STREET CRISIS RESPONSE TEAM ISSUE BRIEF

Mental Health San Francisco Implementation Working Group

Mental Health San Francisco, created through legislation (File No. 191148), calls for the development of a "Crisis Response Street Team". Page 15 lines 16-25 and page 16 lines 1-2 states:

(A) The Crisis Response Street Team shall be a city-wide crisis team led by the Department that operates 24 hours per day, 7 days per week, to intervene with people on the street who are experiencing a substance use or mental health crisis, with the goal of engaging them and having them enter into a system of treatment and coordinated care. A marketing strategy shall be implemented to ensure that the public becomes familiar with the specific telephone number to call to engage the assistance of the Crisis Response Street Team. The public shall also be able to find this team by dialing 311 or, in the case of emergency, 911, and can report someone in need of services through these channels. This team shall coordinate with the Office of Coordinated Care to assign case managers where needed to establish trust and rapport with individuals who refuse to access services and who are not eligible for conservatorship.

The Department of Public Health and the San Francisco Fire Department, in collaboration with partner City agencies and community-based organizations, successfully launched the pilot Street Crisis Response Team (SCRT) on November 30, 2020. This document outlines the program model, its goals and strategies, the planning process, community engagement, plans for expansion, key early data, and questions for consideration by Implementation Working Group members.

I. STREET CRISIS RESPONSE TEAM OVERVIEW

The Street Crisis Response Team is a collaboration between the San Francisco Department of Public Health (DPH), the San Francisco Fire Department (SFFD), and the Department of Emergency Management (DEM) to provide the most appropriate clinical interventions and care coordination for people who experience behavioral health crises in public spaces in San Francisco. Each team includes one community paramedic, one behavioral health clinician (DPH-contracted with HealthRIGHT 360) and one behavioral health peer specialist (DPH-contracted with RAMS, Inc.).

PILOT GOAL: Provide rapid, trauma-informed response to calls for service to people experiencing crisis in public spaces in order to reduce law enforcement encounters and unnecessary emergency room use.

The SCRT will provide citywide coverage of San Francisco with six operational teams. Each team will provide coverage 12 hours a day, seven days a week. The teams will be staggered in shifts in order to provide 24 hours per day coverage. The six operational teams will:

1. Respond to 911 calls requiring a behavioral health and/or medical response rather than law enforcement response.

2. Deliver therapeutic de-escalation and medically appropriate response to people in crisis through a multi-disciplinary team.

3. Provide appropriate linkages and follow up care for people in crisis, including mental health care, substance use treatment, and social services referrals, through partnership with the Office of Coordinated Care.

Figure 1: Implementation Timeline

The first SCRT unit launched on November 30, 2020 and had a geographic emphasis on the Tenderloin area. As hiring allowed, the team increased its service coverage to be 12 hours per day, seven days a week. The operating hours of this team are 9am-9pm, a 12-hour period which represents the highest call volume per DEM data from 2019. The second team launched on February 1, 2021, with a focus on the Mission-Castro neighborhood. These first two neighborhoods were selected for their high emergency call volume, enabling the team to have immediate high impact in delivering an alternative to policing in these neighborhoods. Once the additional teams are hired, the pilot will have citywide coverage seven days per week, 24 hours per day, with the inclusion of one team covering an overnight shift. With a lower anticipated call volume, the overnight shift expects to have citywide coverage.

The Department of Emergency Management (DEM) is responsible for receiving, coding, and dispatching 911 emergency calls for service in San Francisco. Through collaboration with DEM and other partners, and review of recent DEM call data, the SCRT determined which call codes would be best suited for the skills of the new team. The SCRT launched with a focus on responding to 911 calls that are classified as "800" codes, which indicate a call for service for a "mentally disturbed person," at a B-priority level per DEM classifications. According to 2019 DEM data, each year there are approximately 14,000 dispatched "800" calls, of which just over 10,000 are at a B-priority level. The “B” priority calls involve no weapon or violence, indicating low risk for public safety concerns.

Please see Appendix A for more information on 800-B call code criteria as well as other call codes that have been targeted for alternatives to policing program models in San Francisco.

In addition to 800-Bs, SCRT is responding to “on-views”, meaning incidents the team observes when roving through their designated neighborhoods. By responding to on-views, SCRT aims to address needs before they elevate to an emergency service call. Additionally, SCRT is responding to a small number of “special calls” from other agencies who would otherwise call the SFPD for support. According to data from the first two months of operations, roughly 85 percent of calls originate from 911 dispatch, 11 percent from on-views, and 4 percent from special calls. While SCRT is currently not dispatched directly through 311, 311 operators transfer calls appropriate for an emergency response to 911, which potentially leads to SCRT dispatch.

