

May 2022


# Street Crisis Response Team Pilot

Final Report

This report details evaluation results for the Street Crisis Response Team (SCRT) pilot's first year of implementation. The pilot aims to reduce law enforcement encounters and emergency department visits for people experiencing behavioral health crises in San Francisco. The report summarizes:

- the types of calls accepted by the SCRT units,
- the characteristics of clients served, and
- SCRT teams' responses and service linkages.

The goal of the evaluation is to identify early successes and ways that the work of SCRT units can be enhanced or better supported. The report concludes with actionable recommendations and next steps for community engagement around these aims.



The San Francisco Department of Public Health (SFDPH) and the San Francisco Fire Department (SFFD), in collaboration with the Department of Emergency Management (DEM), launched the Street Crisis Response Team (SCRT) pilot program<sup>1</sup> on November 30, 2020. This team is in direct response to the crisis team called for in the Mental Health San Francisco (MHSF) legislation as well as Mayor Breed's commitment to identifying alternatives to law enforcement to respond to unmet needs in the community. The goal of the pilot is to reduce law enforcement encounters and unnecessary emergency department use by providing rapid, trauma-informed response to service calls for people experiencing behavioral health crises.

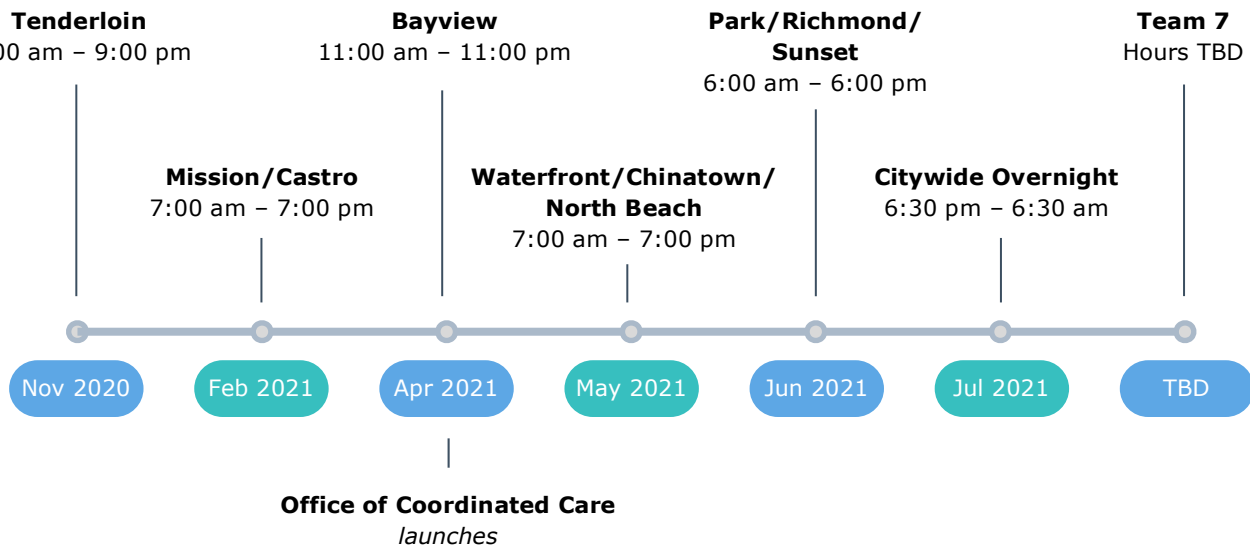
Over the course of the pilot period, the SCRT has engaged community stakeholders and individuals with lived experience in both formal and informal information gathering sessions to better understand how to best implement the team as well as its impact on the communities being served. The MHSF Implementation Working Group continues to be a central partner in informing and shaping the services being provided.

Each SCRT unit is comprised of three team members: a community paramedic, behavioral health clinician, and behavioral health peer specialist. Rather than dispatching law enforcement, SCRT responds to 911 calls that can be better served by a specialized team with a behavioral health focus<sup>2</sup>. Individuals are further supported by a team of clinicians and health workers through the Office of Coordinated Care (OCC). Part of the reforms called for under the MHSF legislation, the OCC was launched in April 2021 to oversee the seamless delivery of mental health care and substance use services across San Francisco's behavioral health systems. This continuum strives to deliver therapeutic de-escalation and medically appropriate responses to people in crisis and provide them service linkages and follow up, including mental health care, substance use treatment, and social services referrals.

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<sup>1</sup> <https://sf.gov/street-crisis-response-team>

<sup>2</sup> The SCRT launched with a focus on responding to the approximately 10,000 annual 911 calls that DEM classifies as "800-B" codes, meaning service for a "mentally disturbed person" with a low risk for violence or weapons, indicating minimal public safety concern ([https://www.sfdph.org/dph/files/IWG/SCRT\\_IWG\\_Issue\\_Brief\\_FINAL.pdf](https://www.sfdph.org/dph/files/IWG/SCRT_IWG_Issue_Brief_FINAL.pdf)).

**Exhibit 1. SCRT unit launch dates and hours**

This report focuses on the first year of implementation from November 2020 to November 2021. The first SCRT unit was deployed on November 30, 2020, with a geographic focus in the Tenderloin area. Since then, five additional units have launched, providing 24 hour / 7 days a week city-wide coverage. A seventh unit is slated to launch mid-2022 to provide additional coverage. **Error! Reference source not found.** shows a timeline of when each unit launched.

The nationwide movement to divert calls from law enforcement and its implementation through SCRT in San Francisco represent a meaningful culture shift in community emergency intervention. The San Francisco SCRT model is unique in the integration of a peer team member as well as the level of crises that teams manage. These significant changes take time and require ongoing conversation and collaboration. The successful implementation of this initiative requires working with law enforcement for appropriate call diversion, ensuring public safety, and supporting the SCRT team if there is an indication of a risk of violence. Success also requires post-encounter supports for clients in need of service connections. These supports are administered through the new Office of Coordinated Care which is responsible for delivery of mental health care and substance use services across San Francisco's behavioral health systems. SCRT is already proving to be a leader in this collaborative and innovative work, consulting with other jurisdictions contemplating similar programs on both a national and international stage.

This final report is the culmination of multiple rounds of qualitative and quantitative data collection, reporting, and community engagement activities that have supported the partner organizations overseeing SCRT operations in a process of continuous quality improvement. It builds off these evaluative activities and the findings from a preliminary report, published in June 2021<sup>3</sup>, with an analysis of a full year of secondary data. The findings are contextualized with insights from a second round of interviews with SCRT members as well as with SCRT clients. The goal is to highlight successes from the first year of the pilot and identify ways that the work of SCRT units can be enhanced or better supported to improve the outcomes for people experiencing behavioral health crises.

<sup>3</sup> Available at:

[https://www.sfdph.org/dph/files/IWG/SCRT\\_Preliminary\\_Report\\_071521.pdf](https://www.sfdph.org/dph/files/IWG/SCRT_Preliminary_Report_071521.pdf)

## SCRT Approach to Equity

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. Each call SCRT accepts represents a diversion from the San Francisco Police Department, inherently reducing law enforcement encounters for the population served. Beyond this, SCRT aims to measure and reduce existing disparities in health outcomes. This evaluation includes an analysis of key outcomes by race and ethnicity to enable the program partners to monitor for equity in the implementation of the program. The program is also closely monitoring its ability to reduce incarceration, emergency room use, and involuntary detentions, especially through the lens of race and ethnicity. SCRT staff receive training on racial equity as part of their onboarding and continuous learning, and twice-yearly equity surveys provide a standardized way for SCRT staff to share their perspectives on how the team is addressing equity. Lastly, SCRT seeks to build relationships and trust with communities of color and those with a distrust of law enforcement by partnering with community leaders and creating pathways to receive constructive feedback from the community (e.g., regular community forums).

