STREET CRISIS RESPONSE TEAM

SFDPH Health Commission

March 16, 2021

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
- Early Pilot Results

BACKGROUND

Why now? How did we get here?

CITYWIDE COMMITMENT TO REFORM

Mental Health SF legislation (Late 2019)

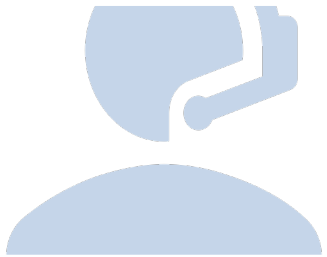
Mayor London Breed commitment to police reform (Summer 2020)

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

Community Planning Processes for Police Reform

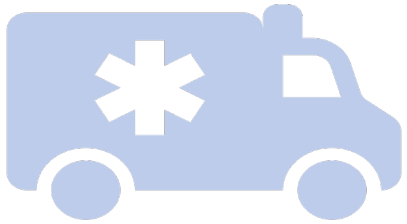
- HRC: Alternatives to Policing Steering Committee
- Coalition on Homelessness: Alternative to Police Response Committee

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:

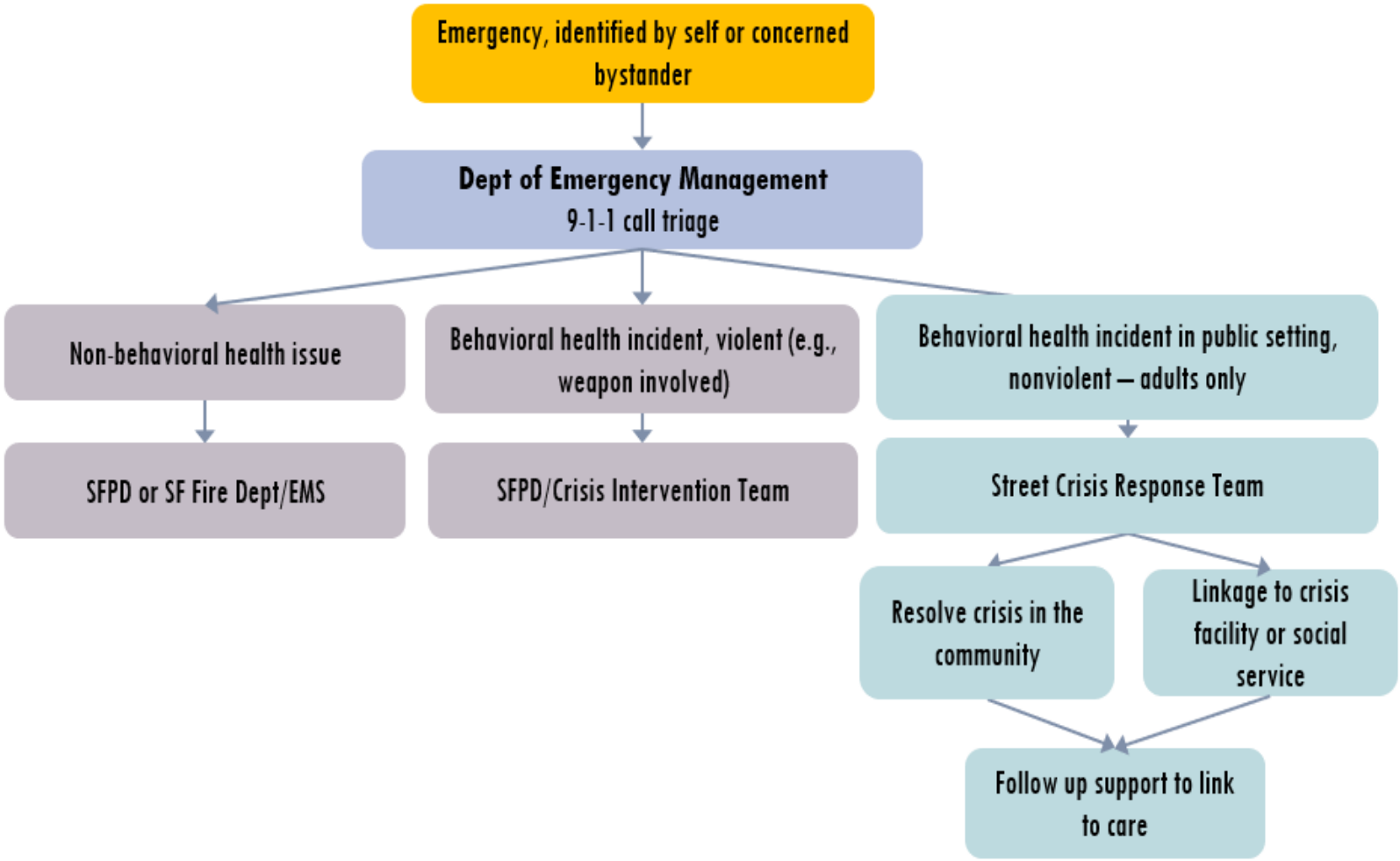
- Community paramedic (SF Fire Department)
- Behavioral health clinician (HealthRIGHT 360)
- Peer specialist (RAMS)
- Office of Coordinated Care staff dedicated to linkages and follow up care coordination

