls often involve someone in crisis?*** *(check all that apply)*
   - People walking into traffic
   - Pedestrian interference
   - Welfare check
   - Sleeper/Person Down
   - Suspicious person or circumstance
   - Unwanted person/Criminal trespass
   - Disturbance/disorderly conduct
   - Suicidal checks
   - Public Service calls in the front lobby of RPD
   - Mentally ill/mental disturbance
   - Confused/elderly person
   - Loitering
   - Intoxicated subject
   - Indecent exposure
   - Keep the peace
   - Noise complaint
   - Runaway
   - Other: _____

10. ***In a typical week, how often do you encounter residents who are "high utilizers" of services - people who frequently interact with emergency responders or other providers?***

None
1-5/week
6-10/week
11-15/week
16or more times/week

11. ***How should the crisis team be requested?*** *(check all that apply)*

Separate, dedicated number for the crisis team
Hotlines (211, 988, etc)
Richmond dispatch of 911/non-emergency calls
Request from Richmond officers/firefighters in the field
County mental health
Comments: _____

12. ***If they can be dispatched safely, should there be a list of calls that the crisis team automatically responds to (for example, disorderly conduct or welfare check)?***

Yes
No

13. ***Do you agree or disagree with these statements?***

1=strongly agree; 5=strongly disagree

I am confident that I know about resources for residents in crisis	1-2-3-4-5
Low-level crisis situations take too much time to resolve	1-2-3-4-5
Low-level crisis situations could be better handled by other responders	1-2-3-4-5
It is not safe to send unarmed teams because calls can be unpredictable	1-2-3-4-5
A sworn/commissioned officer should embedded in the crisis team	1-2-3-4-5
A mental health professional should be embedded in the crisis team	1-2-3-4-5
The new crisis team is taking jobs away from us	1-2-3-4-5

14. ***What will make a low-level crisis team successful?*** *(check all that apply)*

Quick response time
Reliable response to calls
Hours of operation
Able to transport residents
Safety training for crisis team
Connection to immediate services
Connection to long-term care
Crisis team follows up with residents after initial call
Crisis team understands police, fire, and EMS scope of work
Crisis team speaks Spanish and other languages of Richmonders
Police/fire/EMS/dispatch understand when and how to ask for the crisis team
Police/fire/EMS/dispatch understand what situations the crisis responds to
Police/fire/EMS/dispatch understand what the crisis team can do to address a situation
Police/fire/EMS/dispatch understand the safety considerations and protocols for the crisis team

Police/fire/EMS/dispatch understand how the team will handle criminal situations or investigations
A liaison or easy way for officers to get answers or address concerns with the crisis team
Other: _____

15. What else should be considered in the development of a crisis response team?

_____
_____

16. Are there any specific dispatch/firefighter/EMS/police considerations we should know about?

_____
_____

CONFIDENTIAL STATISTICAL INFORMATION (Demographics)

This information is confidential and you can decide not to answer. It helps us understand if personal experiences affect emergency responders' answers.

17. How long have you worked for the city of Richmond?

- ☐ 1-3 years
- ☐ 4-6 years
- ☐ 7-10 years
- ☐ 11-16 years
- ☐ 17 or more years
- ☐ decline to answer

18. How old are you?

- ☐ 18 - 24
- ☐ 25 - 34
- ☐ 35 - 44
- ☐ 45 - 54
- ☐ 55 - 64
- ☐ 65 - 74
- ☐ 75 or older

18. What is your race/ethnicity? (check all that apply)

- ☐ White or Caucasian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Asian or Asian American
- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Arab or Middle-Eastern
- ☐ Another race (please specify) _____

19. What is your gender identity and orientation? (check as many as apply)

- ☐ Female
- ☐ Male
- ☐ Transgender
- ☐ Gender fluid/non-binary
- ☐ LGBQIA+
- ☐ Your chosen term: _____

20. What zip code do you live in?

_____ zip code (5 digit input)

This survey is anonymous and confidential. If you would like to talk to us, please tell us how to get in touch with you.

Name _____

Email Address _____

Phone Number _____

Comment _____

Any other comments you may have: _____

Your voice is heard. Thank you!

