SAN RAFAEL
THE CITY WITH A MISSION

Agenda Item No: 7.a

Meeting Date: July 5, 2022

SAN RAFAEL CITY COUNCIL AGENDA REPORT

Department: Police Department

Prepared by: D.C. Spiller, Police Chief **City Manager Approval:** _____

TOPIC: SAN RAFAEL PUBLIC SAFETY ALTERNATIVE RESPONSE TEAM

SUBJECT: ALTERNATIVE RESPONSE PILOT PROGRAM TO DELIVER SOCIAL SERVICES FOR MENTAL HEALTH AND HOMELESSNESS SUPPORT, AND ACCEPT STAFF'S RECOMMENDATION TO ISSUE A REQUEST FOR PROPOSALS

RECOMMENDATION: Accept informational staff report on a three-year pilot Alternative Response Program to deliver necessary social services for mental health and homelessness support and alleviate impacts to frontline public safety services, and staff's recommendation to issue a Request for Proposals.

BACKGROUND:

Over the past several years, there has been an emerging practice of replacing traditional law enforcement responders to 911 calls involving people in crisis with social workers, mental health counselors, or medical staff. The model for this type of response has been in existence in other jurisdictions for decades. A gold standard example of such a model is a program called Crisis Assistance Helping Out On The Streets (CAHOOTS), which has been nationally recognized as the model for an alternative public safety response. This program, originating in municipalities in Oregon, was developed by the White Bird Clinic to send a crisis counselor and emergency medical technician on the streets to engage in the support of vulnerable community members, specifically those with mental health history and those individuals experiencing homelessness.

Individuals in these circumstances often are involved in public safety calls for service and represent a growing number of calls for service impacting both Police and Fire services. The growing impact of such calls for service limits the "available time" for police and fire units, subsequently impacting response times and other service delivery throughout the community.

The Police Department annually responds to an average of nearly 4,000 calls for service (CFS) involving community members in crisis related to mental health, substance abuse, or homelessness. Combined, these represent roughly 8% of all calls for service that the Police Department responds to annually. Operationally, these types of calls for service are repetitive and generally require two police officers and, in many cases, Fire Department or medical support services for an extended period.

FOR CITY CLERK ONLY

Council Meeting:

Disposition:

In the majority of cases, these calls result in a peaceful resolution with the transport of or placement option for the individual. While a vast majority of these interactions have positive outcomes, some instances result in negative outcomes including required use of force by police that can result in injury to community members or first responders. Staff recognizes that there are individuals and entities that are better trained, suited, and equipped to navigate and deliver services related to mental health, substance abuse, and unsheltered and housing services available to individuals in need.

Alternative Response Teams have the capability to deal with a wide range of mental health-related crises, including conflict resolution, welfare checks, substance abuse and potential suicide threats. Relying on trauma-informed de-escalation and harm reduction techniques, Alternative Response Teams are designed to respond to the following:

- Individuals who are intoxicated or under the influence of controlled substances.
- Transports for mental health services.
- Counseling, support, and intervention for depressed or suicidal individuals.
- Assisting the public with emergency shelter resources.
- Transportation to detox services for intoxicated people.
- Welfare checks (when no crime is suspected).
- Reports of intoxicated subjects in public places.
- Reports of disoriented subjects.
- Non-emergency medical evaluations.
- Transports for non-emergency medical care.
- Delivering emergency/death messages.

In addition to public safety services currently provided by the City of San Rafael, additional services exist to support vulnerable populations. An example of additional services includes the "Care Team" through Community Action Marin, which provides on-the-street engagement with individuals for such things as wellness checks and delivering food, water, clothing, or sleeping bags. Additionally, the Care Teams throughout the county can provide transportation to a detox center, homeless shelter and in some cases medical facility in the process of after / follow up care.

From the perspective of Mental Health Services, Marin County Behavioral Health Mobile Crisis Unit responds to individuals throughout Marin County who present in a crisis. Referral sources for Marin County Mobile Crisis include schools, police departments, and the public. The Marin County Mobile Crisis unit has the capacity to initiate a mental health detention, pursuant to Section 5150 of the Welfare and Institutions Code if warranted or to offer crisis intervention, stabilization, and linkage to appropriate community-based services.

Gaps in these services exist and compound the impacts to frontline public safety responders. The Care Teams, as an example, serve individuals experiencing homelessness only and do not provide mental health services or support. The Care Teams are not integrated with public safety services and cannot serve to decrease service calls impacting police and fire services.

Marin County Behavioral Health Mobile Crisis unit lacks consistent response capability. Despite work to expand, the Mobile Crisis responders manage a volume of service throughout the county that limits their availability, and the hours of deployment and operation further limit support for public safety staff requesting their support.

As depicted in the following table, various services delivered from organizations within the community serve to support our vulnerable populations. Recognizing the gaps that exist among service providers, the proposed Alternative Response Team would functionally serve all

elements listed without any services falling through the gaps between service providers. *(See table.)*

Services Delivered	Mobile Crisis	Care Teams	Fire Dept.	Police Dept.	Proposed Alternative Response
Food / Water (Meals)		X			X
Clothes / Blanket		X			X
Transport	X	X	X	X	X
Case Mgmt.	X	X			X
Mental Health / Intervention	X			X	X
Immediate Response / Support			X	X	X
First Responder to Community Calls, Complaints & Concerns			X	X	X
Support for Unhoused		X		X	X

In consideration of the needs of the members of our community that are experiencing homelessness and those presenting in mental health crisis, staff is proposing the implementation of an Alternative Response Team (ART) to meet the needs and provide support to those in our community that need additional services. As evidenced with similar successful Alternative Response models, such services and support will further serve to mitigate complaints and calls for service made by San Rafael residents and business operators who are impacted by quality-of-life issues.

