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A COLLABORATIVE FRAMEWORK FOR THE

Street Crisis Response Team

Proposed Contract Amendments, Training Standards, and a 24-Month Evaluation

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An implementation booklet expanding the seven recommendations of the Collaborative Framework into working documents

Prepared by Amelia Harmon

Submitted in Individual Capacity • August 2026

Prepared for the San Francisco Mayor’s Office, Board of Supervisors, Health Commission, Fire Commission, Chief of Health, Human Services and Homelessness, Chief of Public Safety, Department of Public Health, and Fire Department

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How to Read This Booklet

A note from the author on purpose, structure, and timing

To the President and Members of each receiving body:

I have urged every public body associated with the Street Crisis Response Team to pause the removal of Peer Counselors, effective August 14, and to keep the DPH Street Crisis Response contract unamended pending review. The one-page Collaborative Framework I circulated in July offers seven recommendations for what that review should consider. This booklet expands each of its seven parts into working implementation documents — draft schedules, training standards, classification language, and evaluation methods. Feedback is welcomed from every reader: guided note pages accompany each section for exactly that purpose.

Nothing here is finished. Every document is a draft for review, designed to give DPH, SFFD, RAMS, the Homeless Outreach Team, the Mayor's Office, and the commissions a cohesive scaffolding for the best possible discussion. However the stakeholders come to the table — separately, jointly, or convened by the Mayor's Office — these seven parts are designed to give each of them a reason to strengthen this once-in-a-generation program rather than dismantle it.

The Fire Commission's August 12 meeting is the last public decision window before the effective date. Supervisor Fielder has formally requested that the restructuring be placed on that agenda and that no permanent staffing changes be made until they have been publicly reviewed. This booklet is built to serve that review. To the best of my understanding, the funding for this program, channeled through DPH, is already budgeted within the current fiscal year — and it is forfeited only if the partnership itself is dismantled. Walking away from appropriated funding for evidence-based care, in a constrained budget year, serves no stakeholder; keeping the Peer and Community Paramedic model intact keeps that funding at work.

I write in my individual capacity and not as a representative of any agency or body I am affiliated with. My affiliations — Peer Supervisor with nine years of behavioral health service including five years on SCRT, member of the San Francisco Behavioral Health Council, and Bloomberg American Health Fellow at the Johns Hopkins Bloomberg School of Public Health with a focus area in Violence and Crisis Response Systems — are noted for identification only. I welcome any body's evaluation of these materials and I look forward to collaborating.

Respectfully,

Amelia Harmon

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Distribution of Copies

Fourteen numbered spiral-bound copies of this booklet have been prepared

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5	President Green, San Francisco Health Commission
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An identical PDF accompanies each physical copy. Supporting references for every part are consolidated at the back of this booklet and are also maintained, with live links, at crisisneedspeers.com/references.html.

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The Seven Recommendations at a Glance

1. Consolidate the peer workforce under a single employer of record

Designate RAMS as the employer of record for all SCRT peer personnel, with a grandfather provision for current HOT specialists and teammates; retain all system database access; and establish Medi-Cal reimbursement pathways that leverage the certified peer workforce.

2. Formalize tiered crisis specialization within the peer role

Codify advancement tiers incorporating first responder training — the RAMS Crisis Responder Academy, EMT certification, and CIT training pending SFPD collaboration — effective immediately for new hires, with timelines for existing staff to meet the increased standard.

3. Increase efficiency of the overlapping deployment model with periodic training operations

Dedicate the shift-overlap window, when all units are on the board, to cross-team drills, case debriefs, and scenario-based practice — so training occurs on shift without reducing street coverage.

4. Maintain engagement with the national alternative response field

Require semiannual convenings with national colleagues to track advancements in alternative crisis response and incorporate implementation science findings as they become evidence-based.

5. Resolve deployment station parking through a formal agreement

Execute a memorandum of understanding with City College of San Francisco’s Evans Campus, or otherwise designate a single equitable pickup and drop-off point with baseline staff facilities.

6. Preserve a pathway toward a permanent civil service classification

Reserve contract language for a future Crisis Response Peer Counselor classification at parity with Health Worker IV, permitting rotation at regular intervals within the system of care. Formalizing the crisis responder role is also an investment in the program’s sustainability and the City’s accountability: a classified, credentialed workforce is the responsible long-term structure for a permanent 911 resource.

7. Co-create an evaluation method for the next 24 months

Six months of baseline through the concurrent operational changes, eighteen months of data collection, conducted or validated by the Controller’s Office or an external academic partner, with findings complete in time to inform the FY 2029–30 budget cycle.

The full one-page Collaborative Framework, as circulated to the commissions in July 2026, remains the controlling summary of these recommendations. This booklet does not amend it; it equips it.

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Table of Contents

Blank and ruled pages between documents are provided for reader notes and feedback; feedback received by Monday, August 10 can be incorporated ahead of the Fire Commission's August 12 review.

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PART 1

Workforce Consolidation

Recommendation 1 — Consolidate the peer workforce under a single employer of record

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IN THIS PART

NOTES & FEEDBACK

These recommendations are designed to work only together — each part depends on the others. Please record any and all feedback on these pages for the preparer's review. Feedback received by Monday, August 10 can be incorporated ahead of the Fire Commission's August 12 review; feedback remains welcome, and wanted, at any time thereafter.

Proposed Organizational Structure

Single employer of record for the SCRT peer workforce, embedded in joint field operations

The structure below consolidates every SCRT peer position under RAMS as employer of record, while preserving the joint operational character of the team: peers deploy with SFFD Community Paramedics, and clinical and care-coordination accountability runs to DPH. Current Homeless Outreach Team (HOT) specialists and teammates transition into the RAMS structure without loss of standing under the grandfather provision (see Document 1.5).

Level	Role	Reports to / coordinates with
Contract	DPH Street Crisis Response contract	Health Commission (contract approval authority); DPH Director
Employer of record	RAMS, Inc. — Director of Peer-Based Services	DPH contract monitor; SFFD Community Paramedicine Division (operational MOU)
Program management	SCRT Peer Program Manager (1.0 FTE)	RAMS Director of Peer-Based Services; joint operations meetings with SFFD EMS-6 / Community Paramedicine leadership
Supervision	Peer Supervisor — Front Half (Sun–Wed) Peer Supervisor — Back Half (Wed–Sat)	SCRT Peer Program Manager; daily coordination with SFFD station officers
Field workforce	Crisis Response Peer Counselors (15–19 positions), deployed one per unit alongside an SFFD Community Paramedic and EMT (or dual CP)	Peer Supervisors; on-scene coordination per SFFD incident command
Training & certification	RAMS Peer Academy — Crisis Responder Academy; CalMHSA-approved Medi-Cal Peer Support Specialist certification and CEU renewal	SCRT Peer Program Manager; CCSF (EMT seats pending collaboration); CIT Lieutenants (pending SFPD collaboration)
Care coordination	Peer follow-up and linkage documentation with coordinated street teams	DPH Office of Coordinated Care; HOT; ONE System and DPH EHR access per Document 1.6

Why a single employer of record

- **Unified coordination and coverage.** One scheduling authority across all shift times ends the split-workforce seams that currently complicate coverage, supervision, and practice standards.
- **Continuity with an established training house.** RAMS operates a CalMHSA-approved Medi-Cal Peer Support Specialist certification course and provides the Continuing Education Units certified peers need for biennial renewal — the employer of record can train, exam-prepare, and maintain certification of its own workforce in-house.
- **The billing key.** A certified peer workforce under one employer is the precondition for the Medi-Cal mobile crisis and peer support billing pathways detailed in Document 1.3 and the attached fiscal note.
- **Trauma-informed employment practice.** Consolidation under a peer-run training and supervision culture is consistent with national best practices for trauma-informed care of a lived-experience workforce.

NOTES & FEEDBACK

Draft Coverage Schedule — Template for Review

Daily coverage 5:00 a.m. to 12:00 midnight, seven days, on a front-half / back-half rotation

The template below shows the proposed shift architecture with names intentionally left blank for scheduling by the Peer Supervisors once staffing is confirmed. Three shift lines provide continuous coverage from 5:00 a.m. to midnight: 5:00 a.m.–5:00 p.m., 7:30 a.m.–7:30 p.m., and 12:00 p.m.–12:00 a.m. Nine positions staff the front half of the week (Sunday–Wednesday), three on each shift line; ten positions staff the back half (Wednesday–Saturday), with a fourth 7:30 a.m. position doubling coverage across the midday peak-demand hours — nineteen field positions overall.

Front half — Sunday through Wednesday (nine positions)

Position / Shift	Sunday	Monday	Tuesday	Wednesday
Position 1 — 0500–1700	_____	_____	_____	_____
Position 2 — 0500–1700	_____	_____	_____	_____
Position 3 — 0500–1700	_____	_____	_____	_____
Position 4 — 0730–1930	_____	_____	_____	_____
Position 5 — 0730–1930	_____	_____	_____	_____
Position 6 — 0730–1930	_____	_____	_____	_____
Position 7 — 1200–2400	_____	_____	_____	_____
Position 8 — 1200–2400	_____	_____	_____	_____
Position 9 — 1200–2400	_____	_____	_____	_____

Notes for review

- All three shift lines are simultaneously on the board from 12:00 p.m. to 5:00 p.m. daily; the 1:00–4:00 p.m. core of that window is reserved for the rotating training operations detailed in Part 3, structured so no unit leaves dispatchable status.
- Wednesday is double-staffed at the supervisor level only: the front-half and back-half Peer Supervisors overlap so the rotating supervisor can complete administrative work, conduct peer supervision, and run overlapping training. All other staff alternate (“flop”) which Wednesdays they work, in the manner of fire service scheduling, so the seam between halves is covered without double-staffing the field.

Back half — Wednesday through Saturday (ten positions; additional 7:30 a.m. line)

Position / Shift	Wednesday	Thursday	Friday	Saturday
Position 1 — 0500–1700	_____	_____	_____	_____
Position 2 — 0500–1700	_____	_____	_____	_____
Position 3 — 0500–1700	_____	_____	_____	_____
Position 4 — 0730–1930	_____	_____	_____	_____
Position 5 — 0730–1930	_____	_____	_____	_____
Position 6 — 0730–1930	_____	_____	_____	_____
Position 7 — 0730–1930	_____	_____	_____	_____
Position 8 — 1200–2400	_____	_____	_____	_____
Position 9 — 1200–2400	_____	_____	_____	_____
Position 10 — 1200–2400	_____	_____	_____	_____

- Each full-time Peer Counselor works an alternating schedule of three 12-hour shifts one week and four the next within their assigned half; assignment blanks above will be filled by the Peer Supervisors with attention to certification mix (at least one Medi-Cal-certified peer per unit at all times, per the billing requirements in Document 1.3).

Cover Page — Medi-Cal Fiscal Note

Why this note matters, what is already underway, and who must act — the note itself follows

Why this is important

Removing Peer Counselors from SCRT does not just cut a valued service — it forfeits federal cost recovery the City is otherwise positioned to claim, in a year when the City faces a severe deficit and is asking philanthropy to backfill core systems of care. Two Medi-Cal pathways depend on a certified peer workforce: the Mobile Crisis Services benefit, billed per encounter at San Francisco's published rate of $3,143.81, and the Peer Support Services benefit under SB 803. Under highly conservative claiming assumptions the attached note estimates $2.2 to $8.9 million per year in forfeited mobile crisis reimbursement alone, with an enhanced 85% federal match available only through March 31, 2027. On the current team, the certified peer is the only member drawn from the behavioral-health provider columns of the state's qualified team-member table — removal moves SCRT away from, not toward, the team composition the benefit is built around.

What is already underway

- San Francisco's county-specific mobile crisis rate is published in the DHCS FY 2025–26 fee schedule and is in effect now; the claiming architecture exists and does not need to be invented.
- SB 803 Medi-Cal Peer Support Specialist certification is operational statewide, with 53 of 58 counties opted in; RAMS is a CalMHSA-approved certification training vendor with more than ten years of peer training history, and City College of San Francisco is an approved vendor as well.
- A certified peer bench already exists on SCRT today. The question before the City is whether to keep it — and bill — or dismantle it and rebuild after the federal match window has closed.

What needs to be done, by whom

Responsible stakeholder	Action
Health Commission	Hold the Street Crisis Response contract unamended pending review; require a revenue analysis of the peer removal before approving any amendment.
DPH — Director's Office	Direct departmental billing staff to determine the claimable share of SCRT encounters and confirm the County's mobile crisis implementation plan reflects the SCRT team composition.
DPH — Office of Coordinated Care	Stand up encounter documentation workflow so qualifying responses generate claims; reconcile against the 72-hour follow-up requirement peers already perform.
SFFD	Preserve current team composition pending the review requested by Supervisor Fielder and the joint review recommended to the Fire Commission.
RAMS	Maintain the certified peer bench and ensure agency infrastructure — certification, CEU renewal, and documentation practice — meets the programmatic standards required for Medi-Cal reimbursement; stand ready as employer of record per Recommendation 1.
Mayor's Office	Convene the stakeholders to align the program's operational and fiscal goals, consistent with the Breaking the Cycle Executive Directive 25-02, which this framework is designed to serve.
Controller's Office	Validate the fiscal projections as part of the 24-month evaluation design in Part 7.

The fiscal note follows on the next pages exactly as circulated for review, including its methodology note and nineteen references.