The following call code criteria has been applied for the SCRT pilot:

- Must be a person who is not actively violent and is displaying signs of a behavioral health crisis (e.g., visibly distraught, talking/yelling to self).
- Person must not have a weapon, be overdosing on drugs, or be displaying self-harm behaviors.
- Person does not pose an imminent threat to themselves, others, or property.
- Person is an adult who is in a public space (focus on outdoors).

Through the implementation of the SCRT, the City seeks to fundamentally change how we respond to people experiencing a behavioral health crisis on our streets, to better support those in need and demonstrate to the general public that the City is working effectively to create healthier

neighborhoods. This team is part of broader efforts to have a health-first response in our communities, especially communities of color, in order to reduce law enforcement response to non-violent activity. Each call SCRT accepts represents a call diversion from the San Francisco Police Department, inherently reducing law enforcement encounters for the population served. This shift will mean police can focus their efforts on public safety situations that they are uniquely qualified to handle. The team will create a more innovative, efficient, and effective system that disrupts the cycle of justice involvement, mental health, and addiction crises we see on our streets.

COMMUNITY ENGAGEMENT

The City prioritizes community engagement as a critical component of program design, program evaluation, and ultimately program success. For SCRT, this community engagement is especially important, and complex, given that it is positioned at the intersection of serious mental illness, substance use, homelessness, police reform, and racial equity. As such, there are many stakeholders in the process, with whom the SCRT planning team engaged to the extent possible prior to the initial pilot launch and plans to intentionally engage throughout the first year of the pilot.

During the pre-launch planning phase, the SCRT planning team engaged with the following groups.

- **Community-based organizations** working with similar populations and/or with intersections with the teams' work, including UCSF Citywide, Progress Foundation, HealthRIGHT360, PRC/Baker Places, Salvation Army, Hospitality House, Glide Foundation, Saint Anthony's Foundation, and Rafiki Coalition.

- **DPH programs** working with similar populations to ensure collaboration and solicit expertise, including Comprehensive Crisis Services, Street Medicine, Sobering Center, Whole Person Integrated Care, and Community Health Response Team. The SCRT will continue to engage with these programs to ensure a coordinated street outreach response system.

- **Other City agencies**, including Department of Emergency Management, San Francisco Police Department, Department of Homelessness and Supportive Housing, Healthy Streets Operation Center (HSOC), and the Emergency Medical Services Authority (EMSA).

- **Behavioral health consumer focus groups**, two with RAMS Peer Services and one with Glide. Participants shared lessons learned from their own interactions with crisis services and law enforcement, helped define a "successful" outcome of an SCRT encounter, and weighed in on such operational details as what the team members could wear to optimize their ability to relate to people in crisis. Additionally, the core planning team, which met weekly prior to launch, included a peer specialist from RAMS.

- **Citywide committees and working groups** – SCRT engaged with both the Human Rights Commission and Coalition on Homelessness committees focused on identifying alternatives to police response in San Francisco. Additionally, the SCRT presented to the Housing Conservatorship Working Group and Tenderloin Neighborhood Roundtable.

During its first year, SCRT intends to maintain engagement with community-based providers and extend community engagement through neighborhood forums. As the program expands its capacity, in order to support high-vulnerability clients in need of this service, the team must consider the impact of structural racism, distrust of law enforcement, and cultural factors that may lead to low 911 usage. The City plans to invite community leaders to present the program and gather feedback in their neighborhoods, identifying potential challenges and opportunities for improvement as the pilot program solidifies its model in its first year of operations. The focus of this effort will be to share information with, collect input from, and increase accountability to historically underserved communities of the City and communities of color where residents may be less likely to dial 911.

As SCRT looks ahead to this next phase of community engagement, the following objectives will guide the work:

- **Develop public awareness** of what makes the street crisis response team distinct from other teams in San Francisco (such as HOT, EMS-6, Comprehensive Crisis, and Street Medicine)

- **Manage community expectations** about the new street crisis response team: what it can and can't do, its gradual growth, and the role of other City agencies in responding to street crises.

- **Build public trust** in the street crisis response team, such that 911 callers might eventually specifically request the team because of its specialized skills, approach, and results.