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

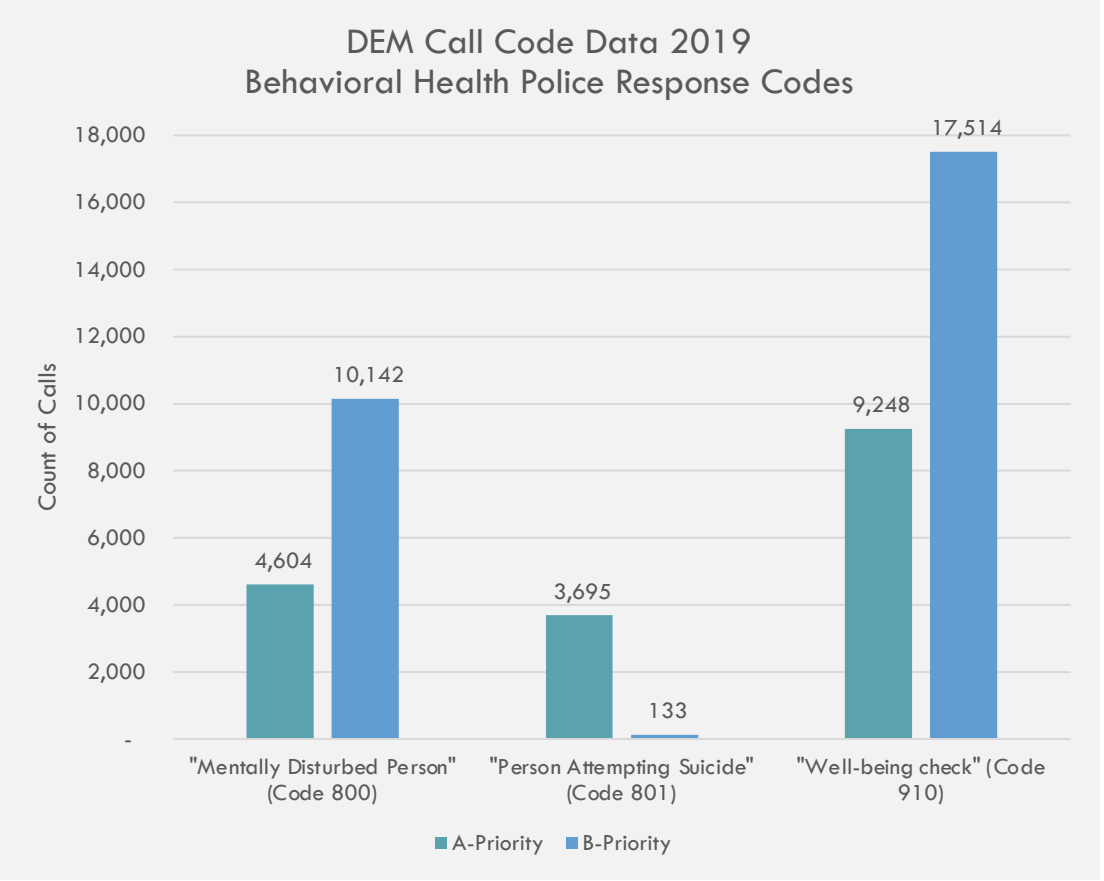
SCRT DEPLOYMENT AND LINKAGE

- 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



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



LOOKING AHEAD

Continued Community Engagement

