CALIFORNIA RACIAL AND IDENTITY PROFILING ADVISORY BOARD
https://oag.ca.gov/ab953/board

CALLS FOR SERVICE SUBCOMMITTEE
MEETING NOTICE AND AGENDA

Tuesday, March 9, 2021
2:30 PM

Via Blue Jeans video and telephone conference ONLY. The public is encouraged to join the meeting at https://bluejeans.com/818781857 or using the "Join Meeting" link below. This will provide access to the meeting video and audio. We recommend that you log in 5-10 minutes before the start of the meeting to allow sufficient time to set up your audio/video, and to download the Blue Jeans application, if desired.

Join Meeting

(Join from computer or phone)

A phone dial-in option will also be available.
(408) 317-9254
Meeting ID: 818 781 857

1. INTRODUCTIONS (7 min.)

2. APPROVAL OF OCTOBER 6, 2020 SUBCOMMITTEE MINUTES (3 min.)

3. OVERVIEW BY DEPARTMENT OF JUSTICE (5 min.)

4. SPEAKERS PANEL, PRESENTATION ON RESPONSES TO CALLS FOR SERVICE AND CRISIS INTERVENTION (45 min.)

5. PUBLIC COMMENT (15 min.)
   Both the Blue Jeans application and dial-in number will permit public comment

6. DISCUSSION OF PROPOSED CALLS FOR SERVICE CHAPTER IN THE 2022 BOARD REPORT (30 min.)

7. PUBLIC COMMENT (10 min.)

8. DISCUSSION OF NEXT STEPS (5 min.)

9. ADJOURN

Documents that will be reviewed during the meeting will be posted prior to the meeting in the Upcoming Meeting section of the Board's website https://oag.ca.gov/ab953/board.

The meeting will begin at the designated time. Other times on the agenda are approximate and may vary as the business of the Board requires. For any questions about the Board meeting, please contact Anna Rick, California Department of Justice, 1515 Clay Street, Suite 2100, Oakland, California 94612, ab953@doj.ca.gov or 510-879-3095. If you need information or assistance with accommodation or interpretation requests, please contact Ms. Rick at least five calendar days before the scheduled meeting.

National Guidelines for Behavioral Health Crisis Care

Best Practice Toolkit Executive Summary

SAMHSA
Substance Abuse and Mental Health
Services Administration

National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit
Knowledge Informing Transformation

The *National Guidelines for Crisis Care – A Best Practice Toolkit* advances national guidelines in crisis care within a toolkit that supports program design, development, implementation and continuous quality improvement efforts. It is intended to help mental health authorities, agency administrators, service providers, state and local leaders think through and develop the structure of crisis systems. The toolkit includes distinct sections for:

- ✓ Defining national guidelines in crisis care;
- ✓ Implementing care that aligns with national guidelines; *and*
- ✓ Evaluating alignment of systems to national guidelines.

Given the ever-expanding inclusion of the term "crisis" by entities describing service offerings that do not truly function as no-wrong-door safety net services, we start by defining what crisis services are and what they are not. Crisis services are for **anyone, anywhere and anytime.** Crisis services include (1) crisis lines accepting all calls and dispatching support based on the assessed need of the caller, (2) mobile crisis teams dispatched to wherever the need is in the community (not hospital emergency departments) and (3) crisis receiving and stabilization facilities that serve everyone that comes through their doors from all referral sources. These services are for **anyone, anywhere and anytime.**

With non-existent or inadequate crisis care, costs escalate due to an overdependence on restrictive, longer-term hospital stays, hospital readmissions, overuse of law enforcement and human tragedies that result from a lack of access to care. Extremely valuable psychiatric inpatient assets are over-burdened with referrals that might be best-supported with less intrusive, less expensive services and supports. In too many communities, the "crisis system" has been unofficially handed over to law enforcement; sometimes with devastating outcomes. The current approach to crisis care is patchwork and delivers minimal treatment for some people while others, often those who have not been engaged in care, fall through the cracks; resulting in multiple hospital readmissions, life in the criminal justice system, homelessness, early death and even suicide.

A comprehensive and integrated crisis network is the first line of defense in preventing tragedies of public and patient safety, civil rights, extraordinary and unacceptable loss of lives, and the waste of resources. There is a better way. Effective crisis care that saves lives and dollars requires a systemic approach. This toolkit will delineate how to estimate the crisis system resource needs of a community, the number of individuals who can be served within the system, the cost of crisis services, the workforce demands of implementing crisis care and the community-changing impact that can be seen when services are delivered in a manner that aligns with this Best Practice Toolkit. Readers will also learn how this approach harnesses data and technology, draws on the expertise of those with lived experience, and incorporates evidence-based suicide prevention practices.

Core Services and Best Practices

The following represent the *National Guidelines for Crisis Care* essential elements within a **no-wrong-door** integrated crisis system:

1. **Regional Crisis Call Center**: Regional 24/7 clinically staffed hub/crisis call center that provides crisis intervention capabilities (telephonic, text and chat). Such a service should meet National Suicide Prevention Lifeline (NSPL) standards for risk assessment and engagement of individuals at imminent risk of suicide and offer quality coordination of crisis care in real-time;

2. **Crisis Mobile Team Response**: Mobile crisis teams available to reach any person in the service area in his or her home, workplace, or any other community-based location of the individual in crisis in a timely manner; *and*

3. **Crisis Receiving and Stabilization Facilities**: Crisis stabilization facilities providing short-term (under 24 hours) observation and crisis stabilization services to all referrals in a home-like, non-hospital environment.

