



City of Cambridge

Executive Department

LOUIS A. DePASQUALE
City Manager

LISA C. PETERSON
Deputy City Manager

October 5, 2020

To the Honorable, the City Council:

Please find attached a response to Awaiting Report Item Number 20-41, regarding a report on the feasibility of an alternative Public Safety Crisis Response System, received from Police Commissioner Branville G. Bard, Assistant City Manager for Human Services Ellen Semonoff, Chief Public Health Officer Claude Jacob and Director of Emergency Communications Christina Giacobbe.

Very truly yours,

Louis A. DePasquale
City Manager

LAD/mec
Attachment(s)





City of Cambridge Police Department

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Dr. Branville G. Bard, Jr.
Police Commissioner

Louis A. DePasquale
City Manager

To: City Manager, Louis A. DePasquale

From: Police Commissioner, Branville G. Bard, Jr.
Assistant City Manager of Human Services, Ellen Semonoff
Chief Public Health Officer, Claude Jacob
Director of Emergency Communications, Christina Giacobbe

Date: September 6, 2020

Re: City Council Order (POR 2020 #149) dated June 29, 2020

ORDERED: That the City Manager confer with the Cambridge Police Department, Emergency Communications Department, Department of Public Health, Department of Human Services and other relevant departments to determine the feasibility of an alternative Public Safety Crisis Response System, which department would be responsible for it, and how it would be funded and implemented in FY2022, and report back to the Council by September 14th; and be it further

This communication is in response to Council Order (POR 2020#149) which requests information pertaining to the feasibility of creating an alternative public safety crisis response system:

Background:

In concert with City Administration and relevant City Departments, the Cambridge Police Department (CPD) has taken great care over the last decade to adopt a community policing philosophy that values the sanctity of human life above all else and to adopt strategies that focus on Prevention, Intervention, and Diversion over traditional law enforcement outcomes. As a department, it is recognized that far more individuals would be better served through a "Social Justice" approach rather than a "Criminal Justice" approach. The resulting paradigm shift led to:

- Increased documentation of calls for service involving mental health and homelessness issues, as well as increased documenting of both involuntary and voluntary psychiatric admissions. Doing so has permitted for a better understanding of service needs among these vulnerable populations. The Department also increased its mandatory training for all officers to receive 40 hours of Crisis Intervention Training (CIT).
- Enhanced partnerships and coordination with area service agencies supporting these vulnerable populations; including but not limited to: (A) other City departments, such as Health and Human Service Programs and Public Health, (B) area healthcare systems such as the entire CHA network and the largest area hospitals, and (C) other community stakeholders such as clergy, courts, businesses, and various advocates for homelessness and for those suffering from mental health and substance use issues.

- In 2018, CPD formed the Family and Social Justice Section (FSJS), in order to bring all services designed to protect vulnerable populations (homeless, juveniles, elders, and those suffering from mental health and substance use issues) under one umbrella. The FSJS is overseen by a Deputy Superintendent and is comprised of three (3) units: The Social Justice Unit, Family Justice Unit and Clinical Support Unit (staffed with a Child Psychologist, Licensed Clinical Social workers, and Domestic Violence Advocates). The desired outcomes of the FSJS are to reduce the incarceration of vulnerable populations, reduce the need for emergency service utilization (e.g., frequent ER trips) and improve access to outpatient and community-based supports and services. The FSJS is home to the City’s renowned Safety Net Collaborative; a partnership between the Police, Human Service Programs, School, and Public Health Departments, which has been empirically recognized for its successes in reducing juvenile arrests and recidivism, while also increasing access to behavioral health services.