NOTES & FEEDBACK

FISCAL NOTE

Medi-Cal Revenue Forfeited by Removing Peer Counselors from the Street Crisis Response Team

Prepared by Amelia Harmon, in individual capacity | July 2026 | Companion to the Collaborative Framework for SCRT

Bottom line

Removing Peer Counselors from SCRT on August 15 does not just cut a valued service — it forfeits federal cost recovery the City is otherwise positioned to claim. Two Medi-Cal pathways depend on a certified peer workforce: the **Mobile Crisis Services benefit** (a bundled payment per crisis encounter, with the non-federal share paid by State General Funds, not the County) and the **Peer Support Services benefit** (per-15-minute billing by certified peers under SB 803). San Francisco's published Medi-Cal mobile crisis rate is **$3,143.81 per encounter** (DHCS FY 2025–26 fee schedule) [5]. At that rate, even highly conservative claiming assumptions put the annual forfeiture at **$2.2 to $8.9 million**, plus peer-billed follow-up revenue. An enhanced 85% federal match for mobile crisis services is available only through March 31, 2027 — a window that closes whether or not San Francisco uses it.

Pathway 1 — Mobile Crisis encounter billing (HCPCS H2011)

Since 2023, every California county bills Medi-Cal a county-specific **all-inclusive bundled rate per mobile crisis encounter** (one claim per response, including assessment, de-escalation, crisis planning, and 72-hour follow-up). San Francisco's published rate for FY 2025–26 (effective 7/1/2025–6/30/2026) is **$3,143.81 per encounter (H2011)**, with add-ons when the team transports: $120.24 per 15 minutes of staff transport time (T2007) and $0.69 per mile (A0140) [5]. DHCS reimburses the non-federal share of qualifying encounters with State General Funds — not County funds [3, §VII]. SCRT responded to 14,230 calls in its first two years — roughly 7,100 per year [14, 15].

Claimable share of ~7,100 annual SCRT responses	Qualifying encounters	Annual recovery at $3,143.81 / encounter
10% (highly conservative)	710	$2,232,000
15%	1,065	$3,348,000
25%	1,775	$5,580,000
40%	2,840	$8,928,000

Rate is actual (DHCS FY 2025–26 SMHS Mobile Crisis fee schedule, San Francisco line, County Code 38). "Claimable share" is the assumption to be refined: only responses to Medi-Cal beneficiaries meeting encounter and documentation requirements qualify, and capture improves with implementation maturity. Transport add-ons would increase these figures.

Pathway 2 — Peer Support Services billing (HCPCS H0038 / H0025)

Under SB 803 (Beall, 2020), certified Medi-Cal Peer Support Specialists are a distinct billable provider type; 53 of 58 counties have opted in [1]. Peers bill in 15-minute units for engagement, care coordination, follow-up, and recovery support delivered outside a bundled mobile-crisis encounter (no double-billing within one) [2, 3 §VII]. The illustration below uses $20 per unit; for comparison, Arizona's Medicaid fee-for-service rate is $21.86 per 15 minutes [10], and San Francisco's applicable rate appears in the DHCS FY 2025–26 SMHS Outpatient fee schedule [5].

Billable direct peer service time	Per certified peer, per year	10-peer SCRT complement
2 hours per shift (8 units × 210 shifts)	≈ $33,600	≈ $336,000
3 hours per shift (12 units × 210 shifts)	≈ $50,400	≈ $504,000

Assumes 210 shifts per FTE per year and counts only direct, documented peer service time — well under the DHCS 24-hour daily cap.

Why certified peers are the billing key

- On today's SCRT unit (community paramedic + EMT + peer), the certified peer is the only member drawn from the behavioral-health provider columns of BHIN 23-025's qualified team-member table; paramedics and EMTs appear under "Other Provider Types" [3, Table 1].
- DHCS explicitly endorses peer-anchored team models: "a mobile crisis team could consist of one LPHA and one peer support specialist… [or] two peer support specialists who have access to a LPHA via telehealth" — and commits to adjusting county rates for peer-heavy team compositions [3, §III, §VII(b)].
- A peer may serve as a mobile crisis team member only with current DHCS/CalMHSA Medi-Cal certification [3, §III(b)] — the exact training standard in the Collaborative Framework (Recommendation 2). RAMS itself is a CalMHSA-approved training vendor for the Medi-Cal Peer Support Specialist certification course, with 10+ years of peer training history, and provides Continuing Education Units for certified peers' biennial renewal [18, 19]. City College of San Francisco is also an approved vendor [13]. The employer of record can train, exam-prepare, and maintain certification of its own workforce in-house.
- Removing peers therefore moves SCRT away from, not toward, the team composition the federal and state benefit is built around — while retaining the two most expensive team members.

The federal match window

ARPA §9813 authorizes the mobile crisis benefit April 1, 2022 – March 31, 2027, with an enhanced **85% federal medical assistance percentage** for qualifying encounters during the state's first 12 eligible quarters [3, 9]. Dismantling the certified peer bench in August 2026 — then rebuilding, recertifying, and re-training after the fact — would consume what remains of the window. This is a use-it-or-lose-it federal revenue opportunity in a constrained budget year.

Precedent: peer crisis services billed to Medicaid

- Federal design intent: CMS guidance (SHO #21-008) names peer support specialists as mobile crisis team members and highlights peers as often best equipped to lead engagement and follow-up [7, 3 §III(b)].
- National adoption: 7 states required peers on Medicaid mobile crisis teams as of FY 2022, with 13 more planning to; Arizona set a requirement that 25% of teams include peers [8]. As of late 2023, 13 states had CMS-approved ARPA mobile crisis SPAs [9].
- Sustainability precedent: Ramsey County, MN turned mobile crisis teams into a fiscally sustainable model through Medicaid and insurance billing; Minnesota Medicaid covers peers as billing members of mobile teams [11, 12].
- Payment-rate precedent: state Medicaid programs reimburse H0038 peer services at documented per-unit rates (e.g., Arizona $21.86; New Jersey $18.77) [10]; six of eight states in an HHS/ASPE study bill mobile crisis via H2011 [16].
- California: the two-peer mobile crisis team model is contemplated in DHCS rate methodology itself, and Georgia's crisis continuum demonstrates Medicaid administrative claiming for crisis infrastructure [3, 17].

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Methodology note: The $3,143.81 encounter rate, transport add-on rates, and the ARPA/BHIN program facts are sourced as cited. Dollar projections are scenarios, not budget estimates: actual recovery depends on the Medi-Cal enrollment of persons served, encounter documentation compliance, and the County's approved mobile crisis implementation plan. Encounter reimbursement is all-inclusive; peer H0038 claims apply only outside bundled encounters. The purpose of this note is to establish that the recoverable amount is material — plausibly in the millions annually — and that certified peers are a precondition for claiming it.

RAMS' Record in Peer Workforce Development

A letter on the training infrastructure the employer of record brings with it

August 2026

To the reviewing bodies:

Recommendation 1 asks the City to consolidate the SCRT peer workforce under RAMS as employer of record. That recommendation rests on a fact worth stating plainly: RAMS is one of the longest-standing peer workforce development institutions in California, and the training infrastructure Recommendation 1 depends on already exists inside it.

RAMS has operated peer training programming for more than a decade. Its Peer Specialist Mental Health Certificate course is approved by CalMHSA as a Medi-Cal Peer Support Specialist certification training — the exact credential state guidance requires for a peer to serve as a Medi-Cal mobile crisis team member — and RAMS is likewise a source of the Continuing Education Units certified peers need for biennial renewal. In practical terms, the employer of record proposed here can recruit, train, exam-prepare, certify, and maintain the certification of its own crisis workforce in-house, on a schedule the program controls. No alternative arrangement reaches the same standard as quickly or at lower cost; consolidation under RAMS is the most efficient route forward.

The RAMS Peer Academy provides the scaffolding on which the Crisis Responder Academy in Part 2 is built: a standing faculty of experienced peers, an established curriculum development practice, and a hiring pipeline that has supplied peer programs across the city's system of care for years. RAMS is also a recognized leader in economic and workforce development for people living with behavioral health conditions, operating vocational and employment services alongside its clinical and peer programs. Consolidation therefore connects the SCRT peer role to a durable professional development pathway — entry certification, crisis specialization, continuing education, supervision, and career growth — under one roof.

I note for completeness that I am employed by RAMS as a Peer Supervisor and write here, as throughout this booklet, in my individual capacity. The facts above are drawn from the publicly available CalMHSA provider listing and RAMS program materials cited in this booklet's references; RAMS leadership can confirm current program details directly.

Respectfully,

Amelia Harmon
Peer Supervisor (nine years behavioral health service; five years SCRT)
Member, San Francisco Behavioral Health Council
Bloomberg American Health Fellow, Johns Hopkins Bloomberg School of Public Health
Written in my individual capacity; affiliations noted for identification only

NOTES & FEEDBACK

PART 1 • INSERT

RAMS Training Materials

Printed pocket insert

In bound copies, this page is a pocket insert containing RAMS Peer Academy and Peer Specialist Mental Health Certificate program collateral.

PDF readers, or readers of a copy whose pocket has been emptied: the materials are published by RAMS, Inc. at ramsinc.org, and the programs they describe are summarized in Documents 1.4 and 2.2 of this booklet.

Statement of Intent — An Expedited Pathway for HOT Colleagues

Honoring experience and reaching state certification without a gap

August 2026

To the reviewing bodies, and to the Homeless Outreach Team specialists and teammates this provision concerns:

The grandfather provision in Recommendation 1 is a floor, not the whole intent. The intent is that every current HOT specialist and teammate who transitions into the consolidated SCRT peer workforce arrives with their standing intact, their experience recognized as the asset it is, and a fully supported, expedited route to the Medi-Cal Peer Support Specialist certification that anchors the new role. In particular, the HOT specialists most engaged with — and most experienced in — the 911 level of response, who wish to make this work their assignment, should and can transition over; this pathway is built for them.

Concretely, this statement of intent commits the transition plan to the following:

- **No loss of standing.** Transitioning staff carry their seniority, compensation standing, and assignment history into the RAMS structure; the transition is a change of employer of record, not a demotion or a restart. Team members beyond the field role — including supervisors, training managers, and data managers — are likewise welcome to continue their contributions to a project of this magnitude, pending DPH's determination of workforce consolidation capacity.
- **Priority cohort placement.** Transitioning HOT staff are enrolled in the next available CalMHSA-approved certification course — RAMS' own course or CCSF's, whichever seats first — with exam preparation provided in-house.
- **Paid training time.** Certification coursework, exam preparation, and the Crisis Responder Academy occur on paid time, scheduled through the overlap-window training structure in Part 3 so that pursuing the credential never means losing hours.
- **A named target.** The plan targets state certification for every transitioning colleague within the first six months of consolidation, with individual timelines set in each person's transition plan and tracked by the Peer Program Manager.

The Specialists who built HOT's field practice should experience this consolidation as a promotion of their profession — because it is one. The tiered standards in Part 2 exist to formalize the expertise this workforce already carries; this pathway exists to make sure no one who carries it is left waiting at the door. One provision is not negotiable: if HOT's training managers or data managers cannot, for any reason, transition into the consolidated structure, a formal working arrangement must be executed in its place — one that guarantees continuity of training quality and data management across the homelessness response and behavioral health systems. Consolidation is the priority; an unbroken standard of training and data integrity across both systems is an absolute.

Respectfully,

Amelia Harmon
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Member, San Francisco Behavioral Health Council
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Written in my individual capacity; affiliations noted for identification only

NOTES & FEEDBACK

Memorandum — Maintaining System Database Access

Continuity of care coordination depends on continuity of access

Re: Retention of all system database access through and after consolidation

Recommendation 1 specifies that all system database access be retained to preserve continuity of care coordination across teams. Access is not an administrative convenience; it is how a 12:00 a.m. crisis contact becomes a 10:00 a.m. warm handoff instead of a lost thread. The consolidation must therefore treat data access as a deliverable with named owners, resolved before the first transitioned shift, as follows:

System	Discussion partners	Access outcome required
ONE System (Homelessness Response System record)	Coordinate with HOT and the Department of Homelessness and Supportive Housing	Transitioning HOT staff retain existing ONE System credentials; RAMS-employed SCRT peers gain or retain read/write access appropriate to street outreach and crisis follow-up roles.
DPH electronic health record (Epic)	Coordinate between RAMS and DPH	SCRT peers document crisis encounters and 72-hour follow-up in the DPH record — which is also the documentation backbone for the Medi-Cal claiming described in Document 1.3.
Outreach Worker Tool (OWT)	All SCRT partners, coordinated through DEM and the Mayor's Office	Every field team stays current in the OWT: shared visibility across SCRT, HOT, and partner street teams — who has been contacted, by whom, and what was offered — with consolidated information available at a glance, including partial-record lookups from the field. Realizing this in full depends on the investment respectfully described below.

A respectful ask of the Mayor's Office regarding the Outreach Worker Tool (OWT)

While this memo's core request is simply to keep every current access in place, the field would be remiss not to mention — in the friendliest possible way — that the OWT is due some love. For the OWT to function as the streamlined resource it is meant to be, it must be updated as quickly and as often as possible across every database it draws from: currency is what makes the tool actually usable on live 911 crisis calls. The teams that rely on it daily would welcome investment in its reliability, its mobile usability in the field, and its cross-team visibility and deduplication features. If the Mayor's Office is looking for a modestly priced improvement with outsized returns for every street team in the city at once, this is it. The workforce using the tool would gladly supply a prioritized improvement list on request.

