Mental Health First:

Evaluating Oakland and Sacramento's Non-Police Crisis Response Program

Health in Partnership

M.H.FIRST
COMMUNITY FIRST RESPONSE

APTP
ANTI-POLICE-TERROR PROJECT

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Key Contributors
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About Health In Partnership (HIP): HIP transforms the field of public health to center equity and builds collective power with social justice movements.

About the Anti Police-Terror Project (APTP): APTP is a Black-led, multi-racial, intergenerational coalition that seeks to build a replicable and sustainable model to eradicate police terror in communities of color.

Executive Summary

When you witness someone in crisis — a mental health emergency or other escalating situation — what are your options to intervene? For most, the only available option is to call 911. And in most places, the 911 system is directly tied to the police department, making police involvement essentially inevitable. But police are not a source of safety, especially for Black, Indigenous, disabled, and people with mental health needs. Policing in the US is a system rooted in violence and punishment, not care. Calling the police can escalate a crisis, turning calls for distress into arrest, violence, or death. Without trusted, community-led alternatives, we are left with a wrenching dilemma: stay silent and unsupportive in moments of crisis, or risk escalation, criminalization, and compounded trauma and violence.

Because of this, many communities across the US are working to interrupt police violence against people with mental health needs by building up community-based, community-led, non-police crisis response programs. While more evaluations of each of these types of programs are needed, there is already a body of literature that suggests these alternative models are both more effective at meeting the needs of people in crisis and more trusted by the community.

One such program is Mental Health First (MH First), a project of the Anti Police-Terror Project (APTP) launched in 2020 in Oakland and Sacramento, CA. MH First is a community-led crisis response hotline outside of the 911 and police system that community members can call when they, or someone in their community, is experiencing a crisis. The program's guiding principles include autonomy, healing justice, abolition, intersectionality, disability justice, and harm reduction. This evaluation — conducted while the program is on a strategic planning hiatus — takes a close look at MH First's first four years of operation to assess how the program is working, what impacts it's had, and what is needed to grow its reach and deepen effectiveness.

Using a mixed-methods process evaluation, we conducted 29 interviews with key stakeholders, and analyzed 167 survey responses from community members in Oakland and Sacramento. Our evaluation focuses on community perceptions of MH First, program strengths, and areas for growth. In particular, we examined the program's

current structure and operations, perceived impact, and potential for deepening and increased services to the Oakland and Sacramento communities

Overall, interviewees and survey respondents were very positive about and appreciative of the program. Interviewees noted that the program is trusted by and rooted in the local communities it serves, an essential part of providing appropriate and accessible care to those who call. Trust is further increased by the clear, transparent values of community, autonomy, and abolition that guide MH First's work. Importantly, MH First is building power and self-efficacy in the local and national community through their trainings, technical assistance, and volunteer recruitment — through which they have trained thousands of volunteers to staff the program. On the national level, interviewees named that MH First provides a strong model that indicates that non-police mental health crisis response programs are practical and possible. Relative to other forms of mental health crisis response, including police and co-response models, MH First is highlighted as more appropriate and more effective at meeting community needs.

Our evaluation also identified areas where MH First could grow and improve to better serve the Oakland and Sacramento communities. Interviewees expressed a desire for MH First to increase reliability by expanding their hours of operation to 24/7, rather than during select hours of the week. Some also suggested that MH First transition from a volunteer-only service, to include at least some paid staff. Finally, interviewees felt that MH First should focus on preventative measures and follow-up care, not just crisis management and intervention. In order to be able to meet these areas of growth, interviewees offered suggestions for expanding the program's reach, including through policy change, a clear narrative and communications strategy, more trainings to build community capacity, and long-term sustainable investment in the program.

Two big picture questions remain for the program's consideration: First, how can MH First avoid the co-optation of their principles and strategy by entities that dilute or stray from MH First's values and purpose? Interviewees spoke of the inevitability of co-optation and shared strategies for how to reframe or leverage co-optation to expand the program, while still maintaining control over the narrative of the program's practice. Second, should MH First remain an entity outside of local, county, or state government, or should it be housed under a governmental office or supported with government funds — or some combination of both? Our interviewees had strong opinions on this question, with some

feeling that operating within the government and social safety net would allow MH First to be more sustainable and accessible, and others believing that moving under a government agency would cause the program to lose its current spirit and vision.

Our evaluation concludes with six recommendations for MH First:

1: Continue to prioritize being deeply rooted in and led by community members in Oakland and Sacramento, particularly Black, Indigenous, Latine, and disabled community members who are most impacted by policing

2: Publicly share more stories of success, including robust qualitative and quantitative data analysis

3: Provide preventative care in order to interrupt pathways to crisis situations and follow-up care in order to ensure people have what they need following crisis

4: Expand hours of operation as much as possible to ensure the hotline is accessible and reliable

5: Increase resources and funding for the program, including considerations of whether MH First is willing and able to receive government funding

6: Pass policy and budget allocations that shift money from the carceral state to non-police grassroots response, including to MH First

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Background and Review of the Literature

Mental health crises — and police response to them — disproportionately affect marginalized communities due to systemic racism, ableism, and the failures of traditional crisis response systems. Over the last five years, police have killed over 1,200 people per year, with police killing more people in 2024 (1,367 people) than any other year in the past decade.[1] Due to the racism and ableism entrenched in the policies and practices of policing, Black people are over three times more likely to be killed by police than White people,[2] Indigenous people are around two times more likely to be killed by police than White people,[3,4] and people with untreated mental health needs are 16 times more likely to be killed by police than those without. [5] In addition, since 2015, more than 400,000 people have been treated in emergency rooms because of a violent interaction with police or security guards, according to CDC data.[6] Beyond physical violence, several studies have found that being stopped by police is associated with symptoms of anxiety, depression, posttraumatic stress disorder, and psychiatric hospitalization.[7–9]

In 2018, the American Public Health Association identified police violence as a public health crisis, calling for public health solutions that "allocate funding from law enforcement agencies to community-based programs that address violence and harm without criminalizing communities, including mental health intervention… particularly in the communities currently most affected by law enforcement violence."[10]

Many communities are taking up this charge and interrupting police violence against people with mental health needs by building up community-based, community-led, non-police crisis response programs. Models like CAHOOTS in Eugene, OR that divert 911 calls to trained crisis responders, and co-response models like that of Los Angeles County's Mental Health Evaluation Team that pair police with mental health professionals, offer important lessons. But these programs remain rooted in state systems — thus often failing to interrupt the violence of carceral systems as intended. In many places, the 911 system is directly tied to the police department, making police involvement essentially inevitable even when the call does not require police presence. Unlike these models, MH First is entirely separate from law enforcement and 911 systems, prioritizing community leadership and trust building over carceral approaches.[11]

While more evaluations of each of these types of programs are needed, there is a body of literature that suggests these alternative models are both more effective at meeting the needs of people in crisis, and more trusted by the community than traditional policing. One systematic review compared models internationally where police are trained in mental health care provision, co-response models, and non-police response models across outcomes such as arrest rates, hospital admissions, and injury, as well as stakeholder perceptions of each model.[12] This research found that police training models did very little to reduce use of force, injury, or hospitalization during a crisis, with mixed stakeholder response, including descriptions of police response as traumatic and stigmatizing. Co-response models were associated with generally improved outcomes, including lower rates of arrest and reductions in emergency department visits. Non-police response programs were not strongly evaluated in the study, but there were clear preferences for this model among service users, including greater ability to resolve crises at home, greater satisfaction with care, and more active participation in decision-making. A later study based on in-depth interviews with 50 people with serious mental illness found that non-police response is their most preferred choice among the available mental health crisis models.[13] More than half of the participants in the study noted that they would want a non-police response when they, a family member, or a friend are experiencing a crisis.

History and Context of Mental Health First

"I have been an organizer for over two decades. The most important lesson I have learned is that we must make room for healing. We must prioritize it. It should not be an afterthought but actually the center of our work — for organizers, advocates, artivists and the people we say we are living to serve. Anything else is putting bandaids on gunshot wounds. Addressing our trauma, healing ourselves and our communities is the pathway toward whole communities, the foundation of reimagining public safety and the most crucial shift we must make in how we approach and engage in our work."

— *Cat Brooks,*
Co-Founder and Executive Director of the Anti Police-Terror Project and Executive Director of Justice Teams Network

Mental Health First (MH First), a project of the Anti Police-Terror Project (APTP), is a model of non-police response for mental health and other community crises, launched in Sacramento, CA in January 2020 and in Oakland, CA in August 2020. It aims to interrupt and eliminate the need for law enforcement by providing mobile peer support, de-escalation assistance, and non-punitive and life-affirming interventions. This strategy decriminalizes emotional and psychological crises and decreases the stigma around mental health, substance use, and domestic violence, while also addressing their root causes.

MH First was created by and with impacted community members, grassroots organizations, and mental health and medical professionals. It is the first and only non-911, Black-led option for response to mental health crises in Sacramento and in Oakland, rooted in community needs and led by community members to reduce state violence. Unlike many community mental health crisis response teams, which are routed through 911, MH First creates a network of local support that bolsters existing community programs and expertise, does not rely on coordination with 911, and emphasizes mental health crisis prevention, reaching people in crisis before police involvement. The program has broad, cross-sectoral support. Indeed, MH First is the model upheld as exemplary to protect the public's health in a 2021 policy statement from the American Public Health Association about the harms of carceral systems.[14]

In April 2022, the city of Oakland also launched a non-emergency crisis response program called Mobile Assistance Community Responders of Oakland (MACRO), housed in the Oakland Fire Department. The city-run program developed with support from MH First and now the two programs are able to refer callers to each other when necessary. It has been helpful for community members in Oakland to have both options available to them in crisis situations — one that operates within the city government and one that operates outside of that system — especially for callers who may not trust a governmental service.

"We do because we must" - Asantewaa Boykin RN,
Photo courtesy of MH First /APTP

MH First is grounded in the following principles:

1. **Agency and Self-determination.** For MH First, this means that crisis, the appropriateness of steps MH First may take, and the resolution of the crisis are defined by the individual the program is responding to. Meeting people where they are and respecting their autonomy is central to providing healing care. When responders speak with a caller on the phone or arrive after dispatch, they prioritize the caller's autonomy, ensuring all decisions are led by the person in crisis.

2. **Healing Justice:** A Healing Justice framework, which holistically addresses the root causes of violence and harm, underlies much of APTP's work, including the work of MH First. In a resource guide created by The Justice Teams Network — a statewide network to respond to state violence, which includes APTP as a member organization — Healing Justice is defined as "one framework within which we organize to end all forms of state violence while nurturing our communities' leadership capacities and healing generations of trauma by utilizing healing modalities indigenous to our communities."[15] Central to MH First's incorporation of a Healing Justice framework is the principle that Black and Brown communities know best what is needed in their communities and should be able to decide what "healing" is to them. MH First participants and volunteershave access to healing services through APTP's People's Clinic, including ancestral medicines, earth medicines, and peer support.[16]

3. **Abolition and Transformative Justice:** The criminal legal system and systems of punishment must be dismantled for true liberation. Alternative methods of

accountability, including Transformative Justice, are a way to move beyond punishment towards healing. Transformative Justice is a non-punitive, non-retributive process that addresses interpersonal harm by bringing together those involved to collectively decide how to repair the harm caused and considering the larger systems and structures that created the conditions for harm to occur in the first place.[17]

4. **Intersectionality:** Intersectionality is a political framework coined by law professor and critical race theorist Kimberlé Crenshaw to describe the ways that various systems of oppression by race, class, gender, sexuality, ability status, etc. overlap to create different experiences for those who hold different intersections of these identities.[18] For instance, someone who is poor and LGTBQ+ is likely to have a different experience with discrimination and state violence compared to someone who is wealthy and LGTBQ+.

