Photo by Tina Russel

Civilian Crisis Response

A Toolkit for Equitable Alternatives to Police

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People experiencing behavioral health crises are in urgent need of compassion, care, and support—to ease their distress, to keep them safe, and to plan for their ongoing wellbeing.

In the vast majority of jurisdictions, police officers—as default first responders for 911 calls—are tasked with meeting these needs. They are often ill-equipped to do so.

Indeed, officer involvement can make these situations worse; this is particularly true in Black communities and other communities of color, which have disproportionately shouldered the harms of policing.[1] Research conducted nationwide shows that most Black people, in contrast to most white people, live with the fear that police will hurt them or their family members.[2] The tragic police killings of Daniel Prude, Deborah Danner, Walter Wallace Jr., Joseph DeWayne Robinson, and far too many others experiencing behavioral health crises have driven community demands for systemic change.[3]

In turn, an increasing number of jurisdictions are developing civilian–led crisis response programs. Staffed by unarmed teams of clinicians, peers, and other specially trained civilian responders, such programs are demonstrating that they can safely act as an alternative to police for people in crisis.[4] However, to truly address the needs of people most harmed by the status quo, jurisdictions must work to eliminate racial disparities and improve outcomes for everyone as they plan, implement, and evaluate these programs. In other words, crisis response programs must prioritize antiracism and equity.

But what does an antiracist and equitable crisis response program look like?

To answer this question, researchers from the Vera Institute of Justice (Vera) interviewed national subject matter experts and local program stakeholders, including people with direct experience in establishing and managing crisis response operations. Vera used the findings of these interviews to produce this toolkit. Vera hopes that it will provide guidance to advocates and practitioners alike who aspire to design and deliver more equitable crisis response services in their communities.

Methodology

The strategies and promising practices highlighted in this report draw on interviews conducted with advocates, practitioners, and researchers, as well as a review of program materials.

Vera researchers completed 35 interviews with a total of 44 national subject matter experts and local program stakeholders with professional and lived experience in behavioral health and crisis intervention, policing, 911 communications, peer support, research, and advocacy. Vera aimed to learn from local programs at different stages of planning and implementation and to include programs with novel approaches and innovations. Vera researchers included communities with diversity in size, geographic location, and demographic composition. Vera also sought to include stakeholders with subject matter expertise in areas relating to equity, such as racial equity, immigration, disability justice and access, and peer advocacy and workforce development.

Decision-making and equity: From caller to crisis response

When someone in crisis needs immediate support, there are numerous decision points that may produce inequities. At each point, local practitioners, depending on the action they take, can help reduce disparities and ensure that all people in crisis receive the care and support they need.

decision maker

Click the boxes below

C Call 911 e

During a behavioral health
people might be unsure wh
call for help—and what nu
call—for themselves, frienc
or strangers.

Overview of recommendations

Through their interviews with subject matter experts and program stakeholders, Vera researchers identified seven key areas where communities can take action to develop antiracist, equitable crisis response programs. The table below summarizes Vera's recommendations for each program area.

Program planning and community collaboration	Partner and collaborate with people with lived experience of behavioral health needs Allocate time and resources to integrate feedback
Navigating 911 triage and culture change	Create additional access points beyond 911 Train and support operators to address communication barriers and gaps in technology

	Identify the types of 911 calls that are appropriate for civilian crisis response beyond those narrowly defined as behavioral health crises Embed behavioral health experts in 911 call centers Refine assessments of safety and violence Support operators through program piloting and expansion
Staffing an equitable response	Recruit responders who reflect the communities they serve Focus on skills and experience Integrate peers into crisis response Conduct joint trainings for multidisciplinary teams Improve cultural competence and responsive practice
Pay equity and program governance	Provide competitive pay Structure program governance to promote adaptability, autonomy, and trust
Learning from grassroots responses	Acknowledge and address distrust in call centers Acknowledge and address distrust in system-based responses
Using data to guide implementation	Track key performance metrics to evaluate for equity Collect feedback from a wide range of stakeholders Regularly share data and evaluation updates with program and community stakeholders

Ongoing oversight for a community-driven program	Establish mechanisms for ongoing feedback and accountability Attend to ongoing community advocacy

1. Program planning and community collaboration

Local programs must be shaped by the perspectives and recommendations of community members. It is particularly important to hear from people who have direct, lived experience of current services and responses; people who have experienced behavioral health crises; and Black, Indigenous, and other people of color that have been disproportionately harmed by policing. Without these perspectives, programs risk perpetuating distrust and reproducing the inequities of status quo approaches.