Respectfully,

Amelia Harmon
Peer Supervisor (nine years behavioral health service; five years SCRT)
Member, San Francisco Behavioral Health Council
Bloomberg American Health Fellow, Johns Hopkins Bloomberg School of Public Health
Written in my individual capacity; affiliations noted for identification only

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PART 2

Tiered Training Standards

Recommendation 2 — Formalize tiered crisis specialization within the peer role

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IN THIS PART

NOTES & FEEDBACK

New Training Standards — Summary

Effective immediately for all new hires; timelines for existing staff follow in Document 2.3

Recommendation 2 codifies crisis specialization within the peer role through three components, layered onto the baseline Medi-Cal Peer Support Specialist certification:

- **RAMS Crisis Responder Academy** — a four-week course modeled on the mobile crisis standards King County's Department of Community and Human Services sets for Seattle's teams, developed with input from SFFD Community Paramedics, and including nationally recognized de-escalation training and precepted ambulance ride-alongs (Document 2.2).
- **A responder-literacy medical credential** — EMT certification or CPR/First Aid, with the selection deferred to the Fire Department's judgment (Document 2.4).
- **Crisis Intervention Team (CIT) training** — pending collaboration with SFPD (Document 2.5).

Effective date

The new standard applies to all new hires effective immediately. Existing staff are grandfathered onto the completion timelines in Document 2.3, which are built to qualify the full current workforce of 15–19 peers within twelve months, and within six months if cohort and preceptor capacity allow.

Nothing in this part is designed to make the peer role something it is not. The standards formalize what the strongest field practice already looks like, make it teachable and auditable, and satisfy the state's certification requirements for the Medi-Cal team composition described in Part 1.

NOTES & FEEDBACK

Cover Letter — The RAMS Crisis Responder Academy

A four-week crisis specialization course, from classroom to precepted field time

August 2026

To the reviewing bodies:

The Crisis Responder Academy is the centerpiece of the tiered standard. Its curriculum is modeled on the mobile crisis response standards that King County's Department of Community and Human Services (DCHS) sets for the Mobile Rapid Response Crisis Teams serving Seattle — teams operated by the Downtown Emergency Service Center that pair behavioral health professionals with peer counselors, with well over a decade of mobile crisis field history, and teams that work closely with their police department partners. Just as importantly, the curriculum was developed with input from SFFD Community Paramedics, so that what peers learn in the Academy matches what their paramedic partners expect on scene.

Structure of the four weeks

- **Weeks 1–2 — Foundations and systems.** Crisis theory and engagement practice; SCRT operations, radio, and documentation; the city's system of care and warm-handoff pathways; scenario labs.
- **Week 3 — De-escalation intensive and first ride-along.** The week is anchored by the nationally recognized de-escalation training delivered by the Crisis Prevention Institute (CPI). I requested funding for this training and it has been approved for the current fiscal year — the budget line exists and is waiting to be used. The week closes with the peer's first ambulance ride-along.
- **Week 4 — Precepted field week.** The peer completes between two and six ambulance ride-alongs in total, scored by the paramedic on shift against a call-variability requirement: the field week ends when the precepting paramedic confirms the peer has seen a sufficient range of call types and acuity, not when a clock runs out. A peer who satisfies the high-acuity training standard early spends the remainder of the week embedded at the SCRT deployment station — meeting the teams, learning station norms, and riding out with different SCRT units to observe and integrate the combined working styles of different teams.

The design principle is deliberate: classroom instruction establishes shared language, CPI establishes a common de-escalation method across the team, and the precepted ride-alongs — satisfying the training standard for high-acuity calls — ensure that every peer meets the situational-awareness literacy the crisis response role requires, and that no peer meets their first chaotic scene alone. The paramedic sign-off gives SFFD a direct quality gate over the field-readiness of every peer who graduates.

Curricula for every session of the schedule are developed — drawing on existing DPH online training resources and the preparer's own research — and are ready for review by any body that wishes to evaluate them. The draft onboarding schedule follows on the next pages.

Respectfully,

Amelia Harmon
Peer Supervisor (nine years behavioral health service; five years SCRT)
Member, San Francisco Behavioral Health Council
Bloomberg American Health Fellow, Johns Hopkins Bloomberg School of Public Health
Written in my individual capacity; affiliations noted for identification only

DRAFT FOR REVIEW
Prepared by Amelia Harmon
Submitted in individual capacity -- August 2026

Internal Operations | Field Skills | Scenario Practice | De-escalation / Safety | Community Resources | Specialized Populations

Peer Counselor Academy Street Crisis Response Team

WEEK 1 SCHEDULE

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Welcome & Intro to Peer Academy	Uniforms	Intro to De-escalation & Safety	ONE RAMS	ONE RAMS
Alternative First Response History [1]	Intro to De-escalation [2]	Motivational Interviewing as a Crisis Response Strategy [3]		
RAMS Overview	Radio 101 [4]	Team Building		
HR / On-boarding Logistics	Day in the shoes - Ride Along 1	Motivational Interviewing as a Crisis Strategy Scenario Practice		
Community Partner of the Day		Community Partner of the Day		

DRAFT FOR REVIEW
Prepared by Amelia Harmon
Submitted in individual capacity -- August 2026

Internal Operations | Field Skills | Scenario Practice | De-escalation / Safety | Community Resources | Specialized Populations

Peer Counselor Academy Street Crisis Response Team

WEEK 2 SCHEDULE

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Geography 101	Working with people experiencing homelessness [1]	Cultural Humility & Trauma Informed Care [2]	Working with Domestic Violence, Coercion, Human Trafficking Calls [3]	Rapid Resource Scenario Practice
Scene Management Scenario Practice	Scenarios	Suicide Intervention & Crisis Planning [4]	Scenarios	Neurodivergence, Intellectual, Developmental Disabilities [5]
Crisis Continuum of Care [8]	Team Culture, Norms, and Expectations [6]	Scenarios	Working with SUD [7]	Scenarios
Introducing yourself as a SCRT Peer Counselor	Dispatch 101	Working with Youth and Older Populations	Scenarios	Working with Veterans
Community Partner of the Day	Day in the shoes - Ride Along 2	Scenarios	Wellness Checks	Scenarios
		Community Partner of the Day	Scenarios	Packing Your Bag
			Compassion Fatigue and Self Care [9]	Administrative habits, report writing, & office access

DRAFT FOR REVIEW
Prepared by Amelia Harmon
Submitted in individual capacity -- August 2026

Internal Operations | Scenario Practice | Community Resources
Field Skills | De-escalation / Safety | Specialized Populations

Peer Counselor Academy
Street Crisis Response Team

WEEK 3 SCHEDULE

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Mental Health First Aid	Advanced Non-Violent De-escalation Skills	Advanced Non-Violent De-escalation Skills	Motivational Interviewing Refresh Scenarios Ambulance Ride Along	Day in the shoes - Ride Along 3, Full shift

DRAFT FOR REVIEW
Prepared by Amelia Harmon
Submitted in individual capacity -- August 2026

Internal Operations | Scenario Practice | Community Resources
Field Skills | De-escalation / Safety | Specialized Populations

Peer Counselor Academy Street Crisis Response Team

WEEK 4 SCHEDULE

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Ambulance Ride Along: Per Paramedic on shift, this could be the last ride along depending on scoring against variability of calls. Station norms. Meeting team, talking through scenarios, debriefing ambulance ride alongs in context of SCRT calls	If the Peer in training satisfied ride along requirements, the rest of this week can include learning station norms, studying previous academy material, finish any administrative onboarding work, making up any missed portions of the academy, or riding out with teammates as a shadow.	"	"	" and GRADUATION!

NOTES & FEEDBACK

Qualification Timelines for Existing Staff

A cohort strategy to qualify 15–19 peers within twelve months — six if capacity allows

New hires meet the standard on entry. For the existing workforce, the constraint is not willingness — it is coverage. The street cannot lose units while the bench trains, and the ride-along weeks are limited by ambulance preceptor capacity. The strategy below threads both constraints.

Design principles

- **Cohorts of four.** Removing four peers from the rotation at a time is absorbable within the schedule in Document 1.2, using the supervisor-covered Wednesday seam and overlap-window hours for classroom components so field coverage is never reduced below minimums.
- **Classroom doubling.** Weeks 1–2 are classroom-based and can host two cohorts simultaneously (eight peers) when scheduling allows, compressing the calendar without touching the precepted-week bottleneck.
- **Preceptor pacing.** Weeks 3–4 (CPI intensive and ride-alongs) run one cohort at a time, keeping the ask of SFFD ambulance crews to a steady, predictable four riders per cycle.
- **Grandfathered standing throughout.** No existing peer's assignment, pay, or standing changes while their timeline runs; the timeline is a completion schedule, not a probation.

Plan A — six-month completion (preferred, capacity permitting)

Window	Activity
Month 1	Cohort 1 (4 peers): full Academy cycle. Cohort 2 joins Weeks 1–2 classroom.
Month 2	Cohort 2 completes Weeks 3–4. Cohort 3 begins classroom.
Month 3	Cohort 3 completes; Cohort 4 begins classroom.
Month 4	Cohort 4 completes; Cohort 5 (remaining 3–7 peers, incl. make-ups) begins.
Month 5	Cohort 5 completes ride-along weeks.
Month 6	Make-up ride-alongs; certification exam sittings; standard fully met, 15–19 peers.

Plan A requires two conditions: (1) SFFD can host one four-rider ride-along cycle per month without strain, and (2) CPI intensive dates can be booked monthly under the approved funding. If either slips, the program falls back to Plan B rather than diluting the standard.

Plan B — twelve-month completion (conservative)

Identical cohort structure on an every-other-month cadence: five cohort cycles across months 1–10, with months 11–12 reserved for make-ups, exam sittings, and documentation audit. Plan B halves the monthly ask of ambulance preceptors and tolerates leave, turnover, and seasonal surge without schedule risk. Under either plan, EMT coursework (if selected under Document 2.4) proceeds in parallel through reserved CCSF seats, since it follows the academic calendar rather than the Academy calendar.

NOTES & FEEDBACK

Letter — The Medical Credential: EMT or CPR/First Aid

Closing the responder literacy gap, with the selection deferred to the Fire Department

August 2026

To Chief Crispen, the Fire Commission, and the reviewing bodies:

The tiered standard includes a medical credential for every SCRT peer, and this letter is written to put the choice of that credential where it belongs. Two options are on the table: EMT certification, or CPR/First Aid certification. Between them, the Fire Department's judgment matters most, and this framework defers to it. SFFD's Community Paramedics work beside these peers on every call; no one is better positioned to say which credential makes the partnership work best on scene.

The purpose deserves to be stated precisely, because it shapes the right answer. The credential is not intended to make peers junior clinicians, and it does not compete with the clinical role of the paramedic in any way. Its purpose is to close the literacy gap among responders: a peer who shares the paramedic's vocabulary for scene safety, patient presentation, and hand-off reads the scene faster, anticipates their partner's next move, and communicates in the terms the medical system understands. That is a teamwork investment, not a scope-of-practice change.

If the Department's judgment is that EMT certification is the right standard, this framework respectfully asks that SFFD lend its longstanding relationship with City College of San Francisco to the effort — specifically, by supporting a request that CCSF hold designated seats in upcoming EMT courses until all grandfathered SCRT peers have qualified. The Department's voice with CCSF would carry further than any provider's, and the ask is modest: predictable seats, not a new program.

There is also a quieter benefit worth naming. Peers and Fire Department members sitting the same coursework, in the same classrooms, is exactly the kind of shoulder-to-shoulder time that builds trust across teams before anyone needs it on a call. The credential is a literacy investment; the classroom is a relationship investment. Both pay off on scene.

Respectfully,

Amelia Harmon
Peer Supervisor (nine years behavioral health service; five years SCRT)
Member, San Francisco Behavioral Health Council
Bloomberg American Health Fellow, Johns Hopkins Bloomberg School of Public Health
Written in my individual capacity; affiliations noted for identification only

NOTES & FEEDBACK

Letter of Inquiry — CIT Collaboration with SFPD

An invitation to explore shared training between officers and crisis peers

August 2026

To the San Francisco Police Department and the Police Commission:

I write first with gratitude: thank you to Lieutenant Donald Anderson for the opportunity to join the Department's team training last year. That experience — officers and a peer learning in the same room — directly informs this inquiry.

Recommendation 2 lists CIT training among the peer role's advancement tiers, pending SFPD collaboration. In that spirit, this letter poses three open questions for the Department's consideration, in whatever order and on whatever timeline suits it:

- **Seats.** Would the Department consider extending CIT course seats to SCRT Peer Counselors, as it has for partner agencies — so that peers responding to persons in crisis are trained in the same de-escalation framework and field tactics vocabulary as the officers they may share scenes with?
- **Cross-training.** Would the Department have interest in peers participating within CIT courses not only as students but as a lived-experience voice — complementing the perspectives the curriculum already includes — so officers and peers train with, and learn from, each other?
- **Field collaboration.** Where a CIT-designated incident would benefit from a certified peer on scene, would the Department be open to exploring protocols for requesting or co-deploying CIT-trained peers — on terms the Department defines and with incident command unambiguous?

None of these questions carries an assumption about the answer. Each is an offer of the same thing: a workforce trained to the Department's own standard, available to make the Department's hardest calls a little less hard. I would welcome the chance to discuss any of them with the CIT Unit or the Working Group at their convenience.

Respectfully,

Amelia Harmon
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PART 3

Training Operations in the Overlap Window

Recommendation 3 — Periodic training operations within the overlapping deployment model

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IN THIS PART

NOTES & FEEDBACK

The 1:00–4:00 p.m. Window — Training Without Losing the Street

A cadence design worked through against 911 call-level responsibilities

Under the schedule in Document 1.2, all three shift lines are on the board from 12:00 p.m. to 5:00 p.m. daily. The core of that window — 1:00 to 4:00 p.m., after the noon line has settled in and before the 5:00 a.m. line begins end-of-shift duties — is the only period when training can draw on surplus capacity rather than street coverage. The question Recommendation 3 poses is how to use it: often enough that cross-team practice is real, without pulling units from the field more than the street can absorb.

