BUILDING THE COMMUNITY BEHAVIORAL HEALTH CRISIS RESPONSE WORKFORCE

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EXECUTIVE SUMMARY

There is growing demand for crisis response in the community that does not involve law enforcement. In some communities, mobile crisis teams comprised of clinicians, or clinicians and peers, are available to provide crisis intervention. However, these teams are often not available for immediate response on a 24/7 basis, and many times are not comfortable responding without law enforcement present. Alternative or community responder teams are emerging across the country, staffed by individuals with various qualifications and backgrounds. To date, there is not a defined skill set or recognized credential for these responders, who may respond primarily to behavioral health related issues, or may respond to a broader range of situations that do not require police. As more communities opt to expand response options and capacity, there is an urgent need to develop a workforce prepared to provide response in the community without police unless clear safety or crime-related concerns are present.

The overall aims of this phase of work to develop the community behavioral health crisis response workforce are to establish the core competencies of a new professional Community Behavioral Health Crisis Responder (CBHCR), determine the steps to create a recognized professional credentialling process to facilitate rapid workforce expansion, and identify policy and implementation barriers and facilitators for non-law enforcement crisis response. To address these aims, we have convened an advisory board to guide the project; reviewed the literature on skills of professionals providing crisis response services and the experiences of people who have used crisis services; asked advisory board members to participate in a survey about the values, characteristics, competencies and skills needed for community crisis response; and conducted key informant interviews and focus groups with a diverse set of experts and stakeholders. This report provides a summary of what we have learned from this work.

Literature Review. There are consistent themes related to the skills needed for crisis response across the literatures on different professional groups. The literature indicates responders need to be able to recognize signs and symptoms of mental illness and substance use crises and have skills to approach and engage individuals experiencing crisis in a compassionate, nonjudgmental manner. De-escalation skills, often defined in terms of active listening, validation, reflective statements, body language, and tone of voice are consistently mentioned, as are conflict resolution and knowledge of community resources. Literature pertaining to mental health professionals and alternative responders highlights the need for suicide prevention and intervention skills, understanding and use of trauma-informed skills, cultural sensitivity and understanding of race equity, motivational interviewing and harm

reduction, conflict resolution/mediation skills and basic medical skills. Safety skills noted include situational awareness and many of the skills listed as important to effective approach and engagement (staying calm, active listening, nonjudgmental, providing choices). Professional boundaries and management of secondary trauma are noted in the literature on violence prevention and alternative responders. The literature on the experiences of people who have used crisis services highlights the qualities of crisis care that people and their family member's desire. These qualities include a compassionate, supportive, respectful, and kind response; involvement in decision making; inclusion/acknowledgment of family members/carers; and attention to basic needs and comfort.

Advisory Board Survey. The advisory board survey responses were consistent with many of the themes derived from the literature review, particularly the literature describing lived experience perspectives. Advisory Board members described values of CBHCRs that include respect for the individual, non-judgement, respect for diversity, and commitment to community-based care and consent. They indicated CBHCRs should be nonjudgmental, collaborative, and supportive and be strong problem solvers, with the ability to adapt and self-regulate. Skills listed were many of the same skills indicated by our literature review, such as communication and de-escalation skills. They also mentioned advocacy skills, cognitive flexibility, and the ability to adapt their response quickly. There was consensus that CBHCRs do not need advanced clinical skills or the ability to restrain people experiencing crisis.

Key Informant Interviews. Overall, the themes emerging from our key informant interviews are consistent with both the literature and our advisory board survey responses, and they provide some additional texture to the necessary characteristics and skills of CBHCRs. Key informants stressed the importance of responders being able to maintain calm in intense situations and to be comfortable in physically and emotionally uncomfortable situations. Responders should be compassionate, and the value of lived experiences, as a resource for compassion, was emphasized. In terms of skills, key informants indicated that responders should have the skills to quickly develop an alliance with the person in crisis, and there was frequent discussion of motivational interviewing (MI) and trauma-informed care (TIC) principles and skills. Overlapping with MI and TIC skills, de-escalation skills related to active listening, summarizing, reflective statements, use of tone of voice, and body language were discussed. Key informants discussed a compassionate approach to suicide intervention. Safety skills that were discussed involved the management of physical space, the approach to and quality of the interaction and specific strategies. There were mixed opinions on the education and qualifications needed for CBHCRs, but

consensus that training for the role should include a mix of didactic, experiential and field training. A few key informants discussed specific benefits of responders without master's degrees and clinical licensure. Implementation issues were mentioned in relation to funding, safety concerns and the legitimacy of community/alternative response teams.

Focus Groups. Focus group findings offered additional support to the characteristics, values, skills, and qualifications necessary for crisis responders identified during previous phases of the project. Participants emphasized the importance of crisis responders being adaptable, empathic, compassionate, and emotionally self-regulated, with a genuine commitment to helping others. They also highlighted the value of diverse lived experiences, suggesting that individuals who have faced similar challenges and had experiences with systems and services can better connect with those in crisis. Core values identified by focus group participants included person-centered practice, transparency, and collaboration. These findings favored crisis responders who possess and maintain strong knowledge of local resources and the diversity of the communities where they work. Participants also stressed the importance of communication skills that allow for genuine connections to be formed with individuals experiencing distress. Focus group participants expressed varied perspectives regarding qualifications needed for this role, with some prioritizing formal education and licensure, and others valuing lived experiences. Overall, focus group participants stressed the need for crisis response teams comprised of individuals with diverse backgrounds to work together to effectively support individuals experiencing crisis in their communities.

Conclusion. Across the components of this project, there is a notable consistency regarding qualities, values, and skills required for effective crisis response work. The literature review, advisory board survey, key informant interviews, and focus groups all underscored the importance of characteristics such as compassion, empathy, adaptability, and a commitment to supporting individuals in crisis. Findings also pointed to a need for communication skills, de-escalation techniques, cultural sensitivity, and an understanding of trauma-informed principles. Additionally, the emphasis on the value of diverse experiences in connecting with those in crisis was echoed throughout the findings.

We also note some variation in perspectives within our advisory group and across key informants and stakeholders in terms of the role of CBHCRs in providing non-consensual interventions and the educational and professional qualifications needed for effective CBHCR work. These two issues are related. Key informants and

stakeholders working on more clinically based teams that have a statutory role in assessing individuals to determine the need for hospitalization (often involuntary) were more inclined to indicate that master's level licensed clinicians, perhaps paired with a peer or bachelor's level crisis worker, are needed for crisis response. Key informants and stakeholders working on less clinically oriented teams, as well as people with lived experience (and many family members), tended to value responder characteristics and experiential knowledge over formal education and licensure, and the provision of consent-based care. Despite these differences, it is clear there is a need across communities for a workforce that is equipped to provide compassionate and effective crisis response.

Building on the findings of this work, we have drafted the **Core Values, Competencies and Skills of Community Behavioral Health Crisis Responders (CBHCRs)** with input from our advisory board. It is attached as *Appendix A* of this document.

INTRODUCTION

A critical step to avoiding the criminalization of mental illness is the development of alternatives to police as primary first responders to people experiencing mental health (MH) crises. While many suggest that teams of master's level licensed clinicians should respond, the current workforce does not have the capacity, is not prepared for this role, and in many cases, citing safety concerns, does not want to go into the community without police. While safety can be an issue in MH crisis response, this concern is often code for not wanting to go into communities where the clinicians are less familiar or comfortable, specifically, urban communities of color. This project addresses the question: How can we develop a non-law enforcement workforce to respond to MH crisis that is rapidly scalable and promotes race equity (benefits communities of color at least as much as white communities)?

Workforce development in the traditional sense, such as providing existing professionals more training or expanding numbers in existing professional roles, is unlikely to adequately address the need for skilled crisis responders prepared to work in diverse communities. We have written about the potential for a new first responder professional that is trained in crisis intervention, has the skills to safely respond to most MH crises without law enforcement, and the judgement to request law enforcement assistance when appropriate (Carroll et al., 2021; Watson, Pope & Compton, 2021). The Community Behavioral Health Crisis Responder (CBHCR)—would be in effect, a psychiatric EMT. Developing this workforce could engage community colleges and/or EMT training programs to provide rapid, accessible entry to the profession, with priority given to trainees from communities most impacted by policing. It could also include advanced training and credentials for certified peer providers.

The overall aims of our work to develop the community behavioral health crisis response workforce are to establish the core competencies of crisis responders, determine the steps to create a recognized professional credentialling process to facilitate rapid workforce expansion, and identify policy and implementation barriers and facilitators for non-law enforcement crisis response. To address these aims, we have convened an advisory board to guide the project, reviewed the literature on skills of professionals providing crisis response services and the experiences of people who have used crisis services, conducted a survey of advisory board members, and conducted key informant interviews and focus groups with a diverse set of experts and stakeholders, including people lived experiences, family members, and people working as crisis responders. This report summarizes the major themes, recommendations, and

considerations for the development of a non-police behavioral health crisis response professional role (community behavioral health crisis responder, CBHCR) as described in the academic and grey literature, through discussion and polls to our advisory group, and from analysis of key informant interviews and focus groups.

