

June 2021

Street Crisis Response Team Pilot

Preliminary Report

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

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

The goal of the early phases of the evaluation is to identify initial 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 (SFPDH), in collaboration with the San Francisco Fire Department (SFFD) and the Department of Emergency Management (DEM), launched the Street Crisis Response Team (SCRT) pilot program on November 30, 2020. This team is in direct response to the crisis team called for in the Mental Health San Francisco legislation as well as Mayor Breed's commitment to identifying alternatives to law enforcement. 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 in public spaces.

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 Mental Health San Francisco 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.¹ Individuals are further supported by a team of clinicians and peer specialists through the Office of Coordinated Care. 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.

This report focuses on the first four months of implementation, where the first SCRT unit deployed had a geographic focus in the Tenderloin area; a second team was launched February 1, 2021, with a focus in the Castro/Mission area.² SCRT will increase to six teams and provide 24 hour / 7 days a week coverage across the city by end of summer 2021.

¹ 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).

² At the time of this report, four total teams were active, including teams focused in Bayview and Chinatown North Beach/Waterfront areas.

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 to ensure success. SCRT is already proving to be a leader in this work, consulting with other jurisdictions contemplating similar programs. Throughout the pilot year, the partner organizations overseeing SCRT operations will engage in a continuous process improvement approach to review data, disseminate evaluation findings, and solicit direct feedback on the program through a series of community engagement sessions with service providers and program partners.

This preliminary report summarizes the types of calls accepted by the first two SCRT units, the characteristics of clients served, and SCRT teams' responses and immediate service linkages. The goal is to identify early successes and ways that the work of SCRT units can be enhanced or better supported to improve the outcomes for people experiencing behavioral health crises on the streets of San Francisco.

Evaluation Methods

A critical part of the pilot is continuous assessment of information from the initial SCRT units. Toward this goal, Harder+Company Community Research conducted an early analysis of data on SCRT calls, clients, and responses in April 2021, roughly five months into the pilot period.

The evaluation team developed an analysis plan in coordination with DEM, SFDPH, and SFFD, based on data from the different systems used to record client information. Client records covering November 2020 through March 2021 were matched across the systems to have a comprehensive overview of clients and the SCRT response.

A total of 789 calls were accepted by SCRT through the end of March 2021. Of these, 68 were cancelled and 11 were out of scope or geographic zone, leaving a total of **710 incidents** for analysis. Forty-three percent of these (n=305) had enough information recorded during the SCRT call to match them to an existing client or create a new client profile in the electronic medical record database used by behavioral health clinicians, which allowed for additional analyses about client characteristics and service linkage.

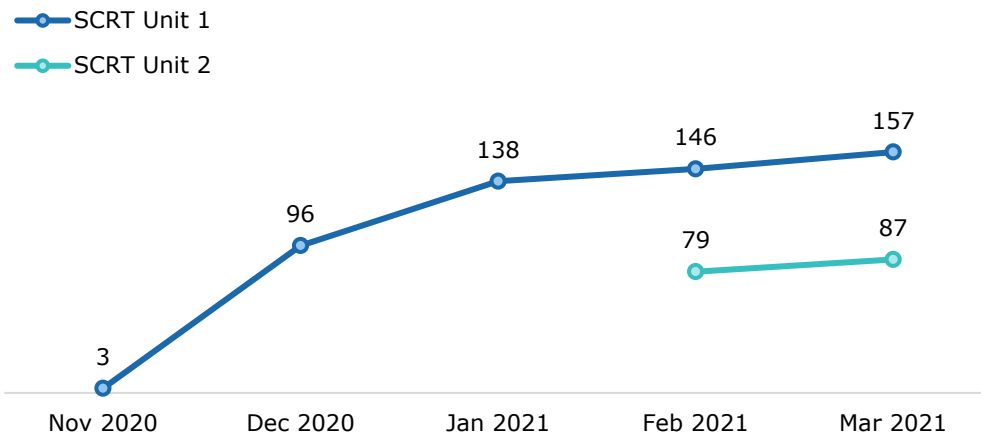
Of note, given the nature of providing crisis services, the amount of demographic or historical information that is able to be collected at the time of a crisis varies; however, the team strives to collect as much information as possible during the crisis event and during follow up encounters to ensure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

Call Characteristics

Since the first SCRT unit launched in late November 2020, the program has been scaling up, increasing calls and decreasing response time. A second SCRT unit launched in February 2021.

