

DATE: DRAFT June 15, 2022

TO: Supervisor Don Horsley, President
Supervisor Dave Pine, Vice-President
Supervisor Carole Groom
Supervisor David Canepa
Supervisor Warren Slocum

CC: Scott Gilman, Director BHRS

FROM: The San Mateo County Behavioral Health Commission,
Sheila Brar, Chair

SUBJECT: Crisis Response Coordination Recommendations

EXECUTIVE SUMMARY

After reviewing the County's current mental health crisis response approach and services, speaking with providers, clients, and agencies, and researching alternative models across the country, the Ad Hoc Committee on Police & Mental Health Partnerships identified the following;

Major findings include:

- The need for mental health services to be inserted into the 911 system
- The need to triage mental health calls for service early
- The need for consistent, county-wide services for mental health crisis
- The need for County wide standards on dealing with a mental health crisis
- The need for comprehensive integrated system of services accessible to anyone, anywhere, and anytime, providing "No Wrong Door"
- The need for a non-armed crisis response team

Recommendations:

- Reviewing and updating dispatcher protocols to reflect complicated mental health concerns and add "mental health" to the 911 answering protocol.
- Embed a trained licensed professional directly to the dispatch center to triage mental health calls for service.
- Create a stand-alone, non-armed, 24/7, crisis response unit designed to independently operate mobile crisis response teams to service the entire County. Several working examples exist including teams with clinicians, peer support, paramedics, and teams with knowledge of veteran services.

- Establish Community Based Crisis Stabilization Centers, sometimes referred to as Mental Health Urgent Care Centers.

CONTEXT

In fulfillment of our roles as advocates, we are respectfully submitting this overview and related recommendations to the San Mateo County Board of Supervisors based on 1) extensive community feedback shared directly with us, 2) research conducted by our Police / Mental Health Partnership Ad Hoc Committee, and 3) our lived experiences as consumers, family members, and advocates.

As stated in Welfare and Institutions Code Section 5604.2, the duties of the San Mateo County Behavioral Health Commission include, but are not limited to, the following:

- ***Review and evaluate** the community's mental health needs, services, facilities, and special problems.*
- ***Advise the Board of Supervisors and the local mental health director** as to any aspect of the local mental health program.*

BACKGROUND:

In January 2020 at our Commission annual retreat one of the priorities we set was to have a more active role in advocating to the “rightsizing” of police and mental health calls for service. We realized that the police were overburdened with mental health calls for service and, in some cases, not the right response. We understood that the County had adequate crisis services but was not fully integrated into the 911 system to be able to respond to mental health calls for service.

As we set out on our journey to build on our own experiences with input from the community, we did not predict the extent of national civil unrest that would come this year as well as local events involving police and the mentally ill. We, as a Commission, heard the call for reform on police response to mental health calls. We also learned that a pilot program between cities was in the works. The Commission established an Ad Hoc committee to provide input and be a resource for this pilot program. After several attempts to be involved in the formation of the pilot program we learned that the cities had already established the framework for the program.

Refocusing our efforts to our county-wide clients, we decided the Ad Hoc should focus on services County wide, and not limit our group to the four cities in the pilot program.

People with serious and untreated mental health and substance use conditions often encounter barriers that prevent receiving the right services. Police officers, behavioral health providers, and community stakeholders face challenges in determining and implementing the proper ways to intervene during behavioral health crises. Unfortunately, as a result, interactions with people with

mental illness in crisis often result in actions that significantly hurt recovery. For example, in 2016, a quarter of all fatal police shootings nationwide involved people with behavioral health or substance use conditions.¹

As a result, persons experiencing mental health or substance use crises may:

- end up in confrontations with law enforcement personnel which have tragic outcomes;
- be transported to emergency rooms and be admitted or committed to inpatient psychiatric facilities when these outcomes are unnecessary and may be harmful to the person; and
- be transported to a jail and subjected to ongoing involvement in the criminal justice system when these outcomes are unnecessary, are harmful to the person, and do not lead to increased public safety.

Many of the problems associated with police involvement in behavioral health crises can be avoided by creating alternatives. Non-behavioral medical emergencies, such as heart attacks, strokes and non-vehicular accidents are often handled by the 911 system. But rather than dispatching a police officer, an ambulance is sent. A law enforcement response to a mental health crisis is almost always stigmatizing for people with mental illnesses and should be avoided when possible. Whenever possible, mental health crises should be treated using medical personnel or, even better, specialized mental health personnel. Substance use disorders need to be handled in a way that promotes recovery, not victimization.²

“The history of negative interactions between police officers and mentally ill individuals hits close to home, and some experts say the risk is even higher for mentally ill people of color”³ Family members and other loved ones are also impacted by traumatic police responses to mental health crises, and these traumatic interactions also affect larger communities.