Even with the best of intentions, community engagement and consultation efforts can be ineffective when they are one-off or infrequent, when they ask for input only and do not share opportunities for decision-making, or when stakeholders with institutional power are not open to critical feedback. People with lived experience should be in leadership and decision-making roles, contributing fully to programmatic and strategic decisions.[5]

Key recommendations

Partner and collaborate with people with lived experience

Allocate time and resources to integrate feedback

Partner and collaborate with people with lived experience

Allocate time and resources to integrate feedback

2. Navigating 911 triage and culture change

Hesitancy, skepticism, and fear of calling 911 are prevalent in Black and other communities of color.[20] Built in the aftermath of civil rights protests in the late 1960s, the centralized 911 system we know today can trace its history to the Kerner Report, which envisioned it as one way to increase the deployment of police to quell civil unrest in Black communities.[21] In the decades since, 911 has become an extension of a public safety system that perpetuates racial injustice and a tool that has entrenched police as the first—and often only—responders to nearly every social problem or request for assistance, further criminalizing communities of color. Yet it remains the most visible and widely available resource for emergency response.[22]

If someone decides to call 911, there are still several critical decision points that influence whether the person in crisis receives the care they need. Importantly, operators must be able to build interpersonal trust to communicate effectively with callers. This often requires engaging in cultural humility, fostering emotional connection, and navigating language barriers and challenges around immigration status, race, ethnicity, and other features of a caller's identity.[23]

Below, Vera presents recommendations on how to increase the likelihood that people in need will call for crisis assistance and that 911 operators will connect them with the support they need. By July 2022, 988 will be in operation nationwide as a number to call for mental health, substance use, and suicide crises, and there are considerable funding and capacity-building efforts underway to support its implementation.[24] These recommendations apply not only to 911 systems, but also to 988 systems.

Key recommendations for increasing access for callers

Create additional access points beyond 911

Train and support operators to address communication barriers and gaps in technology

Key recommendations for program criteria, call-taking, and dispatching

Identify the types of 911 calls that are appropriate for civilian crisis response beyond those narrowly defined as behavioral health crises

Increase access for callers

Create additional access points beyond 911

Train and support operators to address communication barriers and gaps in technology

Program criteria, call-taking, and dispatching

Identify the types of 911 calls that are appropriate for civilian crisis response beyond those narrowly defined as behavioral health crises

Embed behavioral health experts in 911 call centers

Refine assessments of safety and violence

Support operators through program piloting and expansion

3. Staffing an equitable response

Many communities have made progress in reducing police involvement in crisis response, but there remains no clear consensus around exactly who, if not police, should be answering 911 calls involving behavioral health needs.[57]

Experts caution against the notion that replacing police alone will eliminate inequities arising from interactions between first responders and people in crisis. "We know that there's a huge amount of bias within the mental health system as well, so the danger is still there," explained Amy Watson, professor of social work at the University of Wisconsin-Milwaukee. She pointed to the potential for bias in how responders interpret a situation, interact with a person in crisis, assess that person's needs, and rely on involuntary hospitalization to connect them to care.[58] In fact, Black people are disproportionately subject to such coercive mechanisms, which can exacerbate trauma and sow distrust in the very services and supports meant to facilitate recovery.[59] Vinnie Cervantes, organizing director with the Denver Alliance for Street Health Response, stressed the importance of crisis responders who have lived experience with behavioral health concerns and reflect the communities they serve.[60] The behavioral health workforce is still disproportionately white, and a preference for professional designations such as licensed clinicians may present barriers to employing more people with lived experience in both frontline and leadership roles.[61]

Hiring

Civilian crisis response programs are taking shape against a backdrop of workforce shortages and the underrepresentation of people of color and people with lived experience (known as "peers") across the behavioral health field. As local stakeholders navigate these challenges, strategic hiring will play an important role in meeting community needs.