## Evaluation Methods

A critical part of the pilot is the continuous assessment of information from the SCRT units. Toward this goal, Harder+Company Community Research (H+Co) conducted an analysis of secondary data on SCRT calls, clients, and responses in January 2022, just over a year into the pilot period. This analysis builds on the preliminary analyses conducted in June 2021 and incorporates data from the Office of Coordinated Care to further explore the linkages to care that the teams are able to make for clients.

A total of 5,388 calls during the evaluation period were accepted by SCRT and included in the analysis. Thirty-eight percent of these (n=2,046) had identifiable information that allowed the SCRT records to be matched to an existing client in the electronic health record database (or a new client record was created) and subsequently included in additional analyses about client characteristics and service linkage.

Of note, given the nature of providing crisis services, the amount of demographic or historical information that can be collected at the time of a crisis varies; however, the team strives to collect as much information as possible during the crisis event and during follow up encounters to ensure a robust understanding of the population being served. Due to this, the data represented below may have different numbers of individuals represented.

This quantitative analysis of SCRT calls, clients, and responses is contextualized with qualitative findings from interviews with SCRT team members and clients. H+Co conducted three group interviews with SCRT team members (n=5 community paramedics, 3 behavioral health clinicians, and 5 behavioral health peer specialists) in October 2021. The interviews and a supplemental survey (n=10 paramedics, 2 clinicians, and 2 peer specialists) covered the day-to-day operations of the team (including dispatch, team relations, equity, resources and service linkages), data tracking and management, successes, challenges, and lessons learned. Interviews were also conducted with three SCRT clients in December 2021. These conversations explored clients' experiences with SCRT (including facets such as number of visits, safety, comfort, respect, and discrimination), the

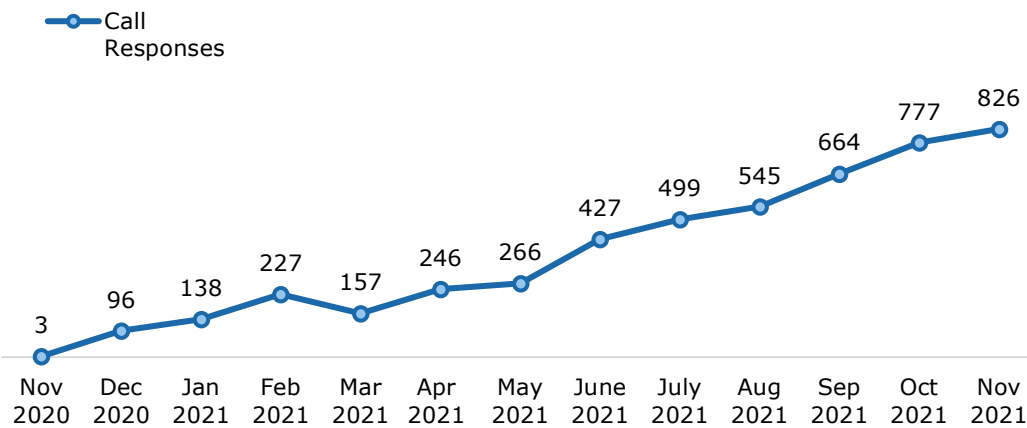
outcome of their encounter (including services linked to and satisfaction with the team), and recommendations for the SCRT units.

### Call Characteristics

Since the first SCRT unit launched in late November 2020, the program has been scaling up, increasing calls and decreasing response time. While each team has a geographic focus to ensure community engagement and development of meaningful relationships, teams respond to calls city-wide.

**SCRT is diverting calls from police response at an increasing rate, and call sources align with the program goal of aiding persons experiencing a behavioral health crisis.** Exhibit 2 displays the number of call responses over each month of operation. Despite the timing of this program’s scale up, during the COVID-19 pandemic which impacted team health and access to services, the daily average number of calls SCRT responds to has increased each month. It began with an average of 3 calls per day in November 2020 and reached a maximum of 28 calls per day in November 2021. This volume of calls is in line with similar established programs. The team has responded to a total of 5,388 calls, 3,083 (57 percent) of which entailed direct client engagements. However, even calls in which the team is unable to locate the individual(s) represent a diversion from police response.

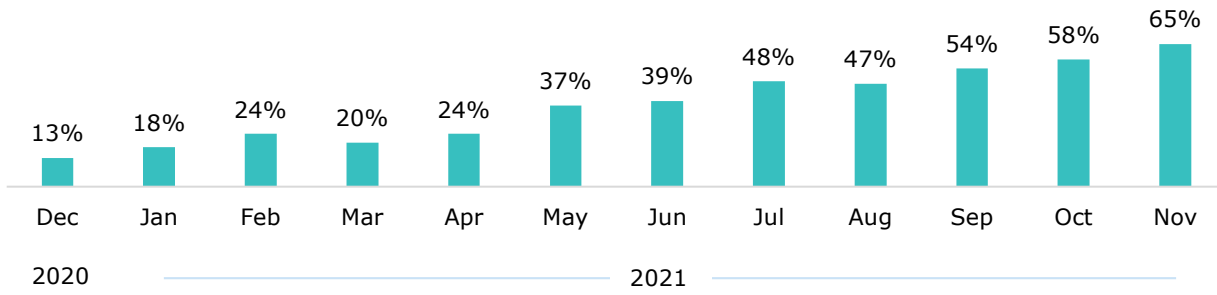
**Exhibit 2. Number of SCRT responses by SCRT unit, November 2020-2021 (n=5,388).**



Data on call volume, source, and client outcomes provide evidence that calls assigned to SCRT align with the program goal to reduce police contact, as each call represents an immediate diversion from a law enforcement response. SCRT responded to an average of 41 percent of calls classified as 800-B and prioritized for a SCRT response. This proportion has increased over time and by mid 2022, when Phase 2 of the initiative begins, all 800-B calls will be diverted to SCRT or an appropriate emergency medical response (Exhibit 3). Interviews with SCRT clients provided testimonial evidence of the early benefits of this diversion from police, with one respondent stating, “I didn't have to deal with the nonsense of police trying to find something that I'm doing wrong... the street crisis team, they tried to find something I was doing right.”