- Using a data driven and experience-based approach, **invite community and consumer input** in the development of the pilot program with a focus on adapting operations to reduce the real and perceived risks of engagement with the service. SCRT will provide data to demonstrate effectiveness of the pilot program and equity of the implementation.

PROJECTED ANNUAL BUDGET

The Board of Supervisors approved the budget presented in Table 1 for the SCRT pilot program through FY20-21. This budget includes the staffing of six teams operating seven days per week and includes field staff, Office of Coordinated Care positions, management costs, and other program costs such as the vehicles and technology. An estimated 60 full-time staff will be hired to directly support this program.

DATA AND EVALUATION

The City has engaged with Harder + Company to perform a robust evaluation of the pilot program. The goals of this evaluation are to use data to inform early programmatic decisions and to share outcomes with the community and key stakeholders.

Evaluation activities in year one of the SCRT pilot will focus on addressing the following learning questions, identified in collaboration with all of the SCRT partner agencies:

1. Who is the Street Crisis Response Team serving, and what are the characteristics of those service calls?

2. How effective is the Street Crisis Response Team in addressing the needs of the individuals it serves?

3. What successes and challenges have Street Crisis Response Team members and community stakeholders observed in the implementation of the pilot program?

One of the core components of the SCRT pilot evaluation is an in-depth analysis of individual-level program data, which will directly address multiple evaluation questions. Since the SCRT initiative is in its pilot year, initial findings from the evaluation will be used to capture early learnings and allow the team to proactively address potential implementation issues. Sharing learnings early and often can also build public support for the program and keep stakeholders informed. Harder will prepare and disseminate reports throughout the initial year of the pilot.

In addition, DPH applied for and received grant funding from the Robert Wood Johnson Foundation (RWJF) to complete a rigorous research evaluation of the pilot project. This research endeavor seeks to enhance the work of the program evaluation led by

Table 1: Projected Annual Budget

Project Costs	Partial Year FY20-21 (approved)	FY21-22 (proposed)
• Six teams of core response team field staff • Care coordination staff • Program supervision and management • Pilot program evaluation • Vehicles, supplies and engagement materials • Staff training	$6,185,850	$13,474,284

Harder, which has a greater emphasis on qualitative operational findings. Three key outcomes post-crisis episode will be studied through this research study: linkage to outpatient mental health and substance use treatment, reutilization of crisis services, and assessment for housing placement. Interviews with clients will help identify facilitators and barriers to effective care. This research will be conducted through June 2022 in collaboration with DPH researchers, Mental Health SF, the UCSF Clinical and Translational Science Institute, and Heluna Health (a fiscal intermediary). Results of this study will be disseminated through national presentations, peer-reviewed manuscripts, and the Health Systems Transformation Research Coordinating Center (a partnership between RWJF and Avalere health).

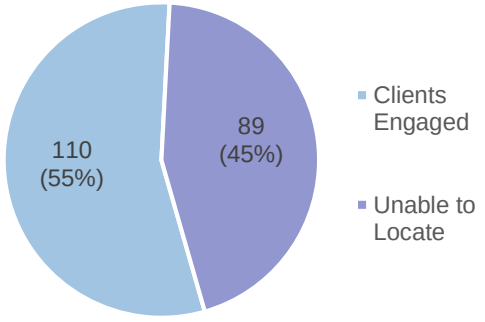
II. DATA COLLECTION

In its first two months of operation (from November 30, 2020 through January 31, 2021), the first SCRT team responded to 199 calls for service, diverting all of these calls from law enforcement. Seven of these calls resulted in the initiation of a 5150 Welfare and Institutions Code (WIC) involuntary psychiatric hold, and none of these incidents required SFPD to be called to the scene for support. The average response time was approximately 15 minutes from dispatch to arrival time on scene. The team reversed two overdoses that they observed in the community and provided transport to social and medical/behavioral services.

All of these calls for service represent successful diversions from the San Francisco Police Department. In each of these cases, in the absence of SCRT, the client would have had an encounter with law enforcement. With only one SCRT unit operational for its first two months, the team was able to respond to roughly 20 percent of all 800-B calls received citywide.

The following graphs represent data from November 30, 2020 through January 31, 2021 representing 51 operational days.[1] It is important to recognize that these early results and trends will likely shift over time as more data become available.

