



City of Tacoma

Questions and Answers

MENTAL AND BEHAVIORAL HEALTH CRISIS RESPONSE TEAM

RFI Specification No. **CM22-0171F**

All interested parties had the opportunity to submit questions in writing by email to Ryan Foster, Senior Buyer by date questions were due. The answers to the questions received are provided below and posted to the City's website at www.TacomaPurchasing.org. Navigate to [Current Contracting Opportunities](#) / *Services Solicitations*, and then click *Questions and Answers* for this Specification. This information IS NOT considered an addendum. Respondents should consider this information when submitting their proposals.

Question 1: What is the Service area (City of Tacoma or to include outlying areas - square miles)?

Answer 1: Please refer to the City of Tacoma – All Police Sectors document below

Question 2: What is Population of area to be serviced?

Answer 2: 219,346 as of the April 1, 2020 census

Question 3: What is the estimated number of yearly calls made to 911, currently handled by first responders, for mental health crisis intervention that would fall under the scope of the Crisis Response Team?

Answer 3: Please refer to the table on section 3(3) on **page 27** of the Tacoma Alternative Response Report (below).

Question 4: In the RFI, page 4, 2A(a) states the responder will “respond to calls for service without initial police and/or fire department co-response, provided there is no threat of violence and/or harm”. Who will make the determination that there is no threat of violence and/or harm?

Answer 4: Please refer to section 3(2) on **page 24** of the Tacoma Alternative Response Report (below). Respondents to the RFI should outline their recommendation for determination of appropriate calls. The City does not have current defining criteria established around the threat of violence and/or harm. The responses to this RFI will help inform the City's approach to this.

Question 5: Page 4, 2B (b) states the service provider will fulfill the role of “A civilian responder that triages the handling of the call and handles procedural issues such as resolving trespassing situations (i.e., largely the function of a civilian community services officer/CSO role). While we are accustomed to requests for licensed mental health personnel and/or EMT's, we are not familiar with this role. Please clarify the role of this individual and confirm that this role is filled by the service provider. What qualifications are required for this civilian responder position?



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Answer 5: Please review section 3(2) on **page 24** of the Tacoma Alternative Response Report (below). Respondents to the RFI should outline their recommendation for qualifications associated with this civilian responder.

Question 6: **Page 4, Section 2C states “Capability to integrate and coordinate with regional 911 dispatch and emergency services”. Please clarify the “integration” part of the responsibility. Are you requesting the service provider have a computer system that will integrate with the 911 system? Who will be answering those calls?**

Answer 6: Please review section 3(3) on **pages 26-27** of the Tacoma Alternative Response Report (below). Respondents to the RFI should outline their recommendations to enable call diversion as described in the study. Communication methods have not been determined at this time.

Question 7: **Page 4, Section 2D states “Provide case management and supportive resources to enable care continuation and facilitate transitions to treatment facilities and medical providers.” Please clarify the role of “case management”. Do you expect the service provider to follow up with the individuals seen during crisis response?**

Answer 7: Please review section 3(4) on **pages 28-29** of the Tacoma Alternative Response Report (below). Respondents to the RFI should outline their recommendation for care continuation support, including records and/or case management to facilitate the “warm handoff approach” described in the study.

Question 8: **What resources will be available to the Crisis Response team for placement of individuals when seen, if needed?**

Answer 8: The City currently has shelter, counseling, and other resources available through several partners. Responses to this RFI will enable the City to assess current resource availability and make determinations for future needs.

3. Diversion of Homelessness and Mental Health Crisis Calls

With the enforcement component diminished and tested to not be effective in achieving desired outcomes, it is worth examining the relative advantages between the police department conducting outreach versus other departments. TPD has been highly proactive in developing positive relationships with the homeless community through the work of the HOT team, as well as on a more general. Despite these efforts and successes, there are inherent barriers and challenges in furthering trust between law enforcement and the homeless population.

These challenges make it more difficult to make inroads when attempting to connect homeless individuals with services, regardless of the progress TPD has made in developing positive relationships with these communities. As a result, the city should pursue other responses to homelessness-related issues, replacing the current model which includes the HOT team organized under the Tacoma Police Department.