The work that the City of Cambridge has done toward implementing these protective strategies is in accordance with best practices and heavily influenced by guidance from authorities such as The Council of State Governments Justice Center and the U.S. Justice Department’s Bureau of Justice Assistance (BJA), which for more than 30 years has emphasized the need for a co-responder model and pioneered Police-Mental Health Collaboration Programs (PMHC). The BJA has produced a useful PMHC toolkit. PMHC emphasizes five types of programs; however, according to the BJA “There is no one ‘right’ type. Agencies need to first assess their community’s needs and resources to determine which type of PMHC is most appropriate...the five approaches are not mutually exclusive...”. The five types of programs are:

- **Crisis Intervention Teams:** After completing a 40-hour training course, CIT officers are dispatched to mental health calls or utilized to assist non-CIT qualified officers. CIT officers rely upon their expertise to work with mental health providers and reach an appropriate [socially just] disposition (currently used by CPD).
- **Co-Responder Teams:** Specially trained officers and mental health crisis workers respond together to mental health calls for service. By drawing upon the combined expertise of the officer and mental health professional, the team is able to link people with mental illnesses to appropriate services or provide other effective and efficient responses. The most common approach is for the officer and crisis worker to ride together in the same vehicle for an entire shift, while in other agencies the crisis worker meets officers at the scene, and they handle the call together. Co-responder teams can respond throughout the entire jurisdiction, or they work in areas with the greatest number of mental health calls.
- **Mobile Crisis Teams:** Utilizes a group of mental health professionals who are available to respond to calls for service at the request of law enforcement officers. The mobile crisis team’s goal is to divert individuals from unnecessary jail bookings and/or emergency rooms. These crisis workers are skilled at helping to stabilize encounters and assume responsibility for securing mental health services for persons, including those in crisis who may need further evaluation and treatment. Mobile crisis teams are not necessarily dedicated to assisting only law enforcement officers but respond to requests directly from community members or their families and friends.
- **Case Management Teams:** A proactive team approach in which behavioral health professionals and officers provide outreach and follow-up to repeat callers and high utilizers of emergency services. Officers do not treat or diagnose the individuals, but work with behavioral health professionals to develop specific solutions to reduce repeat interactions. This approach strives to keep people connected to mental health services and community resources, abide by treatment plans, and meet other responsibilities such as work, school and training. Case management is used in agencies in conjunction with other police-mental health collaboration strategies. (currently used by CPD)

- **Tailored Approach:** A tailored approach is one in which an agency intentionally selects various response options from multiple PMHC programs to build a comprehensive and robust program. This allows the agency to adhere to a consistent policing philosophy while being responsive to community needs. Other factors agencies consider when choosing this approach can include the size of the jurisdiction and the number of officers on a given shift. When using the tailored approach, a law enforcement agency begins with the expectation that every patrol officer must be able to respond effectively to mental health calls. Agencies enhance their patrol force with officers or detectives whose primary responsibilities are to liaise with stakeholders to coordinate criminal justice and mental health resources. (currently used by CPD).

Discussion:

In making recommendations for non-police responses it is crucial to begin with the understanding that it is sometimes difficult and at other times impossible to begin with a non-police response even when a non-police response is most desirable. This will be true for a variety of reasons, including but not limited to:

- Vulnerable populations are at increased risk of being reported for potential criminal offenses and behaviors. These incidents will come in as “crimes in progress” and require a police response. The purpose of the highly specialized Social Justice and Community Outreach teams at CPD is to, whenever possible, divert these vulnerable individuals (when they are reported for offenses) to services or specialized rehabilitative court programs and away from incarceration.
- Calls for service rarely fall neatly into a taxonomy and will not simply present as “a person experiencing a mental health crisis”. The Emergency Communications Center (ECC) screens calls for service and determines the response plan based on the report from the caller. Even after thorough screening, the call may appear to be a disturbance or a fight, etc. and it is rarely clear whether there is a safety risk or if there is an individual experiencing a mental health crisis. In some instances, callers are reporting what they have observed and are no longer in the area to provide additional information that would be useful when screening. Additionally, any calls for a section 12 or “Pink Slip” involving involuntary hospitalization requires a police presence as that person is mandated to be transported and evaluated in an emergency room.
- Any non-police response teams must be heavily integrated with Emergency Communications. Any non-police response will require additional effort by dispatchers to identify behavioral health calls, triage calls to ensure that they are non-violent, and dispatch the Mobile Crisis Teams. Since these teams respond without the Police Department, dispatching and managing them will require added resources and attention during call screening. These teams must be in close contact with dispatchers to ensure that they can call for police back-up if needed, which may likely require further dispatch resources and communication equipment.