5. **Disability Justice and Destigmatization:** Disability Justice incorporates intersectionality as a part of the framework, stating that all systems of oppression are intertwined, including — but not limited to — ableism. In 2005, the Disability Justice Collective — a group of Black, brown, queer, and trans disabled people — developed disability justice as a framework in response to previous frameworks of "disability rights" that identified ability status as the primary lens of oppression and exclusion. The Disability Justice Movement acknowledges that ableism is formed in relationship to other systems of domination, including capitalism, colonialism, racism, and others.[19] MH First incorporates this framework into their work with a particular eye towards destigmatizing mental illness and an understanding that all people are worthy of support and care.

6. **Harm Reduction:** Harm reduction is a central tenet of MH First's approach to offering peer support to callers in crisis. According to Harm Reduction International (HRI), "harm reduction refers to policies, programs and practices that aim to minimize negative health, social and legal impacts associated with drug use, drug policies, and drug laws," though the principle can be applied to many different situations and behaviors. HRI emphasizes that harm reduction "[focuses] on positive change and on working with people without judgement, coercion, discrimination, or requiring that they stop using drugs [or other behaviors] as a precondition of support."[20] For example, MH First staff and volunteers are trained on how to recognize and treat opioid overdoses, with dispatchers carrying naloxone to counteract an overdose.

When MH First initially began operating in Sacramento in January 2020, volunteers worked out of a local clinic together overnight while waiting for calls to the MH First phone line. Volunteers would dispatch as needed, bringing a duffle bag of medical and mutual aid supplies, such as socks and water. For each shift, the team consisted of three members, which allowed volunteers to switch roles and rest throughout the night:

1: A **crisis interventionist** would interact directly with the caller
2: A **medic** would check for medical needs such as broken bones, strokes, or seizures, in order to distinguish these needs from a mental health need and contact emergency medical services if needed
3: A **safety liaison** would observe the area for potential threats

Soon after the Sacramento program began operating, COVID-19 led to global shutdowns. The Oakland program launched in August 2020, still within the context of heightened response, deaths, and hospitalizations due to COVID. This forced MH First to adapt very quickly to changing conditions — which it has done successfully, still training hundreds of volunteers and answering thousands of calls since its inception in 2020. Still, volunteers were no longer able to operate together in person and MH First dispatched with less frequency than they did in the initial months of the Sacramento program.

Currently, the MH First program is on a brief hiatus as staff and volunteers review the results of this evaluation and engage in a strategic process to rebuild and relaunch in Summer 2025 based on its recommendations, as well as additional feedback from staff, volunteers, and community. Historically, the program has been staffed by MH First-trained volunteers in Oakland and Sacramento. All volunteers complete the MH First training curriculum, which consists of multiple modules, including: memorials of people killed by police violence; trauma-informed crisis response; cop watching and accompaniment; psychosis, anxiety, self-injury, and intoxication; de-escalation; basic first aid; and narcan and opiate overdose response. Volunteers also have an opportunity to role play certain scenarios in which a person may call the hotline. In trainings, volunteers learn how to assess their own safety and risk tolerance, as well as to be mindful of their own body language and non-verbal communication during encounters with callers. Finally, MH First encourages volunteers to develop practices of self-care and boundary setting after they respond to a crisis situation, in order to mitigate burnout.

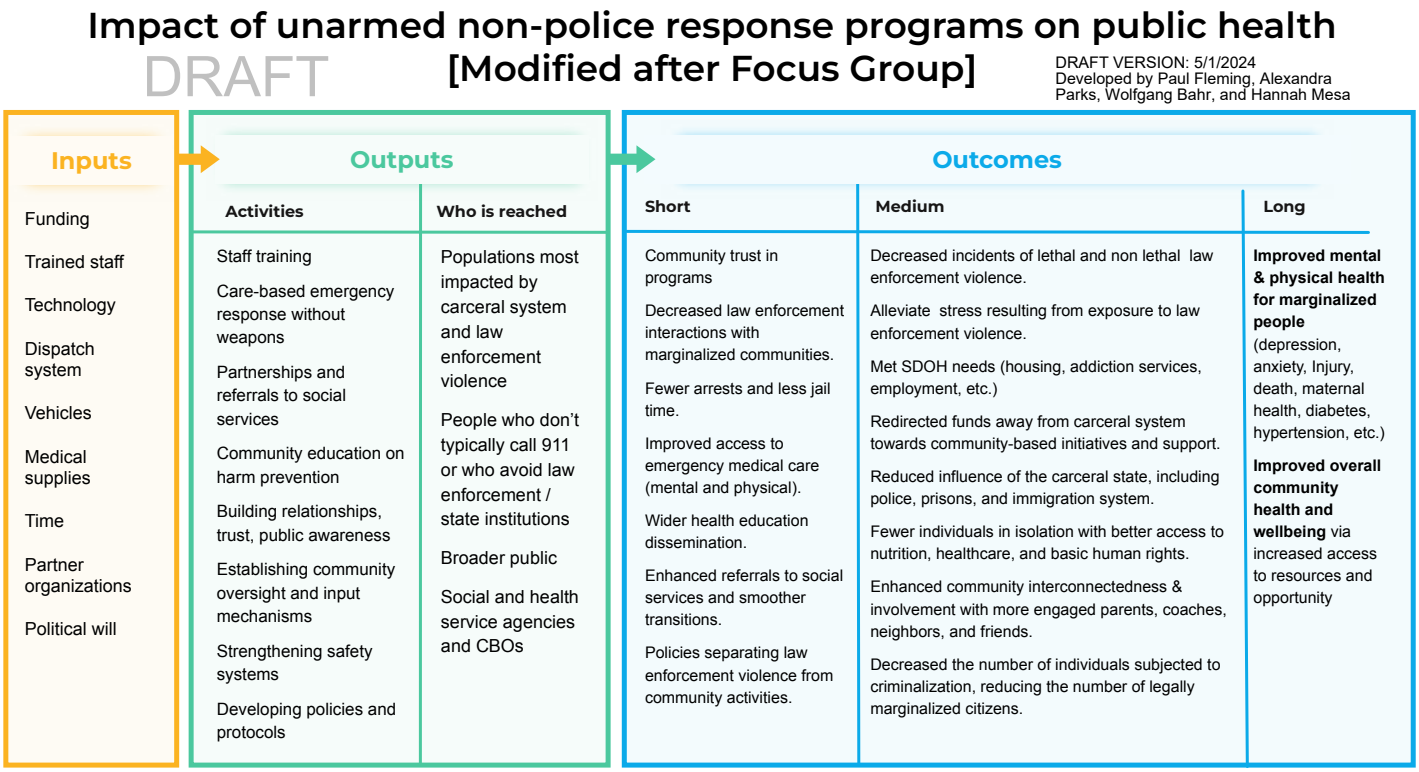
When the program was running, volunteers operated a phone line on weekends, when the fewest mental health resources are available for communities. In Sacramento, the hours of operation were Friday, Saturday, and Sunday from 7 pm to 7 am, while in Oakland, the hours were Friday and Saturday from 2 pm to 2 am. There was a pre-shift check in where volunteers chose their roles for the shift and shared triggers or concerns that they may feel unable to respond to. A volunteer staffed the program's social media accounts and the phone line, which is a separate hotline number from 911. An on-call, more experienced volunteer or APTP staff member was always available for back-up. When capacity allowed, volunteers dispatched to the scene of the crisis to support those in need. If volunteers were unable to dispatch, they provided emotional and logistical support to callers over the phone. The majority of calls received were to address a mental health need, including crisis, trauma, and emotional support, but callers also sought referrals for healthcare, food, and emergency shelter; conflict resolution support; domestic violence safety planning; de-escalation support; and substance use support. MH First held after-shift debriefs as well as monthly volunteer debrief calls.

Evaluation Methodology

MH First approached Health in Partnership (formerly Human Impact Partners) to conduct an evaluation of their program in 2024. The majority of previous public health research on non-police mental health crisis response across the US has evaluated programs that are diverted through 911, making it easier to quantitatively track the impact of the programs. MH First is unique amidst this literature in that it is entirely separate from 911, making it more complicated to track those outcomes, and it is in the first four years of limited operation. Because of this, we decided to undertake a *process evaluation*, with an external analysis of how MH First is being implemented. We used the *logic model* below to guide our study design, a way to understand the relationships between the people, time, and resources that go into running the program; the activities the program conducts; and the *outcomes* the program hopes to achieve.[21]

Our process evaluation focused on the inputs (in yellow below) and outputs (in green below) rather than the outcomes (in blue below). Rather than examining outcomes such as a city-level reduction in 911 calls or emergency room visits, we focused on community perceptions of MH First, the early impacts of the program, and suggested areas of growth. For example, an input such as volunteer training leads to outputs like increased crisis

response capacity and informed community members. Our purpose was to evaluate how MH First is currently operating and the scale of its reach, with an eye towards how the program can continue to operate and expand, while being mindful of potential pitfalls.



We used a mixed-methods approach to better understand the relationships between inputs and outputs of MH First. Between July and August 2024, we conducted 29 semi-structured interviews with key stakeholders, including local and national community organizations, funders, other non-police crisis response teams, and policymakers. Each group of stakeholders had a different guide for interviews (see Appendices B-E) designed to explore participants' perceptions of MH First's strengths, areas for improvement, and broader impacts.

Interviewees were selected in partnership with MH First leadership and contacted up to four times via email. Due to the timeline of this evaluation during the 2024 election season, we were only able to speak with one policymaker of the 17 we reached out to. This limited our ability to capture a robust policy perspective. The response rate for the remaining interviews was 56%. One interviewee withdrew consent for quotes to be used prior to publication of the evaluation, but we included their feedback in the aggregate. We

coded interview data using thematic analysis to identify recurring strengths, challenges, and perceptions of MH First.

Quantitatively, we designed and distributed a community survey in September 2024 to assess local perceptions of MH First in Oakland and Sacramento. APTP and HIP both shared the survey on our listservs and via our social media. Other local organizations in the Bay Area also shared the survey link amongst their constituents. We directly emailed the survey to 17 community members whose insights we wanted to be sure to capture. We offered a chance to win one of five $20 gift cards for survey completion. We received 167 responses to the survey from respondents in the Bay Area and Sacramento. We analyzed the survey data for trends in community awareness, satisfaction, and likelihood of utilizing MH First's services compared to 911.

Strengths of MH First's Current Operations

"If I could rate [MH First] a 10 out of 10, I would say a 15 would be my score."

— *Lauren Williams-Batiste,*
Executive Director of In Our Names Network

To better understand what parts of the program are valued by the local community and by organizations across the US, we asked all interviewees to name the top three things they thought MH First was doing well. Five key themes emerged from this question:

1. MH First — and its umbrella organization, the Anti Police-Terror Project — is trusted by and rooted in the local community

The Anti Police-Terror Project (APTP), the Black-led, multiracial organization that runs MH First, is intentional about centering the Black community. This is particularly important in Oakland, with 22% of the community identifying as Black or African-American (compared to 14% of the national population in the US).[22,23] APTP began as an organization to support the family members of those who had survived or suffered the effects of police terror, following the police murder of Oscar Grant in Oakland in 2009. With 15 years of experience community building in the Bay Area, it has earned the deep trust of the local community. One interviewee, organizer Krea Gomez, said, "APTP is the best group to support [MH First] because of their values and their principles. And because throughout the Bay Area, throughout Sacramento, they're known as this abolition[ist] group that really believes in people power and in people's safety and in community building. And so off top you know you can trust it."