In addition to the essential structural or programmatic elements of a crisis system, the following list of essential qualities must be "baked into" comprehensive crisis systems:

1. Addressing recovery needs, significant use of peers, and trauma-informed care;
2. "Suicide safer" care;
3. Safety and security for staff and those in crisis; *and*
4. Law enforcement and emergency medical services collaboration.

Regional Crisis Call Hub Services – *Someone To Talk To*

Regional, 24/7, clinically staffed call hub/crisis call centers provide telephonic crisis intervention services to all callers, meet National Suicide Prevention Lifeline (NSPL) operational standards regarding suicide risk assessment and engagement and offer quality coordination of crisis care in real-time. Ideally, these programs will also offer text and chat options to better engage entire communities in care. Mental health, substance use and suicide prevention lines must be equipped to take all calls with expertise in delivering telephonic intervention services, triaging the call to assess for additional needs and coordinating connections to additional support based on the assessment of the team and the preferences of the caller.

Minimum Expectations to Operate a Regional Crisis Call Service

1. Operate every moment of every day (24/7/365);
2. Be staffed with clinicians overseeing clinical triage and other trained team members to respond to all calls received;
3. Answer every call or coordinate overflow coverage with a resource that also meets all of the minimum crisis call center expectations defined in this toolkit;
4. Assess risk of suicide in a manner that meets NSPL standards and danger to others within each call;

5. Coordinate connections to crisis mobile team services in the region; *and*
6. Connect individuals to facility-based care through warm hand-offs and coordination of transportation as needed.

Best Practices to Operate Regional Crisis Call Center

To fully align with best practice guidelines, centers must meet the minimum expectations and:

1. Incorporate Caller ID functioning;
2. Implement GPS-enabled technology in collaboration with partner crisis mobile teams to more efficiently dispatch care to those in need;
3. Utilize real-time regional bed registry technology to support efficient connection to needed resources; *and*
4. Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff to support connection to ongoing care following a crisis episode.

To align with National Suicide Prevention Lifeline (NSPL) operational standards, centers must:

1. Practice **active engagement** with callers and make efforts to establish sufficient rapport so as to promote the caller's collaboration in securing his/her own safety;
2. Use the **least invasive intervention** and consider involuntary emergency interventions as a last resort, except for in circumstances as described below;
3. Initiate life-saving services for attempts in progress – in accordance with guidelines that do not require the individual's consent to initiate medically necessary rescue services;
4. Initiate active rescue to secure the immediate safety of the individual at risk if the caller remains unwilling and/or unable to take action to prevent his/her suicide and remains at imminent risk;
5. Practice active engagement with persons calling on behalf of someone else ("third-party callers") towards determining the least invasive, most collaborative actions to best ensure the safety of the person at risk;
6. Have supervisory staff available during all hours of operations for timely consultation in determining the most appropriate intervention for any individual who may be at imminent risk of suicide; *and*
7. Maintain caller ID or other method of identifying the caller's location that is readily accessible to staff.

True regional crisis call center hub services that offer air traffic control-type functioning are essential to the success of a crisis system. Cracks within a system of care widen when individuals experience interminable delays in access to services which are often based on an absence of:

1. Real-time coordination of crisis and outgoing services; *and*
2. Linked, flexible services specific to crisis response; namely mobile crisis teams and crisis stabilization facilities.

Mobile Crisis Team Services – *Someone To Respond*

Mobile crisis team services offering community-based intervention to individuals in need wherever they are; including at home, work, or anywhere else in the community where the person is experiencing a crisis. For safety and optimal engagement, two person teams should be put in place to support emergency department and justice system diversion. EMS services should be aware and partner as warranted.

Minimum Expectations to Operate a Mobile Crisis Team Services

1. Include a licensed and/or credentialed clinician capable to assessing the needs of individuals within the region of operation;
2. Respond where the person is (home, work, park, etc.) and not restrict services to select locations within the region or particular days/times; *and*
3. Connect to facility-based care as needed through warm hand-offs and coordinating transportation when and only if situations warrants transition to other locations.

Best Practices to Operate Mobile Crisis Team Services

To fully align with best practice guidelines, teams must meet the minimum expectations and:

1. Incorporate peers within the mobile crisis team;
2. Respond without law enforcement accompaniment unless special circumstances warrant inclusion in order to support true justice system diversion;
3. Implement real-time GPS technology in partnership with the region's crisis call center hub to support efficient connection to needed resources and tracking of engagement; *and*
4. Schedule outpatient follow-up appointments in a manner synonymous with a warm handoff in order to support connection to ongoing care.

Essential functions of mobile crisis services include:

- Triage/screening, including explicit screening for suicidality;
- Assessment;
- De-escalation/resolution;
- Peer support;
- Coordination with medical and behavioral health services; *and*
- Crisis planning and follow-up.

Crisis Receiving and Stabilization Services – *A Place to Go*

Crisis receiving and stabilization services offer the community a no-wrong-door access to mental health and substance use care; operating much like a hospital emergency department that accepts all walk-ins, ambulance, fire and police drop-offs. The need to say yes to mental health crisis referrals, including working with persons of varying ages (as allowed by facility license) and clinical conditions (such as serious emotional disturbance, serious mental illness, intellectual and developmental disabilities), regardless of acuity, informs program staffing, physical space, structure and use of chairs or recliners in lieu of beds that offer far less capacity or flexibility within a given space. It is important to fund these facility-based programs so they can deliver on

the commitment of never rejecting a first responder or walk-in referral in order to realize actual emergency department and justice system diversion. If an individual's condition is assessed to require medical attention in a hospital or referral to a dedicated withdrawal management (i.e., referred to more commonly and historically as detoxification) program, it is the responsibility of the crisis receiving and stabilization facility to make those arrangements and not shift that responsibility to the initial referral source (family, first responder or mobile team). Law enforcement is not expected to do the triage or assessment for the crisis system and it is important that those lines never become blurred.