(1) Needs to Address in an Alternative Model

There are several needs that must be addressed in any alternative model that are currently fulfilled by the Homeless Outreach Team and TPD patrol:

- Outreach workload that is currently handled by the HOT team that would otherwise fall to NCS outreach workers.
- Security during encampment clearing actions
- Response to mental health crisis events
- Security for clinicians in mental health crisis events
- Response to calls for service involving encampments or other homelessness-related issues

As discussed in the previous section of the report, the outreach conducted by the TPD HOT team members should be transferred to NCS, with a corresponding addition of two outreach worker positions added to NCS.

Given that the current interagency approach to outreach poses a number of issues with coordination and data sharing, it is not feasible to transfer these responsibilities to a third agency or organization should the HOT team be displaced from the role. Instead, the alternative service model should shift any portion of outreach conducted by the HOT

team to NCS, which currently has 2 outreach workers functioning in that role. To be able to accommodate all outreach responsibilities, NCS outreach worker staffing should be increased by two positions, with one functioning as a lead in order to provide field supervision for the team. Should a security issue arise or be anticipated, NCS can request TPD patrol to respond on scene in a backup capacity.

Likewise, security and enforcement during encampment clearing operations and on mental health crisis issues can be handled on a request basis, as there is not a fundamental need to have that provided by a standalone team of officers. Granted, this does have impacts on patrol workload, but it is not a significant enough workload to justify full time positions serving in that role.

Nonetheless, it is clear that **the HOT team spends a significant amount of time developing positive relationships through the outreach function**, and shifting to an enforcement/support role only would *re-focus* the relationship between law enforcement and the homeless community around the pretense of relationship, which must be acknowledged as a weakness of the shifted approach.

(2) The Civilian Crisis Response Model

In responding to mental health crisis events, the feasibility of diversion involves more complicated questions, and has certain limitations. For instance, a key aspect of the designated clinical responder (DCR) position is the ability to place individuals on involuntary holds. This inherently requires a need for an officer to be present given the likelihood of some level of force being needed in such a scenario where an individual is detained or transported, even if that force is low-level.

In an alternative model where the team is organized outside of the police department, there may be greater challenges in filling the positions. The perception and reality of safety issues posed by responding to individuals experiencing mental health crisis would likely be of concern to many clinicians that consider applying to the role, particularly if they are not paired up with an officer.

Even with these limitations in mind, the bulk of situations that the HOT team responds to do not involve use of force, and do not necessarily require the clinician to be paired with an officer. This includes incidents involving encampments, panhandling, persons experiencing mental distress or crisis but otherwise not posing a threat to the public, or individuals making suicidal threats.

A specialized team could be formed to handle these types of calls, a model that has significant precedent around the country and particularly in the Pacific Northwest, having

been pioneered by the Eugene CAHOOTS team in the late 1980s. The types of calls that such a unit would be tasked with handling often involve a nexus between needs for mental health services, connection to homeless services, and in situations such as trespassing, communication with the individual about what the individual must do to resolve the issue.

Despite frequently responding to mental health crisis events, the Eugene CAHOOTS team requested backup in only 0.6% of the roughly 24,000 calls they responded to in 2019. Nonetheless, it should be acknowledged that diverting these types of calls to civilian response does not entirely remove the need for police presence at these events, particularly the more critical incidents involving an individual engaged in or appearing to display a propensity to commit violent acts.

This requires the team to include several different roles:

- A crisis intervention worker or clinician that is trained to respond to mental health crisis events.
- A civilian responder that triages the handling of the call and handles procedural issues such as resolving trespassing situations (i.e., largely the function of a civilian community services officer/CSO role).
- An EMT-trained responder that can provide basic medical care and administer naloxone (Narcan) in emergency situations.
 - Data is not available for how often this is necessary in police/HOT team deployment scenarios.
 - Nonetheless, similar units operating under the same service model, such as the Eugene CAHOOTS program, staff an EMT to provide for additional functionality and a wider range of services beyond mental health.
 - Alternatively, the team could be staffed with a second clinician, but there is less marginal value provided by the second, given that one would necessarily be functioning in a lead communication role. As a result, greater value is added by adding a different *type* of employee.

These roles are not mutually exclusive – one employee can fulfill two roles. Generally, this type of model operates by pairing an EMT with a crisis intervention worker that takes in the lead in handling the procedural elements. This works effectively because the clinician or social worker is the primary communicator in crisis situations.

Given these considerations, teams of two can be established, with a crisis intervention worker under the existing classification of designated clinical responder (DCR), and an

EMT working in an assisting role. Each team would use one vehicle designated for the purpose, which should be outfitted similarly to a patrol vehicle in terms of the hardware installed, but should be visually distinct.