Q4. In what kinds of situations have you interacted with emergency services? (select all that apply)

	Response Percent	Responses
Quality of life (parking problem, noise complaint, dumping, etc)	37.08%	99
Homeless related situation	25.84%	69
Emergency - fire	17.98%	48
Emergency - crime in progress	15.36%	41
Emergency - threat to safety	20.97%	56
Emergency - medical crisis	32.96%	88
Vehicle accident or problem	23.6%	63
Report a crime/accident for a police report	27.72%	74
Mental health crisis	20.97%	56
Drug/alcohol-related situation	10.86%	29
Community dispute	10.86%	29
Domestic violence/family conflict	16.1%	43
Wellness check (asking a responder to check on someone)	13.11%	35
Other (please specify)	10.86%	29
	Answered	267
Q33. ¿En qué tipo de situaciones ha interactuado con los servicios de emergencia? (marque todas las opciones que correspondan)		
Calidad de vida (problema de estacionamiento, queja de ruido, basurero, etc.)	38.46%	5
Situación relacionada con personas sin hogar	15.38%	2
Emergencia - incendio	0.0%	0
Emergencia - delito en progreso	15.38%	2
Emergencia - amenaza a la seguridad	15.38%	2
Emergencia - crisis medica	15.38%	2
Accidente o problema de un vehículo	15.38%	2
Informar un delito/accidente para un informe policial	15.38%	2
Crisis de salud mental	7.69%	1
Situación relacionada con las drogas/alcohol	7.69%	1
Disputa comunitaria	0.0%	0
Violencia doméstica/conflictos familiares	30.77%	4
Control de bienestar (pedir al personal de auxilio que controle a alguien)	0.0%	0
Otra opción(especifique)	15.38%	2
	Answered	13
Q62. Em quais tipos de situações você interagiu com serviços de emergência? (selecione todas que se aplicam)		
Emergência - crise médica	100.0%	1
	Answered	1

Q6. What number(s) have you called for help with a crisis? (select all that apply)

	Response Percent	Responses
I haven't called for emergency responders or resources	10.49%	28
911 (Firefighters, Paramedics, Police)	66.67%	178
211 (Essential Community Services)	14.98%	40
510-233-1214 (Richmond non-emergency)	50.94%	136
County Mental/Behavioral Health Services	9.36%	25
Suicide or other hotline	1.87%	5
Community organization or service provider [non-profit]	9.74%	26
Other resource you've used or called:	7.87%	21
	Answered	267
Q35. ¿A qué números ha llamado para recibir ayuda con una crisis? (marque todas las opciones pertinentes)		
No he llamado a los servicios o recursos de emergencia	0.0%	0
911 (bomberos, paramédicos, policía)	84.62%	11
211 (servicios comunitarios esenciales)	30.77%	4
510-233-1214 (para no emergencias)	30.77%	4
Servicios de salud mental/conductual del condado	7.69%	1
Suicidio u otra línea directa	7.69%	1
Organización comunitaria o proveedor de servicios [sin fines de lucro]	7.69%	1
Otro recurso que haya usado o llamado:	0.0%	0
	Answered	13
Q63. Qual número(s) você ligou para pedir ajuda? (selecione todas que se aplicam)		
911 (Bombeiros, paramédicos, polícia)	100.0%	1
	Answered	1

Q7. Do you or a family member have a disability? (check all that apply)

	Response Percent	Responses
No	61.65%	164
I/a family member have mental health challenges	21.05%	56
I/a family member have a physical disability	20.3%	54
I/a family member have a disability that affects my ability to communicate	4.14%	11
I/a family member have behavioral or autism spectrum challenges	9.02%	24
	Answered	266
Q36. ¿Usted o un miembro de su familia tiene una discapacidad? (marque todas las opciones que corresp		
No	53.85%	7
Yo/un familiar tengo/tiene problemas de salud mental	23.08%	3
Yo/un familiar tengo/tiene una discapacidad física	15.38%	2
Yo/un familiar tengo/tiene una discapacidad que afecta mi/su habilidad de	7.69%	1
Yo/un miembro de mi familia tengo/tiene problemas de comportamiento o	7.69%	1
	Answered	13
Q64. Você ou algum membro da família tem alguma deficiência? (selecione todas que se aplicam)		
Não	100.0%	1
	Answered	1

Q8. Has the disability affected your interaction with emergency services?