LITERATURE REVIEW

To identify the skills needed for crisis response, we searched the literature for research on skills for professionals working in crisis and related services and the experiences of people who have utilized crisis services. We also examined white papers, reports and toolkits related to community responder models. Overall, there was consistency in skills identified. Below, we provide a selective review of literature focused on skills of mental health professionals working in crisis services and other professionals involved in crisis response/providing intervention in the community. Where available, we include literature on the experiences with these services of people with lived experiences and their family members. Finally, while there is very little academic literature on the emerging field of alternative/community response, we include several reports from the grey literature on relevant skills and training.

Mental Health Professionals Working in Crisis Services

There are many textbooks on crisis intervention for mental health professionals that discuss crisis theory, crisis assessment, models of crisis intervention and crisis intervention in specific settings and with specific populations. This literature suggests that traits of effective crisis responders include self-awareness, cultural sensitivity, empathy, genuineness, and warmth (Eaton-Stull & Miller, 2015). A commonly taught model, Roberts Seven Stage Crisis Intervention Model (Roberts & Yeager, 2009) delineates seven stages of crisis intervention: 1) Plan and conduct a crisis assessment (including lethality assessment), 2) Establish rapport and rapidly establish relationship, 3) Identify major problems, 4) Deal with feelings and emotions (active listening and validation), 5) Generate and explore alternatives, 6) Develop and formulate and action plan, 7) Establish follow-up plan and agreement. Professional materials agree that crisis workers who implement these intervention models need knowledge and skills to effectively intervene with clients experiencing crisis. These competencies include elements such as interpersonal skills needed for rapport building, active listening, assessment, and problem-solving skills.

To elaborate on the skills needed for crisis responders, we located literature on the skills of mental health professionals working in specific crisis services or settings, including professionals working on crisis helplines, emergency department telephone triage services, and police co-responder teams. We also located literature on safety training for mental health workers providing services in the community. Also, articles and reports that examine lived experiences of using mental health crisis services were found. Interestingly, the only literature specific to the qualities and skills of professionals working on mobile crisis teams that we located reported on the

perspectives of people with lived experiences and their family members who have experience with the crisis resolution team model. Thus, while mobile crisis teams are not included in this section, they are included in the lived experience section below.

Crisis Lines. Mishara and colleagues (2007) monitored calls to 14 helplines participating in the National Suicide Prevention Hotline and examined helper behaviors and intervention styles associated with better short-term outcomes such as improvements in mood from the beginning to the end of the call, acceptance of a no harm contract and agreement on follow-up. Findings indicated the following were associated with more positive outcomes: helper empathy and respect; a supportive approach and good contact (validation of emotions, moral support, reframing, sharing personal experience, offers to call back); and collaborative problem solving (asking fact questions, inquiring about resources, suggesting a plan of action, offering referrals).

Emergency Department Phone Triage. In an Australian study focusing on competencies for emergency department (ED) mental health telephone triage clinicians, Sands and colleagues (2013) identified requisite knowledge and skills. They identified the following areas of knowledge: community resources, psychopharmacology, drug and alcohol use, co-occurring disorders and complexity, youth and age specific issues, and legal issues. Skills identified included: crisis assessment and intervention, therapeutic approaches/interventions, negotiation with other providers, time management, resource management, and communication/information transfer.

Co-responder teams. Ghelani (2021) conducted a narrative review of the academic and grey literature to examine the knowledge and skills of social workers on mobile crisis intervention teams, or co-responder teams, that pair a social worker with a police officer. Eleven practice skills were identified: engagement, crisis de-escalation, risk assessment, safety planning, conflict resolution, brief addiction counseling, housing and community referrals, advocacy, challenging systemic racism, relationship building, and applied legislation and documentation practices.

Safety. Safety is an issue that comes up frequently when discussing non-police responses to behavioral health crisis. Weisman and Lamberti (2002) have developed Safety and Violence Education (SAVE) training for case managers and other mental health professionals working in the community. SAVE training includes content on understanding risk factors for violence, use of clinical skills to prevent and de-escalate crisis, safety precautions for transporting, situational awareness and staff well-being. Specific de-escalation techniques covered include maintaining calm, providing

personal space, appearing to be in control but not controlling, listening, speaking softly and avoiding judgmental statements, communicating desire to help, not taking the person's behavior personally, not making promises that cannot be kept, backing off and obtaining assistance, if necessary, limit setting, and allowing the person to save face (Weisman, 2011).

Police/First Responder

In a narrative review of knowledge, skills and abilities (KSA) for police officers, Bennell and colleagues (2022) identified the understanding of issues related to mental health as one of ten key KSAs. Specifically, they identified knowledge of the nature of mental illness, the relationship between mental illness and violence, signs and symptoms of mental illnesses, and strategies to effectively address behaviors of people experiencing mental health crises. Further, the authors highlighted the importance of addressing stigmatizing attitudes and knowledge and understanding community mental health resources. Focusing specifically on police officer de-escalation skills, Todak (2017) identified traits and tactics of skilled de-escalators. Qualities of effective de-escalators included being a good communicator and having empathy, perspective, respect for the humanity of all persons, and a calm demeanor. Five tactics identified were: humanity (the ability to emphasize one's human qualities over one's authority); listening (listening and legitimizing a person's concerns); compromise (making small concessions to reward good behavior); honesty (being honest with the person); and empower (providing opportunities for voice and making the person feel they are part of the decision-making process). These skills are consistent with our broader review of the literature on de-escalation and police response to mental health crisis that identified the following tactics and skills: environmental management, use and control of body language, verbal de-escalation, use of reflective statements, emotion labeling, open ended questions, clear directions, concern for the quality of the interaction (respect, empathy, honesty, listening, genuine compassion), direct questions about suicide, and appropriate attention to delusions.

Lived Experience of Mental Health Crisis/First Response Services

While not specifically addressing crisis response skills, several studies have examined experiences of people who have accessed mental/behavioral health crisis care in the community, at emergency departments, or from mobile crisis/crisis resolution teams and first responders.

ED Phone Triage. As part of their larger study of ED mental health phone triage (see above), Sands and colleagues (2016) also interviewed people that had accessed crisis services via the mental health telephone triage service. Central themes highlighted the

importance of listening, caring and providing emotional support, as well as service users' desire for involvement in decision making. Additional qualities of crisis care that participants considered important included ease of access, helpfulness, provision of choices and options, and follow-up care.

ED and Community-Based Crisis Services. A study conducted in North Carolina explored the experiences and preferences of individuals who had received psychiatric crisis intervention in the ED or at a community mental health center (Thomas et al., 2018). Findings highlighted features and attributes of care that participants valued. These included privacy and attention to their basic comfort; attention to preferences; transparent, timely and respectful communication; kindness, courtesy, and respect; shared decision-making; inclusion of family and friends if desired; and follow-up care. Overall, participants preferred accessing community-based crisis services over ED-based crisis services. Studies focused on the experiences of people with mental health or substance use challenges that have utilized ED care during a crisis suggest negative and unhelpful experiences. Themes indicate ED experiences may exacerbate emotional distress due to lack of privacy, stigmatizing attitudes of providers, perfunctory and unsympathetic care, and lack of follow-up support (Harris, et al., 2016; Wise-Harris et al., 2017).

Mobile Crisis Teams/Crisis Resolution Teams (CRT). As discussed above, there is very limited literature on mobile crisis teams, and we were not able to locate any that focused specifically on team member skills. However, reviews of literature from outside the United States on crisis resolution teams provide insight into what service users find helpful during a crisis in the community (Holgersen et al., 2022; Wheeler et al., 2015). This literature suggests that team members should be friendly and have good interpersonal skills, flexible, respectful, nonjudgmental, able to remain calm, and able to work with people from different backgrounds. CRT service users want to be listened to, taken seriously, understood and met as a fellow human being. They would like consideration of their family members and of their parental roles. They also value having people with lived experience and non-clinical staff on teams that provide practical assistance, help with everyday tasks, and non-treatment related helpful activities.

Police/First Responder. Studies focusing on the experience of people with mental illnesses and their family members when they interact with police and other first responders during a crisis provide additional insight. A systematic review of qualitative studies of the experience of first response (police, EMS) to mental health crisis (Xanthopoulou et al., 2022), found that people with mental illnesses believe first

responders need training in compassion, patience, communication skills, de-escalation techniques, building rapport, asking questions and confidentiality. Family members/carers report experiencing first responders as intrusive and traumatic and that first responders failed to communicate with them. Both people with mental illnesses and their family members/carers preferred initiatives that include a clinician (e.g., co-responders) over police alone.