The governing constraint: 911 coverage is not negotiable

SCRT is a 911-dispatched resource, so any training design must answer three questions honestly: how many units can be off the street at once; what happens when call volume spikes mid-drill; and how the design looks to the DEM dispatchers who have to trust it. Three conclusions follow. First, all-hands training during service hours is impossible. Second, taking units fully out of service is unnecessary — the Fire Department has trained on shift for a century by drilling in quarters while remaining dispatchable, and SCRT should borrow the practice outright. Third, the training calendar should follow the demand data: DEM CAD records identify which weekday afternoons run quietest, and training belongs there.

The proposed cadence — three tiers

Tier	Duration / frequency	Who	Content and coverage logic
Tier 1 — Daily huddle	15 minutes, at the window's open, daily	All on-duty units, by radio or at the deployment station as calls allow	Case hand-offs, safety flags, one teaching point. No coverage impact; builds the cross-team habit the larger sessions depend on.
Tier 2 — Unit drill block	90 minutes; each unit rotates through approximately every three weeks	One unit at a time, in "training in quarters" status	Case debriefs, skills refreshers, and scenario run-throughs. The training unit remains in service on the radio and is recallable for priority calls; remaining units cover its zone. Blocks are placed on the quietest afternoons per DEM CAD data — roughly one to two blocks per week program-wide.
Tier 3 — Cross-team training window	As CAD demand data allows; scheduled when the data supports it	Two units together, same recallable status	The signature session of the program. Whenever DEM CAD demand data shows a window in which two units can safely stand down to recallable training status, that window becomes the cross-team session: full joint scenario work with role rotation, SFFD Community Paramedic participation, and — as the CIT inquiry in Document 2.5 matures — invited SFPD participation. DEM is notified in advance and holds recall authority throughout.

Why this cadence and not more — or less

- **One unit down at a time is the safe ceiling.** With multiple units on the board in the window, a single unit in recallable training status leaves the balance fully available — within the normal variation for meal breaks and transports that dispatch already absorbs daily.
- **Every three weeks per unit balances retention with street presence.** The cadence keeps scenario skills well above annual-training decay while asking less of any one zone than a tighter rotation would — dispatchers see a lighter, more predictable footprint.
- **Cross-team training is the point.** Integrated models live or die on how their halves practice together. Rather than forcing a joint drill onto the calendar regardless of demand, the Tier 3 design lets the City's own CAD data open the window: when two units can safely stand down, the program trains as one organization — without gambling coverage to do it.
- **The supervisor seam carries cohesiveness across the halves.** Field staff alternate ("flop") which Wednesdays they work, so the halves do not overlap in the field; the Peer Supervisors do. A supervisor working two consecutive Wednesdays meets two entirely different sets of teams — the best coverage of the program available to any single role — making the supervision layer, by design, the connective tissue that keeps practice standards and culture consistent program-wide.
- **Strong structures make hard collaboration possible.** National best practice in alternative response is candid that interdisciplinary and interdepartmental collaboration is genuinely difficult — and equally clear that it is achievable, and transformative, when supported by strong recurring structures. The huddle, the rotating drill block, and the data-triggered cross-team window are exactly such structures.
- **Recallability is the release valve.** Because training units stay in service, a surge simply converts a drill into a response — the same graceful failure mode fire companies have always used. A drill interrupted by a real call is not a failed drill; it is a precepted one.

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PART 4

National Field Engagement

Recommendation 4 — Maintain engagement with the national alternative response field

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IN THIS PART

NOTES & FEEDBACK

Letter — Recommended Convenings and the Attendance Requirement

Why semiannual national engagement is an accountability requirement, not a perk

August 2026

To the reviewing bodies:

Alternative crisis response is one of the fastest-moving fields in American public health. In the span of a few years the country has stood up the 988 system, states have adopted federally matched Medicaid mobile crisis benefits, and jurisdictions from King County to Georgia have rebuilt their crisis continuums — each generating implementation findings the rest of the field inherits. San Francisco built one of the nation's recognized models; leading with accountability and outcomes requires knowing, at all times, what current evidence-based practice is and how SCRT compares. Recommendation 4 therefore requires semiannual convenings with national colleagues, with findings reported into the program's training calendar (Part 3) and evaluation design (Part 7). The requirement is deliberately modest in cost and deliberately firm in cadence — a program that checks in with its field twice a year cannot drift far.

To satisfy the cadence, this framework recommends anchoring the calendar on two national convenings — one rooted in the first-responder and public-safety world, one in the behavioral health crisis continuum — so the program hears both of its parent fields every year:

- **The Advancing the Field of Alternative Response Convening** — the annual national gathering of alternative response programs, hosted by the Policing Project at NYU School of Law, the Georgetown Law Center for Innovations in Community Safety, and the Alternative Mobile Services Association. The 2026 convening, themed "Establishing Permanence," met June 4–5 in Chicago; the attendance requirement anchors on the 2027 edition forward. The reasoning is direct: this is the room where the field is professionalizing — standards, classification, durability within public safety systems — which is precisely the agenda of this framework's Parts 2 and 6.
- **CrisisCon — the National Crisis Continuum Conference** — the national conference for behavioral health crisis providers, payers, advocates, and system leaders, hosted by the Crisis Residential Association and the International Council for Helplines. CrisisCon26 meets October 5–8, 2026 in Atlanta. The reasoning: it is the widest single view of the crisis continuum SCRT hands off into — 988, mobile crisis, residential, and follow-up — and the natural venue for the measurement and Medi-Cal practices in Parts 1 and 7.

The attendance requirement: representatives from both SFFD and RAMS attend both convenings. That is the requirement, stated in full — not SFFD to the responder table and RAMS to the behavioral health one, but both organizations, at both tables, every year. The point of a paired program is that its halves learn together; split attendance produces two organizations importing two different fields' assumptions, which is how integrated models come apart. Attendees deliver a joint written brief to program leadership and the training calendar within thirty days of each convening. Where budget or scheduling forces substitution in a given year, an equivalent national convening in the same orientation may substitute with program leadership's approval — the cadence and the both-departments rule are the requirement; the specific venues are the recommendation.

Respectfully,

Amelia Harmon
Peer Supervisor (nine years behavioral health service; five years SCRT)
Member, San Francisco Behavioral Health Council
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NOTES & FEEDBACK

PART 5

Deployment Station Parking

Recommendation 5 — Resolve deployment station parking through a formal agreement

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IN THIS PART

NOTES & FEEDBACK

Risk Assessment — The Current Parking Condition

Street parking at the deployment station is an operational and workforce risk, documented

The SCRT deployment station currently offers staff no designated parking. Personnel arriving for 5:00 a.m. shifts and departing at midnight park on surrounding streets governed by overlapping street sweeping schedules — meaning that on many shift patterns there is no legal parking option that spans a 12-hour tour at all. This is not an amenity gap. It is a risk condition, and it has already produced losses. It must also be said, plainly and respectfully: an operational condition the City itself has left unresolved should not be repurposed as a justification for removing the workforce exposed to it. Given the risks documented below, using this condition against the peer workforce would be inappropriate.

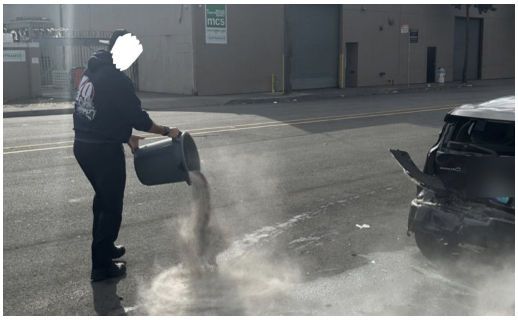

Figure — the street parking condition at the deployment station (identifying details obscured).

Documented incidents

- A staff member’s personal vehicle was totaled while parked on the surrounding streets during a shift.
- A supervisor’s personal vehicle was stolen from the same street parking condition.

Two total-loss vehicle events within one small workforce is not bad luck; it is a sampling of the base rate the location imposes. Every additional month of street parking re-runs the same exposure.

Risk analysis

Category	Exposure
Financial	Vehicle loss, damage, citations, and towing fall on a modest-wage workforce; a single totaled vehicle can exceed a month’s take-home pay. The employer and City bear none of the loss but all of the attrition it causes.
Retention	A role already demanding 5:00 a.m. starts and midnight ends cannot also demand that staff gamble their vehicles to work it. Parking risk converts directly into resignations — the most expensive outcome available, given the training investment in Part 2.
Operational	Sweeping schedules force mid-shift vehicle moves, pulling responders off the board or delaying shift relief; distant parking delays 5:00 a.m. unit starts.
Safety	Staff walking to and from remote street parking in pre-dawn and post-midnight hours, in uniform, in an industrial area, carry a personal safety exposure the City would not accept for other 911-system personnel.

The conclusion is short: this is not a street on which the City can seriously require its workforce to show up reliably — and it is certainly not a street on which the City can park a profession. The remedies follow in Documents 5.2 and 5.3, in order of preference.

NOTES & FEEDBACK

Preferred Remedy — A CCSF Evans Campus MOU

Ten leased spaces, a request for Supervisor Walton's good offices, and a private-lot fallback

Recommendation 5's preferred remedy is a memorandum of understanding with City College of San Francisco's Evans Campus to lease ten parking spaces for SCRT operations. The Evans Campus sits within practical distance of the deployment station, the ask is small against the campus's capacity, and the arrangement would pair naturally with the EMT course-seat relationship described in Document 2.4 — one institutional agreement serving two recommendations. This proposal takes the MOU seriously as a real transaction: it should be specified, priced, and funded like one, with lease costs carried as a line item in the consolidated contract rather than absorbed informally. An unfunded MOU is a handshake; the workforce has been parked on handshakes long enough.

A respectful request of Supervisor Walton

The Evans Campus and the deployment station sit in District 10, and this document respectfully requests Supervisor Walton's assistance in bringing the parties to terms — and, should the CCSF conversation stall, in helping the program identify even a privately operated secured lot nearby willing to lease ten spaces on commercial terms. The Supervisor's office knows the district's property landscape better than any city department does, and a single introduction may be worth more than a year of cold inquiries. The program is agnostic between a public and a private lessor; it needs security, proximity, and a signature.

Terms the MOU or lease should contain

- Ten designated spaces available 24 hours, seven days, matching the 5:00 a.m.–midnight operating footprint with margin on both ends.
- Access control appropriate to a secured facility (gate, permit, or placard system) and exterior lighting on the pedestrian path between the lot and the station.
- A term of at least the 24-month evaluation period in Part 7, with renewal options, so the parking solution and the program review run on the same clock.
- If with CCSF: a companion clause memorializing the EMT course-seat reservation described in Document 2.4, so both halves of the CCSF relationship live in one agreement.

NOTES & FEEDBACK

Fallback — A Single Designated Location, Properly Equipped

If no lot can be secured, the minimum acceptable alternative, specified

If neither a CCSF agreement nor a private secured lot can be reached, Recommendation 5 provides that the Fire Department will designate a single pickup and drop-off point for partnering staff, location pending collaboration. This document specifies what that designation must include for the fallback to be workable rather than merely nominal.

Location standard

One location, not a rotation — predictability is the point. The site must be equitable for the whole workforce: reachable by car and by transit across the span of shift start and end times actually worked (5:00 a.m. starts and midnight ends), and offering lawful long-dwell parking for staff who must drive. A location that works only for day shifts, or only for drivers, fails the standard.

Facility standard

Once the location is approved, it must provide, at minimum:

- **Indoor access at all hours**, opening at least one hour before every shift start and remaining available at least one hour after every shift end — including hygiene facilities for staff freshening up before a 12-hour tour or after one, at 4:00 a.m. and at 1:00 a.m. alike.
- Potable water.
- A restroom.
- **A place to sit** — seating adequate for an arriving and departing unit to overlap, suitable for boot-up, report-writing, and decompression.
- **A small kitchen:** refrigeration, a microwave, and a sink, sufficient for a workforce whose shifts span every mealtime the day contains.
- Secure storage for personal effects during the tour.

These are not amenities; they are the baseline conditions under which a 19-hour-a-day, seven-day field operation can be staffed by human beings. The Fire Department houses its own members to a standard far above this floor, for the same operational reasons. The fallback asks only that the same logic extend to the partners riding beside them.

NOTES & FEEDBACK

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PART 6

Civil Service Classification Pathway

Recommendation 6 — Preserve a pathway toward a permanent civil service classification

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IN THIS PART

NOTES & FEEDBACK

Precedent — Permanent Crisis Peer Positions in Public Service

The classification proposed here would be well-precedented, not novel

Recommendation 6 reserves contract language for a future permanent peer classification. A reviewing body's first fair question is whether governments actually employ certified peers in permanent crisis roles, or whether this proposal asks San Francisco to invent something. The record answers clearly: the model exists at the state, county, and national level, including within classified health-worker series directly analogous to the parity structure proposed in Document 6.3.

- **Pennsylvania** maintains a statewide civil service classification for Certified Peer Specialists, employing peers as government workers in state hospitals and county behavioral health offices — with certification itself qualifying applicants for the classified title.
- **Orange County, California** employs Certified Peer Support Specialists in its classified Mental Health Worker III classification, assigned to the county's Crisis Assessment Team to provide peer support and crisis intervention on mobile crisis responses — a certified peer, classified within a county health-worker series, doing crisis field work. This is the closest structural precedent for the Health Worker parity proposed here.
- **King County, Washington** requires peer counselors as core members of the Mobile Rapid Response Crisis Teams serving Seattle — the same DCHS program standards on which the Crisis Responder Academy in Part 2 is modeled — demonstrating peers as a permanent, specified component of a major metropolitan crisis system rather than a pilot feature.
- **The federal government** employs Peer Specialists as a permanent title within the Department of Veterans Affairs, including on the Veterans Crisis Line — peers in classified public employment doing crisis work at national scale.
- **State Medicaid design** treats the peer crisis role as permanent infrastructure: as of FY 2022, seven states required peers on Medicaid mobile crisis teams with thirteen more planning to, and CMS guidance names peer specialists as mobile crisis team members and highlights peers as often best equipped to lead engagement and follow-up (see the annotated references).