However, there are many non-emergency, non-crisis calls in the City that fall on CPD to respond to that could be served with a non-police response. Some examples include someone with a mental illness who is upset but not in crisis, neighbor complaints, nuisance issues, etc. A non-police/EMS response would be appropriate in these situations and could take some burden off police and the emergency response system.

Prior to entering a discussion as to potential non-police response models the following should be noted: In 2018, the CPD participated in the Justice and Mental Health Collaboration Strategic Planning for Law Enforcement and Mental Health Collaboration funded by the U.S. Department of Justice’s Bureau of Justice Assistance (BJA). The completed planning guide revealed that the major gap in response for vulnerable populations in the City of Cambridge was [the lack of] a “restoration or sobering center.” Such a center is meant to provide a physical location where people in crisis can be transported for short-term stabilization and management that is not an emergency room or criminal justice facility. The data on 911 calls for

service for “high-utilizers” of emergency services indicates that patients are sent to ERs and often discharged or held for very short in-patient stays. Hospitals will play a vital role in the model as there is simply a dearth of places for the most vulnerable to go to for care when they are in acute crisis.

Recommendation:

In order to suggest a non-police response several models were reviewed including the *CAHOOTS* model suggested in the Policy Order and others such as, *23-hour crisis stabilization/observation beds*, *Short-term crisis residential services and crisis stabilization*, *Mobile Crisis Services*, *24/7 crisis hotlines*, *Warm lines*, *Psychiatric Advance Directive Statements* and *Peer Crisis Services* as highlighted by the Substance Abuse and Mental Health Services Administration (SAMHSA) (2014).

The primary recommendation is that the City of Cambridge add a Mobile Crisis Response component that is detached from CPD and operates independently or within another City Department or affiliated agency such as Cambridge Health Alliance. While continuing with the tailored approach currently utilized by CPD which relies on Crisis Intervention Trained officers, trained social workers and clinicians engaging in Case Management—the tailored approach is key in supporting the Safety Net Collaborative and CPD’s support of survivors of domestic violence. It is also recommended that the City of Cambridge support Persons Assisting The Homeless (PATH) (**Item #2 below**) workers as proposed by the Central Square Business Improvement District (BID) as a one (1) year pilot program. The City is currently working with the leadership of the BID on proposed funding for this fall. That program should begin as soon as practicable. The CCRT, (**Item #1 below**) should be considered for implementation by the City of Cambridge for FY22 and funded through normal budgeting measures. Below options Item #3 and Item #4 were considered but determined to be less viable options at this time.