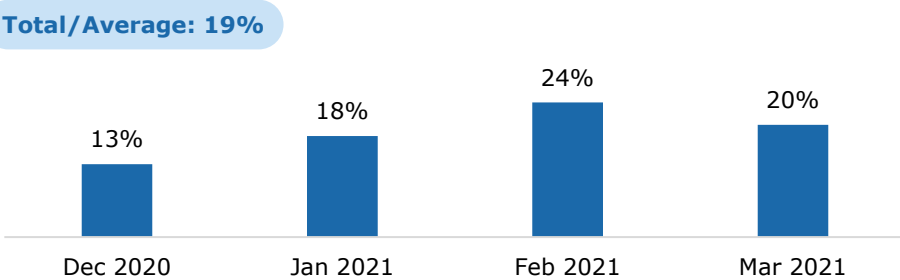
SCRT is diverting calls from police dispatch at an increasing rate, and call sources align with the program goal of aiding persons experiencing a behavioral health crisis. Each month of operation, the number of calls SCRT responds to has increased. The first unit has increased calls taken from 96 during the first full month of operation to 157 in the most recent month for which data is available (Exhibit 1). The second SCRT unit is also showing an increased response in their first two months.

Exhibit 1. Number of SCRT responses by SCRT unit, November 2020-March 2021 (n=706).



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 19 percent of calls classified as 800-B and prioritized for a SCRT response. This proportion has increased over time and SCRT is anticipating being able to respond to all appropriate calls once fully implemented (Exhibit 2).

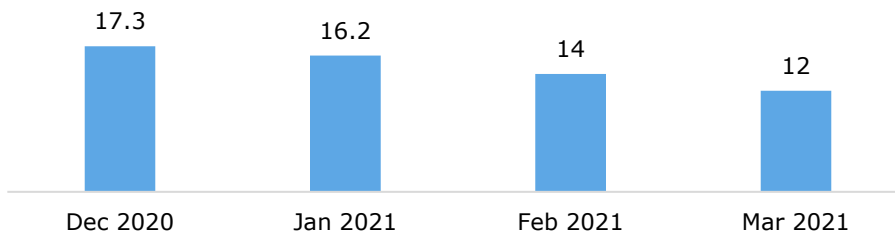
Exhibit 2. Proportion of 800-B calls receiving SCRT response, by month.



Almost all of the calls SCRT responded to (80 percent) were directed from 911 dispatch. A small portion (5 percent) were special requests, and the remaining 15 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. 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, therefore positioning them to be responsive to crises they see emerging.

SCRT unit response time is faster than police dispatch and response times are decreasing with program scale up. The time it takes units to respond (i.e., from when the call is answered to when the unit arrives on scene) is also improving, from a median of 17 minutes in December to 12 minutes in March (Exhibit 3). 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.³

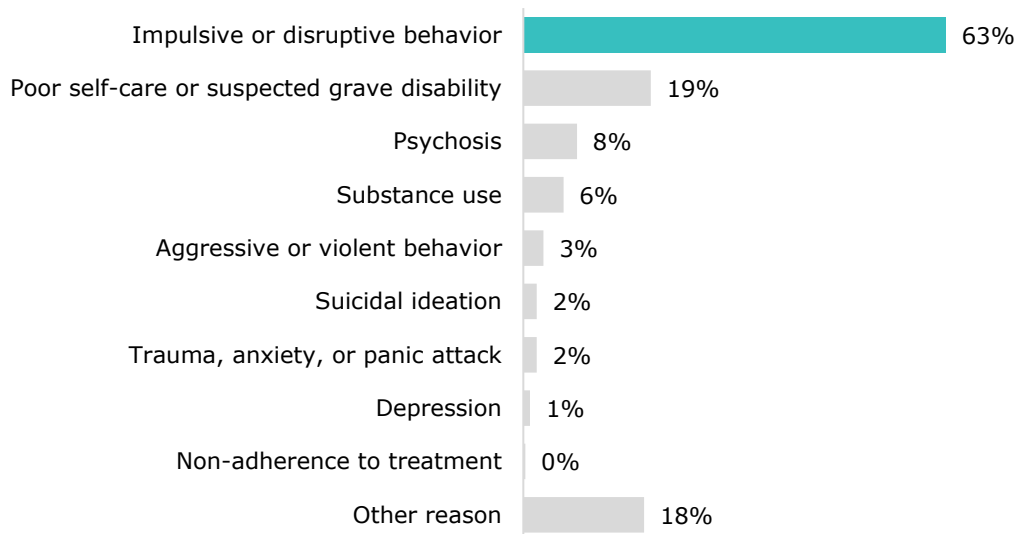
Exhibit 3. Median SCRT response time (minutes) by month (n=470).