Experience with or knowledge of others’ traumatic encounters with law enforcement during mental health crises may leave family members feeling unsafe and cause them to avoid calling 911 during subsequent crises. Since there are few other options during a crisis, people and their families are left with unmet needs.⁴

This letter is our request on behalf of those we represent, the community leaders, and families we’ve engaged over the last several months. Here are the Ad Hoc actions that inform this letter:

¹ Tate, J., Jenkins, J., & Rich, S. (2016). Fatal force 963 people have been shot and killed by police in 2016. *Washington Post*. <https://www.washingtonpost.com/graphics/national/police-shootings-2016/> and <https://store.samhsa.gov/shin/content/SMA14-4848/SMA14-4848.pdf>

² <https://store.samhsa.gov/shin/content/SMA14-4848/SMA14-4848.pdf>

³ Caiola, Sammy. “Should Police Be Responding To Mental Health Calls? This Group Says No, And Offers An Alternative.” Capradio, Sacramento, 16 June 2020. <https://www.capradio.org/articles/2020/06/16/should-police-be-responding-to-mental-health-calls-this-group-says-no-and-offers-an-alternative/>

⁴ Torres, Stacy. “Why we won’t call 911: Too Often Police Officers’ Response to Mental Illness is Deadly.” CalMatters, 13 October 2019. <https://calmatters.org/commentary/crisis-intervention-training/>

- _Collected and reviewed public comments from family members and clients on mental-health, crisis-related interactions with law enforcement
- _Researched and reviewed Crisis Intervention Training (CIT), PERT, and alternative crisis response programs
- _Engaged with and/or heard presentations from:

San Mateo County Crisis Services

John Gardner Center

NAMI San Mateo

San Mateo County Dispatch

San Mateo County PERT & CIT

ACLU MidPen

Democracy for America, Social Justice Task Force

San Mateo Democrat Central Committee, Police Reform Task Force

Santa Clara County Behavioral Health / PERT / Mobile Crisis Response Team

Mental Health First Aid

CAHOOTS

Santa Rosa inRESPONSE Team

University of San Diego, Dr. Erik Fritsvold, Chief James Davis, Ms. Marla Kingkade, Dr.

Mark Marvin, Chief Bernie Colon, DA Summer Stephan

SAMHS-National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit

Knowledge Informing Transformation

CARES team – El Centro de Libertad

RECOMMENDATIONS:

Recommendation 1: Add “Mental Health” to dispatcher protocols

- Our recommendation is to add a criterion in the protocol for dispatchers answering 911 calls for service. We recommend adding “Mental Health” to the 911 answering protocol. Dispatchers should now ask, “911, do you need police, fire, EMS or mental health services.”
- Our current emergency telephone system or 911 must be updated and overhauled to reflect complicated mental health concerns.
- We also recommend looking inside 911 call centers, how they code and dispatch calls, and how to divert on the same or compatible platforms.

Research

The Mental Health crisis in this County goes far beyond law enforcement. Perhaps no group in this country has been tasked to manage and interact with the mentally ill more than our police

and sheriff. One study shows that almost half the people killed by police had a mental illness.⁵ Another study determined that the mentally ill are 16 times more likely to be killed in America than someone without a mental illness.⁶

These policy amendments should also address when it is appropriate to connect callers who do not need a police response to more appropriate services, such as EMS, non-armed crisis team, or the clinician embedded in the call center (described in detail in Element #2 below) at the appropriate time.

With respect to classification codes, Dr. Rebecca Neusteter, executive director at the University of Chicago's Health Lab and former policing program director at the Vera Institute of Justice reported that 911 call classification codes are both over- and under-specific.⁷ In New York, she worked in a jurisdiction with 150 call-taking codes where the most frequently used code was "other." When she and her former colleagues at the Vera Institute of Justice did a multicity 911 analysis evaluating call code inter-rater reliability, they found that two call takers weren't likely to classify calls the same way. "In most cases, the call codes didn't match up," she said.

In Atlanta, Dr. Shila Hawk and Dr. Kevin Baldwin at Applied Research Services, Inc., analyzed 3.5 million 911 calls in the city's metropolitan area and found that roughly 600,000 calls (18.4%) may have been suitable for diversion from 911. These calls were commonly logged as "suspicious person," "criminal trespass," or "street/sidewalk hazard."

Like many call centers, the dispatch process is reminiscent of the children's game Telephone. The caller says their reason for calling, the call taker tells the dispatcher, and then the dispatcher tells the officers what the caller said. In many jurisdictions, points out Dr. Neusteter, a third person is in the mix. "There's often an operator who determines if the call requires police, fire, or EMS," she says. "They then transfer to the call taker who inputs the notes that a dispatcher intercepts to deploy resources and connect with responders through Computer Aided Dispatch and/or the radio."