	Response Percent	Responses
Yes	17.87%	32
No	82.12%	147
	Answered	179
Q37. ¿La discapacidad ha afectado su interacción con los servicios de emergencia?		
Sí	50%	4
No	50%	4
	Answered	8
Q65. A deficiência afetou a sua interação com serviços de emergência?		
	Answered	0

Q10. The situation was for:

	Response Percent	Responses
Myself	31.25%	80
A family member/relative	22.66%	58
A friend/neighbor	16.8%	43
A stranger	18.75%	48
Other (please specify)	10.55%	27
	Answered	256
Q39. La situación era para:		
Mí	30.77%	4
Un familiar/pariente	53.85%	7
Un amigo/vecino	15.38%	2
Un extraño	0.0%	0
Otra opción(especifique)	15.38%	2
	Answered	13
Q67. A situação era para:		
Um membro da família/parente	100.0%	1
	Answered	1

Q11. Who responded? (select all that apply)

	Response Percent	Responses
Police	61.72%	158
Fire Department	35.16%	90
Paramedics/EMS	31.64%	81
Contra Costa County homeless services	6.25%	16
Contra Costa County behavioral health services	3.13%	8
Community-based responder	1.95%	5
No one showed up	13.67%	35
Other (please specify)	6.64%	17
	Answered	256
Q40. ¿Quién respondió? (marque todas las opciones que correspondan)		
Policía	84.62%	11
Cuerpo de bomberos	7.69%	1
Paramédicos/EMS	7.69%	1
Servicios para personas sin hogar del condado d	15.38%	2
Servicios de salud conductual del condado de C	15.38%	2
Personal de auxilio basado en la comunidad	0.0%	0
Nadie apareció	30.77%	4
Otro (especifique)	0.0%	0
	Answered	13
Q68. Quem respondeu? (selecione todas que se aplicam)		
Paramédicos/EMS	100.0%	1
	Answered	1

Q12. How long did it take first responders to arrive?

	Response Percent	Responses
1-5 minutes	16.02%	41
6-10 minutes	24.61%	63
11-15 minutes	19.53%	50
16-60 minutes	19.92%	51
Over 60 minutes	9.77%	25
They never showed up	10.16%	26
	Answered	256
Q41. ¿Cuánto tardaron en llegar los primeros en responder?		
1-5 minutos	7.69%	1
6-10 minutos	30.77%	4
11-15 minutos	23.08%	3
16-60 minutos	15.38%	2
Más de 60 minutos	15.38%	2
Nunca aparecieron	7.69%	1
	Answered	13
Q69. Quanto tempo demorou para a emergência / socorrista chegar?		
Answer Choices	Response Percent	Responses
1-5 minutos	0.0%	0
6-10 minutos	100.0%	1
11-15 minutos	0.0%	0
16-60 minutos	0.0%	0
Mais de 60 minutos	0.0%	0
Eles nunca vieram	0.0%	0
	Answered	1

Q13. How do you feel about the response to the situation?

Q13. How do you feel about the response to the situation?		
	Response Percent	Responses
I'm glad I called - satisfied	50.39%	129
I shouldn't have called - disappointed	0.39%	1
It didn't help or hurt - neutral	29.69%	76
It didn't help or hurt - neutral	0.39%	1
I shouldn't have called - disappointed	19.14%	49
	Answered	256
Q42. ¿Cómo se siente acerca de la respuesta a la situación?		
Answer Choices	Response Percent	Responses
No debí haber llamado - decepcionado/a	0.0%	0
No ayudó ni perjudicó - neutral	0.0%	0
Me alegro de haber llamado - satisfecho/a	46.15%	6
No ayudó ni perjudicó - neutral	46.15%	6
No debí haber llamado - decepcionado/a	7.69%	1
	Answered	13
Q70. Como você se sente sobre a resposta à situação?		
Estou feliz por ter chamado - satisfeito	100.0%	1
Não ajudou nem atrapalhou - neutro	0.0%	0
Não deveria ter chamado - desapontado	0.0%	0
	Answered	1