Key recommendations

- Recruit responders who reflect the communities they serve
- Focus on skills and experience
- Integrate peers into crisis response

Recruit responders who reflect the communities they serve

Focus on skills and experience ***Integrate peers into crisis response***

Professional development

Crisis response programs may require collaboration across different organizations and team members with different skills, experiences, and professional backgrounds. Joint training can be an important way for teams to strengthen their shared knowledge and skills. Training can also strengthen competencies for working with BIPOC and other equity-deserving communities, to support more effective service delivery for people in crisis.[79]

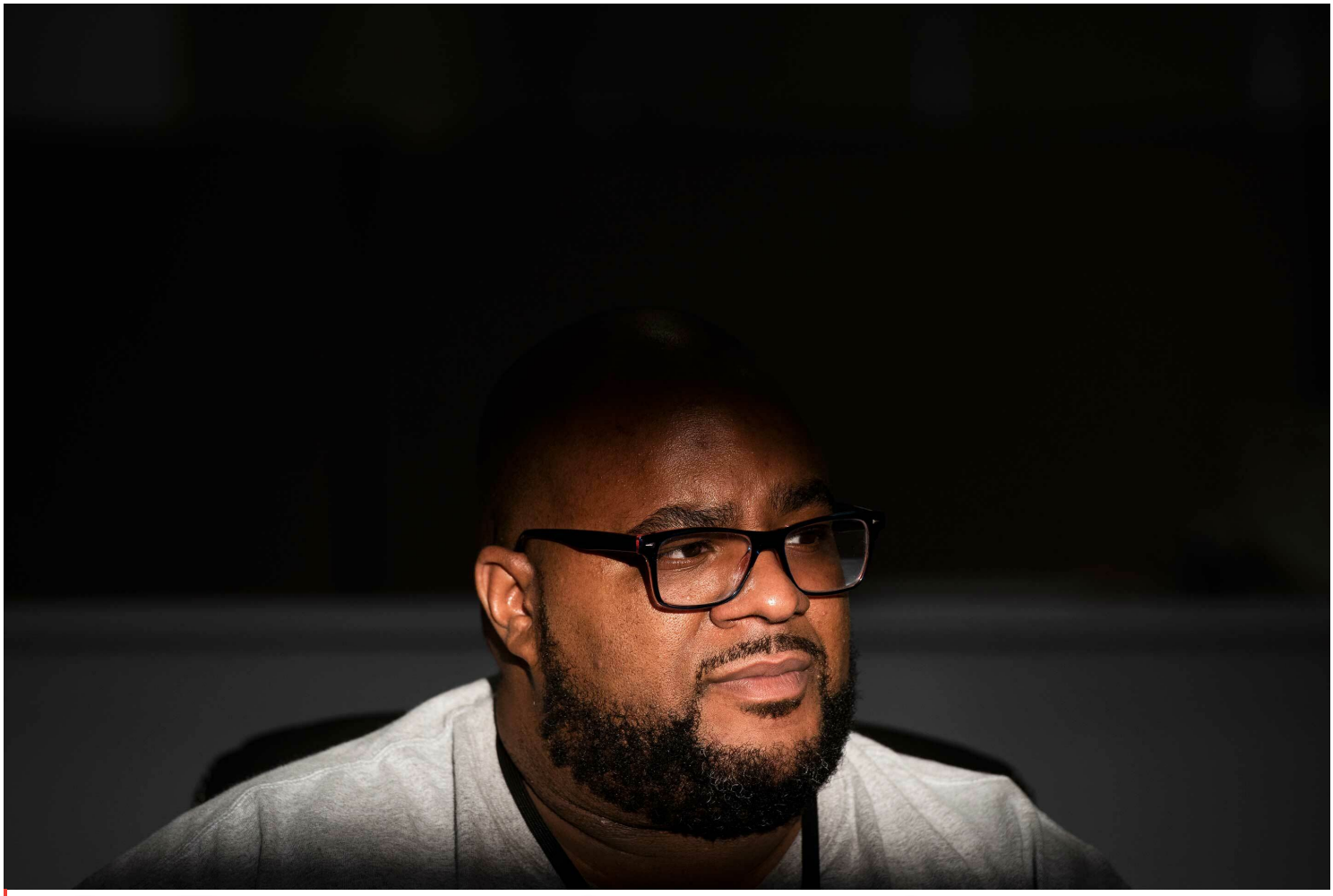
Key recommendations

Conduct joint trainings for multidisciplinary teams

Improve cultural competence and responsive practice

Conduct joint trainings for multidisciplinary teams

Improve cultural competence and responsive practice



4. Pay equity and program governance

The majority of people of color in the behavioral health workforce fill non-licensed, lower-level positions that lack opportunities for career advancement.[88] Moreover, low wages and a high demand for services contribute to burnout and turnover, which hinders patient access to high-quality care.[89] These workforce challenges can undermine the sustainability and growth of civilian response programs. Even in Eugene, Oregon, where CAHOOTS has operated out of the White Bird Clinic for more than 30 years, staff have said the program must secure greater funds from the city to provide a "reasonable wage" that reduces turnover before expanding further.[90]

Jurisdictions must properly compensate frontline responders and adequately fund entities that are trusted by community members to lead these responses. This might mean housing programs in existing or newly created government agencies or contracting with community-based organizations to operate and staff these initiatives. In either case, local governments should be involved in program development efforts, focusing on strong stakeholder coordination and promoting equitable service delivery.