Minimum Expectations to Operate a Crisis Receiving and Stabilization Service

1. Accept all referrals;
2. Not require medical clearance prior to admission but rather assessment and support for medical stability while in the program;
3. Design their services to address mental health and substance use crisis issues;
4. Employ the capacity to assess physical health needs and deliver care for most minor physical health challenges with an identified pathway in order to transfer the individual to more medically staffed services if needed;
5. Be staffed at all times (24/7/365) with a multidisciplinary team capable of meeting the needs of individuals experiencing all levels of crisis in the community; including:
   a. Psychiatrists or psychiatric nurse practitioners (telehealth may be used)
   b. Nurses
   c. Licensed and/or credentialed clinicians capable of completing assessments in the region; *and*
   d. Peers with lived experience similar to the experience of the population served.
6. Offer walk-in and first responder drop-off options;
7. Be structured in a manner that offers capacity to accept all referrals, understanding that facility capacity limitations may result in occasional exceptions when full, with a no rejection policy for first responders;
8. Screen for suicide risk and complete comprehensive suicide risk assessments and planning when clinically indicated; *and*

9. Screen for violence risk and complete more comprehensive violence risk assessments and planning when clinically indicated.

Best Practices to Operate Crisis Receiving and Stabilization Services
To fully align with best practice guidelines, centers must meet the minimum expectations and:

1. Function as a 24 hour or less crisis receiving and stabilization facility;
2. Offer a dedicated first responder drop-off area;
3. Incorporate some form of intensive support beds into a partner program (could be within the services' own program or within another provider) to support flow for individuals who need additional support;
4. Include beds within the real-time regional bed registry system operated by the crisis call center hub to support efficient connection to needed resources; *and*
5. Coordinate connection to ongoing care.

The Role of the Psychiatrist/Psychiatric Nurse Practitioner

Psychiatrists and Psychiatric Nurse Practitioners serve as clinical leaders of the multi-disciplinary crisis team. Essential functions include ensuring clinical soundness of crisis services through evaluation of need, continued monitoring of care and crisis service discharge planning.

Essential Principles for Modern Crisis Care Systems

Best practice crisis care incorporates a set of core principles that must be systematically "baked in" to excellent crisis systems in addition to the core structural elements that are defined as essential for modern crisis systems. These essential principles and practices are:

1. Addressing Recovery Needs,
2. Significant Role for Peers,
3. Trauma-Informed Care,
4. *Zero Suicide*/Suicide Safer Care,
5. Safety/Security for Staff and People in Crisis *and*
6. Crisis Response Partnerships with Law Enforcement, Dispatch, and Emergency Medical Services.

Addressing Recovery Needs

Crisis providers must address the recovery needs of individuals and families to move beyond their mental health and substance use challenges to lead happy, productive and connected lives each and every day.

Implementation Guidance

1. *Commit to a no-force-first approach to quality improvement in care that is characterized by engagement and collaboration.*
2. *Create engaging and supportive environments that are as free of barriers as possible. This should include eliminating Plexiglas from crisis stabilization units and minimal barriers between team members and those being served to support stronger connections.*
3. *Ensure team members engage individuals in the care process during a crisis. Communicate clearly regarding all options clearly and offer materials regarding the process in writing in the individual's preferred language whenever possible.*
4. *Ask the individual served about their preferences and do what can be done to align actions to those preferences.*
5. *Help ensure natural supports and personal attendants are also part of the planning team, such as with youth and persons with intellectual and developmental disabilities.*
6. *Work to convert those with an involuntary commitment to voluntary so they are invested in their own recovery.*

Significant Role for Peers

A transformative element of recovery-oriented care is to fully engage the experience, capabilities and compassion of people who have experienced mental health crises. Including individuals with lived mental health and substance use disorder experience (peers) as core members of a crisis

team supports engagement efforts through the unique power of bonding over common experiences while adding the benefits of the peer modeling that recovery is possible.

Implementation Guidance

1. *Hire credentialed peers with lived experience that reflect the characteristics of the community served as much as possible. Peers should be hired with attention to common characteristics such as gender, race, primary language, ethnicity, religion, veteran status, lived experiences and age.*
2. *Develop support and supervision that aligns with the needs of your program's team members.*
3. *Emphasize engagement as a fundamental pillar of care that includes peers as a vital part of a crisis program's service delivery system. This should include (1) integrating peers within available crisis line operations, (2) having peers serve as one of two mobile team members and (3) ensuring a peer is one of the first individuals to greet an individual admitted to a crisis stabilization facility.*

Trauma-Informed Care

The great majority of individuals served in mental health and substance use services have experienced significant interpersonal trauma. Mental health crises and suicidality often are rooted in trauma. These crises are compounded when crisis care involves loss of freedom, noisy and crowded environments and/or the use of force. These situations can actually re-traumatize individuals at the worst possible time, leading to worsened symptoms and a genuine reluctance to seek help in the future.

On the other hand, environments and treatment approaches that are safe and calm can facilitate healing. Thus, we find that trauma-informed care is an essential element of crisis treatment. In 2014, SAMHSA set the following guiding principles for trauma-informed care:

1. Safety;
2. Trustworthiness and transparency;
3. Peer support and mutual self-help;
4. Collaboration and mutuality;
5. Empowerment, voice and choice; *and*
6. Ensuring cultural, historical and gender considerations inform the care provided.

Trauma-informed systems of care ensure these practices are integrated into service delivery. Developing and maintaining a healthy environment of care also requires support for staff, who may have experienced trauma themselves.