Richmond Resident Survey-- Q14, Q43, Q71

Q14. What did go well interacting with emergency services? (select all that apply)		
	Response Percent	Responses
Responders arrived in a reasonable amount of time	49.17%	119
Responders provided helpful information or resources	30.58%	74
Responders were well trained	32.23%	78
Responders kept things calm or calmed things down	34.71%	84
Responders were culturally sensitive (understanding people of different backgrounds)	19.42%	47
Responders were compassionate	27.69%	67
Responders explained things and answered questions clearly	27.27%	66
I felt safe	31.4%	76
The situation was resolved	34.71%	84
Nothing went well	14.46%	35
Other (please specify)	11.16%	27
	Answered	242
Q43. ¿Qué salió bien cuando interactuó con el personal de servicios de emergencia? (marque todas las opciones que correspondan)		
Llegaron en un tiempo razonable	53.85%	7
Proporcionaron información o recursos útiles	15.38%	2
Estaban bien capacitados	15.38%	2
Fueron culturalmente sensibles	15.38%	2
Fueron compasivos	15.38%	2
Explicaron las cosas y respondieron preguntas con claridad	23.08%	3
Me sentí seguro/a	15.38%	2
La situación se resolvió	7.69%	1
Nada salió bien	15.38%	2
Otra opción:	23.08%	3
	Answered	13
Q71. O que foi bem ao interagir com os serviços de emergência? (selecione todas que	Response Percent	Responses
A emergência chegou em um tempo razoável	100.0%	1
A emergência forneceu informações ou recursos úteis	0.0%	0
A emergência / os socorristas eram bem treinados	0.0%	0
Os socorristas mantiveram as coisas calmas ou acalmaram as coisas	0.0%	0
Os socorristas foram atenciosos (entenderam pessoas de diferentes backgrounds)	0.0%	0
Os socorristas foram compassivos / altruístas	0.0%	0
Os respondentes explicaram coisas e responderam a perguntas de forma clara	0.0%	0
Eu me senti seguro	100.0%	1
A situação foi resolvida	100.0%	1

Richmond Resident Survey Q15, Q44, Q72

Q15. What did not go well interacting with emergency services? (select all that apply)		
Answer Choices	Response Percent	Responses
Responders arrived too late or never arrived	27.27%	66
Responders did not provide any information or resources	13.22%	32
Responders were poorly trained	9.09%	22
Responders were not culturally sensitive (understanding people of different backgrounds)	13.64%	33
Responders did not keep things calm or calm things down	6.61%	16
Responders overused their power	8.26%	20
Responders didn't listen or were not compassionate	18.18%	44
Responders didn't explain things or answer questions clearly	7.44%	18
I felt unsafe	9.5%	23
The response made the situation worse	11.16%	27
Nothing went badly	38.84%	94
Other (please specify)	16.53%	40
	Answered	242
Q44. ¿Qué no salió bien cuando interactuó con el personal de servicios de emergencia? (marque todas las opciones que correspondan)		
Llegaron demasiado tarde o nunca llegaron	46.15%	6
No escucharon	0.0%	0
No explicaron las cosas ni respondieron preguntas con claridad	15.38%	2
No proporcionaron ninguna información ni recursos	0.0%	0
Estaban mal capacitados	0.0%	0
No fueron culturalmente sensibles	0.0%	0
Abusaron de su poder	0.0%	0
La respuesta empeoró la situación	0.0%	0
Me sentí inseguro/a	15.38%	2
Nada salió mal	30.77%	4
Otra opción:	7.69%	1
	Answered	13
Q72. O que não correu bem ao interagir com os serviços de emergência? (selecione todas que se aplicam)		
Os socorristas chegaram tarde demais ou nunca chegaram.	0.0%	0
Os socorristas não forneceram nenhuma informação ou recursos.	0.0%	0
Os socorristas foram mal treinados.	0.0%	0
Os socorristas não eram culturalmente sensíveis (entendendo pessoas de diferentes origer	100.0%	1
Os socorristas não mantiveram a calma ou acalmaram as coisas.	0.0%	0
Os socorristas usaram em demasia seu poder.	0.0%	0
Os socorristas não ouviram ou não foram compassivos.	0.0%	0
Os socorristas não explicaram as coisas nem responderam claramente às perguntas.	0.0%	0