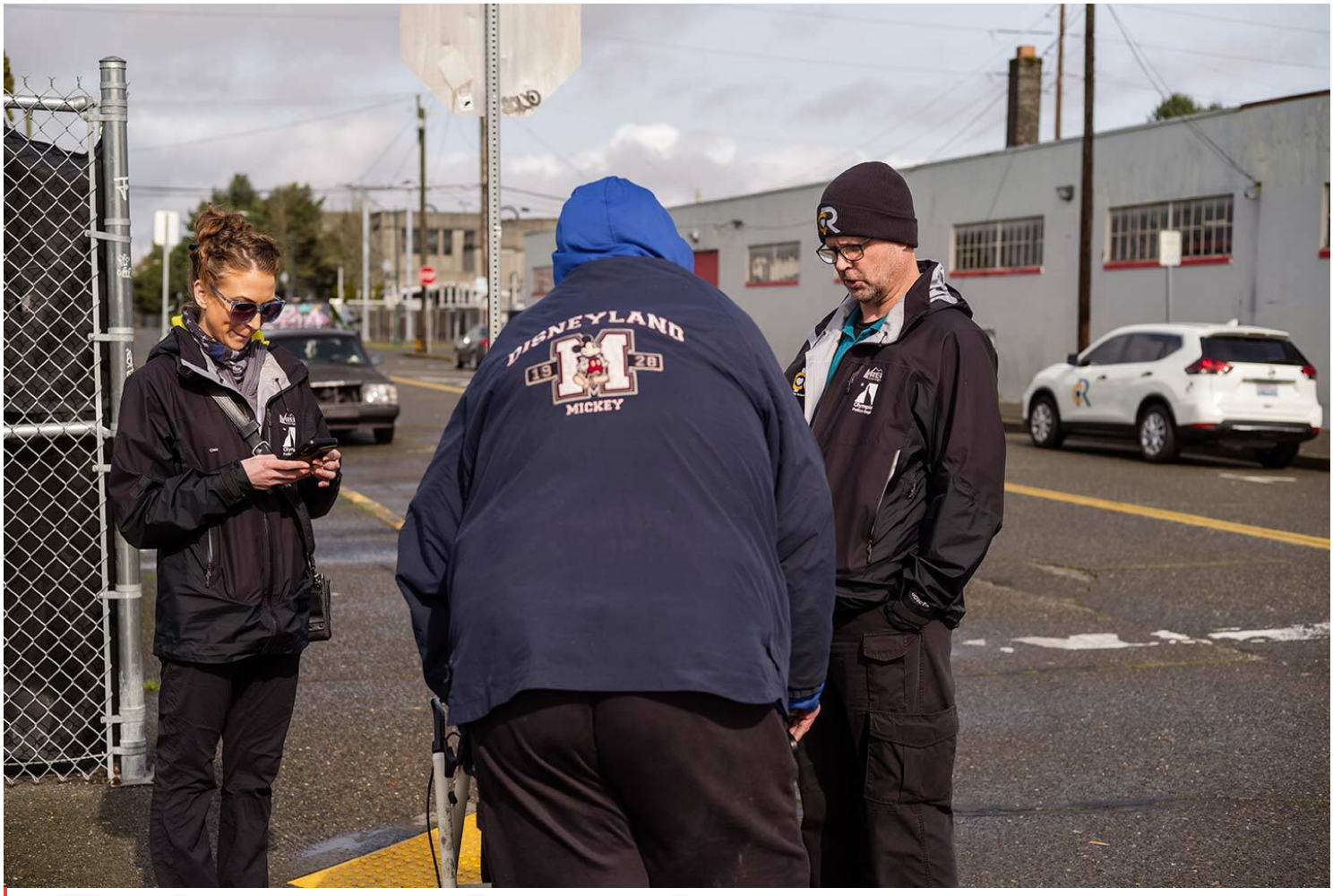
Key recommendations

Provide competitive pay

Structure program governance to promote adaptability, autonomy, and trust

Provide competitive pay

Structure program governance to promote adaptability, autonomy, and trust



5. Learning from grassroots responses

When someone experiences a behavioral health crisis, people might be hesitant to call 911 when armed responders are sent by default. This is particularly true in communities of color and LGBTQ+ communities where people have been disproportionately arrested, incarcerated, and subjected to state violence.[117]

Such hesitancy extends beyond policing, with profound implications for crisis response. People of color are less likely than white people to trust medical institutions and physicians more generally.[118] Among Black people, this distrust can be attributed, at least in part, to historical and contemporary discrimination by the U.S. medical establishment, disproportionate use of involuntary hospitalization, and ongoing disparities in health outcomes.[119] Latinx people similarly confront legacies of harm committed by the medical establishment—such as eugenics-based sterilization in Puerto Rico in the aftermath of Law 116—and today face disparities in access to high-quality, culturally responsive care.[120] Many other communities also experience discrimination and must overcome unique obstacles to receive the support they need. For example, trans people face persistent barriers to gender-affirming care, and in some places, experiencing a mental health crisis that results in involuntary commitment may foreclose future opportunities to access this life-saving treatment entirely.[121]

Amid this widespread distrust, grassroots efforts have taken shape to support people with unmet behavioral health needs. Grassroots organizations like the Black Emotional and Mental Health Collective, Anti Police-Terror Project, Call BlackLine, Trans Lifeline, Project LETS, and others have helped people overcome barriers to care, particularly among BIPOC communities, by providing them with crisis services and peer support in the absence of trusted institutional responses. Jurisdictions should look to these efforts and strive to develop programs that honor the concerns and expertise of grassroots crisis responders.

Key recommendations

- Acknowledge and address distrust in system-based call centers
- Acknowledge and address distrust in system-based responses

Acknowledge and address distrust in system-based call centers

Acknowledge and address distrust in system-based responses

6. Using data to guide implementation

Data should inform all stages of program implementation for crisis response programs, from the earliest stages of planning to ongoing monitoring and evaluation once a program launches. Collecting and using data is critical to understand what's working well and how programs can improve and adapt throughout the process of implementation. Data should be collected, analyzed, and shared regularly with program stakeholders, including community advocates and groups tasked with advisory and oversight.

Effective data collection will help identify where there are gaps in access and delivery to ensure more equitable implementation and outcomes.