Implementation Guidance

1. *Incorporate trauma-informed care training into each team member's new employee orientation with refreshers delivered as needed.*
2. *Apply assessment tools that evaluate the level of trauma experienced by the individuals served by the crisis program and create action steps based on those assessments.*

Zero Suicide/Suicide Safer Care

Two transformational commitments must be made by every crisis provider in the nation: (1) adoption of suicide prevention as a core responsibility, and (2) commitment to dramatic reductions in suicide among people under care. These changes were adopted and advanced in the revised *National Strategy for Suicide Prevention* (2012), specifically via a new Goal 8: "Promote suicide prevention as a core component of health care services" (p. 51).

The following key elements of Zero Suicide or Suicide Safer Care are all applicable to crisis care:

1. Leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care, that includes survivors of suicide attempts and suicide loss in leadership and planning roles;
2. Developing a competent, confident, and caring workforce;
3. Systematically identifying and assessing suicide risk among people receiving care;
4. Ensuring every individual has a pathway to care that is both timely and adequate to meet his or her needs and includes collaborative safety planning and a reduction in access to lethal means;
5. Using effective, evidence-based treatments that directly target suicidal thoughts and behaviors;
6. Providing continuous contact and support; especially after acute care; *and*
7. Applying a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

Safety/Security for Staff and People in Crisis

Safety for both individuals served and staff is a foundational element for all crisis service settings. Crisis settings are also on the front lines of assessing and managing suicidality and possibly violent thoughts or aggressive behaviors, issues with life and death consequences. While ensuring safety for people using crisis services is paramount, the safety for staff cannot be compromised. Keys to safety and security in crisis delivery settings include:

- Evidence-based and trauma-informed crisis training for all staff;
- Role-specific staff training and appropriate staffing ratios to number of clients being served;
- A non-institutional and welcoming physical space and environment for persons in crisis, rather than Plexiglas "fishbowl" observation rooms and keypad-locked doors. This space must also be anti-ligature sensitive and contain safe rooms for people for whom violence may be imminent;
- Established policies and procedures emphasizing "no force first" prior to implementation of safe physical restraint or seclusion procedures;
- Pre-established criteria for crisis system entry;
- Strong relationships with law enforcement and first responders; *and*
- Policies that include the roles of clinical staff (and law enforcement if needed) for management of incidents of behavior that places others at risk.

Providers must establish environments that are safe for those they serve as well as their own team members who are charged with delivering high quality crisis care that aligns with best practice guidelines. The keys to safety and security for home visits by mental health staff include:

- No mental health crisis outreach worker will be required to conduct home visits alone.
- Employers will equip mental health workers who engage in home visits with a communication device.
- Mental health workers dispatched on crisis outreach visits will have prompt access to any information available on history of dangerousness or potential dangerousness of the client they are visiting.

Implementation Guidance

1. *Commit to a no-force-first approach to care.*
2. *Monitor, report and review all incidents of seclusion and restraint with the goal of minimizing the use of these interventions.*
3. *Remember that barriers do not equal safety. The key to safety is engagement and empowerment of the individual served while in crisis.*
4. *Offer enough space in the physical environment to meet the needs of the population served. A lack of space can elevate anxiety for all.*
5. *Incorporate quiet spaces into your crisis facility for those who would benefit from time away from the milieu of the main stabilization area.*
6. *Engage your team members and those you serve in discussions regarding how to enhance safety within the crisis program.*

Law Enforcement and Crisis Response—An Essential Partnership

Law enforcement agencies have reported a significant increase in police contacts with people with mental illness in recent years. Some involvement with mental health crises is inevitable for police. Police officers may (1) provide support in potentially dangerous situations when the need is assessed or (2) make warm hand-offs into crisis care if they happen to be first to engage.

In many communities across the United States, the absence of sufficient and well-integrated mental health crisis care has made local law enforcement the *de facto* mental health mobile crisis system. This is unacceptable and unsafe. The role of local law enforcement in addressing emergent public safety risk is essential and important. With good mental health crisis care in place, the care team can collaborate with law enforcement in a fashion that will improve both public safety and mental health outcomes. Unfortunately, well-intentioned law enforcement responders to a crisis call can escalate the situation solely based on the presence of police vehicles and armed officers that generate anxiety for far too many individuals in a crisis.

Implementation Guidance

1. *Have local crisis providers actively participate in Crisis Intervention Team training or related mental health crisis management training sessions.*

2. *Incorporate regular meetings between law enforcement and crisis providers, including EMS and dispatch, into the schedule so these partners can work to continuously improve their practices.*
3. *Include training on crisis provider and law enforcement partnerships in the training for both partner groups.*
4. *Share aggregate outcomes data such as numbers served, percentage stabilized and returned to the community and connections to ongoing care.*

Psychiatric Advance Directives

A psychiatric or mental health advance directive (PAD) is a legal tool that allows a person with mental illness to state their preferences for treatment in advance of a crisis. They can serve as a way to protect a person's autonomy and ability to self-direct care. Crisis providers are expected to always seek to understand and implement any existing PAD that has been developed by the individual during the evaluation phase and work to ensure the individual discharges from crisis care with an updated and accurate psychiatric advance directive whenever possible. PAD creates a path to express treatment preferences and identify a representative who is trusted and legally empowered to make healthcare decisions on medications, preferred facilities, and listings of visitors.

Funding Crisis Care

The full *Crisis Services Best Practice Toolkit* document contains specific strategies on how a community can fund each of the core crisis system elements in single and multiple-payer environments. Additionally, recommendations on service coding already being reimbursed by Medicaid in multiple states are made available; including the use of *HCPCS code H2011 Crisis Intervention Service per 15 Minutes* for mobile crisis services and *S9484 Crisis Intervention Mental Health Services per Hour* or *S9485 Crisis Intervention Mental Health Services per Diem* for crisis receiving and stabilization facility services.