In a review of the literature focused on family member experiences of mental health crisis, LaVoie (2018) found that family members were hesitant to involve police due to fears that officers would overreact and use force, that their physical presence would be overwhelming to their loved ones in crisis, and their involvement would lead to unnecessary criminalization. Family members wanted police training to address stigma and teach officers negotiation skills, signs and symptoms of mental illness, and clear protocols on use of force in crisis situations. They indicated police should respond in a calm, patient, and empathic manner and communicate with the person in crisis and the family member. Family members felt devalued and excluded by first responders and mental health professionals and wanted them to acknowledge family members and provide them with support.

Policy Matters Ohio and REACH NEO recently conducted a survey of community members' views about first responders for people in crisis in Cleveland, Ohio (Schleiffer & van Lier, 2022). They specifically targeted people most impacted, interviewing people in homeless shelters, social service agencies, transit hubs/stops, and libraries. Participants indicated that responders need a wide range of knowledge, skills and training, inclusive of mental health, trauma-informed care, conflict resolution/mediation, racial equity, youth, LGBTQ+, homeless communities and local resources. They also wanted responders to have strong interpersonal skills and to provide access to medical care, homeless resources, food, water, transportation and harm reduction supplies. Interestingly, participants indicated that paramedics/EMTs made them feel safest (more so than mental health clinicians). One participant stated *"EMS and firefighters because they don't mess with nobody. They're not trying to write you no ticket or trying to take you to jail. They show up ready to help"* (p. 14). When asked what qualities of a response made them feel safer, participants frequently mentioned the words "compassion," "calm," "friendly" and "not the police."

Violence Prevention Professionals

Violence prevention professionals are a newly recognized group of health care providers that "work in programs aimed to address specific patient needs, such as suicide prevention, violence prevention, alcohol avoidance, drug avoidance, and

tobacco prevention" (NUCC, 2019, p.123). Core competencies for these new professionals include trauma-informed practice, confidentiality, documentation, screening for other types of violence, effective management of secondary trauma, professional boundaries, de-escalation and retaliation prevention, personal safety in the community, case management and advocacy, victim compensation, gang violence awareness, and violence as a health issue (Fischer et al., 2020). After gaining recognition as a professional designation the National Network of Hospital-based Violence Intervention Programs (NNHVIP) developed a training and certification process built on the core competencies. Certified violence prevention professionals are now reimbursable in some cities and states through Medicaid.

Alternative/Community Responders

While there is little academic literature on the attributes and skills of community or alternative responders, there are several reports in the grey literature from organizations supporting the implementation of community responder programs. These reports include information/recommendations for the training of responders.

In preparation for the implementation of non-police led mobile crisis response teams in the City of Toronto, the Reach Out Response Network (2021) reviewed training from eleven North American organizations implementing non-police led response teams. They identified 12 essential content areas of training: mental health/illness information and how to support individuals experiencing symptoms; substance use disorder symptoms, withdrawal, harm reduction and how to work with people with substance use issues; marginalized populations/equity and diversity; clinical skills such as trauma-informed care, motivational interviewing, professional boundaries, diagnostic criteria; crisis de-escalation and suicide intervention (ASIST, Zero Suicide, Crisis Prevention Institute's Nonviolent Crisis Intervention Training); situational awareness and personal safety; First Aid and basic medical training (naloxone administration); vehicle operations; operational logistics (data management systems, radio); privacy and legislation; community resources and field training; and other (site specific). The report recommended that, in addition to training in the above content areas, new staff should be provided with at least three weeks of field training.

The Law Enforcement Action Partnership prepared a report with recommendations for the Amherst Community Responder Program (Community Responders for Equity, Safety, and Service, CRESS) (Thompson et al., 2021). In advance of CRESS implementation, LEAP's training recommendations included operational skill-based and field training components. They recommended training content on the following topics: use of police radio, data systems and record keeping; the first response system;

safety and situational awareness; de-escalation; motivational interviewing, signs and symptoms of mental illness; dual relationships and professional boundaries; crisis intervention and suicide prevention; the intersection of mental health, race, culture and stigma; recognizing and de-escalating situations involving people who are intoxicated; harm reduction philosophies; basic medical skills; conflict resolution; cultural competency; recognizing signs of trauma and violence and providing trauma-informed care; differences in presentations of youth/transition age youth; engaging family members; recognizing signs of abuse and human trafficking; connecting people to resources; and training for managers to support peer workers. Field training recommendations included observations of 911 call-takers; ride-alongs with police, mobile crisis teams, and harm reduction teams; and shadowing more experienced community responders for at least three weeks.

This review underscores a consistent emphasis on key skills needed for crisis responders across roles and settings. From mental health professionals to police officers and community responders, traits like empathy, active listening, sensitivity to cultural difference, and de- escalation techniques are centered. The perspectives of individuals who have accessed crisis services highlight the importance of responder qualities of compassion, respect, and collaboration in providing support.

ADVISORY BOARD SURVEY

We have convened an advisory board of 13 members representing people with lived experiences, family members, people working with peer services, policy advocacy, mental health services, community response services, youth-focused services, and law enforcement. We meet with this group on a quarterly basis to get their input on the direction of the project. The table below includes the names of advisory board members, their expertise and professional affiliation.

Name	**Area of Expertise and Affiliation**
Chyrell D. Bellamy, PhD, MSW	Peer Services Professor, Yale School of Medicine, Department of Psychiatry; Director, Yale Program for Recovery Services and Research (PRCH)
Ron Bruno	Law Enforcement Crisis Response Training and Programs
Whitney Bunts	Youth/ young adults Senior Director of Public Policy, TRUE COLO RS UNITED.
Taleed El-Sabawi, JD, MS, PhD	SUD policy, harm reduction Assistant Professor of Law Wayne State University School of Law
Dan Fichter	Crisis Lines, Young Adults, LGBTQ Previously with Trevor Project, SAMHSA
Don Kamin, PhD	Mental Health Services, CIT programming, Mobile Crisis Director, Institute for Police, Mental Health & Community Collaboration
Stefanie Kaufman-Mthimkhulu	Peer crisis services Founder and Executive Director, Project LETS
Angela Kimball	Family member, Advocacy, Policy Senior Vice President of Advocacy and Public Policy, Inseparable

Moki Macias	Alternative Response Executive Director at Policing Alternatives & Diversion Initiative, Atlanta, GA
Ama Merrell	Peer Support/Project LETS
Eric Rafla-Yaun, MD	Policy and Mental Health Services Senior Policy Advisor, County of San Diego
Patricia Strode	Family member/Advocate/CIT Coordinator, Crisis Intervention Team, Georgia Public Safety Training Center
Eduardo Vega, M Psy	Peer Services, Crisis Response Chief Executive Officer, Founder, Humannovations

Early in the project, we surveyed the members of the board and asked them many of the questions we asked of key informants and focus group participants. The survey asked them to provide input on the professional values, personal characteristics, training, qualifications, and skills needed and not needed for community behavioral health response.

Values of CBHCRs. Advisory board members identified a number of professional values. There was consensus on the values of non-judgement, respect for the individual, respect for diversity, commitment to community-based care and consent. Among those who identified consent as important, there was a diversity of responses regarding how to enact this value. These ranged from consent as a primary condition of engagement, to consent as a more general guiding principle. Multiple respondents stated that CBHCR work should be rooted in principles of racial justice, social justice, harm-reduction, and operationalized through a strength-based and relational lens.

Personal Characteristics. Respondents listed the following characteristics of CBHCRs: open-mindedness; non-judgmental; curiosity; collaborative; patient; supportive; honest; the ability to self-regulate; the ability to multitask and prioritize; the ability to develop a plan and implement it quickly; and the ability to re-assess and re-prioritize a plan of action.

Skills. Advisory board members named several dozen skills that broadly mirrored findings in the literature. Most respondents discussed communication skills and mentioned active listening and rapport building. Additional frequently mentioned skills included: de-escalation skills; knowledge of and ability to recognize mental health and substance abuse issues and crises; knowledge of local resources; cultural competency; empathy; cognitive flexibility and adaptiveness; conflict-resolution skills; self-regulatory and self-care skills; basic medical skills; relationship-building and management skills; trauma-informed skills and principles; and outreach skills. Other skills receiving several mentions included advocacy; overdose prevention and substance abuse recovery; violence-prevention or interruption; and case management skills.

In terms of skills that advisory board members reported CBHCRs do not need, there was consensus that they do not need to be able to diagnose or have advanced clinical skills (such as those of a master's level licensed clinician).

Board members also indicated the CBHCRs do not need advanced medical skills or skills needed to use force/restraint.