(3) Alternative Response Scope

Determining the potential for a mobile civilian crisis team to respond to events is not as straightforward as mirroring the calls that the HOT team currently responds to, as a civilian team would have different roles. While the HOT team is largely proactive in its approach to encampments and outreach, the crisis team would essentially function in a reactive capacity, responding to calls featuring a nexus with mental health crisis or homelessness-related issues. Additionally, there would be a somewhat limited scope for a full diversion to be made. If an emergency call occurred featuring an individual experiencing mental health crisis with a knife drawn, the crisis team could not respond on its own – patrol officers would still need to be deployed in response.

There are no specific incident type codes or flags that correspond to events where mental health crisis is involved or that a civilian would be able to respond to. Recommendations have been made earlier in the report to work toward addressing this issue by adding new incident types and subtypes of existing definitions to better stratify categories of response, while not requiring new processes to be implemented, such as adding flags in the CAD/RMS system for these types of events.

Nonetheless, incident types that signal the types of events that a civilian crisis team could potentially respond to. As with the CSO call diversion analysis, estimates must be made based on the percentage of calls that a mobile crisis team could potentially respond to. This is done based on the experience of the project team, which includes former sworn law enforcement personnel.

To focus specifically on the potential scope of a crisis/community response team, the CAD data is filtered to only calls occurring from 6:00AM to 10:00PM. As with the CSO analysis, 2020 data is used for the analysis. The following table provides the results of this analysis, showing the estimated number of calls that could be diverted among the most significant categories:

Estimated Potential for Homelessness and Mental Health Crisis Call Diversion

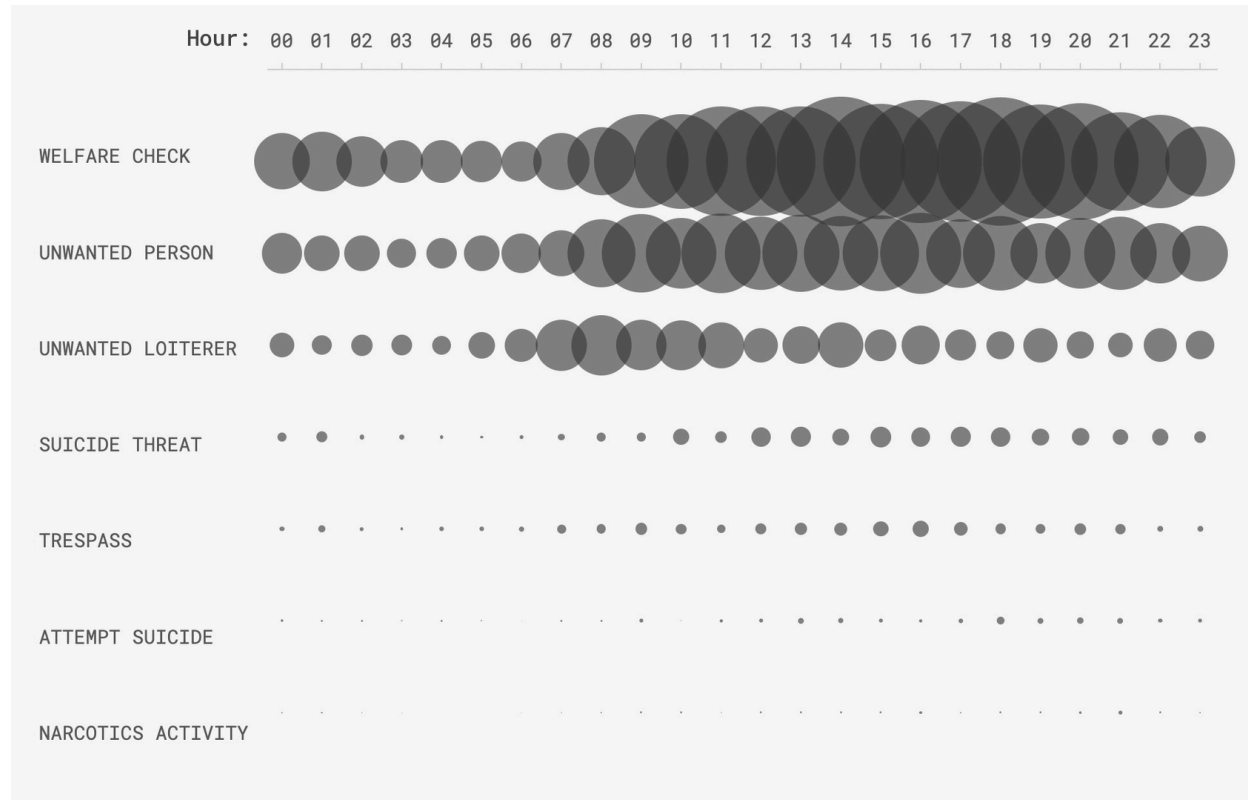
Call Type	# CFS	% Di v.	# Di v e r t e d	Avg. HT
WELFARE CHECK	6, 539	25%	1, 635	27. 5
UNWANTED PERSON	4, 473	15%	671	23. 8
UNWANTED LOITERER	2, 518	20%	504	19. 4
SUICIDE THREAT	989	50%	495	46. 6
TRESPASS	686	10%	69	37. 7
ATTEMPT SUICIDE	264	60%	158	63. 2
NARCOTICS ACTIVITY	123	20%	25	19. 2
PANHANDLING	46	60%	28	8. 9
Overall		23%	3,583	29.9