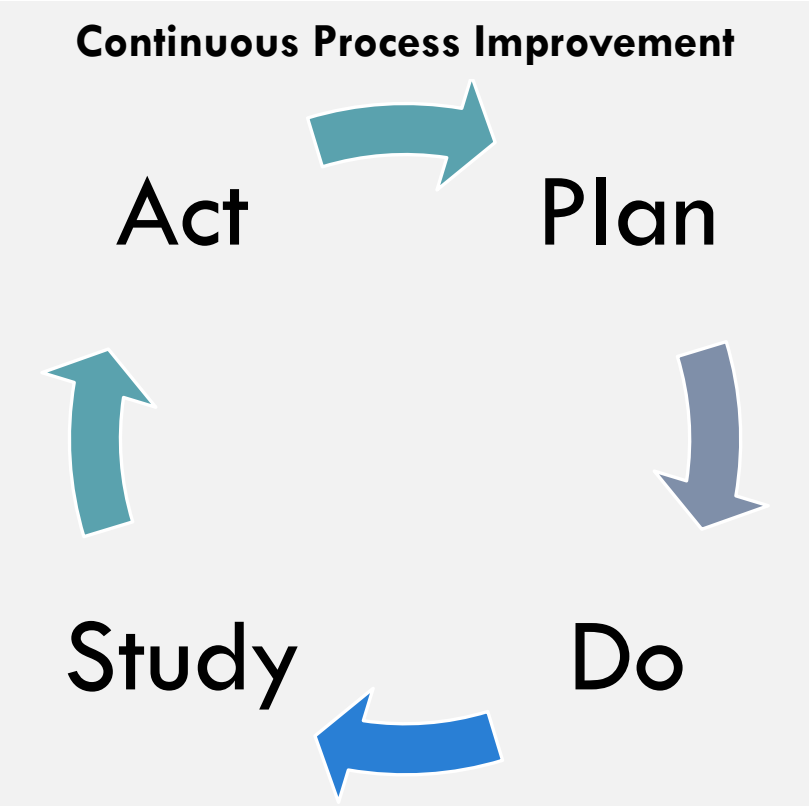
- Public awareness
- Community expectations
- Building trust

Addressing Racial Equity

- Training
- Diverting calls from law enforcement
- Addressing disparities in health outcomes
- Exploring deployment of team outside of 911