Richmond Resident Survey Q16, Q45, Q73

Richmond Resident Survey Q16, Q45, Q73		
Q16. What was the result of your call or interaction? (select all that apply)		
Answer Choices	Response Percent	Responses
Hospitalization	29.34%	71
Arrest	9.92%	24
Referred to services	15.29%	37
Made things more complicated	8.68%	21
Nothing changed	20.25%	49
Officers did not offer any help	10.33%	25
Provided referrals to an aftercare service or facility	7.02%	17
Gave additional resources that could help the situation	15.29%	37
I do not know	21.49%	52
Other (please specify)	13.22%	32
	Answered	242
Q45. ¿Cuál fue el resultado de su llamada o interacción? (marque todas las opciones que correspondan)		
Hospitalización	23.08%	3
Arresto	23.08%	3
Derivaron a servicios	7.69%	1
Se complicaron las cosas	0.0%	0
Nada cambió	15.38%	2
No sé	7.69%	1
Los oficiales no ofrecieron ninguna ayuda	0.0%	0
Hicieron derivación a un servicio o instalación de cuidado posterior	0.0%	0
Dieron recursos adicionales que podrían ayudar con la situación	7.69%	1
Otra opción (explique)	23.08%	3
	Answered	13
Q73. Qual foi o resultado da chamada ou interação? (selecione todas que se aplicam)		
Answer Choices	Response Percent	Responses
Hospitalização	100.0%	1
Prisão	0.0%	0
Referido a serviços	0.0%	0
Tornou as coisas mais complicadas	0.0%	0
Nada mudou	0.0%	0
Os oficiais não ajudaram	0.0%	0

Richmond Resident Survey Q18, Q47, Q75		
Q18. Does anything stop you from calling 911 or interacting with responders? (check all that apply)	Response Percent	Responses
I haven't had a reason to call or interact with emergency responders	36.25%	149
I have had bad experiences with the police	12.9%	53
I am on parole/probation	2.19%	9
I might have an outstanding warrant	2.19%	9
I'm worried about my immigration status	3.16%	13
I don't trust police / they might make it worse	23.6%	97
I have trouble communicating in English or because of a disability	2.19%	9
Emergency services won't come or takes too long	14.6%	60
Emergency services won't help with the situation	9.49%	39
There is no reason that stops me from calling or interacting with emergency services	36.98%	152
Other (please specify)	7.54%	31
	Answered	411
Q47. ¿Algo le impide llamar al 911 o interactuar con el personal de emergencias? (marque todas las opciones que correspondan)		
No he tenido una razón para llamar o interactuar con ellos	52.0%	13
He tenido malas experiencias con la policía	8.0%	2
Estoy en libertad condicional/libertad condicional	0.0%	0
Podría tener una orden pendiente	0.0%	0
Me preocupa mi estatus migratorio	4.0%	1
No confío en la policía / podrían empeorarlo	4.0%	1
Tengo problemas para comunicarme en inglés o debido a una discapacidad	12.0%	3
Los servicios de emergencia no llegan o tardan demasiado	28.0%	7
Los servicios de emergencia no ayudarán con la situación	4.0%	1
No hay motivo que me impida llamar o interactuar con los servicios de emergencia	12.0%	3
Otra opción (especifique)	4.0%	1
	Answered	25
Q75. Algo te impede de ligar para 911 ou interagir com os responsáveis? (selecione todas que se aplicam)		
Eu não tive motivo para ligar ou interagir com os serviços de emergência	66.67%	2
Eu tive experiências ruins com a polícia	0.0%	0
Eu estou em liberdade condicional/probatório	0.0%	0
Eu poderia ter uma ordem de prisão pendente	33.33%	1
Estou preocupado com o meu estatuto de imigração	0.0%	0
Eu não confio na polícia / isso poderia piorar	0.0%	0
Tenho dificuldade em comunicar em inglês ou devido a uma deficiência	0.0%	0
Os serviços de emergência não vêm ou demoram muito	0.0%	0
Os serviços de emergência não ajudam na situação	0.0%	0
Não há motivo que me impeça de ligar ou interagir com os serviços de emergência	0.0%	0
Outro (por favor explique)	0.0%	0
	Answered	3