Key recommendations

Track key performance metrics to evaluate for equity

Collect feedback from a wide range of stakeholders

Regularly share data and evaluation updates with program and community stakeholders

Track key performance metrics to evaluate for equity

Collect feedback from a wide range of stakeholders

Regularly share data and evaluation updates with program and community stakeholders

7. Ongoing oversight for a community-driven program

Crisis response programs should implement processes for community oversight to facilitate accountability and ensure that programs continue to meet the needs of the community members they aim to serve. Approaches to community oversight can build on the principles and practices for community collaboration.

Key recommendations

Establish mechanisms for ongoing feedback and accountability

Attend to ongoing community advocacy

Establish mechanisms for ongoing feedback and accountability

Attend to ongoing community advocacy

Appendices

Additional Resources

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Usher, Laura, Amy Watson, Ron Bruno, Suzanne Andriukaitis, Don Kamin, Carol Speed, and Sabrina Taylor. *Crisis Intervention Team (CIT) Programs: A Best Practice Guide for Transforming Community Responses to Mental Health Crises* (Memphis, TN: CIT International, 2019).

Vera Institute of Justice, *Investing in Evidence-Based Alternatives to Policing: Civilian Crisis Response* (New York: Vera Institute of Justice, 2021).

Interviews with national subject matter experts and local program stakeholders

Interview #	Interview Date	Interviewee Name	Interviewee Organization and Role
1	March 4, 2021	Shannon Scully	Senior Advisor for Justice and Crisis Response Policy, National Alliance on Mental Illness (NAMI)
2	March 9, 2021	Amy Watson	

			Professor of Social Work, Helen Bader School of Social Welfare at the University of Wisconsin-Milwaukee
3	March 17, 2021	Pat Strode	CIT Advocate Coordinator, Georgia Public Safety Training Center
4	March 12, 2021	Jessica Gillooly	Assistant Professor of Sociology & Criminal Justice, Suffolk University
5	March 24, 2021	Chacku Mathai	Ex-patient advocate, Board member for the National Association for Rights Protection and Advocacy (NARPA), President of Friends of Recovery - New York, and SAMHSA Project Director at Center for Practice Innovations at Columbia University,
6	March 25, 2021	Steve Baron	Former Director, District of Columbia Department of Behavioral Health
07, Participant A	April 7, 2021	David Covington	President and CEO, RI International
07, Participant B	April 7, 2021	Joy Brunson-Nsubuga	Vice President of Southeast Region, RI International

8	April 8, 2021	Lorie Fridell	Chief Executive Officer and Executive-Level Instructor, Fair and Impartial Policing
9	April 8, 2021	Gabriella Wong	Executive Director and Founder, accesSOS
10, Participant A	April 9, 2021	Taleed El-Sabawi	Assistant Professor of Law, Florida International University College of Law and Scholar, Addiction & Public Policy Initiative, the O'Neill Institute for National & Global Health Law, Georgetown Law Center
10, Participant B	April 9, 2021	Jennifer J. Carroll	Assistant Professor of Anthropology, North Carolina State University
11	April 7, 2021	Yolo Akili Robinson	Executive Director and Founder, Black Emotional Mental Health Collective (BEAM)
12	April 13, 2021	Melissa Neal Stein, DrPH	Senior Research Associate, Policy Research Associates, Inc.
13	May 10, 2021	Lt. Diane Goldstein (Ret.)	

			Executive Director, Law Enforcement Action Partnership (LEAP)
14	May 17, 2021	Pata Suyemoto	Co-chair of the Greater Boston Regional Suicide Prevention Coalition and Chair of the Massachusetts Coalition for Suicide Prevention (MCSP) Alliance for Equity's People of Color Caucus
15, Participant A	May 18, 2021	Rachel Bromberg	Co-Founder, Reach Out Response Network and Co-Founder, International Crisis Response Association
15, Participant B	May 18, 2021	Asante Haughton	Co-Founder, Reach Out Response Network and Co-Founder, International Crisis Response Association
16	May 20, 2021	Vanessa Green	Founder and Executive Director, Call BlackLine
17	May 21, 2021	Victor Armstrong	Chief Equity Officer, North Carolina Department of Health and Human Services
18	May 25, 2021	Megan McGee	