In November, 2014, in Cleveland Ohio, a caller tells the 911 call taker that there is a youth with a gun pointing it at people. He says the person on the swing is "probably a juvenile" three separate times and points out at least twice that the "gun may be fake." The dispatcher tells the responding officers of the "black male," pointing a gun at people. The dispatcher never mentions that the subject may be a child playing with a fake gun.⁸

⁵ https://www.salon.com/2012/12/10/half_of_people_shot_by_police_are_mentally_ill_investigation_finds/

⁶ <https://www.usatoday.com/story/news/2015/12/10/people-mental-illness-16-times-more-likely-killed-police/77059710/>

⁷ <https://talk.crisisnow.com/the-troubling-history-of-911-and-how-988-can-avoid-the-same-missteps/>

⁸ https://www.washingtonpost.com/video/national/audio-from-the-tamir-rice-shooting/2014/11/26/8389ceda-75bb-11e4-8893-97bf0c02cc5f_video.html

Within two seconds of police arrival 12-year-old Tamir Rice was shot and died the next day. There was no indication in the call-takers notes clarifying the details of the youth or a possible fake gun. Since the dispatcher did not have those notes, they could not pass that information along to responding officers. “Police radio personnel errors were a substantial contributing factor to the tragic outcome.” “Had the officers been aware of those qualifiers, the training officer who was driving might have approached the scene with less urgency and lives may not have been put at stake.”⁹

Often 911 call classification codes are both over- and under-specific. For instance, call takers and responders may have hundreds of codes to choose from to classify a call, yet the system doesn't adequately allow for nuance and detail. 911 systems need to have a method for first responders — including mobile crisis teams — and service providers to update details in the systems, code the call correctly, and add mental health codes to reflect the true nature of the call. This will allow call centers to provide better care and services to the person and to retool the system to truly understand people's needs.

Recommendation 2: Mental Health Integrated Dispatch

- Embed a licensed, professional mental health clinician in the 911 call center, whose purpose is to assist in triaging calls for mental health services

Serving as the first contact a person makes when calling 911 for a crisis, the dispatch center is a vital triage point. There are critical times when behavioral health elements may not be understood by the call taker or passed along to responding officers. There are also times when a law enforcement response may not be the most appropriate response for the person calling 911.

A trained licensed professional play an invaluable role in triaging these needs, ensuring assignment to the most appropriate resources available. This clinician will be able to triage the calls to ensure the proper response to the situation, hence being able to send a non-armed mental health services response to a call that is deemed safe and, conversely, send a police response when deemed an unknown or unsafe situation.

Research

Houston Police Department and the Harris Center initiated a collaborative Crisis Call Diversion (CCD) program in 2015 and, since that time, the program has demonstrated strong efficacy in diverting non-emergent CIT calls away from police and EMS to CCD clinicians embedded in the call center. The clinicians, who are employed by the Harris Center, link the caller to needed services rather than dispatching a police unit or ambulance to the scene. The CCD program has provided cost savings, and, more importantly, significant cost avoidance to Houston first responder agencies. Initial research estimated the program provided Houston agencies with over \$1.3 million in cost avoidance netting first responder agencies over

⁹ <http://prosecutor.cuyahogacounty.us/en-US/SYN/68177/NewsDetailTemplate.aspx>

\$860,000 in cost savings in the first year of operations¹⁰ while connecting thousands of Houston area residents to mental health care services during times of crisis.

If a similar program were developed in San Mateo County, we recommend collaboration with BHRS to place clinicians directly on the dispatch floor as an integrated component of 911 operations. Implementation and program design should reflect the needs of San Mateo County and consider modifications, including participating at an earlier triage point with call takers, ability to divert calls to the most appropriate resources such as a non-armed crisis team as well as providing support and appropriate information to officers on scene (See Element #3 below).

The Call Center Clinicians should hold Criminal Justice Information Systems (CJIS) clearance and complete call-taker training to allow them to enter information directly into the Computer Automated Dispatch (CAD) system and communicate directly with the non-armed crisis team, EMS or, if the subject is a danger to self or others, provides support and appropriate information to officers on scene.

However, these clinicians should not be placed in a primary call answering or dispatch position, as their focus is primarily dispatching appropriate calls to the non-armed crisis team.

The clinician should have access to Avitar¹¹ and data systems while in the call center, and policies should support the sharing of necessary information with police, should the non-armed crisis team indicate that law enforcement is needed for backup.

Lastly, upon implementation of Element #1(above) the call center should immediately transfer any mental health 911 call to a 911 call taker who has completed and demonstrated competency in mental health training for call takers, adding on the clinician when available.

LA County is proposing a true regional crisis call center network, with shared standards for triage, the ability to dispatch non-law enforcement crisis response teams, and a shared view into available crisis stabilization resources with an overall goal of minimizing law enforcement response to the maximum extent possible. They are considering a reconfigured and appropriately resourced 911 call center network integrated with the behavioral health crisis call center network as one means for all calls to be taken directly and functioning as a regional network to screen, triage, and dispatch crisis calls to a non-law enforcement response at every possible opportunity and law enforcement co-response teams where indicated. A reconfigured 911 call center network would include a re-branding media campaign through a lens of racial equity and in consideration of the communities' current perception of 911.