After a recent study facilitated by the consulting services of “Crisis Consulting” and its principal consultant, Ben Adam Climer, the implementation of an Alternative Response Team (ART) is recommended based on an analysis of Police and Fire Department calls for service. The consultant’s report is attached. An examination of the calls for service where an Alternative Response would alleviate the need for public safety responses supports the need to utilize paraprofessionals as an alternative to public safety staff employed by the City of San Rafael.

These paraprofessionals serve as “Integrated Health First Responders.” These responders will have quality knowledge of our local homeless services and will be skilled in engaging with people experiencing homelessness and grasp the unique challenges faced by people in those circumstances. In cases where a community member is experiencing regular crises secondary to their homelessness, the team will serve to bridge and connect that individual to the best supportive services available without impact on other on-duty public safety resources.

An additional advantage to the deployment of an Alternative Response Team includes the shift of the power-based, positional law enforcement model of enforcement and compliance to that of a “person first” compassionate engagement with the strong ability to build trust and develop relationships. While the Alternative Response Team does not serve as traditional “Case Managers” and are not intended to take on such a role, these service providers manage calls for service and complaints that may involve individuals known to be associated with multiple calls and can interact with service recipients as someone they know and trust helping them through

the difficult process of getting off the street or getting support services in the mental health arena.

The City's consultant advanced best practices and recommendations for the implementation of an Alternative Response Team based on the Integrated Health model. This means deploying a team of two people, one who is a mental health worker and one who with a medical certification such as an EMT. The deployment of a team of two mitigates safety concerns. The majority of first responders do not respond to requests for service alone. While it is perhaps for obvious reasons that a team might respond in pairs, it is also for the safety of those receiving a response. The deployment of two staff makes possible independent response without law enforcement on every call.

Additionally, crisis work is centered on connection and trust. Oftentimes, people experiencing mental health crises may feel intense emotional experiences that are difficult to talk about. These emotional experiences may manifest in physical experiences, or they may be caused by physical ailments. Medical personnel who can build rapport and provide support through medical evaluations create opportunities for better care.

The model most effective for an Alternative Response Team is based on a partnership with a community-based organization or non-profit social service provider to deliver and manage these services. Staff recommends a three-year pilot to deliver these services with an on-going evaluation to measure the effectiveness of these Alternative Response services in the City of San Rafael.

The City's consultant prepared cost estimates and proposed budgets to implement 12-, 18- and 24-hour deployments models of Alternative Response resources. In review of the recommendations from the consultant, staff is recommending a 12-hour deployment for the three-year pilot of these services. The proposed 12-hour deployment will primarily cover daytime hours based on the analysis of associated calls that can be diverted to an Alternative Response Unit.

Should the Council accept this staff report, staff will develop and issue a Request for Proposals (RFP) to identify and partner with a local service provider for the services described in this report. Staff will then seek approval from the Council to enter into an agreement with the selected service provider and authorize project funding.

FISCAL IMPACT: Because this is an informational report, there is no fiscal impact. The fiscal impact of this project, if approved in the future, is estimated to be $775,000 annually. Using funds from various sources including funds from the American Rescue Plan Act (ARPA), Cannabis Tax revenues, previously allocated funding from the Marin County Major Crimes Task Force as well as other potential funding sources, staff is confident in the funding sources for the three-year pilot of these services. *(See table.)*

Funding Source	Annual Allocation	Total Allocation for 3-year Pilot
American Rescue Plan Funds	200k	600k
One Time Cannabis Funds	166k	498k

On-going Cannabis Revenue	200k	600K
Marin County Major Crimes Task Force Funding	190k	570K
*AB 109 / Realignment Funding *(Potential Off Set - pending approval from Marin CCPEC)*	300k	900k
Total (Absent AB109 Contribution)	**$756k**	**$2.27M**
Total (w/ AB 109 Contribution)	**$1.06M**	**$3.17M**

OPTIONS:

1. Accept staff report on a three-year pilot Alternative Response Program.
2. Direct staff to return with more information.
3. Do not accept report and provide alternative direction to Staff.

RECOMMENDED ACTION: Accept staff informational report on a three-year pilot Alternative Response Program to deliver necessary social services for mental health and homelessness support and alleviate impacts to frontline public safety services and staff's recommendation to issue a Request for Proposals.

ATTACHMENTS:

1. Consultant's Report *(Implementation of an Integrated Health Response Team)*

REPORT ON THE IMPLEMENTATION OF AN INTEGRATED HEALTH RESPONSE TEAM – MARIN COUNTY

Ben Adam Climer

CRISIS CONSULTING 392 Douglas St. Pasadena, CA 91104

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Executive Summary

- Distinguishing Features of Mobile Integrated Health Teams
    - Staffed by a crisis intervention worker paired with a medical staff member, typically an EMT or nurse
    - Connected to law enforcement via radio in some way
    - Responds to a wide variety of calls for service that are not strictly mental health related
    - Do not require police presence on the majority of responses
- Unlicensed Crisis Intervention Workers
    - Cost less than licensed workers
    - Provide a professional growth opportunity for recent graduates

    - Does not remove licensed professionals from therapy provision
    - Can be supervised by licensed staff the way EMTs are supervised by doctors
- Data
    - A Mobile Integrated Health team could respond to an approximated 5,500 CFS and 8,800 CFS per year that would otherwise be handled by SRPD and NPD, respectively.
    - Based on data, a team could Co-respond with SRPD and NPD to approximately 2,300 CFS and 650 CFS per year, respectively.
- Vehicles
    - Mobile Integrated Health teams typically use Ford Transits or Mercedes Sprinters
    - Ford makes these as electric vehicles
    - Two vans will need to be purchased whether electric or fuel

CRISIS Consulting

Critical Responses in Supportive Integrated Services Consulting (CRISIS Consulting) was started and is run by Ben Adam Climer. Climer worked for the CAHOOTS (Crisis Assistance Helping Out on the Streets) in Eugene, OR for five years as a crisis intervention worker, EMT (Emergency Medical Technician), and part-time administrator. CRISIS Consulting has helped create four different mobile crisis teams based on the CAHOOTS model, two in Sonoma County and two in Orange County. CRISIS Consulting is also contracted with several other cities throughout California including Vallejo, Culver City, and the University California Santa Cruz.