Training and Supervision

Many members of the crisis services delivery team are licensed mental health and substance use professionals operating within the scope of their license and training with supervision delivered in a manner consistent with professional expectations of the licensing board. Licensed professionals are expected to strengthen their skills and knowledge through ongoing CEU and CME professional advancement opportunities focused on improving team members' ability to deliver crisis care.

Providers also incorporate non-licensed individuals within the service delivery team; creating the need for additional training and supervision to ensure services are delivered in a manner that advances positive outcomes for those engaged in care. Verification of skills and knowledge of

non-professional staff is essential to maintaining service delivery standards within a crisis program; including the incorporation of ongoing supervision with licensed professionals available on site at all times. Supervision and the verification of skills and knowledge shall include, but is not limited to, active engagement strategies, trauma-informed care, addressing recovery needs, suicide-safer care, community resources, psychiatric advance directives and role-specific tasks.

Conclusion

Crisis services must be designed to serve **anyone, anywhere and anytime**. Communities that commit to this approach and dedicate resources to address the community need decrease psychiatric boarding in emergency departments and reduce the demands on the justice system. These two benefits translate into better care, better health outcomes and lower costs to the community. The *National Guidelines for Crisis Care – A Best Practice Toolkit* delivers a roadmap that can be used to truly make a positive impact to communities across the country.

STREET CRISIS RESPONSE TEAM

PRESENTATION OUTLINE

- Background
  - Citywide commitment to reform
  - Learning from other jurisdictions
- Street Crisis Response Team (SCRT) Pilot Overview
  - Planning Process
  - San Francisco Model, Strategies and Goals
  - Community Engagement
  - Addressing Institutional Racism
  - Pilot Evaluation

BACKGROUND

Why now? How did we get here?

CITYWIDE COMMITMENT TO REFORM

"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." ([File No. 191148](#))

Mental Health SF legislation (Late 2019)

Mayor London Breed commitment to police reform (Summer 2020)

- Includes call for behavioral health experts to respond to non-violent incidents on the street

Community Planning Processes for Police Reform

- HRC: Alternatives to Policing Steering Committee
- Coalition on Homelessness: Alternative to Police Response Committee

LEARNING FROM OTHER JURISDICTIONS

Other jurisdictions have established successful police alternative models to meet behavioral health needs. The City planning team engaged with a selection of these programs to inform the design of the San Francisco SCRT.

CAHOOTS (Eugene, Oregon)

Community Assessment and Transport Team (Alameda County Behavioral Health Services)

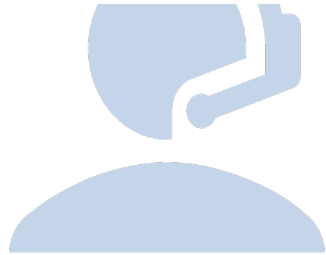Mental Health Support Team – (Part of a large crisis network in Maricopa County, Arizona)

RIGHT Care (Dallas, Texas)

Grady EMS Crisis Intervention Program (Atlanta, Georgia)

EMPACT Suicide Prevention Center at La Frontera Arizona (Tempe, Arizona)
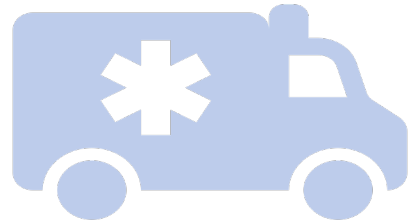
KEY ELEMENTS OF CRISIS SYSTEMS

Someone to call
Must be well publicized and easy to use

Someone to respond
Well trained, trauma-informed and culturally competent

A place to go
True "no wrong door" services that are welcoming

Linkage to ongoing care
Staff to support warm handoffs to stabilizing services

Based on SAMHSA 2020 Best Practices Toolkit

STREET CRISIS RESPONSE TEAM PILOT OVERVIEW

Planning and implementing a model customized for San Francisco

PILOT GOAL AND STRATEGIES

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.