In terms of this network and its inclusion of 911, it should be noted that other jurisdictions, such as Houston, have 911 networks that are not led by law enforcement and have standard protocols

¹⁰ <https://www.houstoncit.org/ccd/>

¹¹ AVATAR an electronic health record system used by BHRS to document all behavioral health services an individual receives from the County,

for when to triage a call to law enforcement. This so-called “opt-in” framework, whereby the default response is non-law enforcement unless explicitly determined to require law enforcement response during triage, stands in stark contrast to the current “opt-out” framework, where law enforcement response is the default unless otherwise indicated. Preliminary data from Houston shows 51% reduced overall dispatches, 50% reduced time for dispatched professionals in the field, and ~\$6:1 ROI. The “opt-in” framework is a model that LA County needs to explore to allow for health and lived experience professionals to facilitate crisis triage options.¹²

Recommendation 3: Stand Alone, Non-Armed, Crisis Services

- Stand-alone, non-armed, 24/7, mobile mental health crisis response unit designed to independently serve the entire County.
- Teams consist of a clinician, peer support, or community members with knowledge of veteran services, **and** a paramedic/EMT

San Mateo County should create a stand-alone, non-armed, crisis unit designed to independently operate mobile crisis response teams to service the entire county. The crisis unit’s comprehensive integrated menu of services should be accessible to anyone, anywhere, and anytime, providing a “No Wrong Door” safety net services approach. The crisis unit shall be a one-stop hub that provides a continuum of care across its clinical and non-clinical wraparound services to ensure stabilization from a crisis, access to treatment, clinical follow-up care, and linkages to ongoing preventive and support services that are established in San Mateo County.

Research

A review of evaluations of co-responder models in the United States, Canada, and Australia concluded that the model demonstrates the potential to offer increased access to community-based mental health treatment and reduce the burden on police officers (e.g., decreasing officer time required on a mental health crisis call). However, studies have found that officers do not perceive the co-responder model as more efficient than standard department response. Further, staffing for this model can be problematic because there are few mental health workers available outside of normal business hours, limiting the availability of the mobile crisis team.¹³

In this review, they identified three major limitations of the current evidence for co-response triage, a) the lack of information on the characteristics of service users b) the lack of detail when describing co-response models and the variation in their operationalization and, c) the lack of rigorous comparative research on effectiveness.¹⁴

There remains a lack of evidence to evaluate the effectiveness of street triage and the characteristics, experience, and outcomes of service users. There is also wide variation in the

¹² <http://file.lacounty.gov/SDSInter/bos/supdocs/149254.pdf>

¹³ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6094921/>

¹⁴ ID

implementation of the co-response model, with differences in hours of operation, staffing, and consistency of incident response.¹⁵

There were differences in times and days of operation, whether the unit was a first or second-response option, whether the police officer and mental health worker were co-located, whether a mobile unit was dispatched or not, and the mode of transportation to the incident (marked or unmarked vehicles). There was also limited, if any, information on other mental health provisions in the study area. While co-responder models have recently received much attention, they are not a panacea but rather one selection of a larger crisis response menu of services.¹⁶

Given the considerable recent investment of resources by police and mental health services, thoughtful evaluation of triage services should lead the development of models rather than be left as an afterthought. Rigorous data on outcomes, both immediate and long-term, following a triage intervention is needed. We also need further exploration of service users and their careers' experience of triage, and their participation in the design of these services. Finally, we need to move towards better model description and evaluation, with the aim of creating fidelity indicators linked to good practice and good outcomes.

In 2016, the Action Alliance's Crisis Services Task Force published a groundbreaking report¹⁷ on crisis mental healthcare services. The report states that most community-based mobile crisis programs have teams made up of professional and paraprofessional staff. For example, the team might include a clinician and a peer support specialist, with back-up from psychiatrists or clinicians. It stated that the peer support team member often takes the lead when engaging with a person in crisis.¹⁸

Last year, SAMHSA (Substance Abuse & Mental Health Services Administration) published National guidelines that further flesh out what a mobile crisis team should include. It states that for safety and optimal engagement, two people should make up a team. Teams must comprise "a licensed and/or credentialed clinician" who can assess people's needs within the region where the service operates and incorporate peer support and lived experience specialists.

The SAMHSA recommendations also included 24/7 crisis call centers that can provide immediate support over the phone and connect callers to community resources.