Understanding a Mobile Integrated Health First Response

History of Its Development

In the late ‘80s, in two very different parts of the country, two different concepts evolved to create a better response from first responders to people experiencing emotional distress. In Memphis, TN, after the tragic killing of a mentally ill man, the police department developed collaborations with local mental health authorities to train their department in appropriate

responses to people experiencing mental health crises and to create a special response for these types of issues. What was born out of this was CIT (Crisis Intervention Training) for Law Enforcement Agencies (LEA) and a response model known as Co-Response.

While CAHOOTS is a specific team, I am going to refer to the CAHOOTS model primarily as an Integrated Health model. While not all the teams that have attempted to mimic CAHOOTS have been integrated health, many are. The distinctive traits of these types of teams make them the most effective crisis response teams around.

In the same year, 1988, a non-profit health clinic in Eugene, OR known as The White Bird Clinic was developing the idea for a mobile mental health response team. Up until that point, White Bird had been operating a walk-in crisis clinic and a 24-hour crisis phone line. They experienced a significant number of calls into their crisis line that necessitated an in-person response, but due to poverty, mental health, intoxication, or all three, the person calling was unable to come to White Bird's walk-in clinic.

The city of Eugene determined that they were going to hire two new police officers to increase their ability to respond to calls. White Bird proposed that instead of hiring more police officers the city should fund a mobile crisis response team. Since the police had the goal of alleviating the burden of response on the existing officers, they proposed having the team carry police radios and respond to calls for service (CFS) to which the police might otherwise respond. This was the birth of CAHOOTS. The following year, on July 4, 1989, CAHOOTS sent off two crisis counselors in a white van for their first ever shift.

As the CAHOOTS team responded to calls throughout the 1990s, they encountered a problem. Many people experiencing homelessness, mental health crises, or intoxication were

dealing with physical health issues that were contributing to the crisis. For example, at times, the team would respond to a drunk person; but when they arrived, they smelled no alcohol and the person denied drinking even though they behaved as though heavily inebriated. Later, they would discover from EMS that the person was diabetic and hypoglycemic. This is one of many circumstances where they realized that a medical professional on the team would enhance their ability to respond to crises and promote safety for the staff and clients. In the late 90s, they removed one of the crisis counselors and added an EMT onto the team. This created the first ever Mobile Integrated Health First Response team.

Distinguishing Features of a Mobile Integrated Health First Response Model

Before we can discuss the distinguishing features of this model, we need to outline other models of behavioral health response. I will elaborate on two other models: Co-response and County-Based Behavioral Health Response. These are broad models and not every team that operates within these two models operate exactly alike. While these two models are utilized throughout the country, I am going to focus on my own experience and discuss how they function in California.

Additionally, CIT should not be considered a "model" in comparison to the others. CIT is a training program that develops the skills of law enforcement officers (LEOs), builds collaboration between mental health agencies and law enforcement, and has the goal of changing how officers interact with people experiencing crises. It is not designed to get mental health professionals onto CFS the way these other models do.

Co-response

Co-response pairs a licensed mental health worker with a law enforcement officer. The officer is given enhanced CIT training, and the two of them together respond to calls that do not require enforcement actions. They are accessed the same way any officer is accessed. They have the ability to respond to CFS Code 3 (emergency response with lights and sirens), and they can write and place involuntary psychiatric (5150) holds the same way any officer in the state of California can.

The primary benefit of this model is ease of access. It effectively gets a mental health professional to the appropriate calls. It does not require the requesting party (RP) to have any special knowledge about the team. It can be easily integrated into the currently existing first responder structure. Transportation of clients is typically handled by the Co-response team in the law enforcement vehicle.

The negative aspects of this model are primarily that it does not effectively divert law enforcement from calls that do not require, by nature, a law enforcement response. This means that an agency who needs to free up officer time from lengthy behavioral health responses will be unable to do so with this model. The related problem is that people in emotional distress may be reluctant to open up or discuss freely how they are feeling with an officer on scene, even if the officer is in plane clothes. Their presence may, therefore, present a barrier to effective interventions, especially when there is no safety risk involved. Additionally, while transport is simple and more flexible than the “ER-only” requirements of EMS, law enforcement vehicles are not therapeutic spaces for someone experiencing severe emotional distress or mental health crisis.

County-based Behavioral Health Teams

In the state of California, each county operates a health authority. These health authorities were initially created as Medi-Cal distribution loci and operators of social safety nets for individual and public health. Within these health authorities, there are subdivisions. One large subdivision is behavioral or mental health. In many counties throughout the state, the behavioral health divisions of the health authorities operate mobile crisis response teams.

These teams are typically composed of two responders. Throughout the state, they are universally composed of mental health professionals. Sometimes they are composed of two licensed mental health clinicians, and other times they contain a licensed mental health clinician paired with a peer support worker or substance use counselor. They are accessed, universally, although this may be changing, by local 10-digit phone numbers that call to either a call-taker or to the response team themselves.