Pilot Evaluation

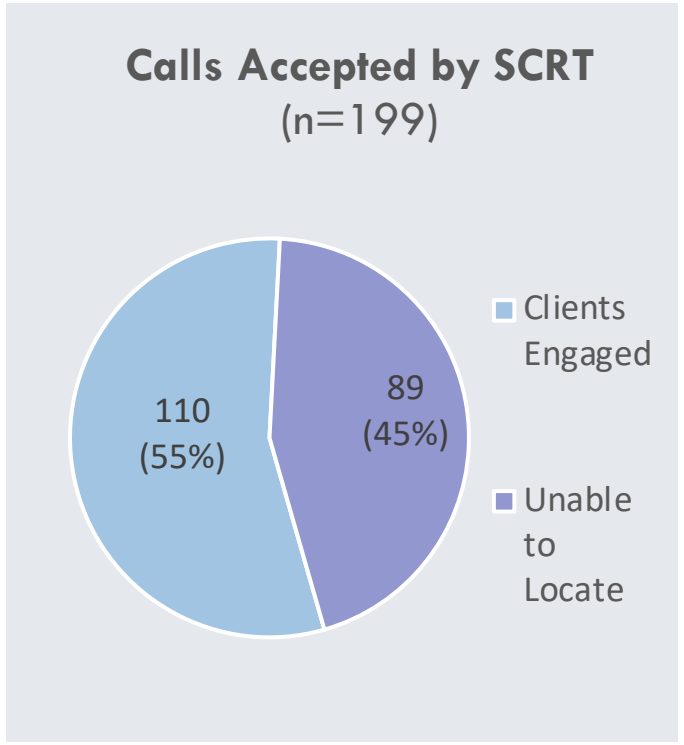
- Continuous Improvement Process

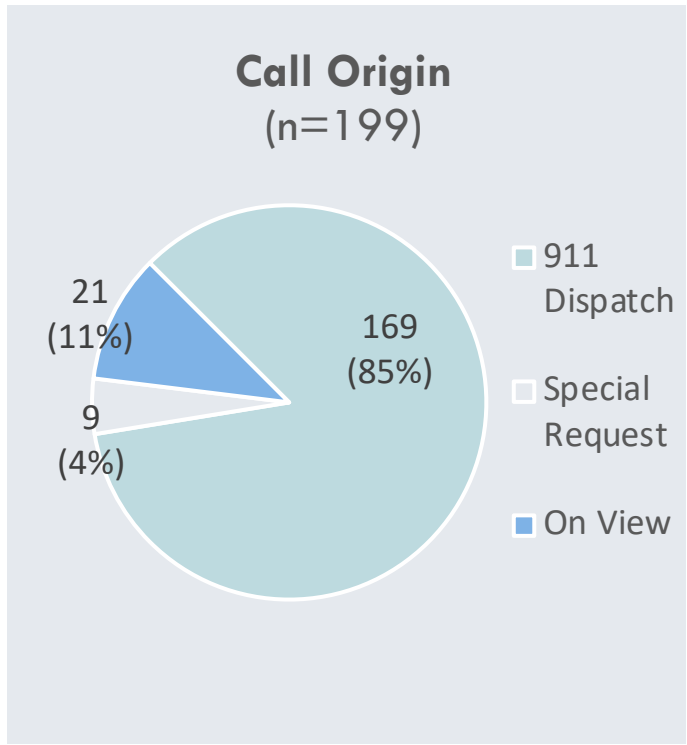


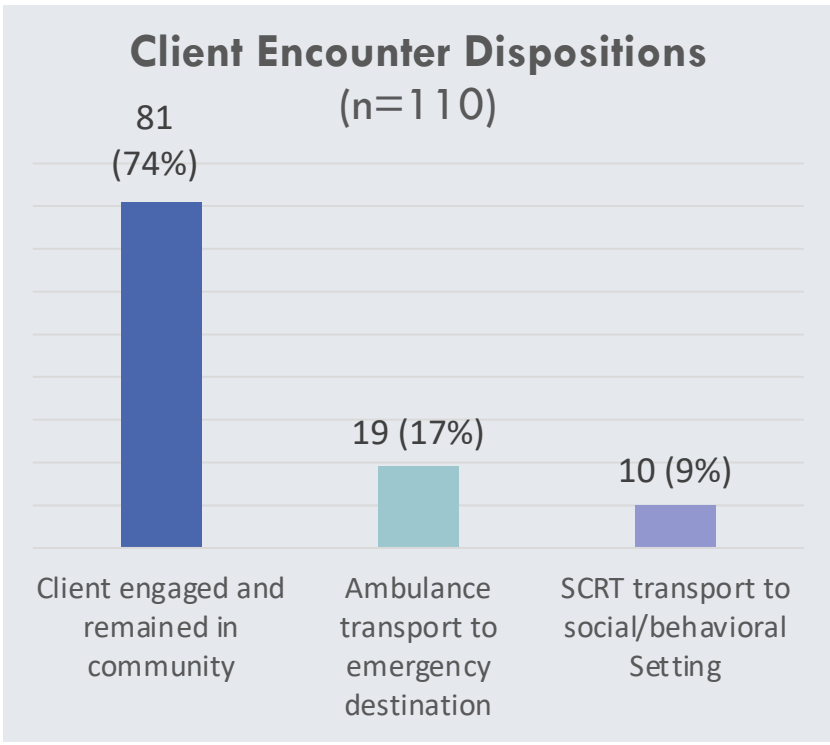
EARLY PILOT RESULTS

What we've learned so far

DATA SUMMARY NOV 30-JAN 31



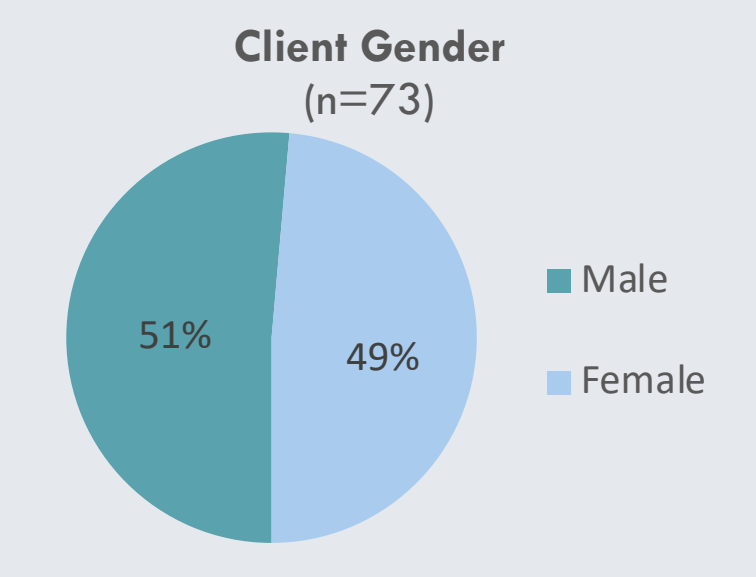


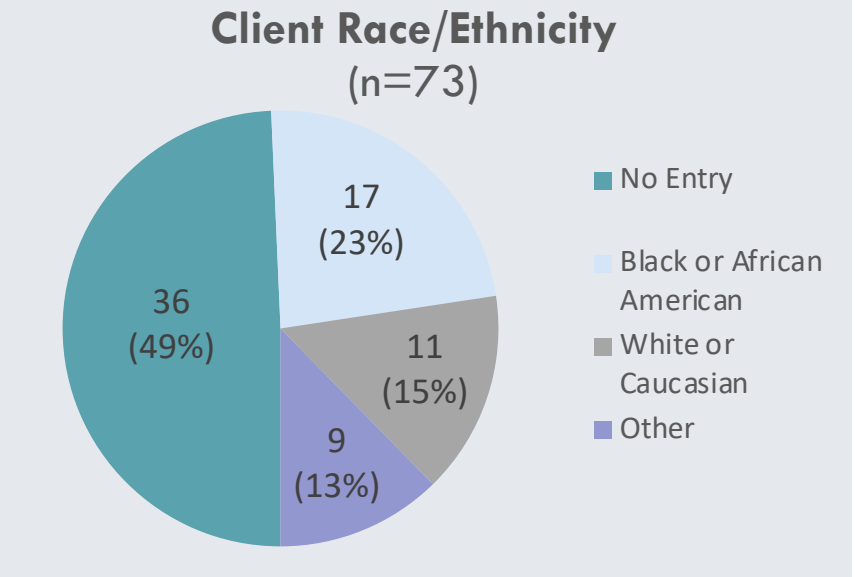


Seventy four percent of clients were engaged by SCRT, offered assessments and therapeutic de-escalation, and ultimately remained safely in the community. These initial results are consistent with the experience of programs in other jurisdictions, such as Maricopa County, Arizona, which reports 71% of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

CLIENT DEMOGRAPHICS

- Client demographics have been a challenge to obtain reliably, as only a subset of encounters lead to complete documentation of the demographic indicators of interest to this project
- Approximately 96 percent of clients were experiencing homelessness: either unsheltered, in congregate sites, or living in other temporary living situations.





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

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…We found him talking to himself down an alley off Van Ness Ave. and I walked down to try and talk again…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

ALIGNMENT WITH OTHER MHSF PROGRAMS

- Office of Coordinated Care (OCC)
- Crisis Stabilization Unit
- Drug Sobering Center
- Intensive Case Management (ICM) Expansion