In San Mateo County, adults in cities that are not a part of the Community Wellness Crisis Response Pilot have no alternative other than dialing 911 or have established their own Crisis Response Units.¹⁹ A mental health crisis scene is often in flux and unpredictable. Without

¹⁵ <https://bmcp psychiatry.biomedcentral.com/articles/10.1186/s12888-018-1836-2>

¹⁶ <https://www.nasmhpd.org/sites/default/files/2020paper11.pdf>

¹⁷ <https://theactionalliance.org/sites/default/files/inline-files/CrisisNow%5B1%5D.pdf>

¹⁸ <https://talk.crisisnow.com/preston-looper-on-how-its-time-to-standardize-mobile-crisis-services/>

¹⁹ 24/7 Youth Stabilization, Opportunity, and Support (Youth SOS) by StarVista, which is a contract of BHRS and the YSOS responds to all BH crises in San Mateo county for youth ages 0-25 years old.

standardized practices, crisis teams respond in highly variable ways. That creates tremendous variability from whether they're willing to go out on a call to how they react on the scene. The service people receive will differ depending on who shows up. You may have teams that are skittish and others that entirely ignore the risks. When mobile crisis dispatch is inconsistent, "officers will stop calling," said Nick Margiotta, a retired Phoenix police officer and president of Crisis System Solutions "For law enforcement to outreach mobile crisis services, they need to be able to depend on a consistent rapid response 24/7."

The crisis unit breaks the cycle of disconnected services, lack of consistent follow-up with someone from initial contact or release from an institution, and unnecessary 5150 initiations and ED visits due to lack of alternatives. Its multidisciplinary teams will collaborate with city police, Sheriff's Office and PERT team.

Other options include the InRESPONSE program established in Santa Rosa, California. The goal is for the inRESPONSE Team to handle all calls for service where mental health is the primary concern. inRESPONSE will also partner with the City's Homeless Outreach Services Team (HOST) to identify unsheltered community members who may be experiencing a mental health crisis. The dual approach will provide the unsheltered community with additional resources, to get individuals into a more stable living environment with ongoing, wrap-around support services.

inRESPONSE will provide service with a single team working 10-hour shifts, seven days a week. As part of a three year-phased plan, SRPD hopes to secure the necessary resources and funding needed to support a 24/7 mental health response model and is actively exploring grants and other state and federal funding opportunities, as well as private funding to help expand the capacity of inRESPONSE. This program estimates it can divert 3,000 to 5,000 mental health, homeless, and minor medical calls to this team annually out of the 146,000 annual total call volume.²⁰

The CARES team in Half Moon Bay responds to 911 calls involving individuals experiencing a mental health crisis. The team consists of a certified emergency medical technician (EMT), AOD technician, and an experienced behavioral health care clinician.

The CARES team is specially trained on the use of culturally competent de-escalation, crisis intervention, motivational interviewing, and suicide prevention tools to work with individuals in crisis. Bilingual services are provided in Spanish and English.

Following initial assessment, the CARES team provides clinical interventions, in-person "warm" handoffs to service providers, and follow-up to ensure individuals and families have the support they need while navigating care systems. Ongoing collaboration with local and regional non-profits, government agencies, and the community will be key to the success of the program, and the long-term success of its participants.

²⁰ <https://srcity.org/3627/inRESPONSE-Mental-Health-Support-Team>

The CARES team is dispatched in instances where there is no immediate threat of violence, with Sheriff's Deputies on standby when a higher level of response is needed. Types of calls appropriate for the CARES team include suicidal ideations, persons under the influence of drugs or alcohol, persons experiencing a mental health crisis, parents calling with concern for an adolescent exhibiting unusual behavior, or community members reporting persons in some form of emotional distress.

The CARES team response is an alternative to law enforcement, fire, or other first responders. Comparable programs have shown that this kind of response to behavioral health emergencies helps divert individuals from costly visits to emergency rooms and unnecessary entry into the criminal justice system and helps prevent the physical harm or loss of life that sometimes results from armed crisis response.²¹

In San Francisco, 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.).

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.²²

In Oakland, The Mobile Assistance Community Responders of Oakland (MACRO) Program is a community response program for non-violent, non-emergency 911 calls. The purpose of MACRO is to meet the needs of the community with a compassionate care first response model grounded in empathy, service, and community. MACRO's goal is to reduce responses by police, resulting in fewer arrests and negative interactions, and increased access to community-based services and resources for impacted individuals and families, and most especially for Black, Indigenous, and People of Color (BIPOC).²³

In San Diego County, one of the key recommendations outlined in the Mental Health Blueprint was to study and implement non-law enforcement responses when appropriate and safe. The

²¹ <https://www.half-moon-bay.ca.us/DocumentCenter/View/4775/CARES-Infosheet?bidid=>

²² https://sf.gov/sites/default/files/2021-07/SCRT_IWG_Issue_Brief_FINAL.pdf

²³ <https://www.oaklandca.gov/projects/macro-mobile-assistance-community-responders-of-oakland>

District Attorney's Office has worked with County Behavioral Health Services and law enforcement agencies to implement non-law enforcement Mobile Crisis Response Teams across the county. Dr. Piedad Garcia from Behavioral Health Services and Assistant Sheriff Theresa Adams-Hydar from the San Diego County Sheriff played a critical role in bringing these teams from vision to reality. The teams operate as part of the behavioral health system of care to provide a non-law enforcement response when safe to do so. When there is no threat of violence, the mobile teams provide same-day intervention and will connect those in a mental health crisis with the appropriate level of care. The pilot MCRT launched in January 2021 and expanded county-wide throughout the rest of that year based on direction and actions by Board of Supervisors Chair Nathan Fletcher and Supervisor Terra Lawson-Remer.²⁴

With a crisis unit functioning in the county, residents would have the option of requesting police, fire, EMS, or Mental Health Services upon activation of the 911 system, as well as a clinician in dispatch to immediately triage the call. Furthermore, when a dedicated non-911 number (such as 988) is implemented, the call could route directly to the crisis unit.