Nearly every person we interviewed recognized this as a strength of MH First. MH First has continued to uphold the value and practice of being Black-led, and offered treatment and training specifically for people of color in the local community. Eighty-five percent of the volunteers leading the program are people of color who have deep roots and connections to the community, which fosters strong community trust in their services. Such trust in a healthcare provider, promoted by a shared racial identity between provider and patient, is associated with better health outcomes, greater likelihood of adhering to a treatment plan, and more favorable patient perceptions of their provider.[24]

In her interview, Erica Gomes, the Clinical Director of Integrative Behavioral Health at La Clínica, identified this strength:

> [MH First] is staffed by individuals in the community. They're very

> committed to understanding all the different dynamics. And so there's things you just don't need to explain. I can only imagine for our patients that would go a really long way. Anytime they can identify with the service provider is usually like automatic increased comfort and then also like more openness to the process.

A similar sentiment was echoed by Lara Kiswani, Executive Director of the Arab Resource and Organizing Center (AROC):

> I think it's significant that [MH First] is led by people who have an understanding of the community, know how to find out the answers, and even if they don't have the answers, they know how to get those answers. When you're with the community on an everyday level, when you're part and parcel of the base that you're organizing or serving, it makes it that much easier for you to shape programs in a way that makes them relevant, impactful, and in some cases, even life changing for the people that you're working with.

2. MH First is grounded in strong, clear, transparent values of community, autonomy, and abolition

When asked about MH First's strengths, interviewees frequently pointed to MH First's values. One grounding value that came up multiple times was their commitment to abolition and building up the alternatives that create community safety, particularly for Black, Brown, and disabled communities. Stephanie Guirand, a core team member and Program Function Manager/Researcher with The Black Response Cambridge noted, "I mean, they're very clearly abolitionists; they are who they say they are. Marginalized populations training other marginalized populations… It just shows how they live into those values. And they do it clearly and openly." Iris Garcia from the Kataly Foundation said, "For me, the work of APTP and MH First specifically is answering this question that a lot of folks are holding, which is, 'What are we building? What's the affirmative vision?' … MH First is leading the edge in terms of a model."

Interviewees also emphasized the value of bodily autonomy and choice for people who call MH First for help. Offering support and resources without judgment or a prescriptive approach to care is a central tenet of MH First's practice. Falilah Bilal with Water Flow Life

noted, "They understood mental health and how it shows up. So there was no judgment, there was no criticism, there was no 'you need to do this,' there was none of that." Charity Whyte, a Program Associate with the San Francisco Foundation, pointed out this value:

> MH First isn't just helping people in crisis. It's not just creating a space for people to have their needs met or people to show up for their community. I think it's also a reminder that we have bodily autonomy, and we have sovereignty, and we have the ability to create our own systems and create our own sense of home and take care of each other.

Indeed, this centering of community care and the need for interdependence was also highlighted by interviewees. MH First not only provides care through the hotline, but also supports communities to care for each other — its model is to build a base of volunteers broad enough that community members are able to respond to crises themselves because they have been trained by MH First. As Krea Gomez said:

> MH First isn't saying we're gonna solve your issues. No, you are part of this community. We're gonna give you the language and the tools, and even some resources to figure out how to handle this. We'll even come out and support you because we're more physically trained to engage in this way, right? But we're not gonna leave you alone…In America, we're taught that independence is the ultimate goal. And MH First says that interdependence is how we're all gonna get free.

Centering the community through training and technical assistance is also essential to MH First's work nationally. Stephanie Guirand said, "They prioritize training other non-carceral organizations and building relationships. Not just training us, but staying in contact with people in our community and making sure that we're developing alongside them… I think about staying in community. That's another key thing that they do really well."

3. MH First is building power and self-efficacy in the local and national community through their trainings, technical assistance, and volunteer recruitment

MH First has trained thousands of volunteers in Oakland and Sacramento and provided trainings for several organizations nationally since its 2020 inception. Interviewees who had experienced MH First's trainings highlighted them as a way to improve community self-efficacy around responding to mental health crises. There is a significant body of public health research on the importance of self-efficacy to drive behavior change,[25] making MH First's trainings an important pathway to empower community members to address mental health needs rather than rely on police response. Funder Charity Whyte, who attended an MH First training in Oakland, said:

> The training helped me understand how to show up in community in moments of crisis, without even feeling the need to involve the police. I think a lot of times in crisis, I felt like I don't want to involve the police, but I kind of have no choice. And I really think this program has changed that for me. I have a choice. We have a choice, and we can keep each other safe.

From her experience being a part of the Oakland community, Lara Kiswani from AROC emphasized the importance of the trainings to build community power, especially among marginalized communities, noting that MH First "engages [the community] in ways that would allow [community members] to feel civically engaged, but also part of the social fabric rather than just disenfranchised in the way they currently feel."

Another important output that MH First trainees shared was the concrete tools the trainings provided, from models of de-escalation, to understanding the history of criminalization in the US and how our current carceral response to mental health came to be, to defending against burnout for service providers. Bárbara Ortiz, a responder with Cambridge HEART, a non-police mental health crisis response program in Cambridge, MA, highlighted a particular tool MH First shared about de-escalation:

> They offered really helpful tools, like there was this diagram of the process of when a person's escalating, when they reach a certain thing, and then this plateau, and at what points it might be helpful to jump in, or where you can pivot it, and that after a certain point, you just have to let it ride out and then come back. So I remember that was really useful. I think, for a lot of folks, it was the first time they really considered what harm reduction is.

Elliott Jones, with MACRO — the other non-police crisis response program in Oakland, housed in the fire department — said of their training:

> [MH First] cared about the staff. They said, you know you guys have to breathe in, you know all sorts of exercises. They gave us some insight on that as well, and we appreciated that we do try to keep that front of mind. It's tough work, I think, is what they were trying to explain to us. So you got to protect against your own burnout.

4. MH First is a strong model showing that non-police mental health crisis response programs are practical and possible

A commonly perceived challenge to alternatives to policing is that such work is not practical or feasible. But interviewees in this evaluation said that MH First proves that non-police response to mental health is in fact both. Sara Mokuria with Building Beyond Policing identified MH First as the "model of possibility" for other cities to follow in building similar programs. Black Lives Matter Grassroots policy coordinator Sheila Bates emphasized this point:

> MH First using a straight up, non-carceral community based model that does not involve the police in any way, shape, or form really sets the stage for showing not only Oakland and Northern California and the State of California, but the rest of the country, that this really truly is possible and that it's not some pie in the sky thing that we are all dreaming of and talking about in theory. It can be actualized on the ground in real, meaningful ways and have a deep impact on the community.

Other interviewees highlighted the ways in which MH First is a model and the many learnings that can come from studying their success. This theme arose again and again, from both local and national organizers, making clear that MH First is really seen as a leader nationwide:

- "MH First is a blueprint of what rapid response should look like, and I think that's why

we've relied upon APTP to be a resource for us to help develop and train our staff at In Our Names Network." — Lauren Williams-Batiste, In Our Names Network

- "I think they've really modeled what it can be to invest in prevention, intervention, disruption of violence in communities, and do it in a way that's beneficial rather than oppressive to communities." — Melina Abdullah, Black Lives Matter Grassroots

- "I think what MH First is doing well is really uplifting itself as a very real concrete model for what an alternatives to policing option looks like and is doing so really via this grassroots effort." — Mohamed Shehk, Critical Resistance

- "It was helpful to talk to the folks that were doing it, even if in Sacramento because it was like, okay, it can be done. You know, somebody's out there responding to some type of call." — Elliott Jones, MACRO

- "It's been very important to lean into alternatives and experiments and try to get there. We know it ain't going to be easy to set up infrastructure that can replace the police overnight, but it's important that we start making a path to get there, and programs like MH first help us visualize what the path should be." — Devonte Jackson, Movement for Black Lives

Still other interviewees highlighted the particular concrete learnings that can be drawn from MH First's first four years of work. Sara Mokuria said:

> I think there are a lot of dynamics that need to be thought through in terms of HIPAA, in terms of data security, in terms of relationship with the state or not, consent for treatment, community-based follow-up support postcrisis. I think these are all things that we have to be thinking out, and I feel like MH First could be at the vanguard in terms of supporting how we think about those things because they've thought about some of these things deeply.

5. Compared to other forms of mental health crisis response, including police and co-response models, MH First is seen as more appropriate and effective at addressing mental health needs

This theme emerged in both interviews and our survey. Quantitatively, we compared people's feelings of safety in calling 911 versus MH First. We also asked about participants' likelihood of calling MH First compared to 911. We found that 26.7% of the 167 people who took our survey would not feel safe calling 911 if they or someone they knew needed help, with the majority of participants (62.7%) saying that it would depend on the situation. Conversely, the majority of participants (77.7%) said that they would feel safe calling MH First if they or someone they knew needed help. When asked if they would be more likely to call 911 or MH First if they or someone they knew was experiencing a mental health crisis, 75% of participants said MH First, 3.4% of participants said 911, and 21.6% of participants said it would depend on the situation. Finally, we asked survey participants how likely they would be to call MH First if they or someone they knew was experiencing a mental health crisis. Eighty-three percent of respondents said they would be either likely or very likely to call MH First.

Qualitatively, interview participants shared that they thought MH First was "worlds ahead" of police response to mental health crises. In part, interviewees named that this was due to the training MH First volunteers receive compared to the largely inadequate training police receive on mental health needs. Sheila Bates with Black Lives Matter Grassroots commented:

> What MH First is doing is, they are responding with a care first model. So they are responding with people who have experience, who have expertise, and have a body of knowledge to respond to the actual crisis at hand, and to de-escalate the situation, and to offer care as opposed to criminalization and carceralization and oftentimes harm in the form of either brutalization or straight up murder and police terror.

Mohamed Shehk, with Critical Resistance, said:

> The problem is that cities throw money at the police for the sake of getting more officers and then training them in mental health response, but a training for a police officer on mental health response is nowhere near adequate, nor appropriate, when compared to someone who actually specializes in mental health care, in de-escalation. And it's not only a waste of public tax dollars, it is actively fueling the problem.

Interviewees also repeatedly named MH First as a better option for mental health crises than police because police often escalate situations due to the fact that they are armed and disproportionately use these weapons against people with mental health needs. One organizer, Krea Gomez, praised MH First for choosing to focus on mental health in light of this state violence, saying:

> I was really impressed with MH First for choosing mental health. Really based on data, knowing that we were seeing folks being severely harmed by law enforcement when they were having mental health crises, and that [MH First] really grew from first person experience with people that APTP has supported in the past.

It was important to interviewees that MH First does not show up with a weapon, while police do. Patrice Strahan from Disability Justice Culture Club said of MH First:

> They are just people who are trying to help out, clearly in a position of help and service, and not people who are employed to be a violent carceral force. Just the fact that that's their position in the community means that when they show up at something, it'll have a different intention and spirit to it than if someone with a uniform flashing lights comes up with a weapon.

Sara Mokuria from Building Beyond Policing echoed this point, saying, "[MH First] isn't killing anyone, and they're not incarcerating anyone. And so already their approach is fundamentally stronger and more based in community safety than [police]."

A few interviewees also compared MH First to other alternative crisis response teams like CAHOOTS (Crisis Assistance Helping Out on the Streets), in Eugene, Oregon. CAHOOTS is one of the earliest non-police mobile response teams, founded by the White Bird Clinic in

1989.[26] Many other cities have modeled their mental health crisis response after CAHOOTS. Still, several interviewees felt that MH First had a more favorable approach to crisis response than programs like CAHOOTS. Shehk said:

> I do think that there are things that are effective about CAHOOTS. I think there's also real limitations. Just when even looking comparatively between a place like Eugene and a place like Oakland. Demographically, race, class, geography. The two places are very different. And then I think one of the other big pieces is that CAHOOTS is funded through the police department. It's within the policing infrastructure. And so MH First looked at CAHOOTS and was like, "Okay, here's what could be taken. Here's what is beneficial. And let's cut out the things that we think are negative and might actually be a barrier to providing effective care."