**Exhibit 3. Proportion of 800-B calls receiving SCRT response, by month.**

Total/Average: 41%

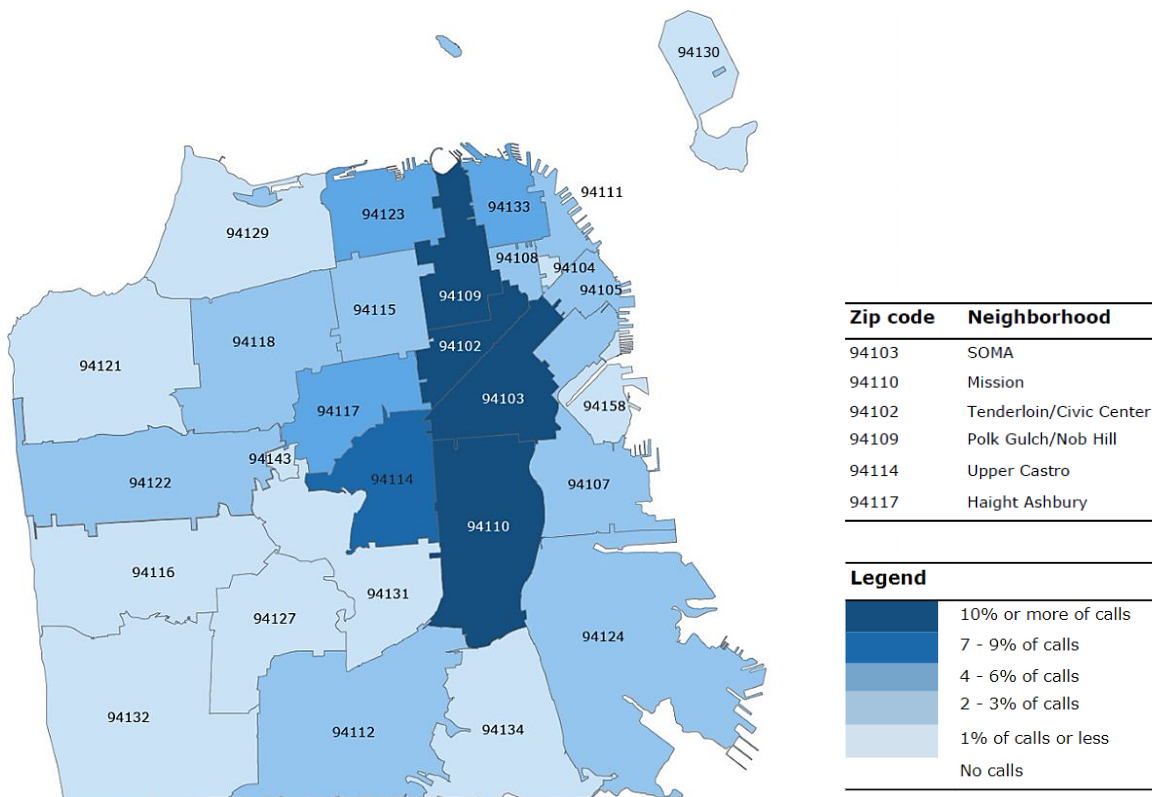


Almost all of the calls SCRT responded to (86 percent) were directed from 911 dispatch. A small portion (4 percent) entailed SCRT team members conducting brief community engagement that did not involve clinical intervention, 2 percent were special requests from partner agencies, and the remaining 8 percent were "on views" (i.e., incidents units observe while in the community). SCRT is charged with responding to on views to address emerging needs before they elevate to an emergency.

**While SCRT is available city-wide, a majority of calls occur in the city's central areas.** Exhibit 4 displays the location of calls SCRT responded to between November 2020 and 2021. Calls were mapped based on the zip code of the associated encounter location, with 6 zip codes accounting for nearly two thirds (63 percent) of calls. These central areas with the highest call volume include: SOMA, Mission, Tenderloin/Civic Center, Polk Gulch/Nob Hill, Upper Castro, and Haight Ashbury.



**Exhibit 4. Heat map of SCRT call responses, by zip code of encounter location.**



During a group interview with community paramedics, one team member shared how they are seeing progress in areas where SCRT has had a long-term presence, stating,

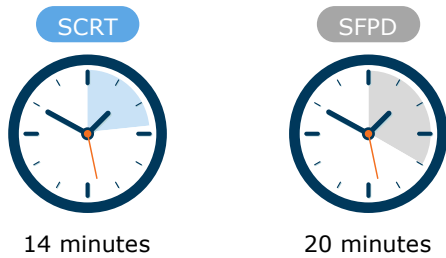
“The pilots of the program were working pretty hard in the Castro and Mission area. It's anecdotal. We can't say that's us, but there were a lot of people who were in crisis who don't feel as invisible now in that area. They know they can be heard. And when we encounter some of these people, their degree of crisis has decreased.”

SCRT's geographic focus, rather than a pure dispatch model (where teams would respond to calls across the whole city), allows units to develop relationships and expertise in responding to calls within their designated community. Following the pilot period, when SCRT will operate in a city-wide dispatch model, Teams will remain in geographic “posts” between calls.

**As the SCRT units provide a focused and dedicated response to crisis calls, this allows response time to be faster than police dispatch.** The time it takes units to respond (i.e., from when the call is answered to when the unit arrives on scene) has been relatively stable after some initial improvements as earlier teams were deployed. Response time began at a median of 17 minutes in December 2020 and improved to 14 minutes in November 2021 (Exhibit 5). This compares with the San Francisco police department's median response time of 20 minutes for similar "priority B" calls for incidents such as verbal fights and burglaries where the perpetrator is no longer on scene<sup>4</sup>.

<sup>4</sup> Data through Q2 2019. In Focus, Police Response. Annual Performance Results, Office of the Controller.

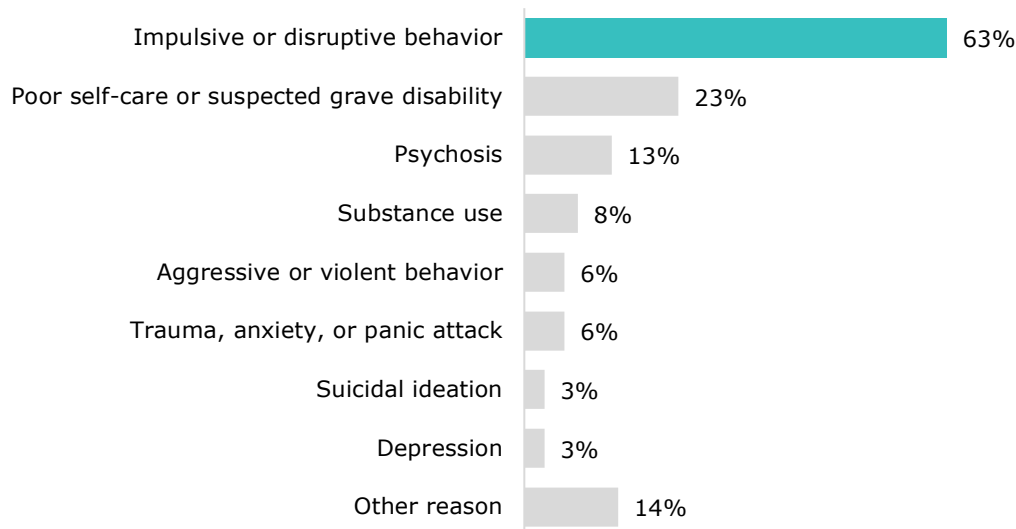
**Exhibit 5. Median response time (minutes) for SCRT vs. SFPD**



**SCRT calls were initiated by community members concerned about individuals experiencing mental health crises, and SCRT is well positioned to connect clients to the appropriate supports.** About a fifth (21 percent) of SCRT calls were from individuals who were present on the scene upon SCRT arrival, and two thirds (66 percent) were from community members who were no longer present on scene but observed someone in distress. Exhibit 6 displays the reasons SCRT calls were initiated as documented by the SCRT behavioral health clinician<sup>5</sup>. Almost two-thirds (63 percent) were classified by SCRT as "impulsive or disruptive behavior" and 19 percent were classified as "poor self-care or suspected grave disability."



**Exhibit 6. Behavioral health clinician assessment of reason for SCRT response (multiple responses allowed) (n=2,861).**



<sup>5</sup> Other reasons for calls included the client was seeking support or the client experienced a mental health related concern.

Interviews with SCRT clients also queried about the reason they were engaged by the team. One client shared, “They came to me because I’m schizophrenic and bipolar, and I was having some mental health issues. They were very polite [asked] how I was feeling, if I was suicidal, if I have any weapons, and if I was dangerous to the community. [They were] knowledgeable, friendly, professional, and approachable.” Together with the results of the teams’ assessments, shown in the previous exhibit, this account highlights that the types of calls SCRT has been responding to during the pilot are well aligned with the teams’ skill set and SCRT approach. Further, a study on how people experiencing homelessness would like to be engaged provides evidence that the team’s demeanor and desire to meet the client’s needs is likely to result in more successful follow-up and linkage to care<sup>6</sup>.