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. The SCRT-directed calls received from dispatch indicate that members of the community are concerned for distressed individuals. About a third (31 percent) were from callers who were present on the scene upon SCRT arrival, and more than half (52 percent) were from community members who were no longer present on scene but observed someone in distress.

Exhibit 4 displays the reasons SCRT calls were initiated as noted by the SCRT behavioral health clinician. Almost two-thirds (63 percent) were for "impulsive or disruptive behavior" and 19 percent were for "poor self-care or suspected grave disability."

Exhibit 4. Behavioral health clinician assessment of reason for SCRT response (multiple responses allowed) (n=367).



³ Data through Q2 2019. In Focus, Police Response. Annual Performance Results, Office of the Controller.

These data provide preliminary evidence that the types of calls SCRT has been responding to during the pilot are also well aligned with the teams’ skill set and SCRT approach.

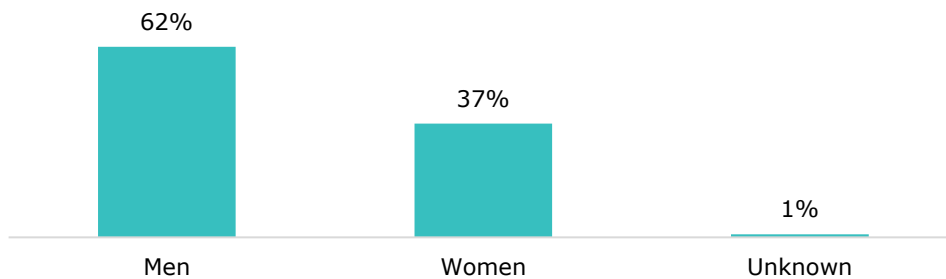
Communities Served

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.

Client demographics resemble those of the population experiencing homelessness in San Francisco, based on the 2019 Point in Time survey.⁴ Many clients (75 percent) served by SCRT report experiencing homelessness. Their median age is 42 years, with a range from 22 to 74 years. Almost all clients (91 percent) speak English, with the remaining speaking Cantonese, Farsi, Spanish, and Tagalog.

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 – 62 percent of SCRT clients and 59 percent of people experiencing homelessness in San Francisco – identify as men (Exhibit 5).

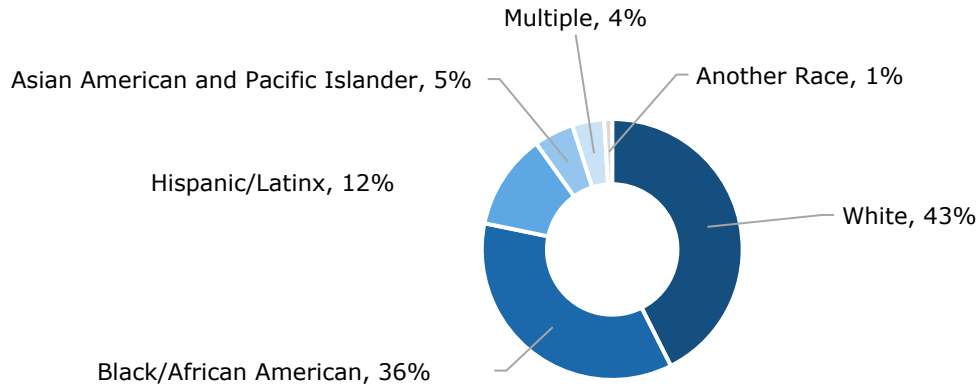
Exhibit 5. Gender of SCRT clients (n=305).