While some teams in the state will respond to any member of the community, others only respond to indigent or Medi-Cal recipients. They tend to only respond to what might be considered mental health crises. This means that they will often screen out requests involving dementia, autism, substance use, and other types of crises. While most of these teams are staffed by county employees, some, such as in Solano County, are staffed with employees of contracted nonprofit organizations. Some of these teams will respond independently of the police. Others mandate police presence for all responses. PMRT (Psychiatric Mobile Response Team) in LA County and MCRT (Mobile Crisis Response Team) in Marin County are examples of teams that respond without law enforcement on scene, and MST (Mobile Support Team) in Sonoma County and CAT (Crisis Assessment Team) in Orange County are examples of teams that respond exclusively with law enforcement on scene. This latter type is nearly identical to the Co-response

model. With the exception of MCRT, I have not encountered a County-based team that provides transport. Typically, transport of clients is accomplished by law enforcement or a private ambulance company.

The benefits of a team like this are that they can respond independently of law enforcement, and they are accessed by something other than Public Safety Access Points (PSAPs). PSAP is the technical terms for a 911 call and dispatch center. The positive aspects of circumventing the PSAP can be a catch-22, however. While we may see it as desirable to avoid the PSAPs for mental health calls, by circumventing them, the types of calls that the Mobile Integrated Health teams respond to are often missed by the County-based behavioral health teams. This leads to very low call volumes.

For example, in Monterey County, their county-based team, in 2017, responded to the same number of calls in a year as CAHOOTS in Lane County, OR responds to in approximately 3 weeks. Monterey County's population is nearly 200,000 more than what CAHOOTS covers. Similarly, in 2019, Los Angeles' Co-response team, SMART (Systemwide Mental Assessment Response Team), responded to 7,700 CFS. This is approximately 33% the amount of CFS that CAHOOTS responded to in the same year in a region with 5% the population of the City of Los Angeles.

In Solano County, Uplift Family Services reports that they responded to 47 CFS in Vallejo during their first three months of operation. Contrast this with the Petaluma SAFE (Specialized Assistance for Everyone) team who responded to approximately 2,000 CFS in their first six months of operation. That is more than 75 CFS per week. They doubled Uplift's quarterly responses in 10 days. Furthermore, of the 47 CFS that Uplift responded to, 9 of them were phone intervention only, and 18 of them included a law enforcement response. This means

that only 20 total CFS in their first quarter were independently handled. For comparison, 20 CFS is approximately how many calls CAHOOTS responds to every 8 hours.

MCRT and the Current System in Marin County

It should be stated clearly how mobile crisis functions currently in Marin County. MCRT is run and funded by the County. It operates 6 days per week. They are available from 8:00 am – 9:00 pm Monday through Friday and 10:00 am – 9:00 pm on Saturday. They are not available on Sundays. They are staffed by licensed and pre-licensed mental health professionals with graduate degrees in psychology or social work. They respond to any location within the county. They are accessed through a phone number that can be found on their website. Law enforcement routinely request their services, but the majority of their calls for service derive from the community. MCRT can write 5150 holds when they deem them necessary. They respond in teams of two. Additionally, they perform phone crisis interventions when possible. When I was meeting with their staff, they performed two phone interventions. MCRT has two vehicles and is able to use them to safely transport patients to Marin General Hospital's Unit B which is a short-term in-patient psychiatric unit.

According to their leadership, MCRT fielded approximately 2,500 calls in 2021. This comes to 8 calls every working day. This is significantly higher than many similar programs in the state, even programs in areas with higher populations.

Between 2/10/21 and 2/21/22, Marin County Sheriff Dispatch chronicled 241 instances when they wanted MCRT to respond, but MCRT was unable to. They were unable to for three factors: the need was after hours, MCRT did not respond to dispatch's phone call and did not call back, or the team reported that they were currently busy on a different call. 241 calls is

approximately 10% of what MCRT responded to last year. This means that with the ability to respond to every request MCSO made, their call volume would increase approximately 10%.

MCRT's leadership reports that approximately 35% of their call volume derives from San Rafael. This is disproportionate to the rest of the county as San Rafael only makes up 22.3% of the county's population. A reduction in MCRT's response to San Rafael would enable them to be more available for the rest of the county and hopefully get to that 10% of additional CFS that are going unassisted.

While we do not know the percentage of calls that MCRT takes in Novato, it was expressed by MCRT's leadership that responses to Novato are difficult due to the distance and traffic between Greenbrae and Novato. NPD and Novato's city leadership expressed that they would like to see more responses to the city. Later in this report, CRISIS Consulting will recommend that Novato utilize a Mobile Integrated Health team to manage many of their non-law enforcement calls. This will benefit their police department, but it will also enable MCRT to respond to calls more efficiently.

Mobile Integrated Health First Response

What makes this model *Integrated* Health is the pairing of a mental health worker with a medical health professional. Typically, these mental health workers are not licensed clinicians. Integrated Health teams are first responders. Mobile Integrated Health teams respond to CFS without assistance from law enforcement or EMS (Emergency Medical Services). This model is designed to respond to mental health calls such as suicidal people, people experiencing anxiety or psychosis, and other types of emotional crises. It is also designed to respond to other call types that might not get coded at the PSAP as mental health.

This model responds to welfare checks, subjects down, homelessness, attempts to contact, intoxication, and many other types of issues. Because the team is carrying police radios, it is easy for them to shift a call into a co-response if a safety need arises during the response. It is also easy for officers to request the team if they arrive to a CFS that does not require their presence.