Qualifications and Training. When asked about the optimal qualifications and training, board members focused on training related to needed skills, named above, for this work. One person indicated that training should be 6 to 12 months at a community college, an apprenticeship, or certificate program. In terms of qualifications, board members focused on experiential knowledge, citing both lived experience of behavioral health issues and experience doing outreach in the community. One participant pointed out that people who have previously worked in more coercive settings and roles (in both the criminal legal and mental health systems) may have to unlearn some things to move from the idea of compliance to leveraging services and support. Another participant pointed out the role that young people (ages 14-16) could play.

Where should CBHCRs be housed? Respondents had divergent perspectives on where CBHCRs should be housed. Most participants felt CBHCRs should be housed in community mental health or social service agencies. A few indicated that they could be housed within a fire department or emergency medical services. Several stressed that CBHCRs should not be housed within law enforcement agencies, while others qualified how law enforcement agencies may not be ideal but could work if roles were clearly defined. Schools, public hospitals, and stand-alone entities were also mentioned.

Overall, there was broad consensus across Advisory Board members in terms of the characteristics and values of CBHCRs, skills needed and not needed, and skills-based training for this workforce. Likewise, there was willingness to imagine workforce qualification based on skills and lived experience, rather than advanced degrees and licensure. While in survey responses and subsequent Advisory Board meeting discussions, there has been strong support for the value of respecting client autonomy, there has been disagreement about when, if ever, CBHCRs should be involved in providing non-consensual interventions.

KEY INFORMANT INTERVIEWS

We conducted 11 formal key informant (KI) interviews with individuals representing law enforcement, emergency medical services, crisis services/mobile crisis, community response and peer services. All participants provided us with permission to acknowledge them by name.

Alyssa Cahoon, MPH, RN, NRP	Program Director, Paramedic Programs, Milwaukee Area Technical College, WI
Guy Dansie	State Emergency Medical Services Director, Utah
Mike Delay, BA SUDP	Mobile Programs Director, Columbia River Mental Health Services, Vancouver, WA
Matthew L. Goldman, MD, MS	Behavioral Health Services, San Francisco Department of Public Health
Anne Larson	Olympia CRU; Project Manager – Behavioral Health, The Council of State Governments Justice Center
Matthew Moody	Director, Contact Center Operations and Clinical Services, Solari, Inc. Tempe, AZ
Kristin Sauerbier	Program Director **|** Mobile Crisis Assessment Team, The Neighborhood Center, Inc, Utica, NY
Lisa St. George, MSW, CPRP	Vice President Peer Support and Empowerment,

	RI International, Phoenix, AZ
Chad Stiles	Milwaukee Police Department, WI
Eduardo Vega, M.Psy.	Chief Executive Officer, Humannovations, CA
Jessica Westmiller, MSW	Chandler Fire Department, Crisis Intervention Coordinator, Chandler, AZ

All interviews were conducted via Zoom, recorded, and transcribed for analysis. We asked each key informant to share their thoughts on community behavioral health crisis response. Specific probes asked them to discuss the skills needed and not needed, safety concerns and safety protocols, training and formal education, characteristics of people well suited for the work, where CBHCRs should be housed, and policy and implementation issues. Interview transcripts were analyzed for themes using Dedoose software. Below we present themes that emerged related to each of the interview topics explored.

Qualities of CBHCRs. Key Informants indicated that crisis responders need to be able to ***keep themselves calm and manage their reactions to intense situations.***

> *So people who are going to work in any kind of crisis situation need to be able to, like, take that deep breath quickly and calm themselves and really keep that calm expression; that friendly person; that voice tone and cadence that's soothing and comforting to every extent that they can, because the more that they react, and the more that they tense up, and the more that their voice sounds, you know, urgent and whatnot, that just increases people's fear and upset and anxiety and stress.*

They need to be ***comfortable in physically and emotionally uncomfortable situations*** and be resilient, as the work is difficult at times.

> *I don't know how this is a skill, but we have found that folks that have come from, like, I almost think like the higher the ACE score. And if they've worked on it, like the better they're gonna be because they're not because they're not going to shy away from screaming and yelling and uncomfortable situations, I think that's truly the thing is like people that are comfortable in uncomfortable situations are really, really good.*

KIs discussed the importance of responders having deep capacity for ***compassion and empathy***, passion for the work, and the right motives (genuine compassion and caring). Responders should be ***non-judgmental and have good communication skills***, or the ability to talk to anyone, adjusting their approach and style to the situation.

> *Sometimes we try, and it's not going to happen, but you know, without the judgment, without the agenda. Just. We're here. You know, and that comes from a place of empathy. So you've got to really be empathetic, you know.*

I think anybody who has ever worked with somebody who is not genuine feels it.

One KI noted that it should not be "savior" motivated. Responders should also be able to observe, assess and adjust approaches, and make decisions quickly. ***Lived experience*** was discussed as valuable in terms of connecting with people in crisis and as a compassion resource.

But, you know, in my view, the more that people, you know, for lack of a better word have had tough experiences, you know, the... sort of the more they have to bring to the table, I think, in terms of a kind of compassion.

I think that the bare essentials are things like, you know, the sort of engagement piece, which I think peers do very well.

One KI talked about hiring people that like the idea of working outside, not behind a desk, experiencing something different every day, and who do not get queasy.

Qualifications and Education. Participant responses varied in terms of the required level of education and the need for clinical licensure. Those working with mobile crisis teams tended to indicate a need for **advanced degrees/clinical licensure for specific purposes**—lethality assessment and hospitalization assessments.

I think that that approach [bachelor's level] works for a good percentage of crisis intervention in the community, but I think that you still need those licensed providers to be able to conduct the lethality assessment; make determinations about whether or not someone might need to be hospitalized, and then facilitate that hospitalization when necessary.

Others noted how required education varied **based on role on team**—assuming a team of a clinician and either a bachelor's level person or peer.

Not everyone needs to be a licensed behavioral health clinician. You don't need two licensed clinicians on every team. That's obviously too high a bar. Some of our health workers who are bachelor's level are some of our best crisis responders.

However, several participants noted the **benefit of responders without traditional clinical training:**

> *I think that's one of the reasons that we're seeing better success out of non-clinical crisis teams. Because they have a more genuine approach**,** as opposed to, "I was taught to do this. This is how I interact with somebody."*

Some workforce issues require considering hiring bachelor's level responders:

> *[I] think it will have to be bachelor's level. I think we will have a hard time staffing with all master's degrees; that would be my preference. But I think with bachelor's degrees, if we give them a track towards this, and give them the specific tools.*

Workforce shortages also raise the possibility of hiring individuals with **less formal degrees with additional skills training**.

> *So, I have on my team individuals that just completed their GED all the way to people that have master's degrees…I think to be an effective crisis intervention specialist, it requires more a goodness of personality and willingness to learn than it does traditional academic acumen.*

In this context, participants often discussed the value of **lived experience** and peers.

Skills. Many of the skills discussed relate to the ability to approach a person in a nonjudgmental, compassionate manner that helps them **feel safe to engage and form an alliance**. Participants described this in a variety of frameworks: trauma informed, de-escalation, motivational interviewing. At the core is compassion and the ability to make the person feel heard.

> *The other kind of core aspect to this is really around alliance—you know, being able to form an alliance with somebody, so that you come along to their side and suspend judgment or other things so that they truly feel, like, seen by you; they feel heard by you; they feel that their distress or their intensity is validated, rather than dismissed or rather than kind of, you know, pushed away.*
>
> *So, when someone feels heard—and in my experience, they start to feel safe and start to engage more and feel like you care—that's another part of it—is communicating genuine concern and compassion for that person. It, like—we learn how to how to do all the interviewing skills and da-da-*

da—but do we learn to emphasize our compassion in our voice in our in our body stance? Do we really understand why it is so valuable to demonstrate compassion, in everything we do, as people who are working with human beings?

This requires good **communication skills**, flexibility to adjust the approach to meet the needs of the situation, and creative problem solving. Participants discussed some skills in terms of personality traits that can be enhanced by training, and more specifically trainable skills.

So you have to be able to talk to everybody at any level at any point in time and have the ability to be the one to adjust. I never expect that our staff are going to expect the folks who are in crisis to make the adjustment. We're going to do it right? So you have to.

So that opens up another whole set of skills and competencies, is–gauge–reading the room, right? Or reading the situation, and attenuating our communication, our behavior, and really everything that we do to meet that person's need at that specific time with the acknowledgement that that can be very different from minute to minute.

De-escalation skills included using time, distance, space, body language, tone of voice, and active listening to help the person feel safe.

They're using their voice, their behavior, their total presentation with this person to feel safe. And they allow themselves to come down from "Red Alert" stage, right?

It's verbal communication skills and empathy and rapport and eye contact, and you know body, language, and all the things that we're talking about for de-escalation. The tone of voice.