Areas for MH First's Growth and Development

"The biggest struggle is resources and capacity to respond beyond the hours that are currently available, because we know shit happens all the time. And I think that if folks feel like this is not a service that's available at all times, then they are going to go back to the easy 911, right?"

— *Sagnicthe Salazar, organizer*

While our research finds that MH First is well respected as a non-police crisis response option in the local Oakland and Sacramento communities, there is also room for the program to improve. The 19 participants in our survey who reported having used the MH First hotline were nearly split in terms of whether their interactions with the hotline were helpful, with 44.4% of participants saying that MH First was not helpful in resolving the issue(s) they called about and 55.6% of participants saying that MH First was helpful or very helpful. We also asked survey participants what MH First could have done to be more helpful, and found that the two most common issues identified were 1) that MH First was not open when needed, and 2) that the situation required someone trained in de-escalation to be dispatched in person and MH First didn't have the staffing or resources to do so.

In order to further evaluate areas for growth, we also asked interviewees what MH First could improve upon in their current operations. While participants had less to share in response to this question, we did hear repeated themes across interview participants:

1. MH First needs to be more regularly and reliably available — ideally 24/7

Across almost every interview, participants named MH First's availability as an essential place for improvement. Currently, the program is only operational for 12-hour shifts on weekends in Oakland and Sacramento. Two interviewees and multiple survey participants shared experiences of trying to call MH First for support in the midst of a crisis, only to find that it was not open. One national organizer shared, "In one instance, I pointed a friend of a friend to MH First and it was during their operating time, and another time I pointed to them, but it was outside of the operating time, and it was kind of urgent. So I think they looked at other options." This is certainly an important anecdote, especially if MH First strives to prevent the need for community members to call 911.

Interviewees were clear that without 24/7 availability, or at least expanded hours during the week, MH First did not feel like a reliable option for crisis care, in opposition to interventions like policing and psychiatric hospitalization. One interviewee said that the program's limited availability made it feel "like a pilot" rather than "a real alternative" — but that increasing availability to 24 hours a day, 7 days a week would increase trust in the program. Erica Gomes, a clinician at La Clinica, wanted to see MH First as an

alternative to psychiatric hospitalization, but felt that that could only be possible if they were available for more hours:

> We would love to bring them in earlier in the process if we're wanting to support someone and stabilize them and not have them cross over the threshold of John George [the psychiatric hospital in Alameda County] or wherever. Bringing [MH First] in to help manage crisis before that would be great. So I think just expansion of hours and availability would be really wonderful.

Roshan Bliss, co-founder and lead organizer with the Denver Justice Project who worked on Denver STAR, was interested in MH First's viability as an alternative to 911:

> If I'm correctly understanding that the Mental Health First model is intended to replace inappropriate police response to this type of thing, it's my opinion that these types of alternative responses would need to be professionally institutionalized, which means they would have to be available 24/7, and kind of competitive with 911 in terms of how frequently and reliably they can offer support. And that means a lot more money, a lot more people, resources, infrastructure.

Even as interviewees recognized the need for MH First to be available more hours — ideally 24/7 — they also recognized that such an expansion would require far more staffing and resources than MH First currently has available. In order for this recommendation to become a reality, funding for the program would need to be sustainable.

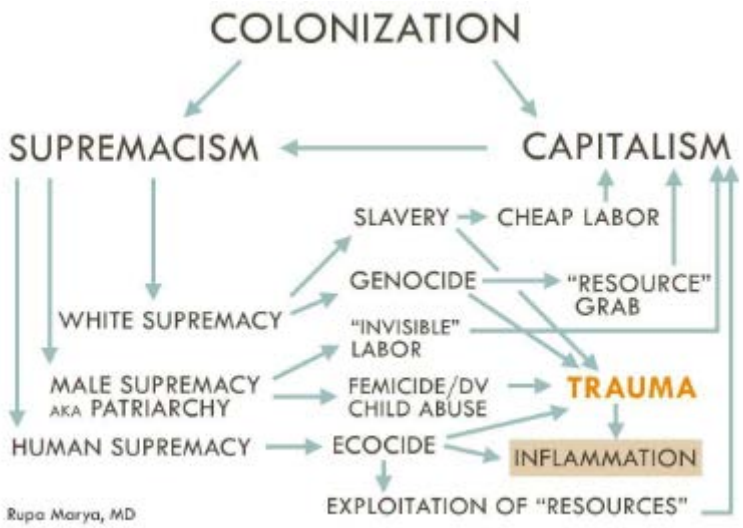
2. MH First needs to focus on preventative measures and follow-up care, not just crisis management and intervention

MH First aims to intervene on the harms of policing and carceral systems at the particular point of entry when callers or those around them are in the midst of crisis. Callers can call the hotline for themselves or others in order to receive immediate support. This is an essential point of intervention, especially given the number of people in the midst of a crisis who are killed by police. But interviewees returned to one key question: what happens once the immediate crisis is addressed? As Jamie Schenker, Program Director

at CalWellness, asked, “MH First is responding to someone who’s having a mental health crisis. They de-escalate whatever is happening. And then what happens after that? So is that person getting continued care? Do they have resources?” Interviewees wanted to see MH First take on some more of this preventative follow-up care after the de-escalation of a crisis.

Interviewee and organizer Roshan Bliss warned against “building a bridge to nowhere,” where a community member receives crisis support but then is left with no short or long-term care: “When the crisis has been de-escalated out there in the field and the crisis care has been provided, then they would need to be able to connect clients to some form of short-term care that has a bridge to long-term care that has a bridge hopefully to self sufficiency.” Currently, MH First does not have the capacity to provide care to callers following a crisis, though they attempt to provide the most holistic care possible for the duration of their interaction. Unfortunately, there are few resources for long-term care in Oakland and Sacramento. Access to mental health care and crisis care is limited, even for those with health insurance or knowledge of the healthcare system. In order to prevent “building a bridge to nowhere,” the cities and the community organizations that operate within them need to distribute more resources towards long-term care.

A public health approach to mental and behavioral health focuses on primary prevention, addressing the root causes upstream, before the point of crisis. This means ensuring that the social determinants of health are met and community members have access to necessities like housing, food, education, transportation, employment, and healthcare. In the context of MH First, volunteers attempt to address the root causes of concerns such as suicidality, trying to understand the reasons someone has reached this point of crisis. For instance, volunteers can provide people with information to help them access housing and healthcare services, as well as provide food and water. MH First uses the below model from Dr. Rupa Marya in their volunteer trainings, to show how oppressive systems like colonization, white supremacy, and capitalism can lead to trauma.[27]



Interviewees suggested that MH First might address the social determinants of health by building a peer respite center — a short-term, voluntary, residential center for people in crisis. Leslie Napper with Disability Rights California said, "I think Mental Health First would be great at running a peer respite center, right? …Something that could support people by housing them, you know, to get to the next transition, to support the psychiatric crisis pieces, that housing crisis piece, that peer respite piece. I would love that." APTP currently operates the People's House, a community center in Oakland for abolitionist organizing, which could provide a physical location for such a care center. At least two interviewees explicitly stated that they wanted to see the People's House expand into a healing center for people before and after crisis.

3. MH First needs to be able to pay well-trained staff to run the hotline and dispatch

Several interviewees named the need for MH First to be able to pay staff in order to be a more reliable service. Virginia Cuello with The Black Response, an organization in Massachusetts that helped lay the groundwork for Cambridge's non-police crisis response team, said, "It's like sometimes when a job is volunteer, it's harder to provide consistent output in the community. Right? And so, I guess that is something to sort of look to improve, to be able to pay the folks that are interacting with the community." In the evaluation process, we interviewed representatives from other non-police crisis response teams across the US, including Denver STAR, Oakland MACRO, and Cambridge HEART. All

of these programs have paid staff, but this requires a great deal of resources.

An analysis of the workforce required for non-police behavioral health crisis response found that CAHOOTS — one of the longest running non-police response programs, which also operates with paid staff — supported staff working a combined 62 hours per day within Eugene, OR serving a population size of roughly 170,000 people.[28] Given this analysis, for a program to be operating at CAHOOTS' capacity in Oakland (with a population of roughly 436,500 people), the program would need to support staff working a combined 152 hours per day. Assuming a program that is operational 24/7 and with staff working 40 hours per week, this would equate to the work capacity of a 27-person full-time team.

One key complication in staffing the crisis response program with paid employees, rather than volunteers, is increased program liability. California's Good Samaritan Law, captured in Section 1799.102 of the California Health and Safety Code, states that, "No person who in good faith, and *not for compensation*, renders emergency medical or nonmedical care at the scene of an emergency shall be liable for any civil damages resulting from any act or omission."[29] Currently, volunteers for MH First are protected from civil liability by the Good Samaritan Law. If MH First begins to pay their staff, this becomes a new challenge, including paying the cost of malpractice or professional liability insurance.

Aside from increasing reliability by paying staff, we also heard a desire for greater transparency and clarity around the current staffing of the MH First hotline. While other non-police response programs across the country are staffed by a specific breakdown of crisis social workers, mental health therapists, nurses, and paramedics, interviewees did not feel clear about the credentials of MH First volunteers. Historically, volunteers for MH First have included community members both within and outside of the healthcare profession, all of whom have gone through one of MH First's trainings. Cinthya Muñoz Ramos, chief of staff for Oakland City Councilmember Nikki Bas, said, "Something that would be great to clearly have around MH First [is that] the people that are on the other side of the phone have X, Y, and Z training and qualifications. There is a level of quality of care people are receiving that feels important to standardize." Indeed, other interviewees suggested that MH First work with nursing students or EMTs-in-training, both to better staff the hotline and to provide training to healthcare providers within a true community-based response.

Expanding the Reach of MH First

"There are so many people who don't even know [MH First] exists, right? So just getting the word out. But I know that has to do with capacity."

- *Falilah Bilal,*
  non-profit executive and community leader with Water Flow Life

We sought to both better understand the current reach of MH First and collect suggestions from interviewees and community members about how to expand its reach so that the program becomes as widely known, available, and accessible as something like Emergency Medical Services (EMS).

We assessed the current reach of MH First locally and nationally, through both the survey and interviews. In the survey, which was distributed through MH First and partners communications channels, we asked participants how well known they thought MH First was in their community. Seventy-two percent of participants said they thought the program was not so well known or not at all known, while only 28% thought the program was somewhat or very well known. We also asked participants how many of their local friends and family they thought knew about MH First. In response to this question, a majority of respondents (73%) said only some or a few, while 19% said none and 8% said most of their friends and family knew about the program.