San Francisco would not be first. It would be joining a settled direction of travel — with the distinction that its classification would sit, appropriately, at the top of the acuity range within the peer profession.

NOTES & FEEDBACK

Draft Classification — Peer Counselor IV

Draft specification language for Civil Service Commission review

Class title (proposed)	Peer Counselor IV
Class code	[TBD]
Appointment type	Permanent Civil Service
Salary range	[TBD — recommend benchmarking above Health Worker IV parity in recognition of added EMT certification and clinical scope; pending formal Classification & Compensation analysis]

Distinguishing features

Peer Counselor IV is the advanced clinical and crisis-response specialist level of the peer profession. Incumbents hold current EMT certification and are deployed on integrated crisis response teams alongside clinicians and emergency medical personnel (for example, paramedic/peer co-response models such as the Street Crisis Response Team). The level is defined by field and clinical scope rather than supervisory authority: incumbents perform crisis intervention and clinically adjacent duties directly, and do not supervise other staff.

Distinguished from Health Worker IV (2588) by

- Qualifying lived experience under California SB 803 standards — the defining professional foundation of the role.
- Completion and continuous maintenance of Medi-Cal Peer Support Specialist certification (DHCS/CalMHSA), with biennial CEU renewal.
- Completion of the RAMS Crisis Responder Academy (or equivalent recognized by the appointing authority).
- Crisis Intervention Team (CIT) training, pending interdepartmental collaboration with SFPD.
- Current EMT certification, pending interdepartmental collaboration on the program's medical credential standard.

Essential duties

- Interview and screen program clients, identifying general client condition; perform crisis intervention activities under professional direction.
- Provide broad social counseling activities and assist in group therapy sessions.
- Serve as a first responder alongside clinical and emergency medical personnel on integrated crisis response teams, providing lived-experience-based engagement, de-escalation, and stabilization support.
- Conduct field-based safety and basic medical assessments consistent with current EMT certification and scope of practice, including pre-clinical examinations of vital signs such as weight, temperature, and blood pressure.
- Assist in de-escalating behavioral health crises in coordination with mobile crisis, clinical, and emergency medical services personnel.
- Provide advanced resource navigation, including referrals and direct linkage to mental health services, housing, transportation, and community resources during and following a crisis response.
- Escort and transport clients to services or facilities as clinically appropriate.
- Document crisis response and clinical contact information in electronic health/program records in compliance with agency policy and applicable regulation.
- Perform other duties as assigned/required.

Minimum qualifications

- Minimum three (3) years of experience as a certified Peer Support Specialist in a crisis-response or field-based setting.
- Demonstrated ability to work effectively within multidisciplinary first-responder teams under high-stress field conditions.

Special requirements

- Possession of a current Medi-Cal Peer Support Specialist Certification, maintained throughout employment.
- Current, valid Emergency Medical Technician (EMT) certification issued by the State of California, or ability to obtain within six (6) months of hire.
- Valid California driver's license and satisfactory driving record.

Open items for further drafting: class code and EEO-4 job category; final salary band; and review by DHR Classification & Compensation, with meet-and-confer with the recognized bargaining unit where applicable.

NOTES & FEEDBACK

Parity Justification — Health Worker IV

Why the peer profession's specialist level belongs at parity with classification 2588

Recommendation 6 positions the Peer Counselor IV at parity with the City's Health Worker IV (2588) classification. Parity is a claim about comparable work, and it should be argued on the comparators a classification analyst would actually use. Parity is argued here as the floor: the draft specification in Document 6.2 recommends benchmarking at or above the 2588 schedule in recognition of the added EMT credential and clinical scope.

Comparator	Analysis
Independence of practice	Health Worker IV performs advanced-level community health work under general direction. The peer IV likewise practices under general direction in the field — on 911-dispatched scenes where the peer's judgment is exercised in real time, without a supervisor present.
Complexity and acuity	The peer IV works the highest-acuity behavioral health crises in the public system — psychosis in traffic, suicidality, post-overdose engagement — as a designated specialist function within a 911 response. Acuity of the service environment meets or exceeds the comparator.
Required credentials	State Medi-Cal certification with biennial CEU renewal, a four-week specialized academy with precepted field weeks, a de-escalation certification, EMT certification, and CIT training as available — a credential stack comparable in depth to the certificate-and-experience requirements of the 2588 level.
Field responsibilities	Direct crisis intervention, field-based safety and basic medical assessment within EMT scope, and advanced resource navigation parallel the advanced program-support functions that distinguish Health Worker IV from journey-level health workers.
Revenue-generating function	The certified peer is the team member whose presence qualifies encounters for Medi-Cal mobile crisis claiming (Part 1) — a direct cost-recovery function few classifications at any level can claim.

What parity purchases: rotation, retention, and moral refreshment

Parity at the 2588 level is not only fair compensation for comparable work; it is the mechanism that makes a sustainable crisis career possible. At parity, Peer Counselors can rotate assignments at regular intervals within the system of care — in the manner of the Fire Department's shift bid system — staying connected and accountable to the system while gaining the variety and moral refreshment the crisis role demands. Published research on alternative response programs, including peer-reviewed work on this workforce (Worthen et al., 2026, Frontiers in Psychiatry), identifies moral injury and burnout as the field's central workforce risks; rotation at parity is the structural answer. The salary benchmark is the City's published 2588 Health Worker IV schedule, aligned step-for-step at minimum; no bespoke pay structure is proposed or needed.

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PART 7

The 24-Month Evaluation

Recommendation 7 — Co-create an evaluation method for the next 24 months

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IN THIS PART

NOTES & FEEDBACK

Evaluation Timeline

Six months of baseline through the operational changes, eighteen of collection — landing on the FY 2029–30 budget cycle

Recommendation 7's original timeline is retained in full and elaborated below with the milestones a co-created evaluation needs: a design phase before the clock starts, quarterly reporting so no body waits two years to learn anything, and a preliminary-findings checkpoint early enough that the final report holds no surprises.

Milestone	Content
Month 0 (pre-clock)	Evaluation design co-created by the stakeholders and the evaluator; measures, data-sharing agreements, and comparison strategy locked before collection begins.
Months 1–6	Baseline period, deliberately buffering the concurrent operational changes (consolidation, training standards, schedule architecture) so the evaluation measures the settled program, not the turbulence of standing it up.
Months 7–24	Eighteen months of data collection.
Quarterly	Public dashboard to the Health and Fire Commissions: response volumes, resolution codes, follow-up completion, Medi-Cal claiming, and workforce indicators.
Month 20	Preliminary findings briefing to the commissions and the Mayor's Office.
Month 24	Final report complete — timed to inform the FY 2029–30 budget cycle.

Evaluation is conducted or validated by the Controller's Office (City Services Auditor) or an external academic partner, per the original recommendation. The two are compatible: an academic partner can lead design and analysis with the Controller validating methods and fiscal findings — a division of labor the City has used successfully before.

A standing reporting commitment

Accountability in this design runs in every direction. The preparer commits to reporting on this evaluation's progress and findings to any body that wishes to receive it — and offers, specifically, to present to each commission at regular intervals of the commission's choosing, and to any stakeholder on request. Operational changes of this magnitude deserve a genuinely collaborative path forward: one in which the people doing the work, the agencies directing it, and the bodies overseeing it are looking at the same numbers at the same time.

NOTES & FEEDBACK

Methods of Evaluation

The candidate methods, with the ones suited to this situation highlighted

The methods below are the standard toolkit for evaluating a service-system change of this kind. The situation's specific features — staged operational changes with known dates, rich linked administrative data, and no possibility of randomization — make some far better suited than others. The best-fit methods are marked ◆ and discussed.

Method	Fit	Application here
◆ **Interrupted time series (ITS)**	Best fit — primary design	The program's changes occur on known dates against years of continuous 911/CAD and clinical data — the exact structure ITS is built for. Monthly series on response volume, on-scene resolution, transport rates, involuntary holds, and 7-/30-day re-encounter, with change-points at each operational transition.
◆ **Difference-in-differences**	Best fit — comparison design	Compare SCRT-eligible call types against similar call strata handled by other resources, and affected neighborhoods against comparable ones, to separate program effects from citywide trends (seasonality, drug supply shifts, policy changes).
◆ **Linked administrative cohort**	Best fit — person-level outcomes	Individuals served, followed across linked systems — DPH clinical records, ONE System, DEM CAD, and Medi-Cal claims — for service linkage, repeat crisis contact, and downstream utilization. San Francisco already holds every dataset required.
◆ **Cost-effectiveness analysis**	Best fit — fiscal question	Program cost per encounter and per resolved encounter, net of Medi-Cal recovery (Part 1), against the comparator cost of ambulance transport, emergency department use, and custodial responses. Controller-validated.
Pre/post outcome comparison	Supporting only	Simple and legible for public reporting, but cannot separate program effects from secular trend; used for dashboards, not conclusions.
◆ **Workforce measures**	Best fit — workforce question	Validated burnout and moral injury instruments administered semiannually, following the peer-reviewed measurement precedent in this workforce (Worthen et al., 2026, Frontiers in Psychiatry), plus retention and vacancy tracking.
Qualitative & client experience	Supporting	Structured client experience surveys and staff interviews; interprets the quantitative findings and surfaces mechanisms the numbers cannot.
Randomized designs	Not suited	Randomizing crisis response is neither ethical nor operationally possible here; noted only to be set aside explicitly.

A measurement framework spanning nine domains using the City's existing administrative data — clinical, homelessness response, dispatch, and claims systems — has been prepared as a formal annotated bibliography (Measuring What Peers Do) and is reproduced within the annotated references at the back of this booklet; the evaluation need not begin from a blank page.

NOTES & FEEDBACK

Request — Ongoing Data Collaboration and the Office of Coordinated Care

Standing access, a standing channel, and a standing invitation

August 2026

An evaluation is only as good as its data pipeline, and a program that intends to lead with accountability needs that pipeline as permanent infrastructure, not a two-year loan. This document makes three requests of DPH, in ascending order of ambition:

- **Continuity of access.** Confirm the database access commitments in Document 1.6 as standing arrangements that survive the evaluation period — clinical records, ONE System, and the Outreach Worker Tool (OWT) — with access governance documented in the consolidated contract.
- **A standing channel with the Office of Coordinated Care.** The Office of Coordinated Care sits at exactly the junction — linking crisis contacts to ongoing care — where SCRT's follow-up work either compounds or evaporates. This document requests a standing collaboration channel: a named OCC liaison to the program, participation in the quarterly dashboard reviews, and shared definitions for linkage outcomes so both offices count success the same way.
- **A research partnership posture.** This program is already generating peer-reviewed knowledge: published work on moral injury and burnout in alternative response programs (Worthen et al., 2026, Frontiers in Psychiatry) drew directly on this workforce, and academic institutions — including the Johns Hopkins Bloomberg School of Public Health — stand ready to study whatever San Francisco builds next, rigorously and publicly. The stakes are national. More than 1,800 mobile crisis teams now operate across all fifty states, and the field still lacks a standardized measurement framework; the program that documents itself best will set the standards the rest adopt. San Francisco built one of the nation's recognized models and already holds, in its existing administrative systems, every dataset a definitive evaluation requires. The City's data partnership converts its crisis program from a local service into a national evidence contribution — the reference point against which the field measures itself — at essentially no marginal cost. Few line items in any department's budget can say that.

Each request is severable; any one of them accepted improves the program. All three together make San Francisco's crisis response what it has always been closest to being: the best-documented, best-evaluated program of its kind in the country.

Respectfully,

Amelia Harmon
Peer Supervisor (nine years behavioral health service; five years SCRT)
Member, San Francisco Behavioral Health Council
Bloomberg American Health Fellow, Johns Hopkins Bloomberg School of Public Health
Written in my individual capacity; affiliations noted for identification only

NOTES & FEEDBACK

Measuring What Peers Do — The Measurement Route

Measures of cross-sector client engagement for alternative crisis response • Working document, prepared July 2026 • Draft for review

Purpose

Alternative crisis response programs are usually judged by traditional first-response statistics — call volume, response time, number of transports. Those numbers cannot see the thing peer counselors and clinicians actually produce: engagement — the client who accepts a shelter bed on the fourth contact, attends a follow-up appointment, stays housed, moves from precontemplation toward change, and stops needing 911. The route summarized here maps how to measure exactly that, across sectors: crisis encounters, behavioral health treatment, shelter and housing, case management, emergency utilization, the justice system, and taxpayer cost. Each domain identifies concrete metrics, validated instruments where they exist, the data system that already holds the numbers, and annotated sources — the sources are folded, alphabetically, into the annotated references that follow.

The central design insight from the literature: the strongest crisis-response studies did not invent new data. They linked records the government already collects — Medicaid claims (Fendrich et al., 2019), county administrative records (Guo et al., 2001), law-enforcement plus provider data (Swanson et al., 2025), and HMIS housing data (HUD system performance measures). San Francisco already operates every one of these systems: the DPH electronic health record (Epic), the ONE System (coordinated entry/HMIS), DEM computer-aided dispatch, Medi-Cal claims, and jail booking data. The measurement route is therefore mostly a record-linkage and governance problem, not a data-collection problem — which is precisely what a Controller's Office or academic-partner evaluation (Recommendation 7) is built to solve.