1. Identify 9-1-1 calls that will receive behavioral health and medical response rather than law enforcement response.
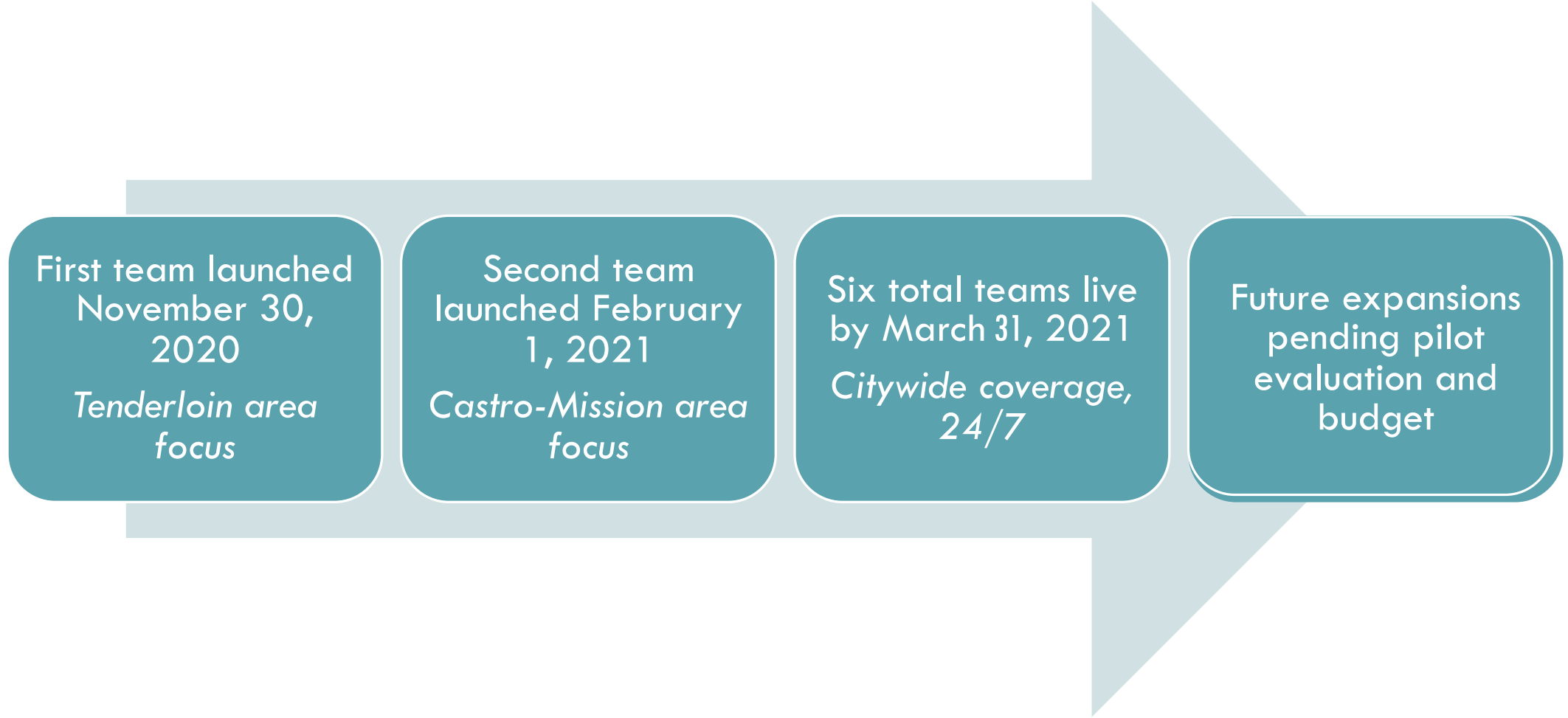
2. Deliver therapeutic de-escalation and medically appropriate response to person in crisis through multi-disciplinary team (paramedic + behavioral health clinician + peer specialist).

3. Provide appropriate linkages and follow up care for people in crisis, including mental health care, substance use treatment, and social services.

TARGET IMPLEMENTATION TIMELINE

First team launched November 30, 2020

Tenderloin area focus

Second team launched February 1, 2021

Castro-Mission area focus

Six total teams live by March 31, 2021

Citywide coverage, 24/7

Future expansions pending pilot evaluation and budget

BUDGET OVERVIEW

Project Costs	Partial Year FY20-21	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

PROGRAM DETAILS

Each SCRT unit includes an emergency services vehicle, with ability to transport and the following core staff:

- Community paramedic (SF Fire Department)
- Behavioral health clinician (HealthRIGHT 360)
- Peer specialist (RAMS)
- Office of Coordinated Care staff dedicated to linkages and follow up care coordination
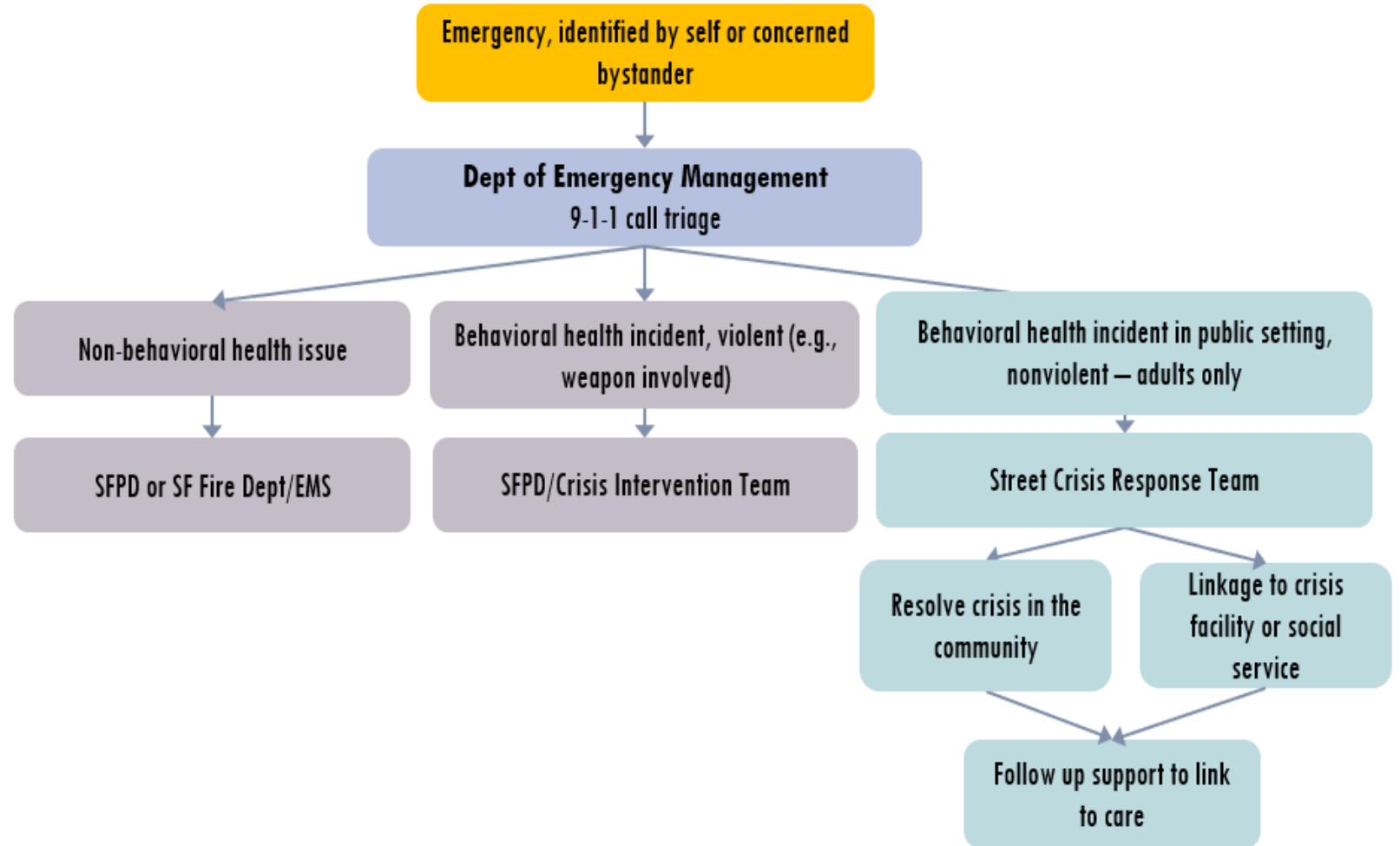
Coverage