While the Point in Time survey collected information about race/ethnicity differently than SCRT, similar proportions identified as Black or African American (36 percent of SCRT clients and 37 percent in the Point in Time survey) and Hispanic/Latinx (12 percent of SCRT clients and 15 percent in the Point in Time survey). More detail about race/ethnicity of SCRT clients is in Exhibit 6.

⁴ San Francisco Homeless Count & Survey, Comprehensive Report. (updated 1.30.2020) San Francisco Department of Homelessness and Supportive Housing. Available [here](#).

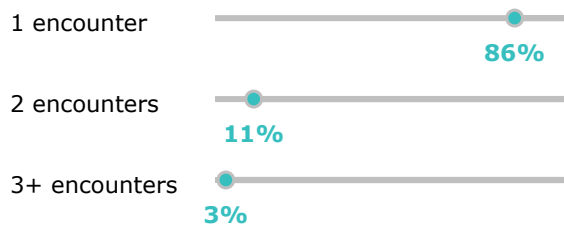
Exhibit 6. SCRT client race/ethnicity (n=224).



Note that, while similar proportions identified as Black / African American among SCRT clients and those experiencing homelessness, this is significantly higher than the overall proportion of Black / African American people living in San Francisco (6 percent).⁵ 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 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 (86 percent) had only one SCRT encounter (Exhibit 7).

Exhibit 7. Number of encounters with SCRT per client (n=256).



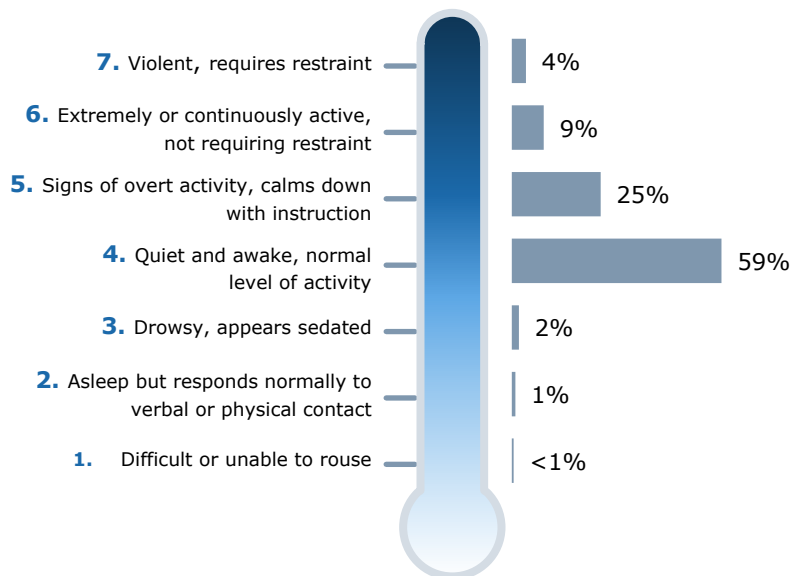
The 14 percent of clients seen by SCRT teams more than once present an opportunity for teams to build relationships and provide ongoing support. SFDPH’s Office of Coordinated Care, which began operations in April, has clinicians and peer health workers dedicated to serving SCRT clients and will play a key role in helping people access the appropriate type of ongoing care for their needs. This follow up care and engagement will be detailed in future reports.

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. SCRT members then evaluate the

⁵ American Community Survey (2019). ACS 1-Year Estimates Detailed Tables. Black or African American alone or in combination with one or more other races. Available [here](#).

nature of the call according to the Behavioral Activity Rating Scale⁶ (BARS), which was created for intensive care units (ICU) and psychiatry patients to assess a patient’s level of agitation. Exhibit 8 shows how calls are rated during an “on scene” BARS evaluation once the team has arrived at the call location and has more complete information.

Exhibit 8. On scene Behavioral Activity Rating Scale (BARS) of SCRT clients (n=435).