The route at a glance — nine domains

- **Domain A — The crisis encounter itself:** de-escalation (BARS pre/post delta), voluntary resolution, disposition mix, restraint and 5150 rates, coercion avoided — carrying forward the 2022 SCRT pilot report's variable definitions as the baseline codebook.
- **Domain B — Readiness to change:** movement through validated stages of change (URICA, readiness rulers, SOCRATES) — the 'precontemplative to contemplative' question is measurable.
- **Domain C — Engagement as relationship:** Service Engagement Scale, working alliance, voluntary-acceptance rates, and qualitative trust measures grounded in San Francisco's own street crisis clients (McDaniel et al., 2024).
- **Domain D — Linkage and follow-up:** the HEDIS behavioral health follow-up family (FUM/FUA/FUH/IET) computed from Medi-Cal claims — the single highest-leverage move, converting the billing pathway in Part 1 into an outcomes-measurement engine.
- **Domain E — Shelter and housing:** HMIS/HUD system performance measures — shelter nights, time-to-housing, days housed, returns to homelessness — computed for the SCRT-engaged cohort in the ONE System.
- **Domain F — Emergency-system and justice utilization:** repeat 911/ED/inpatient/arrest against matched comparisons, with the literature's methods cautions (regression to the mean; housing status as a mandatory matching variable) built into the design.
- **Domain G — Graduation through the system of care:** level-of-care movement (LOCUS), functional outcomes, and 'graduation events' — discharge to a lower level of care that holds.
- **Domain H — Fiscal outcomes:** avoided-cost modeling against published unit costs, net program cost per resolved encounter, and Medi-Cal revenue capture — Controller-validated.
- **Domain I — The workforce as an outcome:** validated burnout and moral injury instruments administered semiannually (Worthen et al., 2026), plus retention and vacancy tracking — a system that measures clients but not its workers will misread its own decline.

The linkage ladder

A composite ‘linkage ladder’ ties the domains together for a single client trajectory: crisis contact → voluntary engagement on scene → warm handoff accepted → follow-up contact within 7/30 days → sustained treatment engagement → shelter/housing entry → housing retention at 6/12/24 months → reduced emergency utilization. Every rung is countable in an existing city data system.

Sequencing the work

- **Step 1 — Freeze definitions.** Adopt the 2022 pilot report’s encounter-level variable definitions as the baseline codebook; add BARS pre/post scoring and a voluntary-acceptance field to existing documentation.
- **Step 2 — Flag the cohort everywhere.** Create a linkage key for SCRT-engaged clients across DPH clinical records, the ONE System, DEM CAD, ZSFG records, Medi-Cal claims, and jail booking data, executed under the Controller’s Office or an academic partner with a data use agreement and IRB oversight — the concrete reason database retention (Recommendation 1) is an evaluation prerequisite.
- **Step 3 — Adopt claims-native measures first.** FUM/FUA-style 7- and 30-day follow-up, IET-style treatment initiation, ED and inpatient utilization, and 5150 rates for the flagged cohort — zero new field instruments required.
- **Step 4 — Layer instruments into follow-up, not the field.** Readiness rulers, the Service Engagement Scale, and a brief alliance measure live naturally in OCC and case-management contacts at 30/90/180 days.
- **Step 5 — Compute housing outcomes from HMIS.** Shelter nights, time-to-housing, days housed, and returns to homelessness, benchmarked against the citywide system performance measures the ONE System already produces.
- **Step 6 — Compare, don’t just describe.** Pre/post numbers alone mislead in a frequent-utilizer population (Finkelstein et al., 2020); use propensity-matched comparisons, matching on housing status above all. The six-month baseline plus eighteen-month window in Recommendation 7 accommodates exactly this design.
- **Step 7 — Stratify everything by race/ethnicity.** The pilot report established equity stratification as standard practice; continuing it tests whether engagement gains are equitably distributed — a first-order question, not a sensitivity analysis.

Candidate primary outcomes for the 24-month evaluation

(1) Any behavioral health service engagement within 30 days of crisis contact; (2) days stably housed in the following 12 months; (3) repeat 911/ED/inpatient utilization at 12 months vs. matched comparison; (4) arrest at 11–12 months vs. matched comparison; (5) stage-of-change movement across repeat contacts; (6) cross-system cost per client per month against comparison; (7) workforce burnout and moral injury trajectory, semiannually. Presented together, these answer the question the transport count cannot: not how fast did we arrive, but did the person’s trajectory bend — toward treatment, toward housing, away from the emergency system — and what did that bending save. That is the evidence architecture in which the specific contribution of workers with lived experience becomes visible, attributable, and defensible in a budget cycle.

Annotated References

Alphabetical, APA style, with annotations describing each source's use throughout this booklet

The Medi-Cal fiscal note (Document 1.3) retains its original numbered references exactly as circulated; each of those sources also appears alphabetically below. Sources drawn from the Measuring What Peers Do measurement route are annotated for the evaluation domain they serve. The consolidated, hyperlinked version of this list is maintained at crisisneedspeers.com/references.html. All web sources verified July–August 2026.

Abramson, A. (2021). Building mental health into emergency responses. Monitor on Psychology, 52(5). https://www.apa.org/monitor/2021/07/emergency-responses
Accessible survey of alternative-response implementation across jurisdictions; supports the national field-engagement requirement in Document 4.1.

American Association for Community Psychiatry. (2020). Level of Care Utilization System (LOCUS) for psychiatric and addiction services, Version 20. https://www.communitypsychiatry.org/keystone-programs/locus
The standard adult level-of-care tool; scoring LOCUS over time quantifies 'graduation' through the system of care (measurement Domain G, Document 7.2).

American Rescue Plan Act of 2021, Pub. L. No. 117-2, § 9813, 135 Stat. 4 (2021).
Statutory basis for the Medicaid mobile crisis option and enhanced 85% federal match; the reason the March 2027 window in Document 1.3 is an evaluation-timeline constraint, not just a budget one.

Balfour, M. E., Hahn Stephenson, A., Delany-Brumsey, A., Winsky, J., & Goldman, M. L. (2022). Cops, clinicians, or both? Collaborative approaches to responding to behavioral health emergencies. Psychiatric Services, 73(6), 658–669. https://doi.org/10.1176/appi.ps.202000721
Cross-jurisdiction benchmark set (e.g., Maricopa County's 71% community-resolution rate) against which SCRT's rates can be compared over time (Domain A).

Blumenthal, D., Gumas, E. D., Shah, A., Gunja, M. Z., & Williams, R. D., II. (2024). Mirror, mirror 2024: A portrait of the failing U.S. health system. The Commonwealth Fund. https://doi.org/10.26099/ta0g-zp66
Macro framing for the taxpayer-burden argument: U.S. spending concentrates in avoidable acute utilization — the utilization crisis engagement is designed to prevent (Domain H).

Brinkley, A., & Volpe, J. (2024). Peer support services across the crisis continuum (Publication No. PEP24-01-019). Substance Abuse and Mental Health Services Administration.
SAMHSA's map of where peers operate across the continuum; the crosswalk for deciding where engagement should be measured and attributed to peer contact (Parts 2 and 7).

California Mental Health Services Authority / California Peer Certification. (n.d.). RAMS provider listing — approved training provider, Medi-Cal Peer Support Specialist Certificate course. https://www.capeercertification.org/rams/
Establishes RAMS as a CalMHSA-approved certification training vendor with 10+ years of peer training history — the in-house training capacity underpinning Documents 1.3 and 1.4.

Centers for Medicare & Medicaid Services. (2021). SHO #21-008: Medicaid guidance on the scope of and payments for qualifying community-based mobile crisis intervention services. U.S. Department of Health and Human Services. https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf
Federal design intent: names peer support specialists as mobile crisis team members and highlights peers as often best equipped to lead engagement and follow-up (Documents 1.3, 6.1); its reporting expectations make every claim a research-grade encounter record.

City & County of San Francisco. (n.d.). Street Crisis Response Team. https://www.sf.gov/street-crisis-response-team
Current team composition; cited in the fiscal note's team-composition argument (Document 1.3).

City College of San Francisco. (n.d.). Medi-Cal Peer Support Specialist Training. https://www.ccsf.edu/degrees-certificates/medi-cal-peer-support-specialist-training
CCSF as a CalMHSA-approved training vendor — a program funded by DPH itself — supporting the certification pathways in Documents 1.3, 1.5, and the course-seat requests in Document 2.4.

County of Orange Health Care Agency. (2024). Certified Peer Support Specialist (Mental Health Worker III) [Recruitment posting]. https://www.governmentjobs.com/careers/oc

The closest structural precedent for Document 6.3's parity argument: a certified peer, classified within a county health-worker series, assigned to the Crisis Assessment Team for mobile crisis field work (Document 6.1).

Crisis Prevention Institute. (n.d.). Nationally recognized de-escalation and crisis prevention training. https://www.crisisprevention.com
The de-escalation training anchoring Academy Week 3 (Document 2.2); funding approved for the current fiscal year.

CrisisCon. (2026). The National Crisis Continuum Conference (CrisisCon26), Hilton Atlanta, October 5–8, 2026. Crisis Residential Association & International Council for Helplines. https://www.crisiscon.org
Recommended behavioral-health-continuum convening in Document 4.1; the widest single view of the continuum SCRT hands off into.

CSG Justice Center. (n.d.). Expanding first response — San Francisco, CA program profile. https://csgjusticecenter.org/publications/expanding-first-response/san-francisco-ca/
SCRT team composition and the 14,230 call volume (Nov. 2020–Nov. 2022) used for the claiming-volume scenarios in Document 1.3.

Culhane, D. P., Metraux, S., & Hadley, T. (2002). Public service reductions associated with placement of homeless persons with severe mental illness in supportive housing. Housing Policy Debate, 13(1), 107–163. https://doi.org/10.1080/10511482.2002.9521437
The landmark cross-sector cost study; its one-person-across-seven-systems record-linkage architecture is the methodological blueprint for the linked administrative cohort in Document 7.2 (Domain H).

Currier, G. W., Fisher, S. G., & Caine, E. D. (2010). Mobile crisis team intervention to enhance linkage of discharged suicidal emergency department patients to outpatient psychiatric services: A randomized controlled trial. Academic Emergency Medicine, 17(1), 36–43. https://doi.org/10.1111/j.1553-2712.2009.00619.x
The only U.S. mobile-crisis RCT; supplies the cleanest single linkage metric (first-appointment attendance) and the caution to measure the full attendance trajectory (Domain D).

Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: A report from the field. Schizophrenia Bulletin, 32(3), 443–450. https://doi.org/10.1093/schbul/sbj043
Foundational conceptual grounding: peers produce engagement through mutuality and modeled recovery — why engagement, not transport, is the correct primary outcome for the peer role (Part 7 framing).

Davis, J., Norris, S., Schmitt, J., Shem-Tov, Y., & Strickland, C. (2025). Mobile crisis response teams support better policing: Evidence from CAHOOTS (NBER Working Paper No. 33761). National Bureau of Economic Research. https://doi.org/10.3386/w33761
First causal CAHOOTS evaluation; its dispatch-data outcome definitions (arrest probability, non-coercive resolution) are directly portable to San Francisco's DEM CAD data (Domain A).

Dee, T. S., & Pyne, J. (2022). A community response approach to mental health and substance abuse crises reduced crime. Science Advances, 8(23), eabm2106. https://doi.org/10.1126/sciadv.abm2106
Causal evidence (Denver STAR) that community response reduced reported crime — establishing neighborhood-level crime as a legitimate program outcome (Domain F).

Department of Health Care Services. (2023). BHIN 23-025: Medi-Cal mobile crisis services benefit implementation. https://www.dhcs.ca.gov/Documents/BHIN-23-025-MediCal-Mobile-Crisis-Services-Benefit-Implementation.pdf
The implementation instruction behind Document 1.3: qualified team-member table (the certified peer's billing role), H2011 claiming, ARPA 85% FMAP, and the State General Fund non-federal share.

Department of Health Care Services. (n.d.). CalAIM behavioral health payment reform — Frequently asked questions. https://www.dhcs.ca.gov/calaim-behavioral-health-payment-reform-frequently-asked-questions/
Mobile crisis rate methodology and transport add-ons; supports the encounter-rate mechanics in Document 1.3.

Department of Health Care Services. (n.d.). Medi-Cal behavioral health fee schedules, fiscal year 2025–26 — SMHS Mobile Crisis workbook, San Francisco (County Code 38). https://www.dhcs.ca.gov/services/mental-health-services-division-default/medi-cal-behavioral-health-fee-schedules-fiscal-year-2025-26/
The published source of San Francisco's $3,143.81 per-encounter mobile crisis rate and transport add-ons — the actual rate on which every scenario in Document 1.3 is built.

Department of Health Care Services. (n.d.). Medi-Cal peer support services (SB 803 benefit; county opt-in status). https://www.dhcs.ca.gov/services/medical-peer-support-services/
The SB 803 benefit and 53-of-58-county opt-in status cited in Document 1.3.

Department of Health Care Services. (n.d.). Medi-Cal Peer Support Services Specialist Program — Frequently asked questions. https://www.dhcs.ca.gov/medi-cal-peer-support-services-specialist-program-frequently-asked-questions/
H0038/H0025 billing guidance for the peer support pathway in Document 1.3.

Department of Health Care Services. (n.d.). Mobile crisis services (CalAIM initiative overview). https://www.dhcs.ca.gov/mobile-crisis-services/
Program-level overview of the CalAIM mobile crisis benefit referenced in Document 1.3.

Downtown Emergency Service Center. (n.d.). Mobile Rapid Response Crisis Team. https://desc.org/what-we-do/crisis-response/
The Seattle teams — county-funded, pairing peer counselors with behavioral health professionals, with over a decade of field history — on whose standards the Crisis Responder Academy is modeled (Documents 2.2, 6.1).