Our qualitative findings were similar, but provided some important context about where and to whom MH First is known. Respondents largely felt that MH First was well known within abolitionist activist communities locally and nationally, but did not have a far reach outside of those communities — including amongst local community members in the Bay Area and Sacramento. This was a repeated theme across multiple interviews:

- "My honest sense is that amongst the organizer and activist community I think it is valued, but beyond that isn't super well known." — Mohamed Shehk, Critical Resistance

- "I think community members don't even know what it really is. I'll be honest. I felt really privileged to find out that it existed." — Falilah Balil, Water Flow Life

- "I'm not sure that I know people who are not specifically engaged in abolitionist thought and abolitionist organizing that would think of MH First as an option or have it in the forefront all the time." — Patrice Strahan, Disability Justice Culture Club

- "I think if you're not connected to a specific organizing community or an entity like a school, I don't think it's something that community in general knows how to access." — Sagnicthe Salazar, organizer

However, the broad reach *within* activist communities is undeniably impactful as organizers in other cities across the US are developing their own mental health crisis response programs. Stephanie Guirand from The Black Response stated, "I don't know if they know how big their footprint is in the creation of the alternatives ecosystem across the country. But they've been really visible, at least from my standpoint." We spoke with some organizers of non-police crisis response teams for the evaluation and were able to track MH First's expansive reach within these circles. For example:

- **Dallas, TX:** "I'll say that in Dallas in 2020, a local coalition was advocating for non-carceral responses. Asantewaa's testimony and model of MH First was impressive and helped to move the county into shifting resources into a Mental Health First model." — Sara Mokuria, Building Beyond Policing

- **Boston, MA:** "For me, the impact [of MH First] is just existing. We can have alternatives. We can do this. We can do our own call center. We can. So these things are a possibility, because MH First exists." — Virginia Cuello, The Black Response

- **Oakland, CA:** "We have a MACRO program now in the city, and to me, I don't know if we would have MACRO if there was no MH First." — Sikander Iqbal, Urban Peace Movement

- **Miami, FL:** "[MH First] lifts the work. Nationally. When people are pointing to the problems in the system, they're looking up Anti Police-Terror Project to see what has been written, what's already going on, and things of that nature. And so I do think that that's important." — Armen Henderson, Dream Defenders

Three primary themes emerged as part of a roadmap to making the program more broadly known and adopted:

1. MH First can expand its reach via long-term sustainable investment in the program

All interviewees were clear that expanding MH First's reach would not be possible without increased investment into the program — though interviewees had different opinions on where to seek funding, a question that will be explored more in the next section. Melina

Abdullah with Black Lives Matter Grassroots made the point clearly and succinctly: "We need more funding. That's the basic bottom line. We need more funding to be able to replicate and expand the model." In order to mount a marketing campaign, advance policy change, make the program available 24/7, pay staff, and ultimately expand its reach, MH First needs long-term, sustainable investment.

Right now, the primary source of funding for MH First is philanthropic grants. The program and APTP have built strong relationships with their current funders, who provide committed support. However, more is needed. George Galvis from CURYJ recommended an increased fundraising push: "I have to be passionate about getting the resources so that we can lean in and do our mission and scale our mission. So I think that more investment in the backbone of the organization is going to be necessary in order to sustain and strengthen this as a movement." One possible way to reach more funders would be for MH First to host a funder briefing, a strategy two separate funders recommended. This would allow MH First to showcase its successes and challenges on the local and national level, as well as to describe the opportunities that would become possible with increased resources. Maria Alejandra Salazar with Borealis Philanthropy shared, "We need [MH First] to let us know how we can support them, as far as doing a funder briefing. We'd invite other other groups that are funding them, they invite their funder colleagues, and I think that would be helpful."

Current funders of APTP and MH First spoke about wanting to further support the program and offered some suggestions of how they might do so. Salazar provided a list of other ways that the Communities Transforming Policing Fund (CTPF) at Borealis could support:

> There are many ways that funders can support groups. Funders can help groups identify new opportunities and resources. For example, CTPF shares bi-weekly newsletters with grantees that include new funding opportunities, training and fellowship offerings, job postings, and news. Funders can cultivate connection opportunities for groups, with their peers and with other funders through peer learning sessions, donor briefings, and conference presentations. Finally, funders can partner with groups to uplift their work in philanthropic news outlets, social media, and within funder network listservs. A part of a funder's role is to be a champion and supporter for their grantee partners and the critical work their partners are leading.

Funders also gave insight into what MH First could emphasize in such a fundraising push in order to be most compelling. They named wanting a brief resource outlining how MH First functions, stories of successes, hours of operation, staffing practices (e.g. how hotline shifts work, whether staff are paid or volunteer), more information on MH First trainings, and quantitative data about people trained and calls answered. A couple funders also mentioned wanting to hear more about where the program has failed and what staff learned from failing. Krea Gomez, who has experience in philanthropy, said, "I don't want to fund theory, right? I don't want you to write a bunch of stuff that you've never practiced. But I do want to fund what you've learned. And I want to hear about times that something went really well on accident." Maria Alejandra Salazar also noted, "We're less interested in, 'Yay, we met all our goals,' and more interested in, 'We didn't meet this goal. And here's why. And here's what we learned from it. And here's how we could use support."

2. MH First can expand its reach by influencing decision-makers through policy change and organizing

In order to expand, interviewees suggested that MH First needed to not only provide direct service, but also to engage in systemic transformation via policy change. Interviewees recognized that APTP already engages in important policy advocacy to defund the police, end state violence, and support the family members of those who have been killed by police. George Galvis, Executive Director of Communities United for Restorative Youth Justice (CURYJ), commented, "I think [MH First] is not just a standalone program. It's paired with the robust, strong, brilliant advocacy arm of APTP. So that they're not just providing direct service and creating a system of care, but actively involved in changing systems and defending and fighting for those that our society and others have deemed disposable." Other interviewees agreed that APTP's policy work is essential to making MH First more accessible and available to the community. Devonte Jackson from the Movement for Black Lives said:

> [MH First] has some knowledge around how to set up different approaches. So a community-based approach like Mental Health First, and then also a state approach like MACRO in Oakland… The fact that they've been able to push for the city to take something on like that is important. The impact, I think, has been pretty profound for our movements.

Interviewees urged MH First to pursue concrete policy changes to create community-based mental health support anchored in an entity outside of the police department. In order to advance these policy changes, there was agreement amongst interviewees that the campaign needs to mount political power by building a strong base. As Lara Kiswani from AROC noted:

> There needs to be an organizing grassroots campaign. I think the more that we can demonstrate the buy-in from a broader base of community partners and allies, that will make it so that it is impossible for those decision makers who have the power to actually leverage those resources or shift those priority to turn a blind eye to it, and actually see it as part and parcel of the broader systems.

Importantly, this point was echoed by the office of the one policymaker we were able to interview, Cinthya Muñoz with Councilmember Nikki Bas's office. Muñoz commented, "I would say it's great ideas, great policy that [APTP] supports and moves forward, but having more power locally would be great. And I don't think that comes without just having more actual numbers of people in a base that is politicized." This makes it clear that a large, organized, politicized base is compelling to policymakers as MH First seeks more resources and a broader reach.

3. MH First can expand its reach by crafting a translocal narrative and communications strategy

Interviewees had many ideas for a communications plan to expand the reach of MH First, including improved branding and narrative building. Most of the people we interviewed felt that MH First needed to "get the word out" more so that community members knew about it and it became a "household name." Elena Serrano, Program Director from East Side Art Alliance posed the question, "How do folks reach you? How can we make that as easy, as simple as possible?"

One strategy interviewees suggested for achieving this goal was creating a clear narrative that MH First works — sharing success stories about MH First interventions and continuing to evaluate the program quantitatively and qualitatively. Patrice Strahan from DJCC emphasized the need to share success stories: "I think that it might be in the interest of people's privacy, but I wonder how much more they could broadcast, 'Hey, we

were able to help this person with this and that person with that.' I feel like I've never heard a single story about a successful dispatch." Interviewees also noted the importance of ensuring that community members know what MH First does and how to reach them. Mohamed Shehk from Critical Resistance suggested reaching out to well-known people who might support the program: "If there's audiences that could be tapped with high profile people that would be supportive or sympathetic — I think that's an easy way to get your message out and make your program known to a lot of people."

Stories of Success: A Note from MH First's Co-Creator

One reason for our lack of storytelling is due to diligently protecting participants' private health information. What we can say is we often provide transportation from one place to another, meaning from a place where participants felt unsafe to a place where they do feel safe, thereby avoiding police contact and/or a visit to the emergency room. We have also found that providing participants a space to actively be listened to without the fear of being hospitalized and/or having 911 called on them has been, in our eyes, a great success.

There have been several occasions where being on scene while police interactions were happening has allowed participants to demand the type of treatment and treatments that they were seeking instead of treatment or treatments being forced upon them. We have also found that accompanying participants to the emergency room has helped participants better advocate for themselves and get the help that they were seeking, instead of the treatment/help that could be forced upon them. We have also provided temporary housing for people facing intimate partner violence, which has decreased the probability of experiencing this violence at home.

— Asantewaa Boykin, RN, Co-founder of Anti Police-Terror Project and Co-Creator of MH First

Interviewees were concerned that community members would not know or remember the number to call MH First when in crisis. Some suggested postcards or refrigerator magnets with the MH First phone number, and perhaps other connected non-police social service numbers, clearly communicated. Sikander Iqbal from Urban Peace Movement suggested that MH First try to get a three digit phone number: "Branding and messaging and being really clear about what you get from calling this number. I know they were trying to get a 3 digit number like a 311, and if they were, I think that would be the

way to go." In Denver, where the non-police response team (Denver STAR) is dispatched through 911, organizer Roshan Bliss felt that being routed through that number was part of what helped the program to reach more people:

> It's actually incumbent on us in our messaging and communications to stop validating the message that police should have first right of refusal for responding to every emergency. Don't cede that ground that calling 911 is the same as calling police. It isn't in all places. It shouldn't be in any place, and you should be able to say to a 911 operator that you want the police to have zero involvement in this and have that request honored, or else be able to look for help elsewhere.

Finally, interviewees were also clear that a broader communications strategy requires resources. As we were asking interviewees for a roadmap to expand the reach of MH First, "I know that requires increased resources" and "I know that requires more capacity" were common refrains. Armen Henderson, with the Dream Defenders, suggested that MH First include an advertising budget in any future fundraising efforts: "They should have some sort of media funding or advertising budget to make sure that people know that the resources do exist. So when they're applying for these grants and things of that nature, they should put in a budget for advertisement as well."

"We Keep Us Safe" - Tur-ha Ak, photo courtesy of MH

4. MH First can expand its reach through building community capacity for crisis response through trainings and political education

While interviewees identified MH First's trainings as a strength, there was also a sentiment that the program's capacity could be increased — at both a local and a national level — by building capacity for all community members to be able to respond to crisis situations in their own contexts. A broad view of community capacity building could extend beyond the MH First program to build up the knowledge and skills needed for community members to keep each other safe during crises without relying on policing. This would support bringing a transformative, non-police, harm reduction approach closer to the scale of need, which is beyond any one organization or program. Organizer Sagnicthe Salazar noted this as a possible pathway towards expansion for the program: "If I were to expand the program, I would think about how to engage … local communities and resources to scale *themselves* up so that the capacity increases."

This suggestion parallels the MH First commitment to a healing justice framework that emphasizes that community members know best what they need. Interviewees saw MH First's trainings as an opportunity to build this community capacity through providing a space for people to increase their skills and knowledge around crisis response. Lara Kiswani of AROC complimented MH First on this:

> [MH First] is helping people understand why it's so important to not just [provide mental health first aid], but also provide everybody with the skills necessary to be able to de-escalate situations, which really kind of shifts this idea that it's the State's responsibility for us to care for each other or to support each other, and says that we all have a role and responsibility, and supporting each other in the community within our capacity.

Interviewees saw opportunities for MH First to use its strong leadership and experience to expand its model and build community capacity by engaging in partnerships, coalitions, networks, and training with other organizations. Working cross-organization creates a network of support for organizations' work, and helps foster relationships and movement-building across various lenses of oppression, in pursuit of intersectional

liberation. Patrice Strahan from the Disability Justice Culture Club said:

> I know that I would love to do more stuff with MH First, and I've been trying to figure out ways to, because I feel like with cross-org collaboration, we can work together on stuff and it also helps different communities understand each other more. For example, we're [focused on] disability justice, but if we partnered and worked together with MH First on things, we could talk about the intersection between disability justice and abolition.

Through trainings, MH First could deliver information, resources, and build skills (e.g. de-escalation, trauma informed crisis response) to the broader community to support people through crises before and after the point of intervention. Interviewee Mimi Kim of Creative Interventions saw this as a pathway towards liberation, commenting, "So I do think that if you have more and more people in communities that have more knowledge and skills around mental health crisis response, but also are forming kind of networks and ecosystems of mutual aid — these are just the very kinds of liberated spaces that we need for so many things."