1. **Community Crisis Response Team (CCRT):** utilizing a previous model within Cambridge Health Alliance, the CCRT, City or CHA could hire 4 to 6 clinicians to provide a mobile response within the model to enhance mental health services to the City of Cambridge. Although CCRT has not been in operation since 2009, CHA has continued to deliver mental health services and programs recognized for supporting mental health patients and individuals in crisis. These support services are currently offered through Integrated Behavioral Health Services, Specialty Mental Health Clinics and Psychiatry Department. Reestablishing CCRT would result in immediate information & referral services, psychiatric evaluations, crisis interventions and treatment (including psychopharmacology), short-term community crisis stabilization programs and referral for ongoing treatment. The enhanced CCRT with a mobile unit would respond as an alternate mental health response. In addition to staffing costs, a space(s) to operate from and vehicles would be additional budgetary concerns.
2. **Person Assisting The Homeless (PATH):** This proposal from the Central Square BID would provide outreach workers to operate within Central Square who would provide outreach, field based case management and referrals for individuals who are unhoused. Under this model, the BID would hire 3 outreach workers with specialized training around mental health and addiction. The outreach team will provide services within Central Square and connect individuals to existing local and regional services. A one-year pilot of this program could provide valuable data on the effectiveness of adding outreach responders trained in mental health response and harm reduction to the Central Square area. That evaluation could inform the best path forward for a city-wide approach to providing an alternative Public Safety Crisis Response System and/or enhanced stabilization options such as a “restoration or sobering center”.
3. **Cambridge BEST Team:** utilizing the existing infrastructure of the Boston Emergency Service Team, Cambridge could hire 4 to 6 clinicians to provide a mobile response within the City of Cambridge. BEST teams offer a highly integrated system of crisis evaluation and treatment services to the greater Boston area; BEST offers immediate information & referrals, psychiatric evaluation, crisis intervention

and treatment (including psychopharmacology), short-term community crisis stabilization programs (3-5 days), and referral for ongoing treatment. In addition to staffing costs, a space(s) to operate from and vehicles would be additional budgetary concerns.

4. **Additional Mental Health Professionals:** Cambridge can onboard a group of mental health professionals who are available to respond to calls for service at the request of emergency dispatch (after screening), or on-scene law enforcement officers who determine a non-police response is appropriate, or via a non-emergency number. If this option is selected, the additional mental health professionals should be embedded in an existing department or affiliated agency, such as CHA. As mentioned earlier, this type of mobile response would need to be heavily integrated with Emergency Communications and therefore may require additional supervision, personnel and infrastructure within that department.

It is critical that whichever model (or amalgamation of models) the City selects as a non-police response to mental health crises has some empirical evidence of its potential efficacy in serving the most vulnerable in the City of Cambridge and complements existing resources and work that is currently underway. It is also essential the model be integrated with the established agencies and services in the City that have established relationships, outreach and work with vulnerable populations. These agencies include but are not limited to: First Step, Eliot PATH and DMH Homeless Outreach Team, Vinfen, Bay Cove, the Cambridge Multidisciplinary Outreach Team, Cambridge Multi-Service Center, BEST, Bridge Over Troubled Waters and the Needle Exchange. There should be consideration for incorporating additional existing resources to the model such as Cambridge Community Response Network (CCRN) and Riverside Trauma Center.

Currently, CPD is working in collaboration with the Health Equity Research Lab (CHA/Harvard Medical School) for a large-scale evaluation of City's efforts with the adult homeless and mentally ill population that will combine CPD, Cambridge Health Alliance and Middlesex Jail data to examine rates of arrest, recidivism, incarceration and service utilization for vulnerable populations. This evaluation will provide additional information to continue the work in the city of Cambridge based on our community needs.

Moving Forward:

It is critical that the City of Cambridge continue to lead reformatory efforts of delivery of services to its citizens; this includes Public Safety and all of its apparatus, particularly how Police Services are delivered. It is recommended that a Guiding Coalition (or Task Force) be created to examine future possibilities. The Task Force would begin with a loose vision, "to examine ways to limit the Police Response to calls for service without diminishing Public Safety or Community Safety, while increasing Community Cohesion to include restorative processes...". To accomplish this vision, the Task Force would work with Cambridge Residents, the City Manager, the Police Commissioner and other City Department leaders to assess overall needs and desires, as well as implementation strategies. Because of the need for widespread engagement, it is recommended that a City Manager appointed Task Force work collaboratively with the City Council's Civic Unity Committee and the Human Services and Veterans Committee. It is anticipated that the recommendations coming from this Task Force will help to shape the future of Public Safety, not just in Cambridge, but becomes the prevailing model of Public Safety in the Nation.

We hope that you find this response satisfactory; as always, City Departments will be available to answer questions that may require advanced expertise.