As mentioned above, the total CFS that these types of teams respond to far outstrips the other models. In Garden Grove, for example, the Integrated Health team responded to 10 CFS per day in the first week of service. The reason for this is that the model does not screen calls out based on a limited range of types of situations that the team might respond to. Instead of a dispatcher attempting to determine if it is a mental health call from the report of the caller, the decision is made to send the team to any type of call that does not include violence or an explicit law violation. This includes public disturbances, suspicious circumstances, family disputes, welfare checks, verbal arguments, and more. Oftentimes, these end up being nothing, or they end up being mental health calls. On rare occasions, they end up needing law enforcement intervention.

When both law enforcement and the Integrated Health team are required to co-respond, this is easily accomplished because they are on the same dispatch system. This means that all the benefits of Co-response are included in this model as the model can be adjusted to be a co-response when needed.

Integrated Health also provides transport. This is an almost unique component of this model. MCRT provides transportation, but very few other non-law enforcement teams do this. TTV (Therapeutic Transport Vehicle) in LA County does, but that is a restricted model that is more akin to the County-based teams. One important note to make here is that in the County-

based model, transport is usually handled by private ambulances (Sonoma, LA, Orange, Contra Costa, Solano, etc.). This is an inefficient way to operate an Integrated Health model. It employs mental health professionals and medical staff the same way CAHOOTS does. However, it adds an unnecessary step by making the response team call for an ambulance. In every county mentioned, during interviews with their staff, I have fielded complaints of wait times of up to 8 hours from the ambulance companies. In Orange County, there have been cases in which the ambulance simply never responded.

The Usage of Unlicensed Crisis Workers

Crisis intervention and therapy share many traits. They are dialogical models of care that rely on conversation and relationship as the primary forms of care provision. They include speaking and listening as the primary form of interaction.

They possess a shared format. In both, there is a person with a problem and a professional who is there to help contextualize, normalize, and strategize about the problem. They are both a form of counseling for emotional and psychological well-being.

While fundamentally similar, there are many ways in which the two diverge. Therapy is a long, arduous process. It requires a trusting relationship through which change is made possible via difficult emotional work that takes place over months or years. The therapist has a responsibility to remain calm, stable, empathetic, and motivating with the express purpose of helping to create significant change in how their client feels about and interacts with the world.

Crisis intervention is designed to manage the client's emotional distress for the day and not for their life. Its focus is to manage the experience of moments rather than forge relationships that produce long-term changes in well-being that may prevent crises in the future. This

approach results in interactions with people who may have no interest in change or self-awareness to know that they can change. Crisis counseling also deals with the acute emotional distress created by drug use and drug withdrawal in ways that therapy is not designed for.

The primary tool of crisis intervention is rapport building that is developed through emotional validation and quickly-formed, positive, humanizing connection. Therapy relies on rapport, but it utilizes rapport differently. Its goal is to form a secure relationship that heals a person's ruptured psychosocial integration.

When the mobile component is added, therapy and crisis intervention become more distinct. Crises derive from an array of circumstances. When these crises become unmanageable within a person's psychosocial context and they are unable to utilize environmental, familial, economic, or social resources to resolve their crisis, they often end up being contacted by emergency services. Our current reliance on emergency services is what is driving the need to create new response models.

Crisis intervention is a set of skills that are centered on quick-formed connections, positive regard, empathetic listening, and the ability to develop a plan for the short-term before getting to long-term care. These are not skills that require years of schooling to develop. Many people have these skills already and can implement them with fine tuning. Furthermore, through multiple interactions with people that routinely experience mental health crises, the mobile crisis responders can build relationships. These positive relationships help reduce the severity and time spent on crises in the future.

There are several other reasons for using unlicensed staff. First, it widens the pool from which to hire. This enables greater diversity among the staff. Second, it reduces cost. Paying

unlicensed workers is simply cheaper than licensed staff who cost nearly double. Third, by taking licensed clinicians out of therapy offices and putting them into mobile teams, the local region loses therapists and program directors who can provide ongoing support using their advanced training. By taking them out of the therapy offices, this decreases the amount of highly trained staff to which the mobile team can refer clients.

As an example, I heard a story out of Marin County, a very wealthy county. A family reported to law enforcement that they were attempting to get their 12-year-old a therapist. They reported that money was no issue. They spent months attempting to find someone to help and were unable to do so. Taking six potential therapists out of the therapy clinics and putting them into a mobile team to respond to welfare checks and subjects down depletes the system of therapeutic care. It is important for teams like this to have therapists to refer clients to. Therefore, the unlicensed workers help keep therapists in therapy offices.

As a useful analogy, these mobile teams are similar to paramedics but for mental health. In EMS, paramedics are sent to medical crises and assess whether the patient should see a doctor or not. They have a limited scope of interventions compared to a doctor. Doctors do not staff ambulances. It would be prohibitively expensive and impossible to do so. Mobile Integrated Health model are the same. They assess the clients in the field and determine if the client should go see a licensed clinician. They do not need to be staffed by the licensed clinicians.

In addition to all of this, the usage of unlicensed crisis workers opens up opportunities for those who have graduated from local psychology departments and social work schools, to work a job that would prepare them for future work as therapists. Mobile crisis teams in the Mobile Integrated Health model provide excellent training for mental health workers, especially those

considering master's degrees and licensure. It could be a useful job for local graduate students who are working while getting their degree, as well.

Distinguishing First Response from Homeless Case Management and Outreach

Integrated Health First Response carries similar responsibilities to homeless outreach workers. The mobile responders need to have quality knowledge of the local homeless services system. They need to be skilled at engaging with people experiencing homelessness and grasp the unique challenges faced by people in those circumstances. Especially when a person is experiencing regular crises secondary to their homelessness, the team needs to be aware of how to connect that person to the best supportive services available.