Dyches, H., Biegel, D. E., Johnsen, J. A., Guo, S., & Min, M. O. (2002). The impact of mobile crisis services on the use of community-based mental health services. Research on Social Work Practice, 12(6), 731–751. https://doi.org/10.1177/104973102237469
Measured 90-day community service receipt from county administrative data with propensity matching — the exact design available to DPH from its own records (Domain D).

Fendrich, M., Ives, M., Kurz, B., Becker, J., Vanderploeg, J., Bory, C., Lin, H.-J., & Plant, R. (2019). Impact of mobile crisis services on emergency department use among youths with behavioral health service needs. Psychiatric Services, 70(10), 881–887. https://doi.org/10.1176/appi.ps.201800450
The model claims-based evaluation (Medicaid claims, propensity quintiles, 18-month window) — directly replicable once SCRT encounters generate Medi-Cal claims (Domains D and F).

Fielder, J. (2026, July 30). Letter to the San Francisco Fire Commission: Agendizing Peer Counselors.
Supervisor Fielder's formal request that the SCRT restructuring be placed on the Commission's August 12 agenda and that no permanent staffing changes be made until publicly reviewed — the review this booklet is built to serve (Transmittal).

Finkelstein, A., Zhou, A., Taubman, S., & Doyle, J. (2020). Health care hotspotting — a randomized, controlled trial. New England Journal of Medicine, 382(2), 152–162. https://doi.org/10.1056/NEJMsa1906848
The Camden Coalition RCT: pre/post declines among super-utilizers vanished against a randomized control. The single most important methods citation here — why Recommendation 7 insists on a validated comparison design (Domain F).

Fortuna, K. L., Cui, S., Lebby, S., Xie, H., Bruce, M. L., & Bartels, S. J. (2025). PeerTECH: A randomized controlled trial of a peer-led mobile health intervention. mHealth, 11, Article 28. https://doi.org/10.21037/mhealth-24-64
Gold-standard demonstration of certified peers delivering a structured intervention with pre-registered outcomes; an instrument-battery template for peer-delivered crisis follow-up (Domain B).

Fuller, D. A., Lamb, H. R., Biasotti, M., & Snook, J. (2015). Overlooked in the undercounted: The role of mental illness in fatal law enforcement encounters. Treatment Advocacy Center.
Grounds zero-event tracking (deaths, serious injuries, uses of force during behavioral crisis calls) as a monitoring measure in the evaluation set (Domain F).

Geller, J., Fisher, W., & McDermeit, M. (1995). A national survey of mobile crisis services and their evaluation. Psychiatric Services, 46(9), 893–897. https://doi.org/10.1176/ps.46.9.893
The historical warning: widespread mobile-crisis adoption on little empirical evidence. Thirty years later the field still lacks standardized measures — the gap the measurement route addresses (Part 7).

Gillooly, J., & Friedman, B. (2024). San Francisco's public safety system: Lessons in first response policy implementation. Policing Project, NYU School of Law.
Implementation-level account of San Francisco's first-response reforms, including a documented SCRT call in which the peer alone incited behavior change — the qualitative case for member-level engagement measurement.

Guo, S., Biegel, D. E., Johnsen, J. A., & Dyches, H. (2001). Assessing the impact of community-based mobile crisis services on preventing hospitalization. Psychiatric Services, 52(2), 223–228. https://doi.org/10.1176/appi.ps.52.2.223
The seminal quasi-experiment: hospital-based crisis care carried 51% higher odds of hospitalization than mobile crisis; defines the inpatient-diversion outcome and its survival-analysis method (Domain F).

Holland, J., & Tran, T. V. (2010). The use of social workers' emergency certificates and factors associated with linkage to services. Social Work in Mental Health, 8(6), 495–509. https://doi.org/10.1080/15332981003744438
A methods caution: composite 'linkage' variables prove uninterpretable. Lesson for the evaluation design — define linkage as discrete, dated, verifiable events (Domain D).

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. Journal of Counseling Psychology, 36(2), 223–233. https://doi.org/10.1037/0022-0167.36.2.223
The standard alliance measure; its short form can test whether alliance formed with a peer differs from alliance formed with uniformed responders (Domain C).

Karaca, Z., & Moore, B. J. (2020). Costs of emergency department visits for mental and substance use disorders in the United States, 2017 (HCUP Statistical Brief No. 257). Agency for Healthcare Research and Quality.
National unit-cost data for behavioral health ED visits — the pricing source for the avoided-ED-visit line of the fiscal model, adjustable via ZSFG charge data (Domain H).

KFF. (n.d.). A look at state take-up of ARPA mobile crisis services in Medicaid. https://www.kff.org/medicaid/a-look-at-state-take-up-of-arpa-mobile-crisis-services-in-medicaid/
Documents the enhanced 85% FMAP and CMS-approved state plan amendments cited in Document 1.3.

KFF. (n.d.). Behavioral health crisis response: Findings from a survey of state Medicaid programs. https://www.kff.org/mental-health/behavioral-health-crisis-response-findings-from-a-survey-of-state-medicaid-programs/
Source of the seven-states-requiring-peers finding (thirteen more planning to) cited in Documents 1.3 and 6.1.

King County Department of Community and Human Services. (n.d.). Crisis services. https://kingcounty.gov/en/dept/dchs/human-social-services/behavioral-health-recovery/crisis-services
The DCHS program standards — mobile crisis teams of trained mental health workers and peers with lived experience — on which the Crisis Responder Academy is modeled (Documents 2.2, 6.1).

Larimer, M. E., Malone, D. K., Garner, M. D., Atkins, D. C., Burlingham, B., Lonczak, H. S., et al. (2009). Health care and public service use and costs before and after provision of housing for chronically homeless persons with severe alcohol problems. JAMA, 301(13), 1349–1357. https://doi.org/10.1001/jama.2009.414
The Seattle 1811 Eastlake study; demonstrates monthly cross-system cost as a trackable per-client outcome with harm-reduction engagement as the mechanism (Domain H).

McConnaughy, E. A., Prochaska, J. O., & Velicer, W. F. (1983). Stages of change in psychotherapy: Measurement and sample profiles. Psychotherapy: Theory, Research & Practice, 20(3), 368–375. https://doi.org/10.1037/h0090198
Introduces the URICA — the standard questionnaire for locating a person on the stage-of-change continuum; a shortened form could live in OCC follow-up documentation (Domain B).

McDaniel, M., Sundaram, S., Manjanatha, D., Odes, R., Lerman, P., Handley, M. A., et al. (2024). "They made me feel like I mattered": A qualitative study of how mobile crisis teams can support people experiencing homelessness. BMC Public Health, 24(1), 2183. https://doi.org/10.1186/s12889-024-19596-2
A qualitative engagement study of San Francisco's own street crisis clients; supplies the interview protocol for a qualitative evaluation arm and local evidence that client-reported trust is a study-worthy outcome (Domain C).

Milbank Memorial Fund. (n.d.). Mobile crisis teams and Medicaid funding: Advancing behavioral health crisis response across the United States. https://www.milbank.org/quarterly/opinions/mobile-crisis-teams-and-medicaid-funding-advancing-behavioral-health-crisis-response-across-the-united-states/
The Ramsey County, MN sustainability case — mobile crisis made fiscally durable through Medicaid and insurance billing (Document 1.3 precedent).

Miller, W. R., & Tonigan, J. S. (1996). Assessing drinkers' motivation for change: The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES). Psychology of Addictive Behaviors, 10(2), 81–89. https://doi.org/10.1037/0893-164X.10.2.81
The substance-use-specific readiness instrument; administered at treatment intake, it can test whether clients engaged by peers arrive more ready than clients arriving through coercive pathways (Domain B).

National Alliance on Mental Illness. (n.d.). Criminalization of people with mental illness. https://www.nami.org/advocacy-at-nami/policy-positions/stopping-harmful-practices/criminalization-of-people-with-mental-illness/
Policy grounding for treating justice-system contact as a health outcome and for equity stratification of all justice measures (Domain F).

National Association of State Health Policy. (n.d.). Mobile crisis: Maximizing new Medicaid opportunities. https://nashp.org/mobile-crisis-maximizing-new-medicaid-opportunities/
Georgia payment strategies, including Medicaid administrative claiming for crisis infrastructure (Document 1.3 precedent).

National Association of State Health Policy. (n.d.). States' use of peers in the mental health crisis continuum. https://nashp.org/states-use-of-peers-in-the-mental-health-crisis-continuum/
Minnesota's coverage of peers as billing members of mobile teams (Document 1.3 precedent).

National Committee for Quality Assurance. (2025). Follow-up after emergency department visit for mental illness (FUM) [HEDIS measure specification]. https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/follow-up-after-emergency-department-visit-for-mental-illness-fum/
The national specification and benchmarks for 7- and 30-day follow-up, with companions FUA, FUH, and IET — the claims-native measure family at the heart of Domain D.

National Suicide Hotline Designation Act of 2020, Pub. L. No. 116-172, 134 Stat. 832 (2020); S.B. 803, 2019–2020 Reg. Sess., ch. 150, 2020 Cal. Stat.
The statutory context: 988 creates the demand-side pipeline into mobile crisis, and SB 803 creates the certified peer workforce whose services Medi-Cal now recognizes (Documents 1.3, 6.2).

NRI. (2023). Use of peer specialists in state behavioral health service settings. https://nri-inc.org/media/ve5b3e5e/use-of-peer-specialists-in-state-bh-service-settings-2023.pdf
Documented state Medicaid H0038 per-unit rates (e.g., Arizona $21.86; New Jersey $18.77) used for the peer-billing illustration in Document 1.3.

NRI. (2024). State mobile crisis teams 2023 [Profiles report]. https://nri-inc.org/media/1xai5vsn/profiles-mobile-crisis-teams-2023.pdf
Documents 1,820+ mobile crisis teams across 50 states — the denominator that makes a rigorous, replicable measurement framework from San Francisco nationally consequential (Document 7.3).

Office of the Mayor, City & County of San Francisco. (2025). Breaking the Cycle Executive Directive 25-02. https://www.sf.gov
The alignment framework this booklet is designed to serve, referenced throughout and in the Mayor's Office action item of Document 1.3.

Ogles, B. M., Melendez, G., Davis, D. C., & Lunnen, K. M. (2001). The Ohio Scales: Practical outcome assessment. Journal of Child and Family Studies, 10(2), 199–212. https://doi.org/10.1023/A:1016651508801
Template for choosing a practical (not research-burden) functional measure administrable inside routine documentation; adult equivalents include the ANSA and DLA-20 (Domain G).

Pennsylvania Peer Support Coalition. (n.d.). Civil service employment. https://papeersupportcoalition.org/employment/civil-service-employment/
Pennsylvania's statewide civil service classification for Certified Peer Specialists — peers as classified government employees in state hospitals and county offices (Document 6.1 precedent).

Peters, R. L., Fine, J., Newton, H., Dalack, G. W., Watson, A., & Lich, K. H. (2025). Mobile crisis effectiveness: A systematic review and associated functions and forms framework. BMC Health Services Research, 26, Article 60. https://doi.org/10.1186/s12913-025-13806-2
The backbone of the measurement route: catalogs every effectiveness outcome in the U.S. mobile-crisis literature since 2000 and names peer-role research a top field priority — making an SCRT evaluation nationally significant, not just locally useful.

Policing Project at NYU School of Law, Georgetown Law Center for Innovations in Community Safety, & Alternative Mobile Services Association. (2026). Advancing the Field of Alternative Response Convening: Establishing Permanence, Chicago, IL, June 4–5, 2026 (annual). https://www.policingproject.org/events
The annual national gathering of the alternative response field, focused on establishing the work as a recognized profession and durable part of public safety systems — the recommended first-responder-side convening in Document 4.1 (2027 edition forward).

Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: Toward an integrative model of change. Journal of Consulting and Clinical Psychology, 51(3), 390–395. https://doi.org/10.1037/0022-006X.51.3.390
The foundational stages-of-change paper — the theoretical source of the precontemplative/contemplative vocabulary; grounds stage movement as a published outcome construct (Domain B).

RAMS, Inc. (n.d.). Peer Specialist Mental Health Certificate — CalMHSA-approved Medi-Cal Peer Support Specialist training and CEU source. https://ramsinc.org/programs/peer-based-services/peer-specialist-mental-health-certificate-entry-course/
The in-house certification course and CEU renewal source that lets the employer of record train, exam-prepare, and maintain certification of its own crisis workforce (Documents 1.3, 1.4).

Richmond, J. S., Berlin, J. S., Fishkind, A. B., Holloman, G. H., Zeller, S. L., Wilson, M. P., Rifai, M. A., & Ng, A. T. (2012). Verbal de-escalation of the agitated patient: Consensus statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. Western Journal of Emergency Medicine, 13(1), 17–25. https://doi.org/10.5811/westjem.2011.9.6864

Establishes de-escalation as a definable clinical practice with fidelity elements — the basis for a de-escalation fidelity checklist tied to the training standards in Part 2 (Domain A).

Sadowski, L. S., Kee, R. A., VanderWeele, T. J., & Buchanan, D. (2009). Effect of a housing and case management program on emergency department visits and hospitalizations among chronically ill homeless adults: A randomized trial. JAMA, 301(17), 1771–1778. https://doi.org/10.1001/jama.2009.561
RCT linking the housing and utilization domains; its outcome battery is the cross-sector template — one cohort tracked simultaneously in health and housing systems (Domains E and F).

San Francisco Department of Public Health, San Francisco Fire Department, & Department of Emergency Management. (2022). Street Crisis Response Team pilot: Final report. City and County of San Francisco. https://media.api.sf.gov/documents/SCRT_Final_Report_FINAL-_1_year.pdf
The local measurement baseline: 59% community resolution, 2% restraint rate, 7% 5150 rate, peer support in 65% of encounters. Any future evaluation should treat this report's variable definitions as the pre-registered baseline (Domain A; Document 7.2, Step 1).