			Special Projects Manager, St. Petersburg Police Department
19	May 27, 2021	Curtis Dann-Messier	Director, NYC Health + Hospitals Peer Academy and Board Member, NYC Justice Peer Initiative
20, Participant A	June 4, 2021	Stefanie Lyn Kaufman-Mthimkhulu	Founder and Executive Director, Project LETS
20, Participant B	June 4, 2021	Xochi Cartland	Former Director of Programs, Chapter Leader, and Peer Support Advocate, Project LETS
21	June 10, 2021	Daniela Hernández Chong Cuy	Immigration Lawyer and co-chair of the Latino Underserved Communities of Color, Los Angeles County Department of Mental Health, and coordinator of the Undocumented / Mixed-Status Families subcommittee
22	June 28, 2021	Greg Townley	Associate Professor of Community Psychology and co-founder of PSU's Homelessness Research & Action Collaborative, Portland State University

23, Participant A	June 30, 2021	Lauren Brown	Strategic Services Division Manager, Portland Police Bureau
23, Participant B	June 30, 2021	Christian Peterson	Police Data Research Supervisor, Portland Police Bureau
24	June 30, 2021	Terri Balliet	Chief Operating Officer, Gulf Coast Jewish Family and Community Services
25	July 6, 2021	Deberah Giles	Clubhouse Supervisor, OurHouse Clubhouse
26	July 7, 2021	Daniele Lyman-Torres	Former Commissioner, Rochester Department of Recreation and Human Services
27	July 8, 2021	Tahlar Rowe	Mental Health Advocate, San Antonio Clubhouse
28, Participant A	July 13, 2021	Kailey Fiedler-Gohlke	Chief Executive Officer, Hero House NW Clubhouse
28, Participant B	July 13, 2021	Michael Brown	Chief Program Officer, Hero House NW Clubhouse
29, Participant A	August 2, 2021	Simon Pang	Assistant Deputy Chief of Community Paramedicine, San Francisco Fire Department

29, Participant B	August 2, 2021	Angelica Almeida, Ph.D.	Director of Forensic and Justice Involved Behavioral Health Services, San Francisco Department of Public Health
30	August 10, 2021	Anne Larsen	Former Outreach Services Coordinator, Olympia Police Department
31	October 1, 2021	Nomi Teutsch	Member of Treatment Not Trauma Coalition and Clinical Social Worker, Treatment Not Trauma Coalition
31	October 1, 2021	Nikki Grant	Member of Treatment Not Trauma Coalition and Amistad Law Project's Policy Director and Co-Founder, Treatment Not Trauma Coalition
32	September 20, 2021	Jason Hansman	Deputy Director, Mental Health Initiatives for Crisis Response/Community Capacity, New York City Mayor's Office of Community Mental Health
33	October 18, 2021	Tobi HIll-Meyer	Equity and Inclusion Coordinator, City of Olympia
34	October 14, 2021	Vinnie Cervantes	

			Organizing Director, Denver Alliance for Street Health Response
35, Participant A	November 4, 2021	Erin Dalton	Director, Allegheny County Department of Human Services
35, Participant B	November 4, 2021	Jenn Batterton	Manager of Special Initiatives, Allegheny County Department of Human Services

Featured programs and jurisdictions

An increasing number of jurisdictions are developing civilian-led crisis response programs staffed by unarmed responders. For an overview of existing crisis response programs highlighted in this toolkit, see below:

Program Name	**Jurisdiction**	**Start Date and Current Scope**	**Program Governance**	**Staffing and Dispatch Model**
Community Assistance and Life Liaison (CALL)	St. Petersburg, FL	January 2021 (citywide)	Program is administered and monitored by the police department and staffed by Gulf Coast Jewish & Family Services	Two-person teams of behavioral health workers and community navigators. Accessible via 911 and a non-emergency line that is connected to the same communications center