However, outreach work and case management have some distinct characteristics that should not be confused with first response work. Case managers have case loads of clients with whom they work. First responders work with anyone and everyone. Outreach is predicated on building trust and relationship so that when housing becomes available, the person experiencing homelessness has someone they know and trust helping them through the difficult process of getting off the street. Homeless outreach and case management are designed to respond to a specific population whereas first responders respond to anyone with the city limits.

Currently, homeless outreach services in San Rafael and Novato are provided by Downtown Streets Team. In the same way that the prospective mobile response team will need to collaborate with MCRT and other first responders, it is expected that a good collaborative environment will exist between local outreach teams and the Mobile Integrated Health team.

Recommended Make-up of the Team

CRISIS Consulting recommends creating a mobile crisis team that is based on the Integrated Health model in San Rafael and Novato. This means deploying a team of two people, one who is a mental health worker and one who with a medical certification, an EMT or some form of nurse. It makes sense to contract with a local social service provider for these services in the same way that other cities have done throughout the state and have already done in four cities in Sonoma County. There are some considerations to make about this.

First, deploying a team of two mitigates safety concerns. The majority of first responders do not respond to requests for service alone. It is, perhaps, for obvious reasons that a team might respond in pairs. It is also for the safety of those receiving a response. By having a colleague present, abuse is less likely to occur. The deployment of two staff makes possible independent response without law enforcement on every call.

Second, crisis work is centered on connection and trust. Oftentimes, people experiencing mental health crises may feel intense emotional experiences that are difficult to talk about. These emotional experiences may manifest in physical experiences, or they may be caused by physical ailments. Medical personnel who can build rapport and provide support through medical evaluations create possibilities for better care. This has been shown by the development of MDT (Multi-disciplinary Teams) among homeless outreach workers throughout the state.

An example of what is meant here can be seen in the deployment of an integrated health team in Petaluma. In the first week of operation, a person who received daily response from police and EMS was engaged by the new team, SAFE. The SAFE team addressed this person's issue of homelessness, but the person was disinterested in discussing that. On second contact, SAFE offered bandages for wounds on their feet. This opened the door for further support, and a

person who had not accepted help in over five years was engaged in medical care at a local clinic and accepting case management within one week of the team's deployment.

Third, there is a consideration to be made regarding 201 rights for SRFD, NFD, and the cities as a whole. 201 rights refer to Health and Safety Code 1797 which established Emergency Medical Services legislation in California. Section 201 of that code lays out who can respond to transport to local Emergency Rooms. San Rafael currently possesses sole rights over transport in an ambulance to an ER when a medical CFS comes into dispatch. If SRFD or NFD gave away some of these transports to another organization, it is possible that an ambulance company could argue that they should have the ability to bid for the right to transport. It will not violate 201 to send a team with an EMT to mental health, substance use, and homelessness related CFS. However, it will potentially violate SRFD's and NFD's 201 rights if the mobile crisis team is dispatched to medical calls and then transports to the ER for medical purposes as though they are a *de facto* ambulance. It will therefore be incumbent upon the dispatchers and team to refrain from doing this.

There are a couple ways this team could be implemented. One is that the City of San Rafael and the City of Novato could attempt to coordinate with MCRT to station a team of a mental health worker and an EMT in San Rafael and Novato, exclusively. Another option would be for San Rafael and Novato to contract with a local nonprofit to provide services similar to how the SAFE team in Sonoma County operates. These two options would create expansion of services and would add capacity. The question becomes what is most effective, efficient, and possible.

Data Assessment

Method

CRISIS Consulting worked with San Rafael Police Department (SRPD) and their dispatchers to extract data from 2019 and 2021 regarding the call types that an Integrated Health team could respond to. CRISIS Consulting also worked with Novato Police Department (NPD). To reduce the considerable time it takes to assess the data, we decided to only use 2021 data from Novato. 2020 data has been excluded due to the COVID-19 pandemic creating anomalies in requests and responses. First, CRISIS Consulting provided a list of call types that a team could respond to. SRPD and NPD catalogued the calls that matched these call types. There were 13,634 CFS from 2019 and 13,271 CFS in 2021 from SRPD and 4,308 CFS from NPD. A subset of these calls was randomly selected then assessed for how appropriate they might be for a CAHOOTS-style response. The information put into the CAD (Computer-Aided Dispatch) for each of the calls in the subsets was put into an excel spreadsheet.

In the assessment, each CFS was assigned one of four categories: Diversion, Co-response, Possible Diversion, or No Response. The only way to know if an Integrated Health team could be sent to a call is by using the initial information given by the person calling to make a request. This person calling to request assistance is known as the reporting party or the RP in radio lingo. It is at the communication point between the RP and the dispatcher that a decision about who should be sent is made. CRISIS Consulting used this information to determine if a Mobile Integrated Health team team could respond.

From 2019, CRISIS Consulting assessed 638 CFS, and from 2021, 648 CFS were assessed for SRPD. For NPD, 400 CFS were assessed. Of the four categories of response,

Diversion, Co-response, and Possible Diversion, all represent CFS that the team could respond to. Of the CFS assessed, 453 of the CFS in 2019 could have received a response from an Integrated Health team in San Rafael. This is 71% of all CFS assessed. This gives an estimate of 9,680 total estimated responses from that year. Of the CFS assessed in 2021, 439 could have received a response from an Integrated Health team. That is 67.7% of all CFS and an estimate of 8,984 responses from that year. While the percentages in Novato were similar, the totals are lower. In 2021, of the 400 CFS that were assessed, 264 were assigned Diversion, Co-response, or Possible Diversion. This is a 66% response rate. It gives us an estimate of 2,843 total CFS per year or approximately 8 CFS per day.