San Francisco Police Department. (n.d.). Crisis Intervention Team (CIT) program. https://www.sanfranciscopolice.org/your-sfpd/explore-department/crisis-intervention-team-cit-program
The Department's CIT program — Working Group since 2011, training extended to partner agencies — the collaboration invited in Document 2.5.

San Francisco Police Department. (n.d.). DGO 5.21 — Crisis Intervention Team response to person in crisis calls for service. https://www.sanfranciscopolice.org/your-sfpd/policies/general-orders/5-21
Defines the 40-hour POST-certified CIT course referenced in the tiered training standard (Documents 2.1, 2.5, 6.2).

Shalaby, R. A. H., & Agyapong, V. I. O. (2020). Peer support in mental health: Literature review. JMIR Mental Health, 7(6), Article e15572. https://doi.org/10.2196/15572
Documents the outcome set repeatedly associated with peer support — fewer hospitalizations; greater hope, empowerment, and treatment engagement — measurable with the instruments in Domain C.

Substance Abuse and Mental Health Services Administration. (2014). Crisis services: Effectiveness, cost-effectiveness, and funding strategies (HHS Publication No. SMA-14-4848).
The federal synthesis of crisis-service cost-effectiveness evidence — the methodological starting point for the avoided-cost model, including which cost categories are defensible to claim (Domain H).

Substance Abuse and Mental Health Services Administration. (2020). National guidelines for behavioral health crisis care: A best practice toolkit.
The prior-generation federal standard specifying peer support within mobile crisis teams — the baseline for judging model fidelity in any evaluation period.

Substance Abuse and Mental Health Services Administration. (2025). 2025 national guidelines for a behavioral health coordinated system of crisis care (Publication No. PEP24-01-037).
The current federal standard: crisis care must connect to the full continuum, with peers throughout — anchoring the claim that cross-sector measurement is what national guidance now expects (Domain E).

Swanson, L., Zettner, C., Watson, A., Hinojosa, M., Roddy, J., & Kubiak, S. (2025). Eleven-month arrest outcomes among three crisis response models in Michigan. Psychiatric Research and Clinical Practice. https://doi.org/10.1176/appi.prcp.20240099
Linked law-enforcement and provider records across five counties; mobile crisis was the only model that significantly reduced arrest in the following year — supplying the justice-side outcome definition (Domain F).

Swift, R. H., Harrigan, E. P., Cappelleri, J. C., Kramer, D., & Chandler, L. P. (2002). Validation of the Behavioural Activity Rating Scale (BARS). Journal of Psychiatric Research, 36(2), 87–95. https://doi.org/10.1016/S0022-3956(01)00052-8
Validation of the 7-point agitation scale SCRT already uses; scoring BARS at first contact and disposition converts de-escalation — the peer's signature skill — into a measurable pre/post delta (Domain A).

Tait, L., Birchwood, M., & Trower, P. (2002). A new scale (SES) to measure engagement with community mental health services. Journal of Mental Health, 11(2), 191–198. https://doi.org/10.1080/09638230020023570-2
The most widely used engagement instrument for serious mental illness, designed for assertive outreach populations — the closest analog to street crisis clients (Domain C).

Townley, G., Sand, K., Kindschuh, T., Brott, H., & Leickly, E. (2021). Engaging unhoused community members in the design of an alternative first responder program aimed at reducing the criminalization of homelessness. Journal of Community Psychology. https://doi.org/10.1002/jcop.22601

Shows how unhoused community members define successful engagement in their own terms — the basis for co-designed, client-defined engagement measures (Domain C).

Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing First, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. American Journal of Public Health, 94(4), 651–656. https://doi.org/10.2105/AJPH.94.4.651
The canonical housing-stability measurement paper; establishes 'days housed' as a rigorous primary outcome for exactly SCRT's population (Domain E).

U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. (n.d.). Crisis services billed to Medicaid. https://aspe.hhs.gov
Documents H2011 use across states (six of eight studied) — supporting the claiming architecture in Document 1.3.

U.S. Department of Housing and Urban Development. (2025). National summary of homeless system performance, 2020–2024. HUD Exchange.
The specification-in-practice for the seven System Performance Measures with national benchmarks; an SCRT-cohort version is methodologically pre-built in the ONE System (Domain E).

U.S. Department of Veterans Affairs. (n.d.). Peer Specialist positions, Veterans Crisis Line / Peer Support Outreach Center. https://www.usajobs.gov
Peers as a permanent federal title doing crisis work at national scale — precedent for the classification pathway (Document 6.1).

Vakkalanka, J. P., Neuhaus, R., Harland, K., Clemsen, L., Himadi, E., & Lee, S. (2021). Mobile crisis outreach and emergency department utilization: A propensity score-matched analysis. Western Journal of Emergency Medicine, 22(5), 1086–1094.
Essential design warning: groups differing fifteen-fold in unhoused status made ED-revisit comparisons uninterpretable. For a population 84% unhoused, housing status is a mandatory matching variable (Domain F).

Vanderploeg, J. J., Lu, J. J., Marshall, T. M., & Stevens, K. (2016). Mobile crisis services for children and families: Advancing a community-based model in Connecticut. Children and Youth Services Review, 71, 103–109. https://doi.org/10.1016/j.childyouth.2016.10.034
Demonstrates intake-to-discharge functional measurement inside a statewide mobile crisis program, including the operational data an evaluation should co-report (Domain G).

Waters, R. (2021). Enlisting mental health workers, not cops, in mobile crisis response. Health Affairs, 40(6), 864–869. https://doi.org/10.1377/hlthaff.2021.00678
The CAHOOTS operational and financial history over three decades — the longitudinal workforce benchmark for any program claiming durability (Domain I).

Watson, A. C., McNally, K., Pope, L. G., & Compton, M. T. (2025). If not police, then who? Building a new workforce for community behavioral health crisis response. Frontiers in Psychology, 16, Article 1579787. https://doi.org/10.3389/fpsyg.2025.1579787
Names lived experience as a core value of the crisis-responder workforce and proposes tiered civil-service career ladders — direct support for the training and classification structures in Parts 2 and 6.

Worthen, M., De Bourbon, S., Breedlove, O., Ewing, C., Graterol, J., Harmon, A., Hines, N., Lundgren, E., Mason, M., Marchiselli, M., Mendoza, V., Nguyen, K., Rubin, B., Sloan, A., & Maguen, S. (2026). We are still in it: A conceptual model for moral injury and burnout in alternative response programs to guide intervention. Frontiers in Psychiatry, 17, Article 1735265. https://doi.org/10.3389/fpsyt.2026.1735265
The peer-reviewed conceptual model for the workforce domain, built from alternative-response workers' own experience including SCRT; identifies the decision-maker/worker disconnect as a measurable structural risk (Documents 6.3, 7.2, 7.3; the preparer is a co-author).

Glossary of Acronyms

For readers coming to any part of this booklet fresh

Term	Meaning
CAD	Computer-Aided Dispatch (DEM 911 records)
CalMHSA	California Mental Health Services Authority (administers Medi-Cal peer certification)
CCSF	City College of San Francisco
CEU	Continuing Education Unit
CIT	Crisis Intervention Team (40-hour POST-certified training; SFPD program)
CPI	Crisis Prevention Institute (de-escalation training provider)
DCHS	Department of Community and Human Services (King County, WA)
DEM	Department of Emergency Management (San Francisco)
DESC	Downtown Emergency Service Center (Seattle mobile crisis operator)
DHCS	California Department of Health Care Services
DPH	San Francisco Department of Public Health
EMT	Emergency Medical Technician
FMAP	Federal Medical Assistance Percentage (federal match rate)
H2011 / H0038 / H0025	HCPCS billing codes: mobile crisis encounter; peer support services
HOT	Homeless Outreach Team
ITS	Interrupted Time Series (evaluation method)
MOU	Memorandum of Understanding
MRRCT	Mobile Rapid Response Crisis Team (King County program)
OCC	Office of Coordinated Care (DPH)
ONE System	Online Navigation and Entry System (Homelessness Response System record)
OWT	Outreach Worker Tool (shared field-visibility tool across SCRT, HOT, and partner street teams)
POST	Peace Officer Standards and Training (California)
RAMS	Richmond Area Multi-Services, Inc.
SB 803	California Senate Bill 803 (2020) — Medi-Cal Peer Support Specialist certification
SCRT	Street Crisis Response Team
SFFD / SFPD	San Francisco Fire Department / Police Department
SRO	Single-Room Occupancy (housing)

From:	Samuel Jain
To:	Commission, Fire (FIR)
Cc:	Oscar Lopez
Subject:	Removal of Peer Counselors from SCRT
Date:	Friday, August 7, 2026 8:21:02 AM
Attachments:	image001.png 2026-08-07 SF Peer Crisis Fire Commission Letter FINAL.pdf

Dear President Collins and Fire Commissioners c/o Kathy Aguas-Aclan:

Please find the attached letter from Disability Rights California concerning the proposed removal of Peer Counselors from the Street Crisis Response Team.

Can you please confirm receipt and whether our letter can be included in the Commission's August 12th meeting materials?

Thank you,
Samuel

Samuel Jain (he/him)
Senior Policy Attorney, Mental Health Practice Group
Disability Rights California
1831 K Street
Sacramento, CA 95811
Tel: (916) 504-5800 | Dir: (916) 504-5929 | Fax: (916) 504-5801
Email: Samuel.Jain@disabilityrightsca.org

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The information in this transmittal (including attachments, if any) is privileged and confidential and is intended only for the recipient(s) listed above. Any review, use, disclosure, distribution or copying of this transmittal is prohibited except by or on behalf of the intended recipient. If you have received this transmittal in error, please notify me immediately by reply email and destroy all copies of the transmittal. Any inadvertent disclosure does not waive the attorney-client privilege. Thank you

The Fire Commission received the attached submissions for public comment. Due to the volume of this submission, it will be available upon request. Please email fire.commission@sfgov.org.

From:	Board of Supervisors (BOS)
To:	BOS-Supervisors; BOS-Legislative Aides
Cc:	BOS-Operations; Calvillo, Angela (BOS); De Asis, Edward (BOS); Mchugh, Eileen (BOS); Ng, Wilson (BOS); Somera, Alisa (BOS)
Subject:	35 Letters Regarding SCRT
Date:	Thursday, July 16, 2026 12:13:34 PM
Attachments:	35 Letters Regarding SCRT.pdf

Hello,

Please see attached 35 letters regarding the San Francisco Fire Department (SFFD) Street Crisis Response Team (SCRT).

Regards,

John Bullock
Office of the Clerk of the Board
San Francisco Board of Supervisors
1 Dr. Carlton B. Goodlett Place, Room 244
San Francisco, CA 94102
(415) 554-5184
BOS@sfgov.org | www.sf.gov/sfbos

From: Vania Mendoza
Subject: Support Specialized 911 Crisis Peer Counselors
Date: Monday, July 27, 2026 11:23:42 AM

To Decision Makers

I have become aware that the San Francisco Fire Department is restructuring their 911-dispatched Street Crisis Response Team, and unfortunately they are removing a crucial pillar of the team, the Peer Providers. This action reduces the once innovative response to acute behavioral health needs to another ambulance/uniformed response, that historically we know is wasteful and unhelpful. I believe this action to be regressive.

Removing the Peers will create more frequent 911 use from our most vulnerable. I have personal experience with crisis, and I would rather speak to a non-uniformed Peer rather than a uniformed first responder. Instead of being supported by a diverse team with lived experience, they are going to have to rely on the limited scope of SFFD EMT and Paramedics. Peers provide a unique perspective, support and de-escalation skills that have resulted in thousands of successful calls.

If efficiency is the goal, including peers in the 911 system is the best route forward. Instead this change will result in an increase in 911 calls and a strain on an ambulance system and suppression reducing those services and overall safety for all San Franciscans.

Peers on different teams is not sufficient and their role in crisis response is crucial. This proposed removal will undermine the Mayor's Office's efforts in street team coordination. I ask Peer providers continue to be deployed *with* our community's 911 calls.

If I ever had to call 911 on a community member, I would hope that staff with appropriate training and context (the Peer) would respond. If I ever had to call 911 on a family member, I would rather a non-uniformed counselor lead the response— with a supporting team that would be able to assess for 5150s. At no point would I consider calling Crisis Support if there was not a peer involved, I would call an ambulance instead and I consider this action to be wasteful to our taxpayers.

I support the creation of permanent civil service opportunities with clear job classifications for Peer Support Specialists, as there are in other counties. I hope you all take into consideration the concerns listed above and urge the SFFD remain with the integrity and structure of the innovative and successful team that Crisis Care in SF has been.

A concerned citizen

From:	Board of Supervisors (BOS)
To:	BOS-Supervisors; BOS-Legislative Aides
Cc:	Calvillo, Angela (BOS); Mchugh, Eileen (BOS); Ng, Wilson (BOS); Somera, Alisa (BOS); De Asis, Edward (BOS); BOS-Operations; Board of Supervisors (BOS)
Subject:	SFFD Street Crisis Response Team (SCRT) 35 letterts
Date:	Thursday, July 23, 2026 4:21:49 PM
Attachments:	35 letters.pdf

Dear Supervisors,

Please see attached 35 letters, from members of the public, regarding the San Francisco Fire Department (SFFD) Street Crisis Response Team (SCRT).

Regards,

Richard Lagunte
Office of the Clerk of the Board
San Francisco Board of Supervisors
1 Dr. Carlton B. Goodlett Place, Room 244
San Francisco, CA 94102
Voice (415) 554-5184 | Fax (415) 554-5163
bos@sfgov.org | www.sf.gov/sfbos

Pronouns: he, him, his