Specific **motivational interviewing** skills were discussed, along with the importance of internalizing the pillars of the approach.

Huge; important. Supportive, validating listening; active listening; open-ended questions – those are things that you can teach in a classroom and roleplay those things out. And it's funny, when you, like, truly listen to somebody, how quickly they calm down because they feel heard.

Participants discussed **trauma informed skills** in terms of understanding that a person's behavior may be shaped by past trauma (including trauma related to the mental health system) and using specific strategies to approach a situation in a trauma informed way. **Staying calm** is included here as a skill, as participants discussed specific elements, behaviors that can be supported as skills.

> *I think you know the trauma literature has a nice way of putting it, which is, like, if when we see somebody, you know, to kind of ask, you know, what's happening? Or what has happened to you? What... as opposed to, you know, what's wrong? What's wrong with you?*
>
> *It's, how, in this moment, can we be as approachable and respectful as possible—to not only the individual we're responding to, but the community that we're responding in?*

Participants discussed the importance of having skills for **a calm, compassionate approach to suicide intervention:**

> *The ability to, you know, enter into conversations around suicidal intensity, thoughts of wanting to die, etc., and be able to kind of hold that conversation and the spirit of respect and compassion is a core thing that many people don't have, and that historically in our systems… conversations related to suicide are treated, you know—have been historically treated as a sort of a red flag area that calls to mind a different kind of response. And so, people tend to shift out of the compassionate listening mode into something that feels more, you know—that might be called risk assessment but often for people feels a little bit more like grilling or testing, and feels driven by... again, by fear rather than compassion.*

Additional skills discussed include the following: **recognizing signs and symptoms of mental illness and substance use disorders, risks assessment and triage skills, harm reduction skills, basic medical skills, advocacy and knowledge of local resources.**

Safety. We asked KIs specifically about the skills that CBHCRs would need to respond in the community. Responses tended to be about **managing physical space** and the **approach and quality of the interaction**. Managing physical space requires situational awareness, staying at an appropriate distance,

knowing routes to exits, backing away if needed, basic self-defense and providing person time/space to regulate.

> *They need space to let that off. And, so, some core skills around creating that are not just about, you know, sort of removing things from the room, but creating space for people to down-regulate themselves. Sometimes, you know, that means just making sure that others don't feel trapped; they don't feel contained.*

Participants indicated the way the CBHCR approaches the situation, and the quality of the interaction impacts safety for all involved. This includes maintaining a calm tone of voice, non-judgmental attitude, non-reactive, flexibility to adjust approach, giving choice, gaining consent, and addressing basic needs and comfort.

> *We never want to do things without them being involved and try to… keep them in charge of their life as much as possible, rather than stepping in and telling them what to do and taking over. Because the more that we can help them to feel in control, the better it will be for them in the long run, and the more that they'll be able to make decisions around what will work for them. But if we start snatching away all their power, it just will escalate things.*

Participants also discussed **safety strategies**. These include gathering information before arriving on scene, meeting with the person outside of their home (while also attending to privacy), communicating between partners, staging police nearby for higher risk encounters, and using radios or other mechanisms to do status checks on team members.

Training. KIs discussed training of CBHCRs in terms of the training content and the structure of the training. Content areas included engagement, de-escalation, risk assessment, suicide intervention, motivational interviewing, harm reduction approaches, trauma informed care, and community resources and geography. There was consensus that training should involve a **mix of didactic, experiential, and field training.**

> *They need to have a structured crisis intervention and de-escalation skill set that has been taught to them in an experiential environment. Like, I don't think there's any way around that. So, a classroom-based de-escalation training followed either by experiential training in, like, a "mock*

city," is what we used at XXXX or in-the-field training with an observation role and then an implementation role prior to certification.

KIs also discussed how existing professionals need additional, **crisis specific training** for this work.

Peers are an important part of mobile teams. And, you know, I think that what we have decided is: they need a core peer training, and then we have a secondary training for them, if they're gonna go into the crisis realm anywhere,

And just to say this, again, I'm a master's level license. My schooling, my counseling schooling, did almost nothing to train me about crisis services.

Yeah. Because they're different. They're different than – well, I haven't been in school for some time, but they're different than I think typical, "here's what a social worker does" – they're different.

Policy and Implementation Challenges. When time allowed, we asked KIs to discuss what they saw as the primary policy and implementation challenges to establishing CBHCRs. They discussed **funding and payment system** challenges:

So, in other words, the Medicaid system has to catch up to have adequate resources to fund this, and billing codes that match what's actually happening.

Concerns about **safety and liability** were discussed:

I think that people are hyper-fixated on safety in a way that isn't helpful. They're too easy to identify something is unsafe, and then that gets bumped to the police… I think liability is another one that the cities think about a lot, and municipalities—"what's our liability here?" —and then just being kind of gun shy about moving forward, and so, like, they have to take baby steps into that. And then anytime—if there is a negative situation that, you know, they might just, like, tank the whole program.

The **tenuous legitimacy** of community/alternative response was also noted.

I feel like we're at the kitchen table. I use that like I feel like I'm at Thanksgiving all the time. And we're like at some like Toys R Us kid table is

what folks think of community responders, and like law enforcement and fire and other folks are still at the big table. And, so, I think that policy, legitimate, legitimizes, whatever.

While there was a fair amount of consensus across KI interviews, there were a few areas of divergence. Those working in more clinically based settings tended to endorse clinical skills and requiring responders to be licensed clinicians or perhaps comprise teams with a licensed clinician and a peer or bachelor's level person. KIs working in a community/alternative response capacity focused more on people with the right characteristics rather than advanced degrees and licensure. There was also divergence in terms of whether CBHCRs should provide only consent-based services or if they should have the ability to initiate involuntary processes.

FOCUS GROUPS

To gain the perspectives of key stakeholders (individuals who provide and/or use crisis services), we conducted focus groups with professionals working in mobile crisis and community response, people with lived experiences of mental illness and crisis services, and family members. We reached out through our professional networks to disseminate recruitment fliers and asked our contacts to share information on the project with their constituents. To recruit professionals working in crisis/community response, we reached out to contacts at organizations at both national and local levels. Adults and young adults with lived experiences were recruited via peer support networks, NAMI groups, youth networks, and Project LETS. Family members were recruited via NAMI and other professional contacts. Interested individuals who contacted the project team by email were provided with information about the project, and if interested in participating, scheduled for a focus group session.

Focus groups were conducted via Zoom and lasted 90 minutes. Crisis response professionals were asked to discuss the types of calls they respond to, the skills they need to do their job, challenges they encounter, and the values, qualifications, characteristics, training and skills that community/crisis responders should have. People with lived experiences and family members were asked to discuss what a behavioral health crisis is like for them (or their loved one), what is helpful and not helpful, what makes them feel safe or unsafe, and a set of questions parallel to those asked of community/crisis responders about the values, characteristics, and qualifications that community crisis responders should have. Participants received a $50 Amazon gift ecard as a thank you for their participation. Sessions were recorded, transcribed verbatim, and analyzed for themes using Dedoose software.

We conducted 13 virtual focus groups from March through July of 2023.

- Community Responders/Mobile Crisis team members (3)
- Adults with lived experience (5)
- Young Adults with lived experience (2)
- Family members of people with lived experience (3)

In total, 60 people participated in the focus groups as follows, 34 adults/young

adults with lived experiences, 11 family members, and 15 community responder/mobile crisis professionals. We did not ask participants to complete a formal demographics survey. Demographics reported here are based on how participants presented in the focus groups based on indicated preferred pronouns and race/ethnicity stated in discussion.

Group	Man	Woman	Trans-gender	Nonbinary	Unk	BLK	WHT	AAPI	LTX	UNK
Lived Experience	4 (11.8)	25 (73.5)	2 (5.9)	2 (5.9)	1 (2.9)	8 (23.5)	14(41.2)	2 (5.9)	8 (23.5)	2 (5.9)
Family	3 (27.3)	8 (72.7)				2 (18.2)	9 (81.8)			
Responder	5 (33.3)	10 (66.7)				2 (13.3)	10 (66.7)		3 (20.0)	
Total	12 (20.0)	43 (71.7)	2 (3.3)	2 (3.3)	1 (1.7)	12 (20.0)	33 (55.0)	2 (3.3)	11 (18.3)	2 (3.3)

We made a concerted effort to distribute the recruitment information to a diverse range of constituents. While the majority of those who participated identified as women (72%), participants were somewhat more diverse in terms of race/ethnicity, particularly for the group of participants who reported lived experiences.

Themes

Below we present themes that emerged from focus group discussions of the personal characteristics, values, skills and competencies, and qualifications needed for effective community behavioral health crisis work. Although there was substantial agreement across stakeholder groups on many topics, we also note several issues on which perspectives varied.