Remaining Questions for MH First to Consider

"How can you protect what you have, given that there's going to be all the forces of the state trying to erode that, trying to take it over? This is cooptation, right? But also know that you're going to be caught up in a huge wave. Do you catch the wave? Do you avoid it completely?"

— *Mimi Kim,*
Creative Interventions

Leveraging and containing co-optation

One open question that MH First is still considering is how to address co-optation, especially as the program aims to grow and expand. Co-optation can and does happen when either the state or other organizations take the principles and strategy of the program, while diluting its original values and purpose. As non-police crisis response became a more widespread alternative in the 2020s, MH First was aware of the likelihood of co-optation of their work and interested in learning from their peers about how to navigate it. We asked organizers with other community organizations how they have addressed this issue in their work, and while almost every organization had experienced some form of co-optation, we received mixed responses about how to respond to it.

First, several interviewees shared that co-optation is simply inevitable. However, the understood reason for why co-optation is so unavoidable was different across interviews. One interviewee with The Black Response stated that the fact that their organization works closely with community and upholds transparency as a deep value opens the organization up to co-optation. Another interviewee with AROC looked to the history of co-optation of social movements as a means of diluting the power of the movement. Executive Director Lara Kiswani said:

> It's inevitable, and it's a tried and true tactic to strip our movements of our power. And I think the main thing is that we have to always reassess our strategies and be able to pivot as needed, both around how we frame something…but also, know that when things are co-opted or even imitated, it's also an indication of your power and your success.

This framing — that co-optation is a sign of a program's power and success — allows organizers to use co-optation to their advantage and to understand it as something that can be leveraged. In other words, some level of co-optation can allow a program to expand in ways it might not have been able to otherwise. As Sara Mokuria with Building Beyond Policing said, "It is a given that co-optation will happen. The Black Panther Survival Programs, particularly the free breakfast program, is aclear example of that. With that in mind, I think we should be bolder in the ideas and strategies we put forth." Mohamed

Shehk from Critical Resistance echoed this point: "If the understanding is there, great! If we're pushing for something and a decision-maker is like, 'I'm gonna take it, it's mine' and goes and does the thing that we wanted them to do in the first place — fantastic, right? But if an idea is being co-opted and warped into something that doesn't align with its original values or purpose, then it should be stopped."

Furthermore, allowing some amount of co-optation can help a program to hone itself and become even more effective. Organizer Krea Gomez said, "If you're doing it for the liberation of all people, you want that to spread like wildfire. When you have a great idea, you don't care who owns it because whoever is owning it may have a better model for what it is that you're doing, and you may be able to learn from them because they had something you didn't have."

However, in order for this strategy to work, organizations need to be able to maintain their strong values and control the narrative of the program. One real danger of co-optation is that a program can be diluted or warped by those with different values from the original program organizers. As Virginia Cuello with The Black Response said, "Government or other entities can copy the words that we say, but because they're not the ones feeling it, or in community really, they can't really create the same things or make the same things, or act up on the same things that we would." Therefore, organizers need to stay deeply grounded in their values and vision in order to meet the goal of community liberation. Lara Kiswani from AROC said, "The objective is transformation, is liberation, is the ways in which our communities can live to their fullest potential. And to continue to keep an eye on that North Star and figuring out ways to use what we have at our disposal to do that." George Galvis from CURYJ shared that their organization had also used this tactic: "How we avoided cooptation is by maintaining a radical vision of how to maintain and create community-led self-determined spaces."

Another way interviewees suggested maintaining control of the narrative is to focus on trainings and political education, with the hope that explaining *how* and *why* a program came to be will ensure that whoever picks it up stays true to the original vision. MH First already conducts regular trainings for volunteers in Oakland and Sacramento who support the hotline, as well as trainings locally and nationally for other non-police crisis response teams. It is important that MH First continue to prioritize this as a pillar of program expansion.

Finally, interviewees emphasized the importance of pushing back against co-optation when it carries the risk of doing harm. This is a particular risk when building up systems of care outside of policing, which is an already harmful system. Sikander Iqbal from the Urban Peace Movement said that this is one way their organization addresses co-optation:

> We buck up against it. We call them out. You know, we're talking to funders about it. We're openly saying when they are co-opting language and co-opting strategies. Nobody with a badge and a gun and a baton can talk about trauma-informed care. Like, it's just not possible. We're pushing back on things that we know cause harm.

Still, it is important for organizers to not get stuck on constantly pushing back on co-optation to the detriment of their movement work. Melina Abdullah with Black Lives Matter Grassroots, an organization that has faced a great deal of co-optation at a national scale, made this point clearly: "The approach we've taken is: it's gonna happen. And we just have to do the work and be righteous in our work. We just gotta keep plowing forward even when they try, and then also slap it down when there is co-optation. We can't just let it stand. But you gotta keep moving work forward."

Working within or outside of the State

Another big remaining question that our interviews left us with is whether MH First should remain an entity outside of local, county, or state government or whether the program should be housed under a governmental office or supported with government funds — or both. Our interviewees had strong opinions on this question, with some feeling that operating within the government and social safety net would allow MH First to be more sustainable and accessible, and others feeling that moving under a government agency would cause the program to lose its current spirit and vision.

Interviewees who believed that MH First should be housed within the local or county government felt that it is the government's role to provide social services to the community and that organizers should be demanding more of the government to do so. Interviewees who believed that MH First should be housed within the local or county government felt that it is the government's role to provide social services to the

community and that organizers should be demanding more of the government to do so. As Mohamed Shehk with Critical Resistance said, "Given our current conditions, we should be pushing the state to fund or provide resources and try and do all that we can to drive a wedge between the social service provision and against the warfare elements of the state. Like, I actually like having running water and that it isn't a DIY volunteer-run service." The one policymaker's office we spoke with, Councilperson Nikki Bas's Chief of Staff, also landed on this side of the issue, strongly advocating for MH First to be institutionalized into the social safety net, perhaps in the department of public health:

> I don't think mental health needs should be privatized. I think they should be part of the safety net. And I wish we could figure out a way to incorporate this into our county system and not have it be within a nonprofit... To me it's a problem that it's within the nonprofit sector, but not because of the nonprofit that it's within. I just don't think it belongs there.

Some interviewees made an important distinction between a program being housed within the government and receiving state funding. The latter would allow MH First to continue to be autonomous, but with increased financial support. To some, this is seen as part of an abolitionist agenda — to divert state funding from policing and incarceration into systems of community care . A strong reason interviewees named for MH First receiving government resources is a more guaranteed and larger funding stream. Iris Garcia, program officer for Mindfulness and Healing Justice with the Kataly Foundation, said, "I worry about [MH First] being solely philanthropically supported in the long term."

Some interviewees felt just as strongly that MH First should continue to operate outside of the state so that it can stay aligned with its vision and values. Melina Abdullah of BLM Grassroots was firm on this point, for MH First to be able to maintain its autonomy: "No, it cannot be under the state. It has to be separate. I mean, the State is eventually gonna get bought by corporate interests and police interests. Right? Yeah. So it has to have autonomy. Autonomy from the state, but beholden to community." Others felt more of a tension — knowing that moving within the state could allow MH First to be more financially sustainable and more easily accessible, but warning that MH First must exercise caution if they are to take this step. Erica Gomes, a clinician with La Clinica said, "I think there is a certain way in which it's like, oh, we have this great new idea and we're going to put money behind it and then all of a sudden, you lose the spirit that it was built

out of. And the intention that it comes out of." Organizer Sagnicthe Salazar also cautioned "I think there is a certain way in which it's like, oh, we have this great new idea and we're going to put money behind it and then all of a sudden, you lose the spirit that it was built out of. And the intention that it comes out of." Organizer Sagnicthe Salazar also cautioned against MH First losing its spirit by becoming a government-run program:

> I think that while there are extreme benefits when it comes to resources and capacity, I think that it becomes dangerous because the intention, vision, framework gets shifted, you know? In a way that loses what we were intending to do, right? And so I think that there needs to be that foresight and vision to ensure that our folks are at the table the whole way through.

Some interviewees did not express an opinion about what MH First should do, but did note the different restrictions the program would face if it operated within the government as opposed to continuing through APTP. Similar to Abdullah's point above, Elliott Jones from Oakland's MACRO program talked about the loss of autonomy that MH First might experience if it began to operate through the city or county:

> I know Richmond, California, is doing [a non-police crisis response program] in their Public Health and Human Services Department, or their Human Services department. Some people do it in their Public Health department — and nonprofits and independent organizations have so much more freedom. You know, these other places have rules.

Working within government or with governmental funding could also require the rest of APTP's operations, especially their activism and policy advocacy work, to change. Armen Henderson with Dream Defenders' non-police crisis response team said, "[This work] is heavily politicized and you can't slap the government with one hand and then turn around and ask them for money with the same hand."

As a cautionary tale, Cambridge HEART, a non-police crisis response program in Cambridge, MA, shared their experience of trying to work with the government, and why they ultimately decided not to. In Cambridge, The Black Response first approached Cambridge City Council to demand an alternative crisis response program. City Council passed a policy order to develop a Community Safety Department, which they advertise

as “an alternative police response that prioritizes issues of mental and behavioral health in some of the city’s most vulnerable communities.” The Community Safety Department, though unstaffed at first, has now developed a Community Assistance Response and Engagement (CARE) team of mental health professionals, social workers, and EMTs to respond to some 911 calls. Bárbara Ortiz from Cambridge HEART tells the story of governmental co-optation their work faced:

> We couldn’t control what the city took from us. They co-opted our language, like everything that [The Black Response] put up on slides, they almost took it, word for word. Put it in the city magazine. Did not mention, “Oh, we will be mandated reporters.” Did not mention, “Oh, these are clinicians responding with police.” Did not mention a lot of things. Just took it like 98% word for word.

From this experience, Ortiz draws the lesson: “One thing we learned is that you can’t rely on the government.” All this being said, this story also illustrates the far greater resources available by working within the government: the Community Safety Department began with a budget of $3 million, while HEART tries to sustain itself through foundation grants and smaller city grants.[30]

Recommendations for MH First

"[Success for MH First] would be for it to be the norm and the standard as opposed to it being an alternative. For that to be the standard of which we deliver care to our community and to people who are dealing with mental health crisis."

— *Sheila Bates,*
Policy Coordinator with Black Lives Matter Grassroots; Policy Lead with Black Lives Matter California

1. **Continue to prioritize being deeply rooted in and led by community members in Oakland and Sacramento, particularly Black, Indigenous, Latine, and disabled community members who are most impacted by policing.** Our interviewees were clear that having deep relationships in the Oakland and Sacramento communities is one of the strengths of MH First. We recommend that MH First continue to prioritize community relationships at the center of their practice, including by focusing their volunteer trainings on Oakland and Sacramento residents of color. At this moment, given limited capacity, we recommend MH First continues to focus on "scaling deep" within Oakland and Sacramento, rather than "scaling out" to reach new cities.[31] Instead, we recommend they continue to support other local grassroots organizations across the country to build up their own similar programs through continued trainings and resource sharing.

2. **Publicly share more stories of success, including robust qualitative and quantitative data analysis.** Funders and organizers alike shared that they did not have clear examples of MH First's success in supporting community members in need. Other non-police crisis response programs across the US have been able to leverage the data about their program (e.g. how many calls they receive, what types of call they receive, how they were able to respond, the cost/benefit analysis of these programs compared to policing or hospitalization, etc.) in order to gain more funding to expand their reach. We recommend MH First begin to use a data management system to better capture information about the numbers and types of calls the hotline is receiving. We also recommend that MH First start collecting and sharing success stories more regularly, perhaps in a monthly newsletter. This will require a robust communications strategy, which MH First plans to expand upon with its relaunch in 2025.