In summary, a stand-alone, non-armed, 24/7, crisis response team is needed for the entire County. Several examples exist including teams with clinicians, peer support, paramedics, and teams with knowledge of veteran services. The default request for services through dispatch should be one of sending a crisis team to the call first and, if needed, Police, Fire or Ambulance, instead of the common practice of sending police as the default first responders regardless of the situation.

Recommendation 4: Community Based Crisis Stabilization Centers

- Establish community-based crisis stabilization centers

Crisis Stabilization Centers (also known as short-term crisis residential stabilization services, community-based behavioral health stabilization, crisis stabilization, and crisis stabilization facilities) are home-like environments that address behavioral health crises in a community-based behavioral health or hospital setting. They have bedded units that range from 6-16 beds and staffed by licensed and unlicensed peer support as well as clinical and non-clinical professionals who hold masters and bachelor degrees^{7,5} (SAMHSA, 2014; Mukherjee & Saxon, 2017). Services may consist of assessment, diagnosis, abbreviated treatment planning, observation, case management, individual and group counseling, skills training, prescribing, and monitoring of psychotropic medication, referral, and linkage. Service delivery is offered on a 24-hour basis to address the client's immediate safety needs, develop resilience, and create a plan to address the cyclical nature of behavioral health challenges and future behavioral health crisis for adults and children.

Research

²⁴ https://onlinedegrees.sandiego.edu/emails/lepsi/DA-Blueprint_Mental_Health_Reform%20Part-2%20Three_Point_Plan_March-21-2022.pdf

The National Alliance for Suicide Prevention (2016) considers Crisis Stabilization Centers to be a “core element” of behavioral health crisis systems. Different from the Living Room Model and the 23-Hour Crisis Stabilization Unit, Crisis Stabilization Centers offer services to individuals whose needs cannot be met in the community. The environment is safe and secure and less restrictive than a hospital setting.²⁵

In a recent study by Mukherjee and Saxon (2017), the authors reported on the creation of a model of care at a Crisis Stabilization Center in rural Illinois that implemented one of three models for deflecting individuals from increased levels of behavioral health care. In this model, clients entering the ED would receive a clinical assessment and based on the assessment could be transferred to a community-based crisis center for treatment. The study showed the LOS in the ED decreased from 7.3 hours to 4.12 hours after the introduction of the behavioral health crisis stabilization center intervention. The study also conducted a cost analysis that showed this intervention saved an approximate \$4.1 million in Medicaid costs.

In a separate study by Wilder Research (2013), a crisis stabilization unit in a metropolitan Minnesota area examined the impact of the unit on the ED, outpatient services and inpatient psychiatric service utilization. The study found the overall cost of providing services in a community-based crisis center was less than providing services in an inpatient unit.

San Diego has many walk-in clinics available for urgent mental health services throughout the county. However, very few of them are available outside of regular business hours or on weekends. Further, several only have walk-in services available on certain days during limited hours. This is insufficient to adequately serve a person in crisis or their loved ones. Additionally, when a police officer contacts someone in a mental health crisis, the officer has limited options. The officer can take the person to an emergency department, a process that can take many hours, or to the County Psychiatric Hospital, which may not be conveniently located, or the officer can take the person to jail. Community-Based Crisis Stabilization Centers, open 24 hours a day, provide walk-in mental health services as well as a safe place for an officer to drop off a person in a mental health crisis and get back to patrolling his or her beat within minutes. These centers provide acute crisis stabilization and medication, as well as a direct connection to appropriate levels of care in an environment that is more conducive to stabilization than an emergency department or jail. They work harmoniously with hospital-based Crisis Stabilization Centers, which have different regulatory considerations. The District Attorney, together with Behavioral Health Services, went before the San Diego County Board of Supervisors in 2019 to receive authorization and allocate funding in the County’s budget to create regional Community Based Crisis Stabilization Centers. The first one opened its doors on September 30, 2021, in Vista, with the leadership of Supervisor Jim Desmond, Board Chair Nathan Fletcher and District Attorney Summer Stephan and is operated by Exodus Recovery. Already, the Vista Community Based Crisis Stabilization Center has made significant impacts, opening more than 800 cases in the first three months of operation. Of those cases, 94% of the clients were successfully returned to the community without needing to access a higher level of care. We must continue to pursue expanding this invaluable community resource throughout the county to provide increased access to immediate mental health care.