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**“They came to me because... I was having some mental health issues. [They were] knowledgeable, friendly, professional, and approachable.”**

**–SCRT Client**

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## Communities Served

One goal of the SCRT pilot is to understand who is being reached by the program. This section presents data on client demographics, encounter frequency, and presenting health conditions to provide insights into the community SCRT serves.

**As the majority of clients served by SCRT (84 percent<sup>7</sup>) report experiencing homelessness, client demographics resemble those of the population experiencing homelessness in San Francisco**, based on the 2019 Point in Time survey<sup>8</sup>, as well as those who have been treated by the Behavioral Health Services (BHS) mental health or substance use programs<sup>9</sup>. Exhibit 7

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<sup>6</sup> Townley, G., Sand, K., Kindschuh, T., Brott, H., & Leickly, E. (2021). Engaging unhoused community members in the design of an alternative first responder program aimed at reducing the criminalization of homelessness. *Journal of Community Psychology*, (20210518). <https://doi.org/10.1002/jcop.22601>

<sup>7</sup> The exact proportion of clients experiencing homelessness is probably around 70-80 percent. The 84 percent calculation excludes all clients for whom “living situation” as captured in Avatar is unknown or not answered.

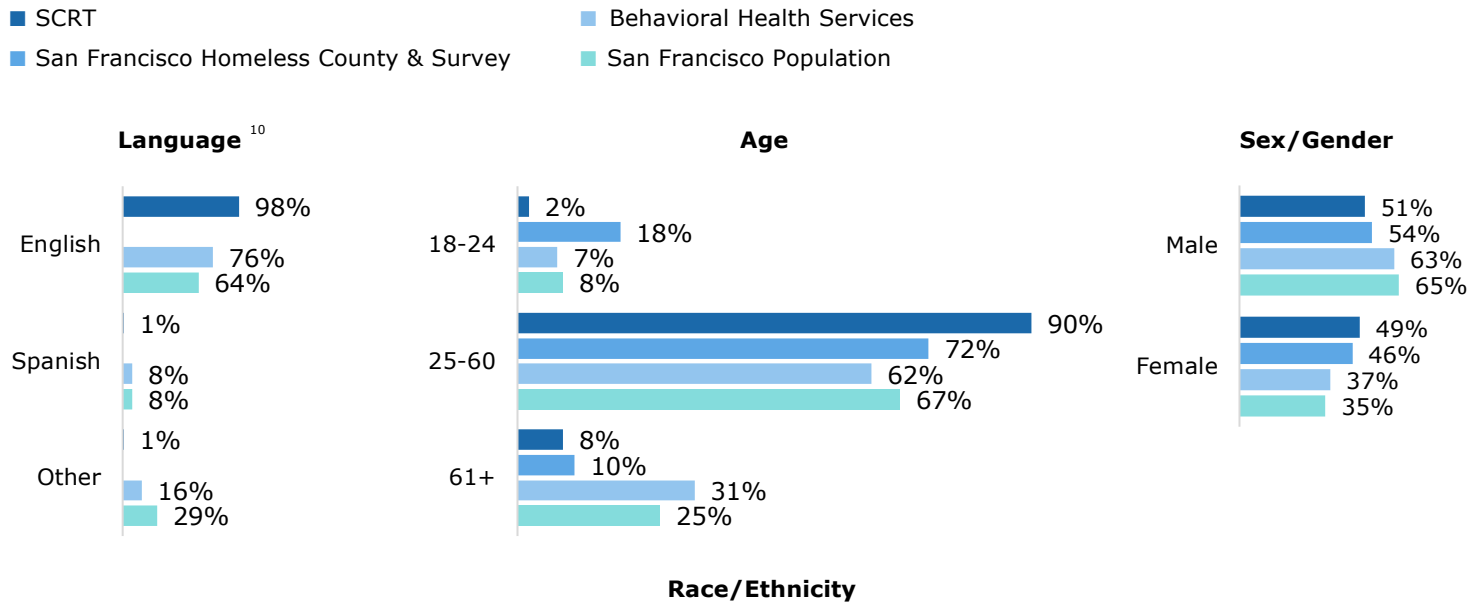
<sup>8</sup> San Francisco Homeless Count & Survey, Comprehensive Report. (updated 1.30.2020) San Francisco Department of Homelessness and Supportive Housing. Available [here](#).

<sup>9</sup> San Francisco Department of Public Health, Behavioral Health Services’ internal data as of January 24, 2022.



compares SCRT clients with these two groups as well as the overall population of San Francisco over 18 years old<sup>10</sup>.

**Exhibit 7. SCRT Client Demographics**



	SCRT	San Francisco Homeless Count & Survey	Behavioral Health Services	San Francisco Population
American Indian or Alaska Native	1%	5%	1%	1%
Asian	5%	5%	21%	34%
Black or African American	31%	37%	21%	6%
Hispanic / Latino	10%	18%	21%	15%
Multiracial	3%	22%	2%	5%
Native Hawaiian or Pacific Islander	0.4%	2%	1%	1%
White	46%	29%	33%	47%
A race not indicated above	3%	--	1%	--

Almost all clients (98 percent) speak English, with the remaining speaking Cantonese, Farsi, Spanish, and Tagalog<sup>12</sup>. This is higher than the proportion of primary English speakers among BHS clients (76 percent) and in the overall San Francisco population (64 percent).

The median age of SCRT clients was 41 years old, and most (90 percent) were between 25 and 60 years old. This represents fewer people in the younger and older age groups than people experiencing homelessness in San Francisco, BHS clients, or San Francisco overall.

<sup>10</sup> U.S. Census Bureau, American Community Survey. Total San Francisco population 18 years and over. Available [here](#).

<sup>11</sup> The San Francisco Homeless Count & Survey did not collection language information.

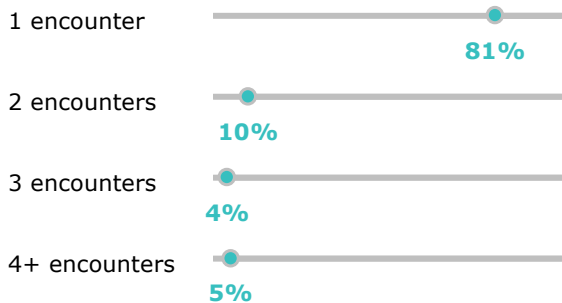
<sup>12</sup> Client language is only available for the 38 percent of clients who had identifiable information that allowed the SCRT records to be matched to an existing client or create a new client profile in the electronic health record database. SCRT units have members who speak multiple languages, including American Sign Language, Hebrew, Mandarin, Russian, Samoan, Spanish, Tagalog, and Vietnamese.

Compared to information in the Point in Time survey, the distribution of clients' gender mirrors that of people experiencing homelessness in San Francisco. The majority of both groups – 65 percent of SCRT clients and 63 percent of people experiencing homelessness in San Francisco – identify as men, slightly more than BHS or San Francisco overall<sup>13</sup>.

SCRT clients were most likely to report their race/ethnicity as white (46 percent) or Black / African American (31 percent). Black residents represent about the same proportion of SCRT clients as people experiencing homelessness in San Francisco (37 percent). However, Black residents make up a smaller portion of BHS clients (21 percent) and San Francisco residents overall (6 percent). This demonstrates the disproportionate impact of homelessness, poor health outcomes, and policing among Black/African American communities and reaffirms the importance of this program, which aims to provide rapid, trauma-informed responses to behavioral health service calls while reducing law enforcement encounters. The peer specialist team members are key to this empathetic outreach. As explained by one peer team member, "I think the dynamic of having us on the team works pretty well, because a lot of times we can see things that the other two can't as far as maybe drug usage or the environment of being homeless... I think that the team has a good mix [of roles] because each one of us offer something completely different."