Figure 2: Calls Accepted by SCRT
(n=199)



**Per DEM data, rate of clients who were unable to locate is approximately that of SFPD for these calls in 2019.*

Figure 3: SCRT Call Origin
(n=199)

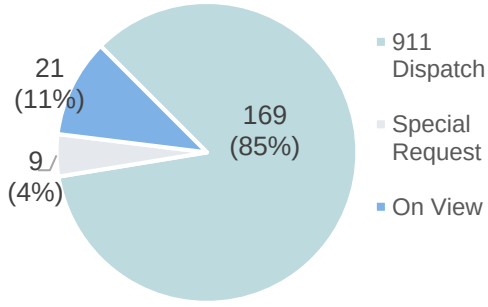
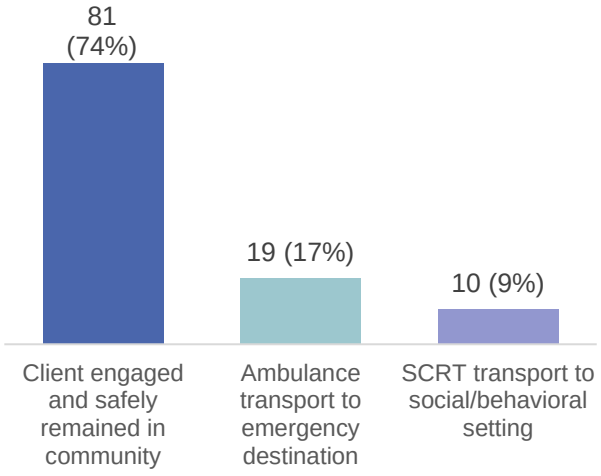


Figure 4: Client Encounter Dispositions
(n=110)



[1] *Most of these operational days were eight hour shifts as the team hired enough staff to cover its targeted 12-hour shifts. As of February 1st, 2021, the first team is covering 12-hour shifts seven days per week.*

The majority of clients, 74 percent, were engaged by SCRT, offered assessments and therapeutic de-escalation, and ultimately were able to safely remain in the community. These initial results are consistent with the experience of programs in other jurisdictions, such as Maricopa County, Arizona, which reports 71 percent of their mobile crisis encounters as resolved in the community.[2] More detail on the nature of these encounters will be available in the evaluation reports from Harder + Company and the RWJF-funded research study.

Figure 5: Client Gender
(n=73)

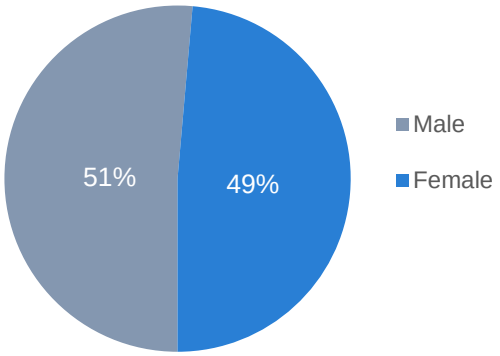
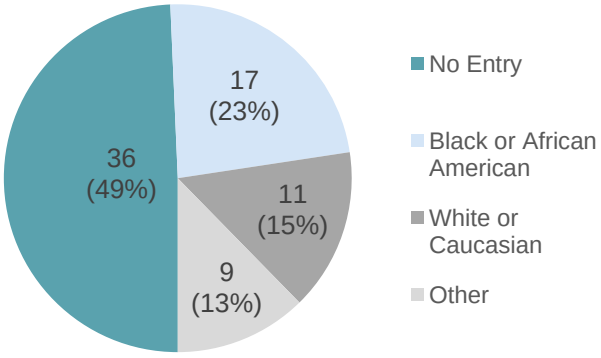


Figure 6: Client Race/Ethnicity
(n=73)



Client demographics have been a challenge to obtain reliably. Only a subset of encounters leads to complete documentation of the demographic indicators of interest to this project, though for clients known to the system, these data are available. Further, we want to ensure that we are gathering missing demographic information directly from those we are serving. Using this historical information combined with information obtained on scene, the client characteristics presented in Figures 5 and 6 were obtained. Approximately 96 percent of clients were experiencing homelessness, either unsheltered, in congregate sites, or living in other temporary living situations.

III. ADDRESSING INSTITUTIONAL RACISM

Addressing racial equity and reducing institutional racism that is often reflected by over-representation of incarcerated Black/African Americans is a key objective of the SCRT. The program will be closely watching its ability to reduce incarceration, emergency room use and involuntary detentions, especially through the lens of race and ethnicity. There are a few ways SCRT expects to specifically address racial equity through its program and evaluation design:

- All calls to which SCRT responds would have received SFPD response in the absence of this team, inherently reducing law enforcement involvement for 100 percent of SCRT clients.
- SCRT aims to reduce racial disparities in health outcomes. The evaluation will include quality measures that track outcomes by race and ethnicity to monitor for equity in the implementation of the program. Each measured outcome, such as linkage to care, SFPD involvement, and 5150 involuntary holds, will be measured for its ability to reduce disparities by race, ethnicity, gender identity and sexual orientation to the extent the data allow.