²⁵ <https://www.mentalhealthjournal.org/articles/behavioral-health-crisis-stabilization-centers-a-new-normal.html>

In 2020 the Substance Abuse and Mental Health Services Administration (SAMHSA), Created National Guidelines for Crisis Care – A Best Practice Toolkit which defines essential elements of effective, modern, and comprehensive crisis care essential elements within a no-wrong-door integrated crisis system. In these recommendations it lists Community Crisis Stabilizations Centers as a core element of an effective crisis care system.²⁶

In the 2014 Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies report, SAMHSA defined crisis stabilization as: A direct service that assists with deescalating the severity of a person’s level of distress and/or need for urgent care associated with a substance use or mental disorder. Crisis stabilization services are designed to prevent or ameliorate a behavioral health crisis and/or reduce acute symptoms of mental illness by providing continuous 24-hour observation and supervision for persons who do not require inpatient services”.

Data suggests that a high proportion of people in crisis who are evaluated for hospitalization can be safely cared for in a crisis facility and that the outcomes for these individuals are at least as good as hospital care while the cost of crisis care is substantially less than the costs of inpatient care and accompanying emergency department “medical clearance” charges.

DATA COLLECTION:

Critical to the success of any program is the establishment of the baseline number of mental health calls for service that the law enforcement is fielding (as a starting point) and other indicators of effectiveness, and the use of that data to review progress and troubleshoot any challenges. By using data, leaders have the ability to assess the impact of the approach over time and measure its success against the outcomes that matter most.

The four key outcomes identified below, together with the **Appendix A** of recommended indicators of success and data to be collected, will provide a picture of whether or not the programs are successful, recognizing that data limitations and local context may necessitate variation in what data can be collected.

- **Increased connections to resources:** The crisis unit should routinely refer people who have mental health needs to community services, and they should ensure a successful linkage to the behavioral health system. 911 dispatchers also play a critical role in collecting mental health information and relaying it to first responders prior to their response to a call for service. As a result, successful programs see an increase in the number of people who have mental health needs connected to appropriate services and resources in the community.
- **Reduced repeat encounters with crisis response teams:**²⁷ A key measure of performance is the number of people who have repeat mental-health-related encounters with the

²⁶ <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>

crisis response unit and law enforcement. Ideally, as programs see an increase in their connections to resources and referrals of people to appropriate services, they would likely see a reduction in the number of repeat encounters because these individuals are provided the care needed to reduce or prevent future crises.²⁸ Furthermore law enforcement will see a decline in repeat calls for service.

Minimized arrests: Arrests will be minimized up-front because the person in crisis will not be confronted by police, but by responders who do not perform arrests. If a situation is deemed to need a police response, then and only then the factors of police having more options than just arrests and having better information about the persons mental health situation, would come into play.

- With an increase in the availability of community resources and services, officers have a greater set of options/primary interventions other than arrest when responding to calls involving people who have mental health needs. Since one of the primary goals of a program is to connect a person to mental health services (especially for low-level and nonviolent offenses, like trespassing and vandalism, in which arrest is at the discretion of the officer and the person does not pose a threat to public safety),²⁹ having more options should ideally result in a lower rate of arrest among people in this population. Additionally, programs are more successful when officers are provided with reliable information about a person's mental health needs prior to responding to a call.

Reduced use of force in encounters with people who have mental health needs: Use of force will be reduced up front by having responders who are non-armed. For non-police response model it is important to track the crisis situations that are managed by responders other than police and how that reduces use of force incidents overall when compared to having police always be involved.

- A critical measure of performance for a program is the frequency of use of force during encounters with people who have mental health needs. Jurisdictions must determine what constitutes use of force in the context of data collection (e.g., use of handcuffs during transport,

Before leaders can determine if fewer repeat encounters are occurring, they first must define what constitutes a repeat encounter. For example, it could be defined as a person having a second mental health call in a six-month period or it could be defined as multiple calls for service to the same location. Once properly defined, this target population can be prioritized for tailored interventions and treatment, and more accurate benchmarks can be established to gauge success. Gregory H. Watson, *Benchmarking Workbook: Adapting the Best Practices for Performance Improvement* (Portland, Oregon: Productivity Press, 1992); and Theodore H. Poister, *Measuring Performance in Public and Nonprofit Organizations* (San Francisco, CA: Jossey-Bass, 2003).

28

Jennifer L. S. Teller et al., "Crisis intervention team training for police officers responding to mental disturbance calls," *Psychiatric Services* 57, no. 2 (2006): 232-237, <https://doi.org/10.1176/appi.ps.57.2.232>.