Characteristics of CBHCRs:

Focus group participants identified several key characteristics needed for crisis responders. These qualities included being adaptable and able to work under pressure, responding to their environment, shifting their approach when needed, and staying calm and emotionally self-regulated. Effective crisis responders were also described as empathic and compassionate, humble, genuine, and self-aware. Participants emphasized that professionals did their work "for the right reasons," were good at establishing rapport, and were team players. Finally, focus group participants centered the importance of diverse lived experiences as a core characteristic of crisis responders.

> *And, so, I think they really need to walk in, like you said, non-judgmental, and showing that empathy. Not, you know, kind of laughing inwardly or being afraid; in relief. People can sense that stuff, so I think that belief system really has to be inside of them.* [family member]

> *For me, I would say curiosity would be number one, and then compassion. I would say those two. People that have questions about what happened to me, or what was going on, or why I did that. And then not, not judging me, you know; to be able to ask questions, and I know they're not kind of categorizing me, or, you know, they're actually trying to find out what happened and trying to help. I would say those two, for me.* [person with lived experiences]

> *I think, for me, something that I really value - and [name] might have spoke on this a little bit - is that ability to admit that we don't know everything, and that eagerness to learn. I think this is such a niche of our profession; that there is a lot of moments of taking a step back, reflecting on our own biases, and asking questions. So, that ability, or that willingness, is incredibly important to me when I'm looking for a candidate.* [responder]

> *I'm saying I think, if you just leave it to, if you take living experience out of it and just look at the degrees or the certifications, you're not gonna get people that really actually care about the job. You need those people who have been houseless in their lives for them to know, you know, they've already been in those shoes. They don't have to imagine themselves.*

People who've been in those mental hospitals, people who nobody's given a chance to, because that's essentially what we're needing out there [responder]

Values of CBHCRs:

Focus group participants discussed the core values needed for community behavioral health crisis response. These values reflect an overall commitment to an anti-oppressive and person-centered practice that is non-hierarchical, empowering, and collaborative. Moreover, participants felt crisis responders should be trustworthy and transparent in their conduct and should show unconditional positive regard for the individuals, families, and other caregivers who they encounter and support. Participants also expressed a belief that crisis responders ought to concern themselves with both the near and longer-term well-being of those they serve. Finally, these participants and the systems in which they work should value the importance of diversity and of diverse lived experiences.

I also think that remaining multiculturally competent and curious, more than anything; To not be closed off to what we know, you know, what we grew up with, the experiences that we were exposed to, you know. And wanting to learn what other people are going through and how that's affecting their lives. [person with lived experiences]

This job needs people that are anti-racist. Public safety has been full of racism. Division. Just too much of that. You cannot be racist. You cannot be a person who hates, you know, other people and how they identify as themselves, doing this job... Just to all that, like, self-aware, someone said self-aware. And if you're self-aware that you do not like Black people, that you do not like kids, that you do not like Hispanics, that you do not like women, that you do not like - there's just so many things - and if that's you, this is not for you. Period. [responder]

...having those important conversations with these individuals and being transparent with them so that we're not breaking this relationship with them. Because we don't want it to be an involuntary situation where, okay, we've started this process, they've been hospitalized, and now I can't find them after the hospitalization. [responder]

Competencies and Skills of CBHCRs:

Focus group participants identified a range of skill sets needed for crisis responders to do their work effectively. The competencies and skills that were discussed fell into the following categories: communication skills, knowledge-based skills, rapport and trust-building skills, and safety skills. An overview of each of these competencies is reviewed here along with several key quotes provided by focus group participants.

Communication: Focus groups participants identified skills needed by crisis responders to communicate effectively with all parties who are involved in crisis encounters. Examples of these skills included actively listening, controlling tone, speaking respectfully, helping people feel safe, and being transparent. Competencies tied to communication were also considered central to helping others to feel safe, meeting people where they are, and building rapport.

> *What I find to be helpful is just, like, transparency and understanding. Making sure that, when coming in, just, the worker, the crisis workers, should come in just expecting anything, but being ready to listen, is super important. To take the listening ear, and to be, to be patient with the, um, with the person who is in crisis and, also, with the family* [family member]
>
> *Listen. Just listen to you, and talk to you, and tell you. It's not always gonna be okay, but, just, I think that listening aspect, and, instead of talking, someone who does a lot more listening than talking, I think would be helpful.* [person with lived experiences]
>
> Y*eah, we do a lot of meeting people where they are. Not necessarily where we want them to be, but exactly where they are. If you're having the worst day of your life, let's meet there. Let's not meet at a promise, or everything is gonna be okay, or. Let's just meet where you are in that second.* [responder]

Knowledge-based: Focus group participants frequently spoke about general approaches and specific training that would enhance crisis responses and allow for helpful interactions. Some of these recommendations meant crisis responders should know about local services and populations in the communities where they work, have basic de-escalation skills, be able to identify basic signs of mental/behavioral health distress, and understand how to

demonstrate cultural competence/humility. Some participants spoke about the importance of more specific skill sets that might entail advanced training and/or certification. Mentions of these skill sets included Motivational Interviewing, emergency medical skills (including the administration of naloxone), and Basic First Aid.

> *…we really emphasize trauma-informed care as well as person-centered interventions. So, we want the clients to come in and know that they're being heard, and that we're not just, like, sticking a label on them or trying to force them into a service that they don't want.* [responder]

> *I guess I would like for them to have a knowledge of places I could go. I'm not expecting this person is ever going to be a super person that can give me every single thing, but it would be nice if they said, "You could go here," or "You could go here," or "I can help you go here," or "I know somebody here."* [person with lived experiences]

Rapport/Trust: Focus group participants viewed effective crisis work not only in terms of technical knowledge, but also in relation to responders' ability to form genuine and supportive connections with individuals in distress. By showing respect for and centering the expressed needs of individuals for whom concerns were raised, crisis responders could build connections that empowered clients and supported their autonomy. Participants regarded the ability to maintain a calm tone, show patience, and use non-verbal skills as key to fostering trust. With that rapport, focus group participants reported clients would be better able to express their needs and less likely to have resources and services imposed upon them that were ill-fit to their actual concerns and goals.

> *…let them know 100%, like, we're here for you. 100%, you know, like, we're here for you, and we want to be there for you, to help you on your mental health journey, or your substance—your recovery journey, or wherever it is you're at. We want to help you where you're at and help you to become the best you in this timeframe that we have.* [person with lived experiences]

> *Being with someone, like, with a calm voice, patient. Just having someone where I'm not alone. I'm not alone, but I have to have that initial, like, trust—like, that comfort when they're introducing themselves, that initial reaction, like, "Hey, this is someone coming at me from a good place." You*

know? Just that comforting, peaceful voice, you know? You can feel that rapport, like, immediately with someone, not someone coming in, like, all clinical with all their paperwork out ready to get signed and pushing their goals on you. [person with lived experiences]

Yeah, we do a lot of meeting people where they are. Not necessarily where we want them to be, but exactly where they are. If you're having the worst day of your life, let's meet there. Let's not meet at a promise, or everything is gonna be okay, or—let's just meet where you are in that second. And let's move from there. If you're standing up, I'll stand with you. If you're sitting down, I'll sit with you. If you're crying, I'll find a way to also tap into that, as well, to show you that I might not cry, but I'm there for you. I'm feeling you, I'm 100% there with you in every second of it. [responder]

Safety: A range of practices and skills to enhance people's feelings of safety during crisis responses were identified by focus group participants. For some, this ability meant maintaining a calm and warm demeanor, not rushing the process, asking permission, and giving undivided attention. For others, feelings of safety were diminished when crisis services felt designed to take away a person's agency, were provided in police stations or hospital settings, and when crisis responders did not share the experiences and identities of the people they served. Such sensitivity to contextual and interactional factors can be seen as an extension of empathic practices that highly regard the comfort of those individuals and communities they assist.