- Teams 1 and 2 launched with 12-hour daily coverage, 7 days per week
- Target March 31, 2021 for citywide, 24 hours/7 days coverage
- Ensure geographic areas covered represent need and promote equity

SCRT DEPLOYMENT AND LINKAGE

- SCRT predominantly responds to calls through 911 emergency dispatch

- SCRT also responds to "on views" of people who they encounter between calls who are in visible need of support and "special calls" from select City agencies

Emergency, identified by self or concerned bystander

Dept of Emergency Management
9-1-1 call triage

| Non-behavioral health issue | Behavioral health incident, violent (e.g., weapon involved) | Behavioral health incident in public setting, nonviolent — adults only |

SFPD or SF Fire Dept/EMS

SFPD/Crisis Intervention Team

Street Crisis Response Team

Resolve crisis in the community

Linkage to crisis facility or social service

Follow up support to link to care

IDENTIFYING APPROPRIATE CALL CODES

- 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.

- "B" priority calls indicate that there is no weapon or violence involved

DEM Call Code Data 2019
Behavioral Health Police Response Codes

Category	A-Priority	B-Priority
"Mentally Disturbed Person" (Code 800)	4,604	10,142
"Person Attempting Suicide" (Code 801)	3,695	133
"Well-being check" (Code 910)	9,248	17,514
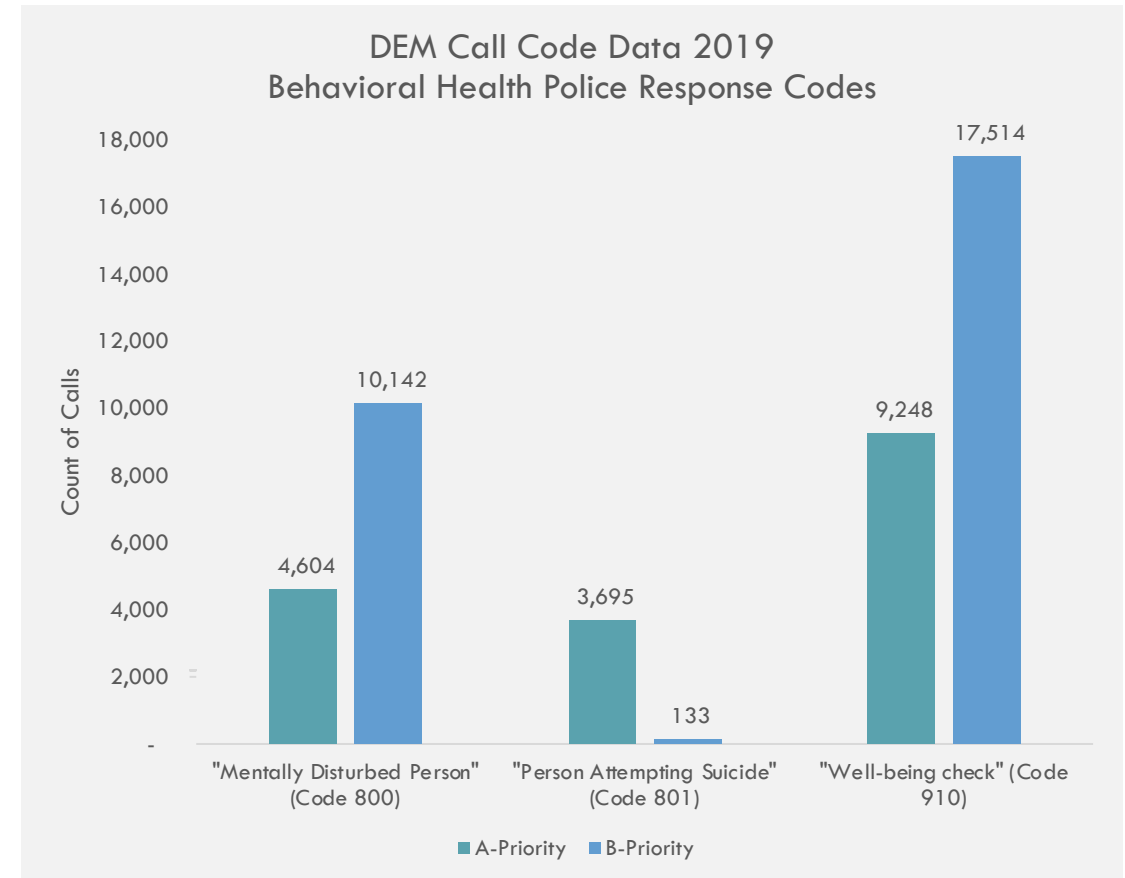
PRE-LAUNCH COMMUNITY ENGAGEMENT

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.