Richmond Resident Survey Q19, Q48, Q76

Q19. What would make Richmond's current emergency responses better? (select all that apply)		
	Response Percent	Responses
Improve response/arrival time	48.66%	200
More focus on keeping residents safe	38.44%	158
Improve de-escalation (calming down a situation)	45.74%	188
Improve cultural sensitivity (understanding people of different cultures or backgrounds)	41.61%	171
Offer more resources to support residents in crisis situations	45.26%	186
Offer alternative mobile crisis assistance without police	47.69%	196
Other (please specify)	14.36%	59
	Answered	411
Q48. ¿Qué mejoraría las respuestas a emergencias actuales de Richmond? (marque todas las opciones que correspondan)		
Mejorar el tiempo de respuesta/llegada	60.0%	15
Más enfoque en mantener seguros a los residentes	48.0%	12
Mejorar la desescalada (calmar una situación)	28.0%	7
Mejorar la sensibilidad cultural (comprender a las personas de diferentes culturas u orígenes)	20.0%	5
Ofrecer más recursos para apoyar a los residentes en situaciones de crisis	52.0%	13
Ofrecer asistencia de crisis móvil alternativa sin policía	20.0%	5
Otra opción (especifique)	8.0%	2
	Answered	25
Q76. O que tornaria as respostas de emergência atuais de Richmond melhores?		
Melhore o tempo de resposta/chegada	100.0%	3
Mais foco em manter os residentes seguros	33.33%	1
Melhore o desescalação (acalmar uma situação)	0.0%	0
Melhore a sensibilidade cultural (entendendo pessoas de diferentes culturas ou origens)	33.33%	1
Ofereça mais recursos para apoiar os residentes em crises	0.0%	0
Ofereça assistência móvel de crise alternativa sem a polícia	0.0%	0
Outro (por favor, explique)	0.0%	0
	Answered	3

Richmond Resident Survey Q20, Q49, Q77

Q20. What stops you from getting help with crisis situations - other than 911? (select all that apply)		
	Response Percent	Responses
I don't know how to find help or resources	28.47%	117
Help isn't available on nights or weekends	17.03%	70
There are rules or restrictions on who can get help	13.38%	55
There are too many rules about getting help	16.06%	66
Calling for help might involve the police	22.38%	92
The right kind of help is not available	21.65%	89
I have never had trouble getting help during a crisis	25.79%	106
There are people in my community who help out (mutual aid)	11.19%	46
Other (please specify)	11.19%	46
	Answered	411
Q49. ¿Qué le impide obtener ayuda en situaciones de crisis, aparte del 911? (marque todas las opciones que correspondan)		
No sé cómo encontrar ayuda o recursos	32.0%	8
La ayuda no está disponible en las noches o los fines de semana	8.0%	2
Hay reglas o restricciones sobre quién puede obtener ayuda	8.0%	2
Hay demasiadas reglas para obtener ayuda	16.0%	4
Pedir ayuda puede involucrar a la policía	8.0%	2
El tipo correcto de ayuda no está disponible	4.0%	1
Nunca he tenido problemas para obtener ayuda durante una crisis	8.0%	2
Hay personas en mi comunidad que ayudan (ayuda mutua)	28.0%	7
Otra opción (especifique)	8.0%	2
	Answered	25
Q77. Qual é que te impede de obter ajuda em crises - além do 911?		
Não sei como encontrar ajuda ou recursos	100.0%	3
A ajuda não está disponível à noite ou aos fins de semana	33.33%	1
Há regras ou restrições sobre quem pode obter ajuda	0.0%	0
Há muitas regras sobre como obter ajuda	0.0%	0
Chamar por ajuda pode envolver a polícia	0.0%	0
O tipo certo de ajuda não está disponível	0.0%	0
Nunca tive problemas para obter ajuda durante uma crise	0.0%	0
Há pessoas na minha comunidade que ajudam (ajuda mútua)	0.0%	0
Quais são os números ou organizações que você liga para encontrar ajuda?	0.0%	0
	Answered	3

Richmond Resident Survey Q22, Q51, Q78

Q22. The City of Richmond is developing a Community Crisis Response Program to respond to certain low-level emergency calls.		
Do you support a program where well-trained community members respond to some appropriate situations instead of police?		
	Response Percent	Responses
Yes	86.62%	356
No	13.38%	55
	Answered	411
Q51. La Ciudad de Richmond está desarrollando un Programa de respuesta a crisis de la comunidad para responder a ciertas		
llamadas de emergencia de bajo nivel. ¿Usted apoya que haya un programa en el que miembros de la comunidad bien		
capacitados respondan a algunas situaciones adecuadas en lugar de la policía?		
Sí	96.0%	24
No	4.0%	1
	Answered	25
Q78. A cidade de Richmond está desenvolvendo o Programa de Resposta a Crise na Comunidade (Community Crisis Response		
Program) para responder a certas chamadas de emergência de baixo nível. Você apoia um programa onde membros da		
comunidade bem treinados respondem a algumas situações apropriadas ao invés da polícia?		
Sim	100.0%	3
Não	0.0%	0
	Answered	3