So, that's big for us. And, helping them feel safe is making sure that they know that they have a voice and they're the ones kind of making the final decisions on their treatment plan. [responder]

…for the participants that we've dealt with, what makes them feel safe is knowing that, one, it's a judgment-free zone, and our last, like, resort would be to inform our supervisor and see if they would have to be hospitalized. So, they know that from the beginning. Judgement free approach—transparency. [responder]

I think, like, things that help to kind of preserve your sense of agency are really valuable. So, for everything that exists in the system, it seems like the goal is to take away your agency, and for me, that is, I can't imagine how

that would be grounding or healing or reassuring for anyone at all. And, so, I think being able to make decisions, and people trust the things I'm saying, and, like, trust that I can still say what I need. It feels like there's some aspect of people being in crisis that leads people to be a little paternalistic towards them often and not really believe what they're saying. So, I think when people trust me, believe me, and that, like, still want to protect my agency and feeling of choice, you know, I think that's really valuable and makes me feel safe and healthy. [person with lived experiences]

Participants with lived experience of using mental health services also shared things that make them feel less safe during crisis situations:

...what makes me fearful? When I'm symptomatic, if somebody has a heightened voice, like, I already, I'm having a hard time focusing. I'm already hearing a voice, my voice, you know, and it's usually pretty pronounced, and then as I get more stressed, it gets louder. So, if somebody is, if somebody seems aggressive, or if somebody seems like they know they're not focusing me, so they're like, "Hey! Hey!" You know? Or they're, they're like, you know what I mean? To me, it seems like they're, they're starting to threaten me—that that can make me feel like I'm backed into a corner, and that can be very frightening. [person with lived experiences]

Focus group participants also named specific approaches to enhance the physical safety of crisis responders. Although some discussed de-escalation training, others described logistical elements that participants considered necessary for this work to happen safely, such as wearing uniforms, linking responders to police radio systems with panic buttons, wearing ballistic vests, having police first "clear the scene," and always responding in teams of at least two. Other participants saw safety as enhanced by removing features that they associated more with police. They believed community crisis responders should never use physical force, should always be unarmed, and should not dress in a militarized manner. Despite these divergent perspectives, participants shared a belief that crisis responder trainings ought to increase the situational awareness of these professionals to perform their work across complex and unpredictable environments.

So, one of the trainings that we have all of our staff go through is, like, a

nonviolent crisis intervention training, which will hopefully, you know, give us the tools to deescalate when clients start to maybe get a little bit more aggressive. We also make sure that we always have two staff on every shift so that there's always someone available. [responder]

They also have the discretion, right, to maintain their own safety, so if they arrive on a call and it just—something doesn't feel right or maybe things do escalate—they're able to remove themselves and then call the appropriate response. So, maybe it's communicating with our co-responders and saying, "Hey, this is a little bit of a higher acuity. Can you come out and support us on that?" So, we give them a lot of independence in maintaining that safety. [responder]

Qualifications: Views on educational and professional qualifications reflected focus group participants' conceptions of the work that crisis responders were expected to perform. For example, participants who saw crisis encounters as a critical step in the process of linking people to acute psychiatric and hospital-based services regarded master's-level preparation and licensure as a needed qualification for completing petitions. Other participants framed lived experience, rather than formal education, as central to preparation for working as a crisis responder. From that perspective, they pointed to a deep and genuine drive to serve others that came from personal experiences with the same hardships and systems that clients dealt with and struggled to overcome. Across this range of ideas about qualifications, focus group participants noted the importance of crisis teams made up of people with diverse backgrounds and education levels.

If you take living experience out of it and just look at the degrees or the certifications, you're not gonna get people that really actually care about the job. You need people who have been houseless in their lives for them to know. You know? They've already been in those shoes. They don't have to imagine themselves. [responder]

...They've been through it. So, they know what it looks like to be inpatient. They know what it looks like to go through the hospital. They know what it looks like to sit at the nice, cozy agency. Like, they have these different experiences... They have a well-rounded, and, if they don't, I think it'd be really helpful when people are onboarding that they have to do the, like,

> *the agency itself has to do something to give exposure to these other systems, because there's just such ignorance on what's happening on the other side.* [person with lived experiences]
>
> *Yeah. I think those things are just, like, really important, is that they do share, like, some kind of identity to you. Because I do sometimes think that, like, honestly, that can be more valuable than a degree.* [person with lived experiences]

The focus group findings augmented understanding of the core characteristics, values, skills, and qualifications needed for effective crisis responses. Across stakeholder groups, there was an agreement on the importance of crisis responders that were adaptable, empathetic, and compassionate, and who possessed a diverse range of lived experiences. Participants emphasized the need for a person-centered approach that was anti-oppressive, non-hierarchical, and collaborative. Communication skills, including active listening and respectful engagement, were also highlighted, along with knowledge-based competencies such as de-escalation techniques, cultural competence, and an understanding of local resources. There was strong emphasis on lived experiences, which for some participants exceeded the value of formal education in fostering genuine connections. Perspectives on safety protocols and qualifications showed some divergence, with varied views expressed by focus group participants on the role of formal training versus the value of personal experience. Overall, these findings underscore a view that the development of a crisis response service should prioritize empathy, inclusivity, and an understanding of the communities that they seek to serve.

DISCUSSION

The findings from the literature review, advisory board survey, key informant interviews, and focus groups provided the basis of a foundational document, **Community Behavioral Health Crisis Responder Core Values, Competencies and Skills** (see Appendix A). This document was created to support the ethical foundation and skill set of the CBHCR workforce, and address the urgent need for a skilled, compassionate, and responsive workforce prepared to respond to the majority of community behavioral health crises without the involvement of law enforcement.

Designed to guide CBHCRs in their work, the **Values** and ethical principles described in the document emphasize dignity, relationship-building, collaboration, autonomy, support for the client's social system, integrity, advocacy, anti-oppressive practices, and the integration of lived experiences. These values reflect a humanistic approach to crisis response that ensures CBHCRs operate with respect, empathy, and a commitment to justice and equity in their interactions with individuals in crisis.

The **Core Competencies and Skills** section outlines the practical skills and knowledge areas essential for CBHCRs. It details competencies across various domains, including mental and behavioral health practice, anti-oppressive practice, physical health, safety assessment and intervention, interventions, documentation and privacy practices, communication-related competencies, relationship building, and safety-related skills. This comprehensive framework ensures that CBHCRs are equipped with the necessary tools to effectively recognize and respond to crises, provide empathetic support, navigate resources, and advocate for individuals' needs while maintaining safety and professionalism.

Together, the components of this endeavor have not only illuminated foundational elements for building a CBHCR workforce but also areas of tension and unresolved questions that merit further exploration. The positive feedback from the advisory board on the developed documents underscores considerable agreement on the core values and competencies of CBHCRs. Yet, questions that remain open reflect the complexity involved in implementing a CBHCR workforce within diverse community settings. These include

considerations on how CBHCRs should navigate situations where their assistance is not welcomed, the implications of integrating clinically licensed mental health practitioners within the workforce, the potential impacts of the physical location of CBHCR services, and the vital role of community involvement in ensuring that this alternative to police intervention aligns with local needs, values equity, and promotes fairness. Addressing these questions will require ongoing dialogue, adaptive policymaking, and community engagement to refine and evolve the CBHCR model to meet the unique challenges and opportunities of providing compassionate, effective crisis services and support.

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APPENDIX A

CORE VALUES, COMPETENCIES ANDSKILLS OF COMMUNITY BEHAVIORAL HEALTH CRISIS RESPONDERS (CBHCRs)

Core Values of CBHCRs

- **DIGNITY**: CBHCRs respect the inherent dignity and worth of every person. They demonstrate this by responding to community members non-judgmentally and with compassion. Through their actions, as well as ongoing learning and self-reflection, CBHCRs strive to consistently recognize the wholeness and humanity of every person they serve.
- **RELATIONSHIP**: CBHCRs recognize the central importance of human relationships and are committed to providing care in a compassionate and trustworthy manner that supports the need of those contacted to feel safe as they make decisions about engaging in care. This requires conveying genuine respect for the person, focusing on needs and preferences as defined by that person, and demonstrating clear, honest, and transparent communication.
- **COLLABORATION**: CBHCRs view their role as collaborative, and work to support people in expressing their personal goals and preferences, and in harnessing their own strengths and resources.
- **AUTONOMY**: CBHCRs are committed to forms of support, interventions,

and approaches that enhance the autonomy of the people they serve.

- **SUPPORT SYSTEM**: CBHCRs recognize the importance of the person's family/chosen family/social support system. As they work to support people in crisis, CBHCRs demonstrate an awareness of these dynamics, and strive to support the relevant needs of others in those relationships/networks. At times, this work includes helping people who have been isolated forge new connections to communities of support, if they want them.
- **INTEGRITY**: CBHCRs act with integrity. They are committed, honest, trustworthy, and reliable. They act conscientiously, consistently, and in accordance with the other stated values.
- **ADVOCACY**: CBHCRs stay informed of and are ready to advocate for resources in the communities where they work. Their advocacy addresses barriers and gaps in services that impact people at individual and systemic levels, and work to bring about change by directly communicating the needs of those who they support to providers and policymakers.
- **TRAUMA-INFORMED**: CBHCRs have an ongoing commitment to evolving their knowledge about trauma, harm reduction, and histories of oppression in all forms.
- **LIVED EXPERIENCES**: CBHCRs recognize the value of lived experiences in providing effective responses. On teams where they work, CBHCRs listen, learn from, and partner with those who have experiences and carry understandings that differ from their own.

Core Competencies and Skills of CBHCRs

CBHCRs work requires competency in multiple areas. Below, the core competencies are described with examples of knowledge and skills in each area.