**The vast majority of SCRT responses are reaching unique individuals and a lower proportion of calls serve higher need, repeat clients.** An initial question before launch of the SCRT program was whether a few individuals would make up a majority of SCRT calls, leading to a disproportionate use of program resources. Data to date shows that the vast majority of clients (81 percent) have had only one SCRT encounter (Exhibit 8).

**Exhibit 8. Number of encounters with SCRT per client (n=1,657).**



The 19 percent of clients seen by SCRT more than once present an opportunity for teams to build relationships and provide ongoing support. SFDPH's Office of Coordinated Care (OCC), which began operations in April, has behavioral health clinicians and health workers dedicated to serving SCRT clients, and plays a key role in helping people access the appropriate type of ongoing care for their needs. Individuals with repeat SCRT contacts are a priority population for OCC follow up.

**SCRT members only respond to calls that do not demonstrate a significant safety concern.** To ensure that SCRT is only responding to calls for which they are well trained and equipped to handle, the dispatch call center first determines whether a call is in the purview of the team. 911 dispatchers are key partners in the SCRT program. These highly trained individuals are equipped to assess and triage calls so that the right resource responds to each incident.

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**"I think that the team has a good mix [of roles] because each one of us offer something completely different."**

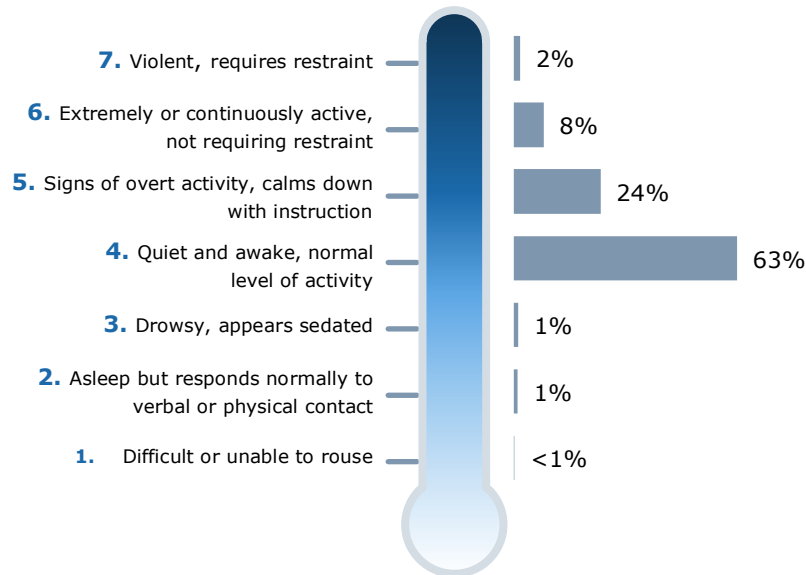
**–Peer Team Member**

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<sup>13</sup> Note that this data is collected as "sex" for SCRT and the overall San Francisco population, where there are only options for male, female, and unknown. The Point in Time survey and BHS collect this information as "gender" and include options for people to report as transgender and non-binary.

Once SCRT members have arrived at the call location, they evaluate the client and nature of the call according to the Behavioral Activity Rating Scale (BARS)<sup>14</sup>, which was created for intensive care units (ICU) and psychiatry patients to assess their level of agitation. Exhibit 9 shows how calls are rated during this "on scene" BARS evaluation.

**Exhibit 9. On scene Behavioral Activity Rating Scale (BARS) of SCRT clients (n=1,863).**



The vast majority of incidents that SCRT responds to (98 percent) are non-violent and do not require restraint of the distressed individual. Due in part to the teams' skill and de-escalation techniques, there were very few instances (2 percent, or 34 incidents) in which an individual required restraint to be transported to the hospital and no incidences of violence from clients<sup>15</sup>. Among the 3 percent of encounters that required police, 69 percent were not violent and did not require restraint. While teams' training keeps encounters safe for themselves, clients, and the public, responding to actively violent persons is in the purview of the police department, who are trained to respond using the Crisis Intervention Team (CIT) model that helps officers better understand the state of mind of the mentally ill and emphasizes de-escalation of potential crises by allowing "time and distance" — slowing down and giving the mentally ill person space<sup>16</sup>.

**The types of mental health histories and traumatic life events experienced by clients provide further evidence that SCRT skills are well matched to client needs.** Another important measure for understanding who is served by SCRT relates to clients' presenting medical and mental health needs. Exhibit 10 shows clients' mental health histories. The timeframe for this information refers to 'any prior mental health history,' as long as it was recorded prior to the SCRT

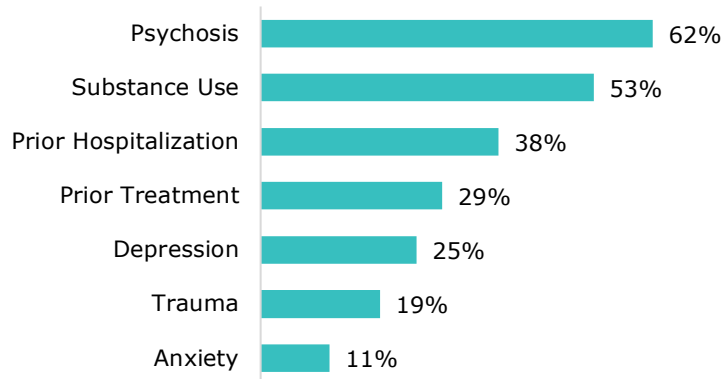
<sup>14</sup> Richmond, Janet & Berlin, Jon & Fishkind, Avrim & Holloman, Garland & Zeller, Scott & Wilson, Michael & Rifai, Muhamad & Ng, Anthony. (2012). Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. The Western Journal of Emergency Medicine. 13. 17-25. 10.5811/westjem.2011.9.6864.

<sup>15</sup> As another indicator of encounter safety, following each call, the team behavioral health clinician records whether a call entailed any safety concerns such as the presence of an object that could be used as a weapon. On this measure also, 96 percent of calls were deemed safe, and it should be reiterated that the team has reported no instances of violence.

<sup>16</sup> San Francisco Police Department, Police Commission Report. Crisis Intervention Team Annual Report 2020. Available [here](#).

encounter. Psychosis (62 percent) and substance use (53 percent) are among the most common, followed by prior hospitalization (38 percent), prior treatment (29 percent), and depression (25 percent). Among SCRT clients with existing records in the City's electronic health record system, 48 percent had records of previous hospitalization for psychiatric reasons prior to their encounter with the team.

**Exhibit 10. Clients' mental health histories (n=2,750)<sup>17</sup>.**



These mental health concerns are well aligned with the expertise of a behavioral health clinician, lived experiences of peer specialists, and medical knowledge of the community paramedic. The three-part structure of the SCRT units is well suited to address clients' behavioral health needs. As summarized by a clinician team member, "It's nice to have some diversity because sometimes that paramedic uniform is really calming to people, sometimes people want to talk to a woman, sometimes people want to talk to a man, sometimes people want to talk to a peer; and it gives our clients more options in deciding who they want to connect to and reach out to."