[2] *Balfour ME, Stephenson AH, Winsky J, Goldman ML. Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. Alexandria, Virginia: National Association of State Mental Health Program Directors; 2020.* https://www.nasmhpd.org/sites/default/files/2020paper11.pdf

- As mentioned in the Community Engagement section (pages 3-4), SCRT is developing strategies to best engage and deploy this new team to serve people of color. For communities with distrust of law enforcement and other institutions, SCRT hopes to build relationships and trust by training community leaders and creating pathways to receive constructive feedback from these communities. Furthermore, the SCRT will evaluate options for deploying the team in alternative pathways from 911 call center if this helps achieve equity goals.

- SCRT staff will receive training on racial equity as part of their onboarding and continuous learning.

IV. SIMILAR PROGRAM MODELS IN OTHER JURISDICTIONS

A key component of planning the initial design and launch of the SCRT in San Francisco involved consulting with other jurisdictions that have successfully implemented alternatives to policing models for response to people in crisis. These conversations focused on best practices, overcoming barriers, strategies for building community support, as well as key operational details such as dispatch protocol and transport. The CAHOOTS model in Eugene, Oregon is the most prominent similar program which was reviewed and considered during the SCRT program design.

More detail on a few of these organizations is linked below:

- CAHOOTS *(Eugene, Oregon)*
- Community Assessment and Transport Team *(Alameda County Behavioral Health Services)*
- Mental Health Support Team – *(Part of a large crisis network in Maricopa County, Arizona)*
- RIGHT Care *(Dallas, Texas)*
- Grady EMS Crisis Intervention Program *(Atlanta, Georgia)*
- EMPACT Suicide Prevention Center at La Frontera Arizona *(Tempe, Arizona)*

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), there are four key elements in an effective crisis response system, as illustrated in Figure 7. In the development of the SCRT program model, DPH has considered and offered recommendations for additional crisis system improvements that will support the success of the response team. As one example, integrating a care coordinator from the Office of Coordinated Care will enable warm

Figure 7: Key Elements of Crisis Response Systems

Based on SAMHSA 2020 Best Practices Toolkit

handoffs from SCRT engagement to ongoing behavioral health care. DPH recommends using this framework for continuous evaluation of other aspects of the crisis response system in addition to the SCRT itself, to help ensure comprehensive care for clients.

V. ALIGNMENT WITH OTHER MHSF PROGRAMS

The Street Crisis Response Team has many intersections with other components of Mental Health SF. While the initial launch of the pilot is not dependent on these other aspects of the legislation, the work will be enhanced by the following efforts in particular:

- ***Office of Coordinated Care (OCC)*** – The SCRT model includes a team of care coordinators assigned to SCRT responsible for following up with existing providers and/or clients with whom SCRT engages within 24 hours of contact with the team. The care coordinator will function as a part of the OCC and will support clients in navigating the system and aim to reduce readmission to crisis services. As part of the evaluation, we will be assessing both immediate linkages to care, as well as long-term impacts of these interventions (e.g., reductions in emergency psychiatric care and contact with the criminal justice system).

- ***Crisis Stabilization Unit*** – The establishment of a new low-barrier resource to accept clients in a behavioral health crisis as an alternative to Psychiatric Emergency Services and in addition to Dore Urgent Care Clinic is a critical linkage resource for the SCRT.

- ***Drug Sobering Center*** – The establishment of the new Drug Sobering Center will enable clients encountered by SCRT who use drugs – especially methamphetamine – to safely recover from intoxication.

- ***Intensive case management expansion*** – Intensive case management is a community-based complement of services to help clients obtain housing and achieve an optimum quality of life through developing plans, enhancing life skills, addressing health and mental health needs, engaging in meaningful activities and building social and community relations. This service would benefit a subset of the clients with whom SCRT engages. In addition to intensive case management services, other levels of case management, such as low-threshold case management, would likely benefit some SCRT clients.