People in Crisis (PIC)	Rochester, NY	January 2021 (citywide)	Program is administered, overseen, and staffed by the Crisis Intervention Services Office in Rochester's Department of Recreation and Human Services.	Two-person teams of behavioral health professionals, secured a grant for a peer role. Accessible via 911 and through 211, the region's 24/7 crisis line.
Support Team Assistance Response (STAR)	Denver, CO	June 2020 (citywide)	Program is administered and overseen by the Department of Health & Environment and staffed by the Mental Health Center of Denver.	Two-person teams, including a mental health clinician and paramedic. Accessible via 911.
	New York, NY	Spring 2021 (pilot)	Program is jointly operated by the NYC Fire Department and Health + Hospitals, with oversight from	

Behavioral Health Emergency Assistance Response Division (B-HEARD)			the Mayor's Office of Community Mental Health	Teams of two Fire Department EMTs/paramedics and one social worker from Health + Hospitals Accessible via 911
Crisis Assistance Helping Out On The Streets (CAHOOTS)	Eugene and Springfield, OR	1984 (citywide)	Program is funded through the police department and integrated into their communications system but administered and staffed by White Bird Clinic	Two person teams of crisis workers and EMTs Accessible via 911 and a non-emergency line that is connected to the same communications center
Street Crisis Response Team (SCRT)	San Francisco, CA	November 2020 (citywide)	Program is collaboratively administered by the Department of Public Health (DPH), Fire Department, and Department of Emergency Management, and staffed by	Three-person teams of peer health worker, paramedic, behavioral health clinician Accessible via 911

			the Fire Department and two DPH contractors, HealthRight 360 and RAMS, Inc.	
Portland Street Response (PSR)	Portland, OR	January 2021 (citywide)	Program is administered and staffed by Portland's Fire and Rescue Department	Two four-person teams that include one firefighter/EMT or paramedic, one licensed mental health crisis therapist, and two community health workers or two peer support specialists Accessible via 911
Crisis Response Unit (CRU)	Olympia, WA	April 2019 (citywide)	Program is administered and staffed by civilian employees of the police department	Two behavioral health specialists Accessible via 911

Community Crisis Support Services (CCSS)	Toronto, Canada	March 2022 (pilot)	The City of Toronto is contracting with four community-based service providers (TAIBU Community Health Centre, Gerstein Crisis Centre, The Canadian Mental Health Association Toronto, and 2-Spirited People of the 1st Nations) to operate and staff four distinct pilot programs	Multidisciplinary teams of trained crisis support specialists (e.g. community health nurses, crisis counsellors, harm reduction workers, peer workers) Accessible via 911, and 211 - 211 operators will triage and dispatch calls to mobile teams.

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Endnotes

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[4] Jackson Beck, Melissa Reuland, and Leah Pope, "Behavioral Health Crisis Alternatives: Shifting from Police to Community Responses," Vera Institute of Justice, November 2020; Vera Institute of Justice, *Investing in Evidence-Based Alternatives to Policing: Civilian Crisis Response* (New York: Vera Institute of Justice, 2021); and Council of State Governments Justice Center, "Expanding First Response: A Toolkit for Community Responder Programs."

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[7] Street Roots, "About," accessed February 3, 2022; and Kaia Sand, "Believe Our Stories and Listen: Perspectives on First Response on the Streets," *Street Roots*, September 19, 2019.

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[10] Kaia Sand, "Believe Our Stories and Listen: Perspectives on First Response on the Streets," *Street Roots*, September 19, 2019. For an overview of the community engagement work group's goals and activities, see The Justice Collaborative Policing Task Force, *Developing a Community-Based Emergency First Responders (EFR) Program* (San Francisco: The Justice Collaborative Institute, 2020), 40-43.

[11] Reach Out Response Network, *Final Report on Alternative Crisis Response Models for Toronto* (Toronto, ON: Reach Out Response Network, 2020), 5.

[12] Reach Out Response Network, *Final Report on Alternative Crisis Response Models for Toronto* (Toronto, ON: Reach Out Response Network, 2020).

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[18] Interview 05. [19] Interview 01.

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