3. **Provide preventative care in order to interrupt pathways to crisis situations and follow-up care in order to ensure people have what they need following crisis.** In order to truly address the root causes of crisis and harm in the community, MH First needs to be able to provide support outside of the moments of a crisis, too — even if this support takes the shape of referrals to other aligned social service agencies. We recommend that MH First direct energy towards scaling up the People's House in Oakland as one means of providing this type of care to community members.

4. **Expand hours of operation as much as possible to ensure the hotline is accessible and reliable.** In order for community members to consider MH First as a viable alternative to police response in crises, it is clear that MH First needs to be available for more hours during the week. Interviewees and survey participants shared stories of needing MH First's support, but not being able to reach them because it was outside their hours of operation. We recommend that MH First begin to incrementally increase hours as it obtains more funding and staffing, and build capacity to eventually sustain a program that operates 24 hours a day, 7 days a week.

5. **Increase resources and funding for the program, including considerations of whether MH First is willing and able to receive government funding.** While it is an open question whether MH First should operate within the state or outside of it, it is clear that MH First needs more sustainable resources and that government funding is often a more reliable source than philanthropic funding. We recommend that MH First seek city, county, state, and federal funding where available, while negotiating the retention of their autonomy and ownership over the program vision, values, and strategy. We also recommend that the cities of Oakland and Sacramento divert funding from local law enforcement into non-police crisis response programs like MH First.

6. **Pass policy and budget allocations that shift money from the carceral state to non-police grassroots response, including to MH First.** In 2021, APTP worked with the Alliance for Boys & Men of Color and a statewide coalition to write and pass the Community Response Initiative to Strengthen Emergency Systems (CRISES) Act. The effort was meant to redirect money from the state budget to grassroots organizations across California in support of their efforts to build non-carceral responses to community crises. The CRISES Act passed in 2021 and has distributed $9.5 million to four jurisdictions to build up emergency response programs. Still, more funding is needed for community-based and community-led programs that operate outside of city or county systems. A coalition of statewide partners led by APTP and the Alliance for Boys & Men of Color will be leading efforts for a CRISES Act 2.0 in an effort to secure additional funding for growth of these models and support and training for the organizations.

Works Cited

1. Mapping Police Violence. Mapping Police Violence. Accessed April 28, 2025. https://mappingpoliceviolence.org/

2. Schwartz GL, Jahn JL. Mapping fatal police violence across U.S. metropolitan areas: Overall rates and racial/ethnic inequities, 2013-2017. PLOS ONE. 2020;15(6):e0229686. doi:10.1371/journal.pone.0229686

3. Edwards F, Lee H, Esposito M. Risk of being killed by police use of force in the United States by age, race—ethnicity, and sex. Proc Natl Acad Sci. 2019;116(34):16793-16798. doi:10.1073/pnas.1821204116

4. Fatal police violence by race and state in the USA, 1980—2019: a network meta-regression. The Lancet. 2021;398(10307):1239-1255. doi:10.1016/S0140-6736(21)01609-3

5. Reinhart E. Moving from crisis response to crisis prevention in U.S. mental health systems. STAT. February 8, 2024. Accessed April 28, 2025. https://www.statnews.com/2024/02/08/treatment-not-trauma-chicago-mental-health-police-violence-community/

6. Weichselbaum S, Seville LR, Siegel E, Neff J, VanSickle A. Violent Encounters With Police Send Thousands of People to the ER Every Year. The Marshall Project. June 23, 2021. Accessed April 28, 2025. https://www.themarshallproject.org/2021/06/23/violent-encounters-with-police-send-thousands-of-people-to-the-er-every-year

7. Packard SE, Verzani Z, Finsaas MC, et al. Maintaining disorder: estimating the association between policing and psychiatric hospitalization among youth in New York City by neighborhood racial composition, 2006—2014. Soc Psychiatry Psychiatr Epidemiol. 2025;60(1):125-137. doi:10.1007/s00127-024-02738-7

8. Geller A, Fagan J, Tyler T. Police Contact and Mental Health. Published online December 1, 2017. Accessed April 28, 2025. https://papers.ssrn.com/abstract=3096076

9. Jackson DB, Fahmy C, Vaughn MG, Testa A. Police Stops Among At-Risk Youth: Repercussions for Mental Health. J Adolesc Health Off Publ Soc Adolesc Med. 2019;65(5):627-632. doi:10.1016/j.jadohealth.2019.05.027

10. American Public Health Association. Addressing Law Enforcement Violence as a Public Health Issue. November 2018. Accessed April 28, 2025. https://www.apha.org/policy-and-advocacy/public-health-policy-briefs/policy-database/2019/01/29/law-enforcement-violence

11. Non-Police Crisis Response Guide. Interrupting Criminalization. May 2021. Accessed April 28, 2025 https://www.interruptingcriminalization.com/non-police-crisis-response-guide

12. Marcus N, Stergiopoulos V. Re-examining mental health crisis intervention: A rapid review comparing outcomes across police, co-responder and non-police models. Health Soc Care Community. 2022;30(5):1665-1679. doi:10.1111/hsc.13731

13. Pope LG, Patel A, Fu E, et al. Crisis Response Model Preferences of Mental Health Care Clients with Prior Misdemeanor Arrests and of their Family and Friends. Psychiatr Serv Wash DC. 2023;74(11):1163-1170. doi:10.1176/appi.ps.20220363

14. American Public Health Association. Advancing Public Health Interventions to Address the Harms of the Carceral System. October 2021. Accessed April 28, 2025. https://www.apha.org/policy-and-advocacy/public-health-policy-briefs/policy-database/2022/01/07/advancing-public-health-interventions-to-address-the-harms-of-the-carceral-system

15. Healing Justice Train the Trainer. Justice Teams Network. 2021. Accessed April 28, 2025. https://justiceteams.org/healing-justice/train-the-trainer

16. Guadalupe. Without Healing There is No Justice: The People's Clinic Takes Off in West Oakland. APTP. August 14, 2024. Accessed April 28, 2025. https://www.antipoliceterror-project.org/blog-entire/2024/8/14/without-healing-there-is-no-justice-the-peoples-clinic-takes-off-in-west-oakland

17. Kim ME. Transformative justice and restorative justice: Gender-based violence and alternative visions of justice in the United States. Int Rev Vict. 2021;27(2):162-172. doi:10.1177/0269758020970414

18. Crenshaw K. Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. Stanford Law Rev. 1991;43(6):1241-1299. doi:10.2307/1229039

19. Movement Generation. Disability Justice. 2024. Accessed April 28, 2025. https://movementgeneration.org/disability-justice/

20. What is Harm Reduction? Harm Reduction International. 2022. Accessed April 28, 2025. https://hri.global/what-is-harm-reduction/

21. Fleming P, Bahr W, Brinkley-Rubinstein L, et al. A logic model for alternative response programs to guide public health research and practice. Manuscript Submitted for Publication. 2025.

22. U.S. Census Bureau QuickFacts: Oakland city, California. Accessed April 28, 2025. https://www.census.gov/quickfacts/oaklandcitycalifornia

23. Black/African American Health | Office of Minority Health. Accessed April 28, 2025. https://minorityhealth.hhs.gov/blackafrican-american-health

24. Boyle P. Do Black patients fare better with Black doctors? AAMC. June 6, 2023. Accessed April 28, 2025. https://web.archive.org/web/20250205112755/https://www.aamc.org/news/do-black-patients-fare-better-black-doctors

25. Strecher VJ, McEvoy DeVellis B, Becker MH, Rosenstock IM. The Role of Self-Efficacy in Achieving Health Behavior Change. Health Educ Q. 1986;13(1):73-92 doi:10.1177/109019818601300108

26. CAHOOTS (Crisis Assistance Helping Out on the Streets). White Bird Clinic. Accessed April 28, 2025. https://whitebirdclinic.org/cahoots/

27. Marya R. Health and Justice — The Path of Liberation Through Medicine. Medium. June 12, 2020. Accessed April 28, 2025. https://medium.com/@radiorupa/health-and-justice-the-path-of-liberation-through-medicine-86c4c1252fb9

28. Carroll JJ, El-Sabawi T, Fichter D, et al. The Workforce For Non-Police Behavioral Health Crisis Response Doesn't Exist—We Need To Create It. Health Aff (Millwood). Published online September 8, 2021. doi:10.1377/forefront.20210903.856934

29. California Code, HSC 1799.102. Accessed April 28, 2025. https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1799.102.&lawCode=HSC

30. Girma S, Kingdollar BL. Cambridge Advances $3M Community Safety Department Proposal Seeking to Provide Non-Police Public Safety Alternatives. The Harvard Crimson. May 11, 2022. Accessed April 28, 2025. https://www.thecrimson.com/article/2022/5/11/cambridge-community-safety-proposal/

31. Fraser T. Scaling Deep: Where it came from and more to go. Refuge for systems leaders. February 20, 2024. Accessed April 28, 2025. https://medium.com/refuge-for-systems-leaders/scaling-deep-where-it-came-from-and-more-to-go-f80d953c3ac9

APPENDIX A: List of interviewees

1. **Melina Abdullah**, Co-founder and Director of Black Lives Matter Grassroots; Co-founder of Black Lives Matter LA

2. **Sheila Bates**, Policy Coordinator with Black Lives Matter Grassroots; Policy Lead with Black Lives Matter California

3. **Falilah "Aisha" Bilal**, Founder of WaterFlowLife and Non Profit Executive Leader

4. **Roshan Bliss**, Co-founder and Lead Organizer with Denver Justice Project; Co-coordinator of International Crisis Response Association (now known as The 4th Branch Institute); Principal Consultant at Bliss Collaborations

5. **Virginia Cuello**, The Black Response Core Team Member; Owner at Karaya Implementation Consulting LLC

6. **George Galvis**, Executive Director of Communities United for Restorative Youth Justice (CURYJ)

7. **Iris Garcia**, Program Officer for Mindfulness and Healing Justice at the Kataly Foundation

8. **Erica Gomes**, Clinical Director of Integrative Behavioral Health at La Clinica

9. **Krea Gomez**, organizer in Oakland, CA

10. **Stephanie Guirand**, The Black Response Core Team Member and Program Function Manager/Researcher

11. **Armen Henderson**, Medical Director for Healing and Justice Center with Dream Defenders

12. **Sikander Iqbal**, Deputy Director of Urban Peace Movement

13. **Devonte Jackson**, National Organizing Director for Movement 4 Black Lives

14. **Elliott Jones**, Program Manager of Oakland Fire Department's Mobile Assistance Community Respondents of Oakland (MACRO)

15. **Mimi Kim**, Founder of Creative Interventions

16. **Lara Kiswani**, Executive Director of the Arab Resource and Organizing Center (AROC)

17. **Sara Mokuria**, Director of Building Beyond Policing

18. **Leslie Napper**, Senior Advocate at Disability Rights California (DRC)

19. **Bárbara Ortiz**, Responder and Responder Team Manager with Cambridge Holistic Emergency Alternative Response Team (HEART)

20. **Cinthya Muñoz Ramos**, Chief of Staff for Nikki Bas, Oakland City Council President

21. **Maria Alejandra Salazar**, Program Officer with the Communities Transforming Policing Fund at Borealis Philanthropy

22. **Sagnicthe Salazar**, coalition organizer

23. **Jamie Schenker**, Program Director at The California Wellness Foundation

24. **Mohamed Shehk**, Campaigns Director at Critical Resistance

25. **Elena Serrano**, Program Director at EastSide Arts Alliance

26. **Patrice Strahan**, Core Team of Disability Justice Culture Club (DJCC)

27. **Charity Sonia Whyte**, Ceremonial Artist, Death Doula, Associate at the San Francisco Foundation, Black Funders Network Planning Committee Member

28. **Lauren Williams-Batiste**, Executive Director of In Our Names Network

APPENDIX B: Interview Guide for People in Government (Local and National)

Please share a little about yourself, your areas of focus in government, and how you are connected to MH First (if at all).