The vast majority of incidents that SCRT responds to (96.5 percent) are non-violent and do not require restraint of the distressed individual. Due in part to the teams’ skill and training de-escalation techniques, there were very few instances (3.5 percent, or 13 cases) in which an individual required restraint to be transported to the hospital. 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. Importantly, there have been no incidences of violence from clients.⁷

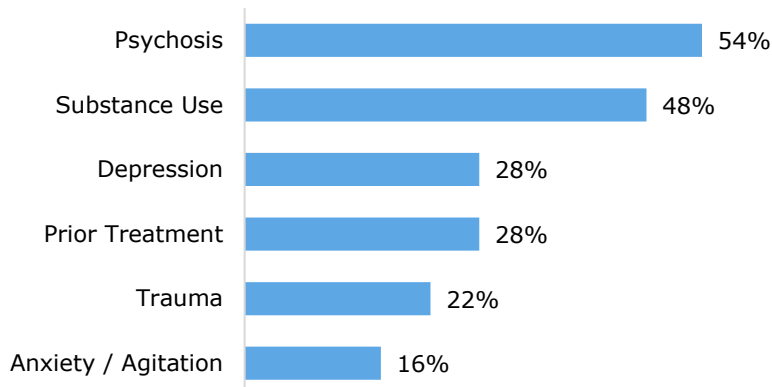
The types of mental health histories and traumatic life events experienced by clients provide further evidence that SCRT skills are well matched to client needs.

Another important measure for understanding who is served by SCRT relates to clients’ presenting medical and mental health needs. Exhibit 9 shows clients’ mental health histories. Psychosis (54 percent) and substance use (48 percent) are the most common client mental health histories, followed by prior treatment (28 percent), and trauma (22 percent). Among SCRT clients with existing records in the City’s electronic health record system, 44% had been hospitalized for psychiatric reasons prior to their encounter with the team.

⁶ 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.

⁷ 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.

Exhibit 9. Clients’ mental health histories (n=305).⁸



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’ mental health needs.

In addition to their complex and varied mental health histories, clients have also experienced a host of psychosocial stressors. Psychosocial stressors 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. A top psychosocial stressor experienced by individuals served by the SCRT includes unstable housing (83 percent), finances (19 percent), illness or injury (13 percent), and community violence (7 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. These service responses and linkages are described in more detail in the following section.

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.

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 10 shows direct client interventions by the SCRT team. These are services provided by team members on scene in the area of the city where the client was located. The most common interventions include providing peer support (63 percent of encounters), providing psycho-education/resources (50 percent), using de-escalation techniques (40 percent), and motivational interviewing (27 percent).

⁸ Percentages do not total to 100, since this measure allows for multiple selections. Fewer than 10% of clients had a history of impulsive/disruptive behavior, suicidal ideation, mania, homicidal ideation, aggressive/violent behavior, suicide attempt, or non-suicidal injurious behavior.

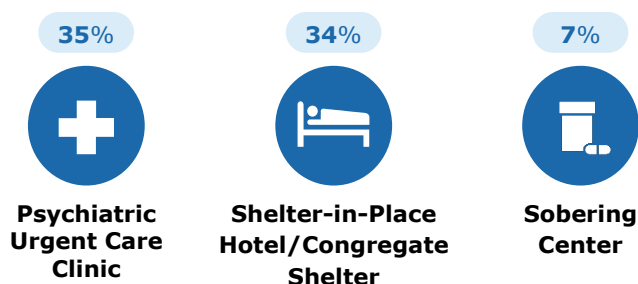
Exhibit 10. Direct client interventions provided by the SCRT team (n=303).⁹

Intervention	Percent
Provided peer support	63%
Provided psychoeducation/resources	50%
Used de-escalation techniques	39%
Other intervention	32%
Provided motivational interviewing	27%
Coordinated care with providers	19%
Made safety plan	16%
Supported coping skills	13%
Arranged for inpatient admission	9%
Required physical restraints	4%
Worked with family/support system	2%
Removed access to means of self-harm	1%
Required emergency medication by EMS	1%
Administered Naloxone	1%

Most of the direct client interventions provided by SCRT involve psychological and educational support techniques as compared to emergency interventions, because clients requiring emergency medical attention or meeting criteria for an involuntary psychiatric hold are transported to a hospital facility or mental health clinic.