Fewer than one in 15 clients (7 percent) required urgent medical attention entailing transport to the hospital. This is also an area where the SCRT team approach provides the opportunity to maximize client care. As shared by a team clinician who had supported a diabetic client, "Sometimes as a clinician, I can get focused in on something, and a paramedic can be like, 'Yeah, [the issue could be] their insulin.' I'm like 'You're absolutely right... Let's chat with them in 30 minutes. Let's get them to hang out and let their blood sugar [normalize] and maybe we're going to have a completely different person with us.'"

In addition to their complex and varied mental health histories, clients have also experienced a host of psychosocial stressors. These are life situations that create unusual or intense levels of stress and may contribute to the development or aggravation of mental disorders, illnesses, or maladaptive behaviors. Top psychosocial stressors experienced by individuals served by the SCRT include unstable housing (81 percent), illness or injury (18 percent), social relationships (15 percent), and finances (13 percent). As with mental health needs, these types of lived experiences are exactly what the SCRT was created to address. The team is trained to provide on scene supports and connect clients to appropriate services; addressing basic needs like food, water, and medical needs is often the first step in stabilizing mental health status. These service responses and linkages are described in more detail in the following section.

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**"It's nice to have some diversity [...] it gives our clients more options in deciding who they want to connect to and reach out to."**

**–Clinician Team Member**

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<sup>17</sup> Percents do not total to 100, since this measure allows for multiple selections. Fewer than 10 percent of clients had a history of impulsive/disruptive behavior, suicidal ideation, mania, homicidal ideation, aggressive/violent behavior, suicide attempt, or non-suicidal injurious behavior.

## SCRT Service Responses and Linkage

The SCRT pilot evaluation also seeks to understand what direct support is provided to clients, as well as how and whether they are being linked to crucial services. This information can help the planning team assess the alignment between client needs and services and inform work by the Office of Coordinated Care to improve access to social supports for vulnerable individuals across the city. Dispositions, interventions, and referrals capture the range of diverse services SCRT can provide and the types of services available for continued care coordination.

**There was variation in the ultimate dispositions for clients with a common disposition being some form of client transport.** Due to the nature of the Emergency Medical System which dispatches SCRT, all individuals with whom SCRT interacts are offered transport to an emergency department. Excluding individuals that SCRT was unable to locate, the most frequently noted disposition was clients declining ambulance transport. Among the clients that declined transport to a hospital (73 percent), 19 percent were transported by SCRT to resources (not by an ambulance) and 81 percent remained safely in the community. Ambulance transports only accounted for 15 percent of encounters. Only 11 percent of patients walked away after a brief encounter (indicating no immediate need for intervention and a desire to remain safely in their preferred location) and just 1 percent declined transport against medical advice.

### Exhibit 11. Dispositions excluding those that were unable to locate (n=2,790).

Disposition	Percent
Remain in community	59%
Non-ambulance transport to resources	14%
Ambulance transport <sup>18</sup>	15%
Walked away after brief encounter	11%
Declined transport against medical advice	1%

**Since most clients are not transported to a medical facility, they are either transported by SCRT to a variety of resources or remain safely in the community where they receive direct services.** Clients transported by SCRT are brought to Hummingbird (21 percent), Dore Urgent Care Clinic (19 percent), congregate shelter (15 percent), shelter in place hotel (10 percent), SF Sobering Center (7 percent), and the remainder to other locations.

**In line with the harm-reduction philosophy underpinning the SCRT approach, team members recognize the support needed for individuals to safely remain in the community.** Sixty-eight percent of individuals neither receive ambulance transport to a hospital facility nor SCRT transport to other social support services<sup>19</sup>. These individuals are physically and mentally well enough to remain in the community where they were located by the SCRT team, which is likely the community they feel most comfortable and prefer to be<sup>20</sup>. These initial

<sup>18</sup> The racial/ethnic breakdown of clients transported to a hospital is consistent with the racial/ethnic breakdown of the total client pool.

<sup>19</sup> The racial/ethnic breakdown of clients remaining in the community is consistent with the racial/ethnic breakdown of the total client pool.

<sup>20</sup> Some clients (1 percent) do decline transportation to a hospital facility "against medical advice."

results are consistent with the experience of programs in other jurisdictions, such as Maricopa County, Arizona, which reports 71 percent of their mobile crisis encounters as resolved in the community<sup>21</sup>.

Among this subset of clients, the most common direct interventions include:



SCRT simultaneously employs a variety of interventions and sometimes their efforts extend across repeat encounters with the same client. As noted in the success stories (pg. 15) shared by SCRT members and clients, those repeat efforts can result in successful interventions over time as they are able to build trust in the community.

**The SCRT provides a host of psychological supports and educational resources for clients, ensuring they are safe and secure before planning for future service interventions.** Exhibit 12 shows direct client interventions provided by the SCRT team. These are services provided by team members on the scene of the call. The most common interventions include providing psychoeducation/resources (70 percent), working with family/support system (68 percent), providing peer support (65 percent), motivational interviewing (26 percent), and de-escalation techniques (24 percent).

**Exhibit 12. Direct client interventions provided by the SCRT team (n= 2037)<sup>22</sup>.**

Intervention	Percent
Provided psychoeducation/resources	70%
Worked with family/support system	68%
Provided peer support	65%
Motivational interviewing	26%
Used de-escalation techniques	24%
Coordinated care with providers	23%
Other intervention <sup>23</sup>	30%
Supported coping skills	16%
Made safety plan	13%

Additionally, medical assessments are included in every encounter. Resource coordination and scene management with other first responders and non-emergent transport are other interventions handled by the community paramedic if indicated.

<sup>21</sup> Balfour ME, Stephenson AH, Winsky J, Goldman ML. Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. Alexandria, Virginia: National Association of State Mental Health Program Directors; 2020. <https://www.nasmhpd.org/sites/default/files/2020paper11.pdf>

<sup>22</sup> Percentages do not total to 100, since this measure allows for multiple selections.

<sup>23</sup> Other interventions included removing access to means of self-harm, paramedics taking clients vitals, and providing wound care, water, and community education.

## SCRT Client Success Stories

The following quotations from SCRT members and clients capture how the team’s approach can result in successful outcomes for clients.

One client shared how connecting with a clinician triggered a string of referrals to needed services following contact with SCRT. The client recounted, “A clinician - she helped me out exponentially. **She changed my life. Everything that I needed, she did for me.** She pointed me in a proper direction and [I got] a long-term case worker and he got me an ID and got me housed. I'm about to move into an apartment because of him.”

Through relationship building, even those experiencing long term homelessness can make progress towards stable housing. A clinician shared, “We have gotten the person who's been number one on San Francisco's housing list, we got him housed. We advocated for him to have a case manager that he was connected with. He's doing a lot better. And we got somebody who'd been in the streets for 27 years - refused to get off the street - she's in her own house. And **we had to work really hard with a lot of different agencies** to make that happen. That only comes with trust and time.”

A peer specialist relayed how multiple visits can create trust which is important to successful referrals. They stated, “We had three or four calls with him, and eventually they trusted us enough and we set a date and time to meet ...And sometimes leaving a call feeling unfulfilled that we didn't get to do anything with them. And then later realizing that those calls ... still mean we still got a lot done because we were still **building trust with that person and rapport.** And we got them into the shelter, and it was the longest time that they'd ever stayed inside in a shelter.”