At a baseline estimate of 3,583 calls that have the potential to be diverted, this equates to approximately 9.8 divertible calls per day, or about 0.63 per hour over the 16-hour period. With an average handling time of just under 30 minutes, and a lower report writing time than would be the case for a CSO program taking crime reports, workload is sufficient for one on duty team handle the calls occurring.

Hours of deployment should be focused around the times in which these events are most likely to occur, maximizing call diversion opportunities and the probability of significant outcomes being achieved, such as connection with services or reduction in the rate of police use of force.

The following table provides a visualization of the frequency of the event types selected for the civilian community crisis response team:

Frequency of Divertible Homelessness and Mental Health Calls



Although occurrence rates are fairly broad, there is a clear period of highly increased activity for the two most significant call types – “WELFARE CHECK” and “UNWANTED PERSON” – that lasts from around 7:00AM (0700) to 10:00PM (2200). The increased activity levels then subsequently taper off into the early morning hours.

If the starting hour of this range is extended back one hour to 6:00AM, a 16-hour period ending at 10:00PM could be staffed by two back-to-back 8-hour shifts. Importantly, this would allow for a single vehicle to be shared by two shift teams.

(4) Case Management Approaches Upon Release From Treatment

Establishing a team that is fully oriented around crisis response present opportunities to provide new types of services for those who are placed on involuntary holds or connected with inpatient treatment, with the goal of reducing recidivism in criminal justice system contacts and increase the potential for better clinical outcomes, including survival and placement into long-term housing.

When individuals accept treatment or are placed on involuntary holds when needed, they are able to receive acute care and can have improved likelihood of better mental health

outcomes. When they are released without continuation of care, however, the likelihood of recidivism is extremely high, as individuals often return to the same environments that presented factors contributing to prior behavioral health crises. This risk is exacerbated by the sudden disconnect from care and connection to services upon release from treatment.

The warm handoff approach seeks to address these issues by ensuring that the release from a treatment facility does not represent a complete disconnect from the care provided. A mental health worker, or in this case, the crisis response team, would meet with and pick the individual up from the treatment location and discuss the treatment plan details with the individual. They can assist the individual with setting up future appointments, locating ID or other documents needed for housing or other services, and even offer to provide transport to future appointments (e.g., treatment at a methadone clinic). At the time of release, the team can then offer to transport the individual to their desired location. A time at which the team can follow up with the individual by conducting a site visit can then be planned as well.

Critically, this also brings the crisis response team into the medical/mental health care team, as they would meet with the treatment facility staff and discuss their case and the specific aspects of their care plan. This information can then be logged in the team's records management system, where it can be pulled up later when making contact with the individual in the future.

This is a key advantage of the crisis response team approach, as it further orients the practice away from the criminal justice system by centering the civilian team within any plan for treatment that was discussed with the individual patient.

Recommendation:

Adopt a warm handoff approach for individuals being released from treatment, where the crisis response team meets with the individual patient's clinical team and the individual to discuss care plan, set up appointments, and provide transport.

(5) Costs of Establishing Homeless and Mental Health Crisis Alternative

In addition outlining the various service alternatives available and their impacts, it is critical that the analysis also examine their feasibility from a financial standpoint. To do this, the project team has developed estimates for the full cost of positions involved in alternative models, as well as associated equipment and startup costs.

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Tacoma Police Department Sectors and Reporting Blocks