29

Henry J. Steadman and Michelle Naples, "Assessing the effectiveness of jail diversion programs for persons with serious mental illness and co-occurring substance use disorders," *Behavioral Sciences and the Law* 23, no. 2 (2005): 163-170, <https://doi.org/10.1002/bsl.640>; and Henry J. Steadman et al., "Comparing Outcomes of Major Models of Police Responses to Mental Health Emergencies," *Psychiatric Services* 51, no. 5 (2000): 645-649, <https://ps.psychiatryonline.org/doi/abs/10.1176/appi.ps.51.5.645>.

hands-on maneuvers) so consistent analysis is possible in the future. With training and a comprehensive PMHC in place, police officers are better able to manage encounters with people experiencing a mental health crisis, and force is then proportionate to the situation the officer encounters. It is important to track and analyze this outcome for both mental health calls and non-mental health calls for service.

CLOSING:

In the fall of 2020, Congress passed the National Suicide Hotline Designation Act³⁰ creating a nationwide number, 988, for mental health and suicidal crises. The FCC has acted to make 988 available in every community by July 2022.

The upcoming rollout of 988 means that we have the opportunity to push for not only crisis call centers, or expanding existing services (such as embedded clinicians in dispatch) but the other components of a crisis response system such as stand-alone non-armed crisis teams or county-wide PERT services (although PERT is still a co-response model) along with crisis receiving and stabilization services offering the community a no-wrong-door, space to access 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 argument for making these changes now is simple: when someone dials 911 or 988, we need to make sure appropriate mental health services are available to respond to a range of crises.

Currently, very few communities offer anything close to the standard of care for these services. Without adequate crisis response services, communities are left to depend on law enforcement and emergency departments that are ill-equipped to help someone experiencing a mental health crisis. Making sure there is a range of services to help anyone in crisis, no matter where they live in San Mateo County, will help ensure no one in a mental health crisis fall through the cracks.

“Most calls that go through 911 don’t require a law enforcement response and can be transferred to a crisis line where we know the majority of calls, 80% and upward, are resolved at that level, and there’s no need for police involvement.”³¹

CR/ 0622

³⁰ <https://www.congress.gov/bill/116th-congress/senate-bill/2661/text>

³¹ <https://talk.crisisnow.com/mental-health-care-shouldnt-come-in-a-police-car/>

APPENDIX A

Success of Program

1. Increase connection to services
 - Front door / County Crisis Hotline/ Alternative to 911
 - 911 dispatchers key to collecting mental health info and relay to officers
 - Officers aware how to connect people to BHRS absent a Crisis clinician
2. Reduce repeat encounters with Law enforcement
 - Known repeat clients
 - Clients are provided the care needed and recourses to prevent future crises and alternatives to 911
3. Minimized arrests
 - Officers have more options for reducing arrest
 - More successful when officers are provided with reliable information prior to the call
 - Track dispositions of calls to analyze trends or fluctuations and increase attention to the rates of arrest.
4. Reduce use of force encounters
 - Define Use of Force
 - Handcuffs, control holds, weapons use, deadly force

Data to Collect to Measure Success

Agree on a definition of a “Mental Health Call for Service”
Re-code call if necessary

1. Level of Need
 - # of calls for service with mental health needs
2. Minimized arrests
 - # arrests of clients with mental health needs
 - # people with mental health needs arrested in last 12 months
 - Disposition of Call
 - Arrested, SOS (settled on scene) voluntary evaluation, 5150, etc)
 - Clinician dispo (referred to SMART, AOT, etc)
3. Reduced Repeat Encounters
 - # of calls to the same location
 - # of calls to the same person
4. Reduced Use of Force
 - # of encounters with people with mental health needs were forced was used
 - Types of force used
 - Injuries to client, officers, bystanders
5. Administrative Process and Outcomes
 - Officers receiving advanced training
 - Types of training and hours
 - Dispatchers training
 - Types of training and hours
 - # of dispatchers trained

- Dispositions of calls for service with a clinician and w/o clinician
 - # of calls for service with MH needs w/o clinician on duty
6. Cost-effectiveness
 - Officer time on scene etc.
 7. Community perception of the Program

APPENDIX B

ADDITIONAL REFERENCES:

“Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies”

<https://www.nasmhpd.org/sites/default/files/2020paper11.pdf>

“Roadmap to the Ideal Crisis System;” https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031121_GAP_Crisis-Report_Final.pdf?dof=375ateTbd56

“Reengineering LA County’s Crisis Systems;”

<https://talk.crisisnow.com/reengineering-la-countys-crisis-systems/>

“National Guidelines for Behavioral Health Crisis Care;”

<https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>

“Crisis Now;” <https://theactionalliance.org/sites/default/files/inline-files/CrisisNow%5B1%5D.pdf>

“Care First Jails Last;”

https://ceo.lacounty.gov/wp-content/uploads/2020/10/1077045_AlternativestoIncarcerationWorkGroupFinalReport.pdf

“Defunding the police and people with mental illness; ”<http://www.bazelon.org/wp-content/uploads/2020/08/Defunding-the-Police-and-People-with-MI-81020.pdf>

“AB 988;” https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB988

SAMHSA National Guidelines for Behavioral Crisis Care.

<https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>

San Diego County Blueprint for Mental Health Reform;

<https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>