Richmond Resident Survey Q24, Q53, Q80

Q24. How old are you?		
	Response Percent	Responses
Under 18	2.72%	11
18-24	5.2%	21
25-34	16.58%	67
35-44	22.52%	91
45-54	13.61%	55
55-64	11.14%	45
65-74	14.85%	60
75 or older	8.66%	35
Decline to state	4.7%	19
	Answered	404
Q53. ¿Cuántos años tiene?		
menores de 18 años	8.33%	2
18-24	0.0%	0
25 - 34	4.17%	1
35 - 44	25.0%	6
45 - 54	41.67%	10
55 - 64	12.5%	3
65 - 74	4.17%	1
75 años o más	0.0%	0
No quiero contestar	4.17%	1
	Answered	24
Q80. Quantos anos você tem?		
18 - 24	0.0%	0
25 - 34	0.0%	0
35 - 44	0.0%	0
45 - 54	33.33%	1

Richmond Resident Survey Q25, Q54, Q81

Q25. What is your race/ethnicity? (select all that apply)		
	Response Percent	Responses
White/Caucasian	38.62%	151
Black/African American	23.53%	92
Hispanic/Latino	26.09%	102
Asian/Asian American	10.74%	42
American Indian or Alaska Native	2.81%	11
Native Hawaiian or Other Pacific Islander	1.28%	5
Decline to state	0.0%	0
Arab/Middle Eastern	0.51%	2
Other (please specify)	7.16%	28
	Answered	391
Q54. ¿Cuál es su raza/etnicidad? (marque todas las opciones que correspondan)		
Blanco o caucásico	0.0%	0
Negro o afroamericano	0.0%	0
Hispano o latino	95.65%	22
Asiático o asiático americano	0.0%	0
Indio americano o nativo de Alaska	4.35%	1
Nativo de Hawái u otra isla del Pacífico	0.0%	0
No quiero contestar	0.0%	0
Árabe o persona del medio oriente	0.0%	0
Otra raza (Especifique)	0.0%	0
	Answered	23
Q81. Qual sua raça/etnia? (selecione todas que se aplicam)		
Branco ou caucasiano	0.0%	0
Preto ou afro-americano	100.0%	3
Hispânico ou latino	33.33%	1
Asiático ou ásio-americano	0.0%	0

Richmond Resident Survey Q26, Q55, Q82

Q26. What is your gender identity and orientation? (select all that apply)		
	Response Percent	Responses
Female	62.92%	246
Male	30.43%	119
Transgender	0.77%	3
Gender fluid/non-binary	3.32%	13
LGBQIA+	8.18%	32
Decline to state	0.0%	0
Other (your chosen term)	2.56%	10
	Answered	391
Q55. ¿Cuál es su identidad y orientación de género? (marque todas las opciones que correspondan)		
Mujer	86.96%	20
Hombre	13.04%	3
Transgénero	0.0%	0
Género fluido / no binario	0.0%	0
LGBQIA+	0.0%	0
No quiero contestar	0.0%	0
Su término elegido:	0.0%	0
	Answered	23
Q82. Qual sua identidade de gênero e orientação? (selecione todas que se aplicam)		
Answer Choices	Response Percent	Responses
Mulher	66.67%	2
Homem	33.33%	1
Transgênero	0.0%	0
Gênero fluído/não binário	0.0%	0
LGBQI+	0.0%	0
Seu termo de escolha:	0.0%	0
	Answered	3

Richmond Resident Survey Q27, Q56, Q83

Q27. How do you describe your housing situation?		
	Response Percent	Responses
Unhoused	5.9%	23
At risk of being unhoused	1.03%	4
In transitional housing	1.79%	7
Renter/Tenant	28.97%	113
Home owner	56.67%	221
Decline to state	0.0%	0
Other (please specify)	5.64%	22
	Answered	390
Q56. ¿Cómo describe su situación de vivienda?		
Sin casa	0.0%	0
En riesgo de quedarse sin casa	5.0%	1
En vivienda transitoria	0.0%	0
Inquilino	40.0%	8
Propietario de casa	45.0%	9
No quiero contestar	0.0%	0
Otra:	10.0%	2
	Answered	20
Q83. Como você descreve sua atual situação de domicílio?		
Pessoa em situação de rua	0.0%	0
Em risco de se tornar uma pessoa em situação de r	66.67%	2
De mudança	0.0%	0
Inquilino	33.33%	1
Proprietário de casa	0.0%	0
Outro:	0.0%	0
	Answered	3