The two numbers for San Rafael, 9,680 and 8,984 are very high, and most likely, they do not reflect what would be the actual call volume for a team. We were liberal in categorizing calls as "Possible Diversions." The goal was to demonstrate that an Integrated Health team can respond to more than what is typically expected of a mobile crisis team that responds strictly to mental health. Therefore, the Diversion and Co-response assignations give a better picture of what might actually be the call volume for a team. More details about what kind of responses are below.

Diversions

A CFS that is assessed as a Diversion is a CFS that, from the initial information given by the caller, could by handled by a Mobile Integrated Health team without police assistance. Frequently, objections to this model bring up the consideration of safety for the staff. In order to combat stigma toward mental health, Integrated Health teams operate with the belief that people experiencing crises are rarely dangerous toward those offering them assistance. This belief means that LEOs are not mandatory for safe responses. However, being closely linked to law

enforcement and maintaining the ability to request their assistance for safety reasons is critical. By diverting LEAs from these types of CFS, a better therapeutic environment is created.

In San Rafael, of the 638 CFS assessed in 2019, 275 of them were categorized as Diversions. This is 43.1% of the CFS that were assessed. This means that with an Integrated Health team, 5,877 CFS could have been diverted from SRPD in 2019. The numbers from 2021 are similarly promising. Of the 648 total CFS assessed, 271, or 41.8%, were categorized as Diversions. This translates to 5,550 total Diversions for SRPD in 2021. This is approximately 10 CFS per day for both years. The benefit this could provide to SRPD is large.

In Novato, 167 of the 400 CFS assessed were categorized as Diversions. This is approximately 42% of all calls or 1,799 Diversions for the year. This works out to be about five CFS per day that an Integrated Health Team could handle instead of the police. Only 14 of the 167 CFS assigned as a Diversion were between midnight and 6:00 a.m. This indicates a very low need during that time.

Of the 275 CFS categorized as Diversions in 2019, 29 of them occurred between the hours of midnight and 6:00 a.m. Of the 271 CFS categorized as Diversion in 2021, 21 of them occurred during that time frame. That equates to approximately 620 CFS in 2019 and 430 CFS in 2021. These numbers are low enough that it might not be advisable to implement a 24-hour team or at least not right away. At approximately 6:00 a.m., call volume begins to increase. Between the hours of 6:00 and 9:00 a.m. in 2021, for example, there were 28 CFS assessed as Diversions. That means that more than 10% of all CFS assessed as Diversion occurred during that three hour window.

Co-response

Some of the details of Co-response are explained above so I will not belabor the point here. What is important to note is that when the person calling makes a request for assistance, there can be public safety and mental health considerations involved. When this is the case, the Integrated Health team and LEA can be dispatched simultaneously. Unlike Diversions which completely relieve LEAs from handling social service or mental health CFS, Co-responses require the LEA's presence. However, the purpose of their presence is strictly safety. What this means is that if they arrive and the scene is safe, they do not need to remain on scene for extended periods. In this way, a Co-response in the Mobile Integrated Health model can relieve LEOs of time spent on CFS that might otherwise be prolonged interactions.

Of the 638 CFS assessed in 2019 in San Rafael, 108 of them were categorized as Co-response. This is 16.9% of the CFS that were assessed. This means that with an Integrated Health team, 2,308 CFS could have included SRPD with an Integrated Health team in 2019. The numbers from 2021 are similar. Of the 648 total CFS assessed, 114, or 17.6%, were categorized as Co-response. This translates to 2,335 potential Co-responses with SRPD in 2021. This is approximately 6.3 CFS per day in 2019 and 6.4 CFS per day in 2021. For Novato, 15%, or 60 out of 400, of the assessed calls were assigned Co-response. That comes to 646 estimated annual CFS that could involve an Integrated Health Team and NPD.

Possible Diversions and No Responses

In determining what kinds of CFS to assess, we cast a very wide net. This produced a huge number of CFS to draw from. This is not the typical method CRISIS Consulting has used in other cities where we typically narrow down the search before moving to the assessment stage. Nevertheless, the method we used in San Rafael and Novato proved to be more accurate to how

the process of dispatching an Integrated Health team works in real time. For example, most of the time, a “Suspicious Circumstances” CFS would typically go to police. On some occasions, the caller may sound as though they are reporting something suspicious because they are experiencing paranoia or are experiencing other mental health issues. There are other reasons that a “Suspicious Circumstances” call might go to a crisis team rather than police. By drawing from all of the call types that potentially had the possibility of a crisis response, we were able to see how call types that might seem to have no possibility for the team do have room for it.

70 CFS in 2019 and 54 in 2021 were categorized as Possible Diversions in San Rafael. In Novato, there were only 20 CFS assigned as Possible Diversions. There is little reason to spend much time on this. Most of these were things like jail release notifications and noise complaints outside of the restricted nighttime hours. Most of these are “Possible” Diversions because an Integrated Health team *could* respond to these, if necessary, especially if all other officers were busy. The numbers from Diversions and Co-response were high enough that we should focus on those for demonstrating what the call volume for a team would be.

As for CFS categorized as No Response, the numbers are below. While they may seem high, it is good to remember that we made the assessment very broad. The No Response calls were call types that indicated that maybe an Integrated Health team could respond, but upon further investigation, it was determined that these CFS should remain with the PD. In 2019 and 2021, in San Rafael, 29% and 32.3%, respectively, of the CFS assessed were categorized as No Responses. For Novato, 29% of all CFS were categorized as No Response.