About a quarter of clients are transported to a hospital facility, a fifth are transported to other temporary housing/shelter, mental health, or substance use treatment locations, and the rest receive direct services in their communities. Transported clients receive ambulance transport to a hospital facility for emergency medical or psychiatric treatment (23 percent) or SCRT transport to another clinic or social support service (19 percent).

These placements allow the team to address substance use disorder and mental health treatment needs as well as psychosocial stressors such as experiencing homelessness. The most common non-hospital transportations¹⁰ made by SCRT include:

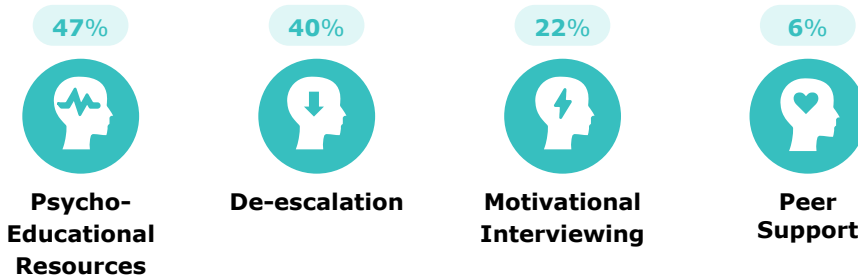


Apart from these two groups of “transported clients,” are the 59 percent of folks who neither receive ambulance transport to a hospital facility nor SCRT transport to other social support services. These individuals are physically and mentally well enough to remain in the community where they were located by the SCRT team,

⁹ Percentages do not total to 100, since this measure allows for multiple selections.

which is likely the community they feel most comfortable and prefer to be.¹¹ These initial results are consistent with the experience of programs in other jurisdictions, such as Maricopa County, Arizona, which reports 71 percent of their mobile crisis encounters as resolved in the community¹².

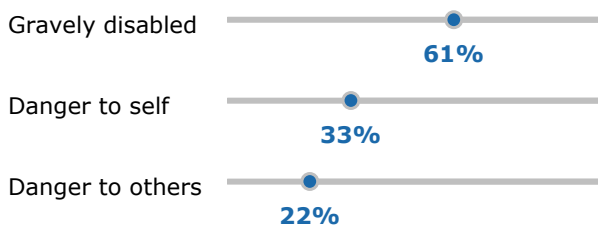
In line with the harm-reduction philosophy underpinning the SCRT approach, team members recognize the support needed for individuals to safely remain in the community. Among this subset of clients, the most common direct interventions include:



Those who remain in the community are also given referrals (not transportation) to additional social supports along with information about how to navigate the services. Additionally, the new Office of Coordinated Care will support future referrals, as it is tasked with building ongoing relationships with individuals and connecting clients to appropriate social services through a more streamlined and centralized venue. While the Office of Coordinated Care was launched after the data collection period informing this report, it will be the focus of future evaluation updates.

Involuntary holds of clients are rare and, for an even smaller subset of clients (36 encounters), 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 11 shows the reasons individuals have been placed under a 5150 hold by the SCRT.

Exhibit 11. Reason for 5150 holds of clients (n=36).

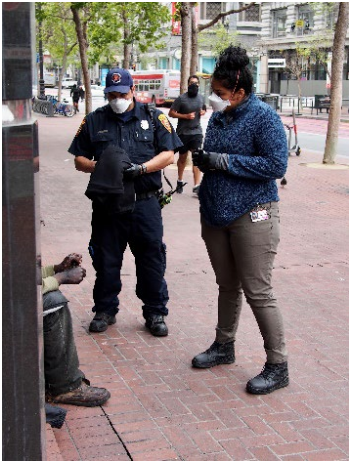


The rarity of 5150 holds represents a success for the team, since a primary goal of SCRT is to reduce unnecessary emergency room use and support individuals where they feel most comfortable. When holds did occur, the most common reason was

¹¹ Some clients (3 percent) do decline transportation to a hospital facility “against medical advice.”

¹² 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>

that the client was gravely disabled (61 percent). Grave disability describes a condition in which a person, as a result of a mental health disorder, is unable to provide for his or her basic needs such as food, clothing, or shelter. The next most common reasons for 5150 holds were that clients posed a danger to themselves (33 percent) or presented a danger to others (22 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.