COMMUNITY ENGAGEMENT LOOKING AHEAD

OBJECTIVES

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.

A community forum is scheduled for March 10 to re-engage community-based providers and engage newly identified leaders. This session aims to inform community of early pilot results, collect feedback, and establish collective action plans for building community trust and pathways for feedback from community members.

ADDRESSING INSTITUTIONAL RACISM

- Each call SCRT accepts represents a call diversion from the San Francisco Police Department, inherently reducing law enforcement encounters for the population served.

- SCRT aims to reduce existing 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, and for each target outcome, SCRT will measure the ability of the program to reduce disparities

- SCRT seeks to build relationships and trust with communities of color and/or distrust of law enforcement by partnering with community leaders and establishing creative pathways to receive constructive feedback from community

- 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

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 monitoring its ability to reduce incarceration, emergency room use and involuntary detentions, especially through the lens of race and ethnicity.

PILOT EVALUATION

Pilot Program Evaluation led by Harder + Company key questions:

- Who is the Street Crisis Response Team serving, and what are the characteristics of those service calls?
- How effective is the Street Crisis Response Team in addressing the needs of the individuals it serves?
- What successes and challenges have Street Crisis Response Team members and community stakeholders observed in the implementation of the pilot program?

Research Study funded by Robert Wood Johnson Foundation

- 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.

Act   Plan

Study   Do

17
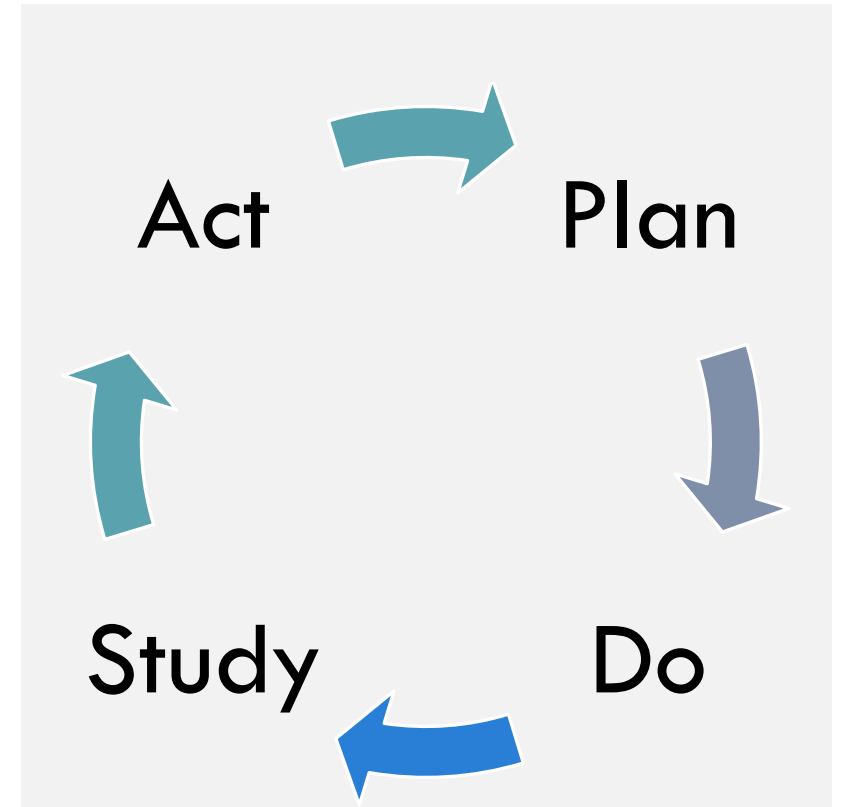
CLARIFYING QUESTIONS

APPENDIX

Client impact stories and alignment with other MHSF programs

CLIENT IMPACT #1

The SCRT received a call about a person walking in and out of the streets, throwing trash. The fire and sheriff's departments were on the scene but requested SCRT help with the person's mental health issues. The team found the client in an agitated, paranoid state. The clinician used active listening and de-escalation techniques to engage the client, who reported using fentanyl earlier in the day. She expressed that she was very cold and wanted coffee, so the clinician offered to get the coffee. As they waited for the coffee and the conversation continued, the client told the clinician about her bipolar and psychosis diagnoses and about her case manager. The team referred the client back to that provider.

CLIENT IMPACT #2

Within the first month in operation The Street Crisis Response Team had its first repeat engagement. Over the course of one week the team engaged with a young male in his 20's that was reported to be naked in the community. Each time the team was dispatched to the location they tried continuously to get the client to stop for even one second to have a conversation and each time the client quickly said no thank you and ran off. On the third or fourth time being dispatched out to this unclothed individual I was able to follow him a block and he surprisingly accepted food that I was offering him. As I handed him the snack I thought that this might be my chance to get him to stop for a second and talk. To my surprise he responded to a few questions and lingered longer than he had in past engagements before running off again. This was witnessed by the other members of the team. We debriefed for a minute before trying to engage one more time and came to an agreement that since he looked willing to talk to me that I would do my best to try and engage with him again and try and get him to put on some clothing. We found him talking to himself down an alley off Van Ness Ave. and I walked down to try and talk again... while my team members tried their best to remain unseen but within sight in case I needed assistance. Even though the conversation was confusing and didn't make much sense to me he still took the clothes I was offering and put on the underwear and shirt and even took a new blanket. Ultimately, he declined services but felt that the repeated compassionate care that the team showed and maybe the relative heart of the peer he was able to receive was a win indeed.

-Michael Marchiselli, Peer Counselor, Street Crisis Response Team