Importantly SCRT’s interventions don’t take place in a vacuum. A peer specialist shared about the importance of coordinating with OCC, stating, “[The client] had some trust issues with shelters, [but], there was a friend of his from the streets who was in that shelter. We tapped into him as an advocate, and so he stayed with us. And we got him in, and at the same time, the clinician coordinated with OCC, and OCC was able to come out right away, and so we did a warm handoff. **Not only did SCRT do their part, we worked with the shelter in addition to OCC, all those entities came together.**”

Finally, a community paramedic emphasized how the team is aiming to have a lasting impact rather than strive for quick fixes to intractable problems. They shared, “For me, a success story would be going to somebody that we see all the time that's in crisis, [but] we could actually talk to him. He knows who we are and we are able to help him. Initially, he would refuse but now when we go, we say, ‘Hey, sir. Let's get you off the street tonight.’ That's a success story. That took weeks and weeks, to get to that point. What I want the community to know is that these things take time. This person's been homeless or these individuals have been unhoused for months and years. **We need to be patient with their process, and that there's no quick fix this.**”

**In addition to interventions, SCRT provides clients with referrals to additional social support services.** By program design, all SCRT clients are referred to the Office of Coordinated Care for follow-up support and linkage. Other frequent resources to which clients were referred to at time of crisis by SCRT team members included: shelter/navigation center (22 percent), Dore Urgent Care Clinic (21 percent), and Hummingbird (10 percent). While Dore Urgent Care Clinic is open 24 hours, other services have limited evening and weekend hours. SCRT team members have expressed the need for more overnight services, and a planned expansion of behavioral health services in the city aims to address this challenge. The expansion includes about 400 new overnight treatment spaces, or beds, a 20% increase in treatment capacity. Notably, the new SOMA Rise Center will be open 24-7 as a pilot program for people experiencing homelessness with drug intoxication<sup>24</sup>.

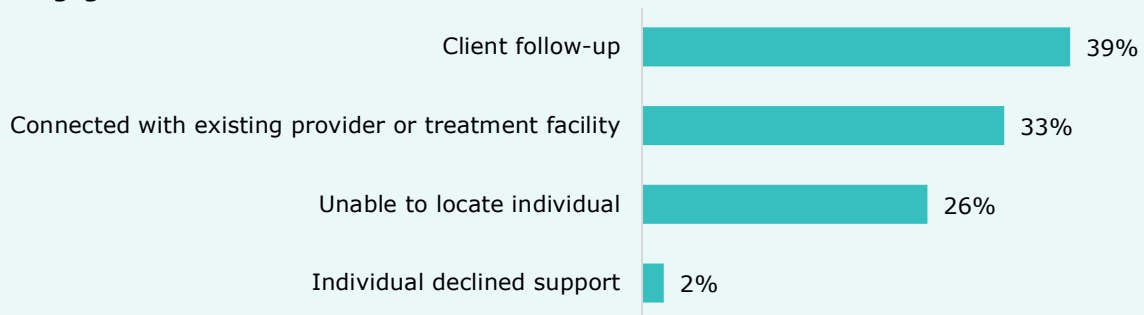
<sup>24</sup> Details available here: <https://sf.gov/residential-care-and-treatment#whats-new>

### Office of Coordinated Care

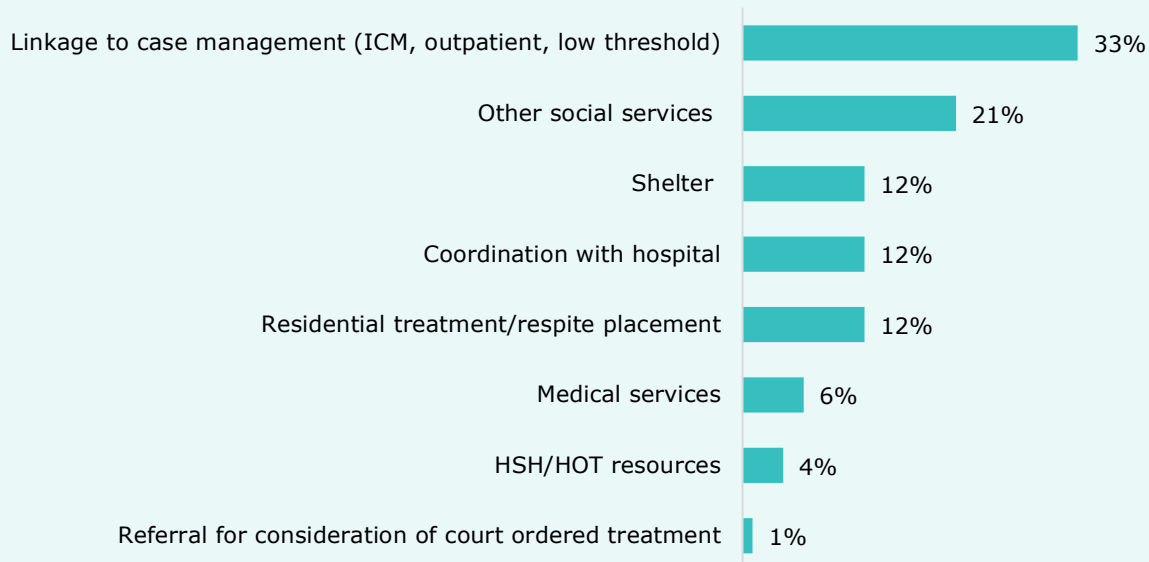
The Office of Coordinated Care (OCC) launched in April 2021 to oversee the seamless delivery of mental health care and substance use services across San Francisco’s behavioral health systems. Staffed with clinicians and peer specialists, the OCC supports clients in navigating systems with the ultimate aim of reducing readmission to crisis services. While the OCC is a citywide effort that supports all San Francisco residents in need of its services, a special team of care coordinators is assigned to SCRT and is responsible for following up with existing providers and/or clients with whom SCRT engages within 24 hours of contact with the team.

OCC has served an increasing number of clients since its launch. Between April and November 2021 OCC attempted to provide follow-up and linkage support services to 667 clients. They were able to successfully engage with 63 percent of clients (n=420) and attempted to engage an additional 247 who they were ultimately unable to locate. Thirty-six clients (9 percent) were seen more than once. The chart below details the outreach services OCC staff have provided to SCRT clients since April. OCC staff have ramped up their services provided during that same period, and between September and November were providing an average of 324 services a month. The average OCC visit is 30 minutes long, with about half (55 percent) of visits completed via telehealth.

#### OCC Client Engagement Efforts



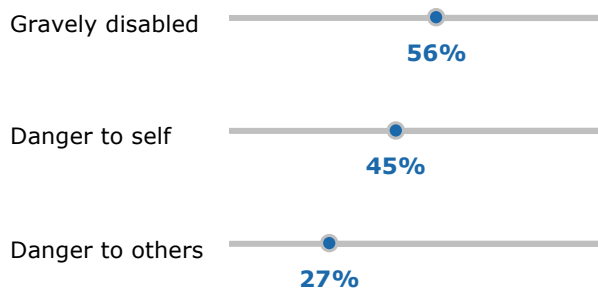
#### OCC Referrals / Connections to Care





**The rare number of involuntary holds of clients represents a success for the SCRT.** For a small subset of clients (7 percent)<sup>25</sup>, the SCRT team has had to invoke the California Welfare and Institutions Code (WIC) 5150. This law was established as part of the 1967 Lanterman–Petris–Short (LPS) Act and allows individuals who, as a result of their mental health crises, are deemed by the SCRT team to be a danger to themselves/others or gravely disabled due to a mental disorder, to be held in a psychiatric treatment facility for a period of no more than 72 hours. Exhibit 13 shows the reasons individuals have been placed under a 5150 hold by the SCRT.