VI. IDEAS FOR CONSIDERATION FROM IMPLEMENTATION WORKING GROUP

While the SCRT pilot launched in November 2020 with an initial scope and program design, there are several areas of consideration for the MHSF Implementation Working Group as the SCRT expands and solidifies its program model beyond the pilot period (anticipated January 2022). A few questions for critical review and response include:

1. ***If the team had additional resources, and were to respond to more calls for service beyond the "800Bs", which types of calls should they prioritize?***

Additional call codes currently receiving law enforcement response could be considered for this program. For example, call code 801, "person attempting suicide" could be a well suited for SCRT response for the portion of these calls involving only ideation or other circumstances not requiring a "lights and sirens" response.

The Coalition on Homelessness and Human Rights Commission have also contemplated this question. The Coalition on Homelessness has recommended a "Compassionate Alternate Response Team (CART)" which could be a complementary solution to a subset of these additional call codes. For example, upon initial representative call data reviews, DEM has indicated that many of the 911 calls for service coded as "well-being" checks (code 910) present similarly to the needs of the code 800 calls.[3] With additional staff training and further refined definitions

[3] *See appendix for detail on DEM call codes*

of the call codes, some well-being check calls could be directed to SCRT while others could be directed to a homelessness response focused team such as CART. A comprehensive data analysis, essential to this exercise, will require additional resources to be identified.

2. How can the SCRT best be deployed in communities of color and other populations with distrust of law enforcement and other institutions?

In order to address the needs and concerns of communities with widespread distrust of law enforcement, SCRT may need to identify and create pathways to deploy the SCRT independent of 911. Because developing new call-center infrastructure requires significant resources, this could be achieved through leveraging existing crisis call lines (e.g. SF Suicide Prevention line, Comprehensive Crisis Services) who could develop workflows to deploy SCRT as needed. Other programs, such as Maricopa County in Arizona, indicate crisis call centers can reduce the need for deploying mobile teams while still providing therapeutic intervention to clients in need.

3. How can SCRT best engage the community to support its clients using the strength of existing community-based networks?

It is essential that SCRT builds on the strengths of existing community-based resources and trusted community members to maximize program sustainability and impact. Identifying opportunities to promote an individual's resiliency within their communities by integrating existing networks, such as churches and community-based organizations, would yield positive outcomes for both clients of SCRT and concerned community members. The role of Office of Coordinated Care staff, and the types of strategies they employ in their care coordination work, are a potential opportunity for collaboration.

4. Starting March 31, SCRT is targeting to have one team on an overnight shift to enable 24/7 coverage. What is your experience about the need for 24/7 coverage for this service?

During the hours between 11pm and 7am, code 800 calls decrease dramatically, with the average call volume during these hours approximately 65 percent lower according to DEM data from 2019. At the same time, options for referral to services will be much more limited during these hours than during the day. Furthermore, hiring and retaining staff to provide coverage for these service hours is expected to be more challenging and costly. A financial analysis of this difference in cost will be provided once available.

APPENDIX A: DEPARTMENT OF EMERGENCY MANAGEMENT CALL CODE DETAIL

In alignment with calls for alternative to policing, the Department of Emergency Management (DEM) has identified an initial list of call codes which are used for mental/behavioral incidents that involve police, as opposed to medical, for response. These codes include, but are not limited to:

- **800**: "Mentally disturbed person" – selected for SCRT pilot
- **801**: "Person attempting suicide"
- **806**: "Juvenile beyond control"
- **910**: "Well-being check" - Not restricted to mental / behavioral health incidents. Someone calling from out of town saying they hadn't been able to reach their elderly relative, for instance, would be a 910.
- **5150**: "Mental Health Detention" - This code is typically used as a final code after officers are on scene.

Sometimes codes are appended with a suffix for further information. "CR" indicates that a Crisis Intervention Team was dispatched, primarily because the incident involved weapons; "DV" indicates a domestic/intimate partner violence incident; "EA" indicates possible elder abuse; and "CA" indicates possible child abuse. 222 is the code for "person with a knife." There is not a good way aside from going through individual call details, to determine what percentage are related to mental/behavioral health.

The following table indicates these codes, their suffices, and their relative call volumes in 2019 as they appeared in the initial coding and priority. Most of the C-priorities shown and a few of the B-priorities (most of the ones with suffixes, for instance) are report calls, and not about active incidents.

Initial Call Code	A-Priority	B-Priority	C-Priority	Total
800	4,604	10,142	215	14,961
801	3,695	133	9	3,837
806	143	178	8	329
910	9,248	17,514	220	26,982
5150	29	119		148
800CR	88	5	1	94
801CR	21	1		22
222CR	8			8
910DV		10		10
910EA		7		7
910CA		8	1	9
Total	17,836	28,117	454	46,407