RELATIONSHIP BUILDING-RELATED COMPETENCIES AND SKILLS

- **Self-awareness:** CBHCRs possess and practice self-awareness that allows them to forge trusting and collaborative connections. By understanding their personal biases and monitoring themselves for emotional reactions, CBHCRs provide support based on the needs and preferences of the people they serve. They utilize self-disclosure appropriately for the benefit of people they support. By caring for themselves and regulating any intense emotions, CBHCRs assist people

as they access resources.

Example Knowledge/Skill Areas

Emotional self-regulation and care
Flexibility in thinking and decision making
Meeting people where they are at
Trusting the person
Use of self-disclosure for the benefit of the person served

- **Interpersonal:** CBHCRs engage with the people they support in a shared process of planning for and accessing resources. In this collaborative process, CBHCRs learn from the person they are serving what their unmet are, provide information on available resources to meet those needs, and assist the person in accessing desired resources.

  Example Knowledge/Skill Areas

  Engagement/rapport
  Relationship building
  Meeting people where they are
  Collaborative/shared action

- **Unconditional positive regard:** CBHCRs can be relied on to consistently show respect and convey genuine concern and a desire to help. By maintaining a compassionate approach, trust is built as CBHCRs learn from each person what they need and what their goals are. CBHCRs understand that even if a person's behavior seems unhealthy or problematic, it is directed toward getting a need met. The goal of CBHCRs is to help people find safer and healthier ways to meet their needs.

  Example Knowledge/Skill Areas

  Respect, nonjudgment, and compassion
  Genuine
  Concern about and providing for person's comfort and wellbeing

COMMUNICATION-RELATED COMPETENCIES AND SKILLS

- **Engagement:** CBHCRs communicate their genuine desire to help. They recognize and validate harm caused by the structural conditions that people face. Selective disclosure of personal experiences fosters understanding and deepens connections with people who are in distress.

  Example Knowledge/Skill Areas

Communicating a desire to help
Providing emotional support/validation
Sharing personal experience

- **Active listening:** CBHCRs possess an ability to listen, acknowledge, and validate, making purposeful use of personal experiences to facilitate understanding and connection. They communicate honestly about the availability of resources and support people to make informed choices.

  Example Knowledge/Skill Areas
  Providing emotional support/validation
  Openly and honestly discussing the availability of resources

- **Language and communication:** CBHCRs know how to adjust and control the tone and pitch of their voices to build trust and clearly convey information. They avoid jargon and other professional scripts. Technical skills may also reflect the use of communication technologies, language resources, and translation services that increase access to information and support. CBHCRs use non-verbal communication as well as body and facial expressions that increase feelings of safety and support.

  Example Knowledge/Skill Areas
  Vocal modulation
  Communication technologies
  Non-English and non-hearing language resources
  Non-verbal communication

- **Cross-cultural:** CBHCRs tailor their communication to engage individuals from diverse experiences and backgrounds while maintaining an openness to learning. Skill in this area allows for open discussions across differing views and perceptions of resources that may be requested and recommended.

  Example Knowledge/Skill Areas
  Flexibility in thinking and decision making
  Age-related preferences
  Developmental and learning differences
  Transcultural skills

KNOWLEDGE BASED COMPETENCIES AND SKILLS

- **Mental/Behavioral health:** CBHCRs possess the introductory-level skills and knowledge required to recognize signs of behavioral health distress, including

those stemming from mental health and substance-related conditions. This knowledge allows CBHCRs to evaluate acuity for individuals experiencing a behavioral health crisis and an ability to triage cases to the appropriate and least-restrictive level of care. Basic understanding of common symptoms and crisis states allows CBHCRs to foster trust and facilitate connection without alienating individuals or contributing to their distress. Competency in this area includes the ability to identify common medications used in psychiatric and substance use disorder treatment and changes in behavior and/or physical health that indicate adverse reactions.

Example Knowledge/Skill Areas

Signs and symptoms of psychiatric disorder, also including substance use and co-occurring disorders
Knowledge of common medications
Evaluation of symptoms acuity and appropriate level of care
Seeking support/supervision when indicated

- **Cultural humility and anti-oppressive practice:** CBHCRs understand the effects of racism and other forms of institutionalized oppression. They engage in cultural humility and anti-racist practices while making timely use of team-based and non-English language resources and ensuring services are provided confidentially within a trauma-informed framework.

  Example Knowledge/Skill Areas

  Anti-racist/Anti-oppressive practice
  Disability justice
  Cultural humility
  Trauma-informed care

- **Physical health:** CBHCRs are alert to the signs of physical health conditions (e.g., hypoglycemia, post-seizure state, delirium) that can mimic psychiatric distress as well as other basic medical issues that may warrant EMS/medical attention. SBHCRs recognize physical health concerns related to the use of substances, including use patterns and that put people at risk for life threatening withdrawal and signs of overdose, and provide emergency intervention to reverse overdose with medications when appropriate. CBHCRs employ harm-reduction strategies to minimize harmful impacts of high-risk behavior and engage emergency medical services when needed.

  Example Knowledge/Skill Areas

Alert to signs indicating the need to engage EMS/medical services
Recognition of signs of overdose and administration of emergency overdose reversal medications
Harm reduction approaches
Basic CPR/first aid

- **Safety assessment and intervention:** CBHCRs evaluate risks and strengths in complex situations. Skills in this domain include an ability to engage in conversations related to basic suicide/self-harm and violence risk assessment and intervention. Other assessment capabilities may be driven by local contexts that increase the problems like gang violence and human trafficking.

  Example Knowledge/Skill Areas
  Suicide/self-harm risk assessment and intervention
  Violence risk assessment and intervention

- **Interventions:** CBHCRs have training in structured, evidence-based approaches such as motivational interviewing, brief addiction counseling, and collaborative problem-solving. They use these skill sets in ways that create options for people as they learn about and engage with services.

  Example Knowledge/Skill Areas
  Motivational interviewing
  Brief addiction counseling
  Collaborative problem solving
  Safety planning

- **Documentation and privacy practices:** CBHCRs demonstrate proficiency in timely documentation, which is essential for compliance, accurate record-keeping, and team-based services. CBHCRs understand regulations related to information sharing and confidentiality, especially as it relates to sharing protected health information with law enforcement.

  Example Knowledge/Skill Areas
  Federal and state regulatory and legal requirements
  Documentation practices
  Health Insurance Portability and Accountability Act (HIPAA)/privacy regulations

SAFETY-RELATED COMPETENCIES AND SKILLS

- **Managing the physical environment:** By assessing and managing the physical environments where services occur, CBHCRs maintain their own and others safety. CBHCRs remain prepared to de-escalate and disengage when indicated.

    Example Knowledge/Skill Areas
    Spatial/physical safety considerations
    Environment management/physical space
    Self-regulation

- **Preparation:** A CBHCRs preparation before entering an encounter lays the groundwork for effective and safe service. Preliminary and ongoing assessment of resources and risks includes making both individual and environmental considerations. This includes assessing for potential weapons and other risks in the response environment and developing plans to manage those risks. This planning may involve collaboration with the person to be served (for example, asking the person to secure weapons or pets in advance of arrival). Active assessment during encounters ensures the CBHCRs adjust their approach in response to dynamic risk factors.

    Example Knowledge/Skill Areas
    Gathering information
    Planning for safety
    Collaboration with person to be served
Dynamic risk assessment

- **Crisis de-escalation and maintaining safety:** CBHCRs are equipped to actively maintain safety and possess skills that include clear limit setting, crisis de-escalation skills, disengagement when needed, and basic nonviolent self-defense. These active skills enable them to respond to challenges without compromising their well-being or the safety of those who they assist.

    Example Knowledge/Skill Areas
    Limit setting/boundaries
    Crisis de-escalation
    Disengagement
    Nonviolent self-defense

RESOURCE NAVIGATION AND ADVOCACY-RELATED COMPETENCIES AND SKILLS

CBHCRs utilize knowledge of local resources, relationships with other service providers, and advocacy skills to help people find needed resources. CBHCRs are adept in basic

case management and able to support people as they navigate complex and multi-step social systems such as those pertaining to housing, physical health and behavioral health treatment, legal needs, food security, and child welfare.

Example Knowledge/Skill Areas

Knowledge of local resources
Basic housing system knowledge
Basic legal system navigation
Family/social network engagement
Advocacy
Case Management

SELF-CARE RELATED COMPETENCIES AND SKILLS

CBHCRs self-advocate, seek supervision, and cope with the potential stress their work can pose to their health. This includes considering aspects of their work that may trigger personal reactions (e.g., sexual assault, domestic violence), and working with their supervisors to manage these situations. Self-care also involves setting boundaries and finding a work-life balance that helps prevent burnout, compassion fatigue, or empathetic distress.

Example Knowledge/Skill Areas

Routine practice of stress management and effective coping skills
Boundary setting
Utilizing supervision