**Exhibit 13. Reason for 5150 holds of clients (n=169).**



Since a primary goal of SCRT is to reduce unnecessary emergency room use and support individuals where they feel most comfortable, the low percentage of 5150 holds is a notable strength. This reserves acute services for those most in need, ensuring they are able to receive appropriate assessment and targeted advocacy, while redirecting less high-need individuals to less restrictive and more appropriate resources. When holds did occur, the most common reason was that the client was gravely disabled (56 percent). Grave disability describes a condition in which a person, as a result of a mental health disorder, is unable to provide for their basic needs such as food, clothing, or shelter. The next most common reason is that clients posed a danger to themselves (45 percent) or presented a danger to others (27 percent). While the team tries to minimize any need for the involuntary restraint of a community member, it is recognized that involuntary treatment is an important and necessary intervention in some cases. The low prevalence of holds and even lower prevalence of potential danger to other community members provides further evidence that the team is generally succeeding at meeting clients where they are, respecting their individual needs and desires, and minimizing the potential for harm to all people involved in street crisis encounters.

The top interventions for 5150 holds included working with the client's family/support system (68 percent), peer support (64 percent), psychoeducation (55 percent), coordinated care with providers (55 percent), de-escalation (51 percent), and inpatient admission (49 percent).

## Conclusion

In its first year of operation, the Street Crisis Response Team (SCRT) has accomplished some major milestones, which are supported by the data on call characteristics, communities served, and service responses and linkage. The first six planned teams have been successfully implemented, the number of encounters continues to increase each month, a stable response time has been established that compares favorably to police response, and the portion of behavioral health crisis calls diverted through police dispatch has increased. As evidence that the team is reaching their target population, presenting health needs of clients are well

<sup>25</sup> The racial/ethnic breakdown of clients receiving an involuntary hold is consistent with the racial/ethnic breakdown of the total client pool.

aligned with team member skills and the SCRT approach. There have been no instances of violent encounters among the mostly unduplicated client base. Further, team members' skillsets are well matched to presenting client needs. Once on scene, clients are either connected to the appropriate medical and mental health services or supported in their communities through direct services and referrals for future interventions. Finally, the Office of Coordinated care provides SCRT clients with necessary follow-up, information about their service options, and knowledgeable support personnel to oversee their continued progress. As the pilot period concludes and SCRT moves to phase 2, increased staffing will allow SCRT, OCC, and Emergency Medical Dispatch (EMD) to be operational seven days a week.

In addition to capturing these early successes, as part of the continuous process improvement framework, the evaluation team identified considerations to expand and better support the work of SCRT units. Where relevant, we contextualize these recommendations with reference to the work of the Mental Health San Francisco Implementation Working Group (MHSF IWG), which has also conducted a preliminary review of the SCRT initiative and provided its own recommendations<sup>26</sup>.

- **Revisit recommendations from previous evaluation reports to assess progress**, including: continuing to clarify team roles and responsibilities, decreasing call response time, and increasing the portion of 800Bs diverted. While MHSF IWG has asked the SCRT to expand its scope to include all 800A and 800B calls, this evaluation can only provide evidence of the low safety concerns for team members in the current dispatch model. Finally, SCRT units have requested the establishment of more home bases for teams throughout the city, such as SOMA Rise which will serve as a central location.
- **Continue to track linkages through the Office of Coordinated Care and support ongoing enhancements to address identified gaps in services connections.** The establishment of this office was a major accomplishment in the first year of operations. During focus groups with team members, several additional services were requested to improve SCRT client linkage (e.g. services with low barrier access, need for additional shelter, and services for women/victims of sexual assault). Identifying service gaps was also recommended by MHSF IWG. Increasing OCC's capacity to meet clients quickly and connect them to appropriate services will improve long-term results and further enhance community trust in the team.
- **Work with community organizations and the shelter system to improve referral options for clients.** One of the major tasks of SCRT is to meet clients where they are and address their needs without causing harm. For example, SCRT does not enforce Sit-Lie ordinances, which require removing individuals from a public place of rest. The team approaches agitated clients with de-escalation techniques, and this approach was recommended by the MHSF IWG. Still, many individuals do not meet the threshold for 5150 but are too escalated to remain safely in the community. Alternative venues could provide them with a peaceful place to rest and stabilize.
- **Promote SCRT's purpose and accessibility in the community.** While SCRT's reputation among the client community is positive and spreading, the first two community engagement events facilitated by the evaluation team revealed that many San Francisco residents hold misconceptions

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<sup>26</sup> Available at:

[https://www.sfdph.org/dph/files/IWG/Street\\_Crisis\\_Response\\_Team\\_IWG\\_recommendations\\_Final\\_5.25.21.pdf](https://www.sfdph.org/dph/files/IWG/Street_Crisis_Response_Team_IWG_recommendations_Final_5.25.21.pdf)

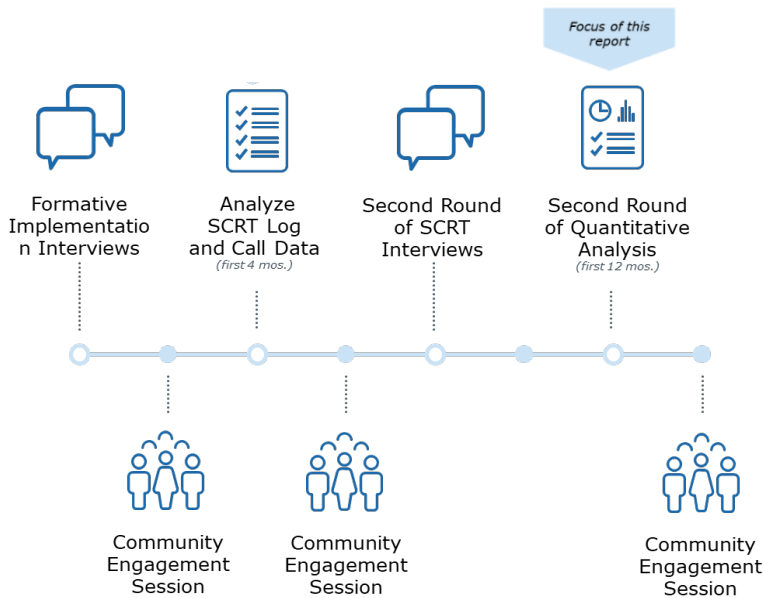
about its purpose. For example, there are frequent request to remove individuals experiencing homelessness from a premises. Some clients expressed difficulty in requesting SCRT through 911 dispatch. Further, the community engagement meetings clearly illustrated how central questions of accessibility and trust are in the minds of San Franciscans. As the Department of Public Health works to establish an alternative call number, a clear process for accessing services should be widely publicized. The need to revisit how SCRT is contacted is also aligned with instructions from the MHSF IWG which called for SCRT to be publicized, an alternative to 911 established, and the direct line promoted.

- Build upon early successes and continue best practices**, including: working with community organizations and OCC to make care connections, getting to know the communities in which teams are posted and building rapport with repeat clients to increase trust and successful referrals, maintaining a low violence rate during encounters, and implementing training procedures to promote successful team working dynamics.

Importantly, the SCRT pilot program is embedded in a larger set of comprehensive reforms through Mental Health San Francisco, created through the legislation ([File No. 191148](#)) planning group. This alignment highlights the cohesiveness of partners at all levels and provides a collaborative body for implementing these recommendations.

These data analysis results will be presented at a third SCRT Community Engagement Forum in April 2022. Exhibit 14 displays an evaluation plan overview.

**Exhibit 14. Evaluation Plan Overview**



In addition to these evaluative activities, quarterly data analyses have been conducted since the summer of 2021 to provide the Department of Public Health with current point-in-time updates on the team scale-up and the geographic distribution of call responses. A final Community Engagement Forum will conclude the pilot evaluation, where the evaluation team will share back comprehensive results from the pilot evaluation and gather community perspectives on how the SCRT approach can decrease feelings of public disorder and increase perceptions of community safety in San Francisco.