1. What is your overall perception of MH First and the impact it is having on the community?

2. What are the top three things you believe MH First is doing well?
    a. How does MH First compare to other forms of response to mental health needs?
    b. What are the characteristics of MH First that you think lead to its success?

3. What are the top three things you'd like to see MH First improve upon?

4. What impact do you think MH First has had on local, state, and/or national policy and budgets?
    a. How has the program impacted the way legislators at your level are talking about mental health and alternative responses? How have those conversations impacted legislation?

6. [for Ryan] How do you view the role of EMS, emergency rooms in hospitals, and free-standing mental health facilities in supporting, creating, or expanding programs like MH First, as a means of ER diversion?

7. What do you think it would take to shift culture and resources so that MH First and programs like MH First are as widely available and accessible as something like EMS? (i.e. what does a roadmap look like?)
    a. Within your knowledge, is there an identifiable pathway for this to happen?

8. What additional data, stories, or information would you want to see from MH First to understand the impact of the program and/or to deepen your support of it?
    a. [*if they say things like reduction in 911 calls, ER visits, etc.*] Is there an identifiable pathway for MH First to get access to this information/data?
    b. How can you support MH First in building the infrastructure to be able to see those changes?

9. Is there any past or current legislation that you are working on that the MH First story could aid in uplifting?

End of interview: That's all for the questions I have for you. Is there anything else you think we should know about you or about MH First as we evaluate the program?

APPENDIX C: Interview Guide for Grassroots & Non-Profit Orgs (Local and National)

1. Please share a little about yourself, the work of your organization, and how you are connected to MH First (if at all).

2. What are the top three things you believe MH First is doing well?
    a. How does MH First compare to other forms of response to mental health needs?
    b. What are the characteristics of MH First that you think lead to its success?

3. What are the top three things you'd like to see MH First improve upon?

4. [*for local orgs*] Why or why not does our community need MH First and/or programs like MH First?
    a. How do you think community members perceive MH First?
    b. What more do you think community members want or need from MH First?

5. [*for national orgs*] What impact is MH First having on the shape and structure of non-police mental health crisis response programs across the US?
    a. Do you think MH First is known nationally?
        i. If so, what do you think general perceptions of MH First are?
        ii. If not, what do you think MH First needs to do to extend its reach?

6. What kind of trainings, support, and/or resources are needed to expand the MH First model into more cities?
    a. What do you think it would take to shift culture and resources so that MH First and programs like MH First are as widely available, known, and accessible as something like EMS? (i.e. what does a roadmap look like?)

7. What impact do you think MH First has had on local, state, and/or national policy or programs?

8. What does “success” look like to you for MH First?
    a. What does “success” look like to you for non-police, non-carceral responses to mental health needs in general?

9. In your experience, what has your organization done to avoid the co-optation of your work?

End of interview: That’s all for the questions I have for you. Is there anything else you think we should know about you or about MH First as we evaluate the program?

APPENDIX D: Interview Guide for Other Non-Police Crisis Response Programs (Including Those Trained by MH First)

1. Please share a little about yourself, the work of your organization/program, and how you are connected to MH First, if at all?
    a. What model of non-police crisis response do you follow (e.g. co-response, totally separate from police)?
    b. What are the goals of your organization/program with regards to non-police crisis response?
    c. What sorts of needs are folks calling your team with? How is your team addressing those needs?

2. [for those trained by MH First] What was your experience like being trained by MH First?
    a. How did the training from MH First help shape your organization/program's work?
    b. What lessons stand out to you from the training?
    c. What characteristics of MH First have you found the most useful as it relates to your own program's work?
    d. What was the least useful information you learned in the training?
    e. What more would you have liked to learn in the training?

3. [*for those not trained by MH First*] Did you draw upon learnings from the MH First model when shaping your own program? If so, which parts did you draw from?
    a. What parts of your own program did you shape differently from MH First, and why? What impact did that have on your program's outcomes?

4. What kind of trainings, support, and/or resources are needed to expand the MH First model into more cities?

5. What do you think it would take to shift culture and resources so that MH First and programs like MH First are as widely available and accessible as something like EMS? (i.e. what does a roadmap look like?)
    a. Within your knowledge, is there an identifiable pathway for this to happen?

6. What are the main challenges that you think non-police mental health crisis response systems are facing right now?
    a. How is your team approaching those challenges?

7. What does "success" look like to you for your program?
    a. What does "success" look like to you for MH First?
    b. What does "success" look like to you for non-police, non-carceral responses to mental health needs in general?

End of interview: That's all for the questions I have for you. Is there anything else you think we should know about you or about MH First as we evaluate the program?

APPENDIX E: Interview Guide for Funders

1. Please share a little about yourself, your organization/foundation, and how you are connected to MH First (if at all).

2. What is your overall perception of MH First and the impact it is having on the community?

3. What are the top three things you believe MH First is doing well?
    a. How does MH First compare to other forms of response to mental health needs?
    b. What are the characteristics of MH First that you think lead to its success?

4. What are the top three things you'd like to see MH First improve upon?
    a. What more would you like to see MH First do to improve the mental health of communities?

5. What do you think it would take to shift culture and resources so that MH First and programs like MH First are as widely available and accessible as something like EMS? (i.e. what does a roadmap look like?)
    a. What amount do you think it would take?
    b. Within your knowledge, is there an identifiable pathway for this to happen?

6. What additional data, stories, or information would you want to see from MH First to understand the impact of the program?

7. What do you need to continue, deepen, or begin your investment in MH First?

End of interview: That's all for the questions I have for you. Is there anything else you think we should know about you or about MH First as we evaluate the program?

APPENDIX F: Evaluation Survey Questions

This survey is a part of a research partnership between Human Impact Partners and the Anti Police-Terror Project / Mental Health First (MH First). Our purpose with this survey is to understand the health and community effects of MH First in Oakland and Sacramento. We will be compiling information from this survey, reviews of public health literature, and interviews with key stakeholders into an evaluation report.

We expect this survey will take about 10 minutes to complete. Participating in the survey is voluntary . You do not have to answer any question you do not feel comfortable answering. All identifying information will be kept confidential and presented in the aggregate.

1. Have you ever called MH First's hotline?
   - ☐ Yes
   - ☐ No

Your Experience with MH First

2. How many times have you called MH First's hotline?
   - ☐ Once
   - ☐ 2-5 times
   - ☐ 6-10 times
   - ☐ More than 10 times

3. Did you call MH First for yourself or for someone else?
   - ☐ For myself
   - ☐ For someone else
   - ☐ Both

4. . What were the main concerns that led you to call MH First? (open response)

5. Which of the following services did MH First provide to you or to the person you called about? (check all that apply)
   - ☐ Emotional support
   - ☐ Mental health crisis support
   - ☐ Social interaction/support
   - ☐ Safety planning
   - ☐ Referral for healthcare
   - ☐ Referral for emergency shelter
   - ☐ Referral for food source
   - ☐ Deescalation support
   - ☐ Conflict resolution support
   - ☐ Information about a health need
   - ☐ Substance use support
   - ☐ Other (please specify)

6. For the most recent time you called MH First, how helpful was MH First in addressing the reason(s) you were calling?
   - ☐ Extremely helpful
   - ☐ Very helpful
   - ☐ Somewhat helpful
   - ☐ Not so helpful
   - ☐ Not at all helpful

7. If MH First was not helpful, what could they have done differently to be more helpful to you? (open response)

8. For the most recent time you called MH First, did you also call 911 during the particular concern(s) you called about?
   - ☐ No, I did not call 911 at all during the crisis/crises
   - ☐ Yes, I called 911 before speaking to MH First
   - ☐ Yes, I called 911 after speaking to MH First

9. For the most recent time you called MH First, did you or the person you called about also go to the ER during the particular concern(s) you called about?
   - ☐ No, I/they did not go to the ER after speaking with MH First
   - ☐ Yes, I/they went to the ER before speaking with MH First
   - ☐ Yes, I/they went to the ER after speaking with MH First
   - ☐ I don't know .

10. For the most recent time you called MH First, was there any other resource you tried to call before or after MH First? (open response)

Impressions of MH First

11. How did you first learn about MH First?
   - ☐ Social media
   - ☐ Billboard
   - ☐ Friend or family member
   - ☐ Other (please specify)

12. How well-known do you think MH First is in your local community?
   - ☐ Extremely well-known
   - ☐ Very well-known
   - ☐ Somewhat well-known
   - ☐ Not so well-known
   - ☐ Not at all known

13. If you had to estimate, how many of your local friends and family members know about MH First?
   - ☐ All
   - ☐ Most
   - ☐ Some
   - ☐ A few
   - ☐ None
   - ☐ I'm not sure

14. What is your overall impression of MH First and the work the program does in your local community?
    - ☐ Very positive
    - ☐ Positive
    - ☐ Neutral
    - ☐ Negative
    - ☐ Very negative

15. How would you describe your community's overall impression of MH First and the work the program does in your local community?
    - ☐ Very positive
    - ☐ Positive
    - ☐ Neutral
    - ☐ Negative
    - ☐ Very negative
    - ☐ I'm not sure

Likelihood of Calling MH First

16. Would you feel safe calling 911 if you or someone else needed help?
    - ☐ Yes
    - ☐ No
    - ☐ It depends on the situation

17. Would you feel safe calling MH First if you or someone else needed help?
    - ☐ Yes
    - ☐ No
    - ☐ It depends on the situation

18. If you or someone you know were experiencing a mental health crisis, would you be more likely to call MH First or 911?
    - ☐ I am more likely to call MH First
    - ☐ I am more likely to call 911
    - ☐ It depends on the situation

19. How likely are you to call MH First if you or someone you know was experiencing a mental health crisis?
- ☐ Very likely
- ☐ Likely
- ☐ Neither likely nor unlikely
- ☐ Unlikely
- ☐ Very unlikely

20. How likely are you to call MH First if you or someone you know needed access to emergency food and/or shelter?
- ☐ Very likely
- ☐ Likely
- ☐ Neither likely nor unlikely
- ☐ Unlikely
- ☐ Very unlikely

21. How likely are you to call MH First if you or someone you know needed domestic violence safety planning?
- ☐ Very likely
- ☐ Likely
- ☐ Neither likely nor unlikely
- ☐ Unlikely
- ☐ Very unlikely

22. How likely are you to call MH First if you or someone you know needed conflict resolution support?
- ☐ Very likely
- ☐ Likely
- ☐ Neither likely nor unlikely
- ☐ Unlikely
- ☐ Very unlikely

23. How likely are you to call MH First if you or someone you know needed substance use support?

- ☐ Very likely
- ☐ Likely
- ☐ Neither likely nor unlikely
- ☐ Unlikely
- ☐ Very unlikely

24. If you said you would be unlikely or very unlikely to call MH First for any of the above questions, please explain. (open response)

Demographic Info

25. How do you identify your sex and/or gender? (open response)

26. How do you identify racially or ethnically? Check all that apply .

- ☐ American Indian or Alaska Native
- ☐ Asian or Asian American
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Other (please specify)

27. What is your current age? Check one.

- ☐ Under 18
- ☐ 18-29
- ☐ 30-39
- ☐ 40-49
- ☐ 50-59
- ☐ 60-69
- ☐ 70+

28. Do you currently identify as disabled?

- ☐ Yes
- ☐ No

29. Do you currently have stable housing?

- ☐ Yes
- ☐ No
- ☐ Other (please specify)

30. What city do you live in? (open response)

Remaining Thoughts on MH First

31. What do you think MH First is doing well? (open response)

32. How would you like to see MH First change, improve, and/or expand? (open response)

33. Is there anything else about your experience with MH First that you'd like to share? (open response)

34. If you'd like to enter a raffle to win one of five $20 digital Visa gift cards, please share your email address here. We will send the gift card to randomly selected winners the first week of October.