Conclusion

The Street Crisis Response Team (SCRT) has achieved some important early successes, which are evident in the data on call characteristics, communities served, and service responses and linkage. The team is scaling up, as seen in the increased number of encounters per month, decreased response time, and increased portion of diverted police dispatch for behavioral health crises. As evidence that the team is reaching their target population, client demographics resemble the population of people experiencing homelessness in San Francisco, as do their presenting mental health needs. 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 hospital or mental health facility or supported in their communities through direct services and referrals for future interventions.

In addition to capturing these early successes, as part of the continuous process improvement framework, the evaluation team identified data management and tracking improvements. Additionally, the evaluation team offers the following recommendations to expand and better support the work of SCRT units:

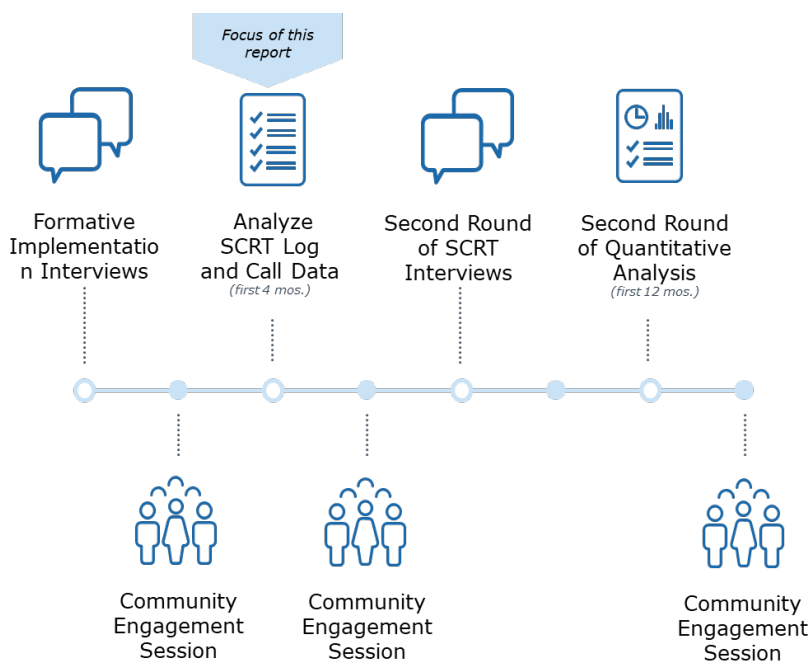
- Promote early successes such as the program scale up, team and public safety, and direct interventions and service connections. Increase community awareness of SCRT throughout the city.
- Continue to monitor and improve call response times and the proportion of 800-B calls that are diverted from police department dispatch.
- For the subset of clients who have been seen by the team over multiple encounters, review intervention data to better understand their needs and connect them with appropriate services and case management.

- Given the racial diversity of the population served, continue to integrate equity training into SCRT onboarding and hiring. Ensure that the team is reflective of the diverse communities served and has access to appropriate translation services when required.
- Continue to explore additional service connections and work with the Office of Coordinated Care to review SCRT client needs. Request additional investments and community support where needed.
- Prioritize shelters and pathways to housing given the high portion of unhoused clients, especially with the closure of shelter-in-place hotels.

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 were presented at a second SCRT Community Engagement Forum in June 2021. Exhibit 12 displays an evaluation plan overview.

Exhibit 12. Evaluation Plan Overview



At the Community Engagement Forum, leaders from non-profits and community benefit organizations shared their own insights and perspectives about SCRT successes and challenges to inform planning for future phases of the initiative and identified how to leverage community expertise to improve the SCRT approach. In the summer of 2021, the evaluation team will conduct a second round of key informant interviews including participation from new SCRT members and community members served by the program. Results from these interviews will inform planning and analysis for a full year of SCRT data in the fall of 2021. After a full year of implementation, a third community engagement event will share back comprehensive results from the pilot evaluation and gather community perspectives on how the SCRT approach has contributed to a decrease in perceived public disorder and increased feelings of community safety in San Francisco.