Integrating with Local Fire Departments

CRISIS Consulting spoke at length with Jason Hatfield of SRFD. San Rafael has shown interest and leadership in developing innovative programs designed to benefit people with the highest needs. One of these programs was SRFD's Direct Connect. Direct Connect utilized nurses to evaluate and support the highest utilizers of EMS. They found this program to be useful and successful.

He reported that our EMS system correctly trains fire fighters and paramedics to be prepared for intense and dangerous situations. However, the majority of their interactions with patients are mundane and simple. He views it as an important step to deploy a team that can assess physical wellness but also manage a person's emotional and mental health needs.

While we don't have precise numbers, there were several calls for service in the data assessment section where SRFD was called to assist police during a check on a subject down. Nearly all of these calls ended with the person sleeping being woken up with no acute medical issue. This means that SRFD is routinely being sent on calls out of caution. A CAHOOTS-style team alleviates this over-deployment by making the EMT on the team the one who determines if EMS is needed after the client is contacted. This enables the vast majority of subject down and sleeper calls to receive the appropriate response of two people in one vehicle instead of seven people in three vehicles (two officer in two cars, five fire fighter-paramedics in an engine and an ambulance). Additionally, no one wants a delayed response to an actual emergency because medics are responding to someone sleeping.

Qualitative Data

Throughout the process of developing this report, CRISIS Consulting met with numerous agencies in the area. These include Homeward Bound, Ritter Center, Buckelew, Marin County Fire, Marin County Sheriffs, Novato PD, San Rafael PD, MCRT, San Rafael Fire Department, and the dispatchers for SRPD, NPD, MCSO, and the fire departments. Out of these conversations, important information was contributed.

When talking to the social service agencies, they universally expressed that there were times when they were in need of assistance with a crisis but felt that neither police nor fire were the correct response. Both law enforcement and the fire departments corroborated these observations. The social service agencies expressed interest in having a team based on the CAHOOTS-model and stated that they look forward to it. One critical component of this was the prospect of having increased capacity for cooperation facilitated through the team. The police departments made similar comments. They noted that there used to be a coordinated care team that focused on the highest utilizers of emergency and social services. They report that they hope a Mobile Integrated Health team could function as the hub for recreating a similar team.

There has been a lot of energy and willingness to collaborate in Marin County. Oftentimes, in other counties, County-based behavioral health response teams look at new responders with incredulity, but MCRT has warmly welcomed the idea of a new team. There is strong interest in working with whoever operates a new team.

The dispatchers at all departments expressed confidence that they could handle incorporating a mobile response team into their system. They indicated that they were excited about the prospect. Police dispatch in San Rafael and Novato are straightforward operations

where only two staff work at any given time. MCSO dispatch, however, is a massive operation that receives many frequent callers who are experiencing mental health crises. They dispatch for nearly all agencies in the county except for SRPD and NPD. They expressed hope that a mobile crisis team in San Rafael would free up MCRT to respond to the rest of the county with more regularity.

Homeward Bound brought up a few specific situations where an Integrated Health team could be useful. These situations are crises deriving from substance use and minor wounds in their permanent supportive housing units. They report that when their clients become intoxicated, their case managers respond but do not know what to do to support the client. They report that MCRT will not respond because it is substance use rather than mental health. They feel as though calling for EMS is unwarranted. These responses can often occur after business hours. This causes the case managers to have to work long hours which leads to overtime and burnout. With a team who could respond, assess, and assist the client, they could prevent case managers from spending long hours handling these crises.

They also report that some of their clients develop wounds due to physical health or mental health issues. They routinely taxi these clients to urgent care for assistance. They report that a team who could assess and bandage these injuries would be of great use to them.

The dispatchers expressed interest in having an expanded mental health response team capacity within the cities and county. Each dispatch brought up the situation of frequent callers who are seeking psychosocial support through dispatch and police response. They reported that having a team who could go to these clients to provide crisis counseling would be of great use to them.

A Note About Implementation

The critical component of this assessment is that this gives a benchmark by which to measure the success of the first year after implementation of the program. We expect that the number of Co-responses will be higher than our estimates in the first year as the system and the staff adjust to having the alternate team available. However, if after one year, the team's total responses are significantly lower than our estimates here, that will create a space from which we can assess the system. Is the team not being dispatched appropriately? Are they not agreeing to go to calls appropriately? Are they taking too long to respond? Are they not resolving CFS adequately?

Building Capacity and Phased Launch

Starting a mobile crisis team is an important step for all cities. Having trained staff who are skilled at behavioral health first response is a benefit to all first responders and all residents. Many people have worked doing crisis intervention, many people have worked as first responders, but few have done both. CRISIS Consulting provides training to teams in how to do this and supports contracted organizations with the development, hiring, and implementation of these teams. It is less daunting than it may first appear.

With 12-hour or 9-hour shifts, it is possible to train one group of responders at a time, but this cannot be done 24 hours a day. CRISIS Consulting, therefore, recommends starting with 12 hours per day of coverage. After running that schedule for at least 2 months, a second set of employees can be brought on and trained. Either six hours per day could be added to get to 18 hours per day, or 12 hours could be added for 24-hour coverage.

The Countywide Effects of Integrated Health Teams in San Rafael and Novato

The County is expecting to expand MCRT this year. They received a grant to do so. While this is good, it will not cover all the need that is there for an alternative response, especially in San Rafael and Novato. By implementing an Integrated Health team in those two cities while expanding MCRT, the majority of non-law enforcement calls for service within Marin County could be handled by someone other than the police and sheriffs. This would build the necessary fourth arm of the first response system that currently exists only in part. It would enable MCRT to respond to West County without feeling pressure to return quickly to cover San Rafael and Novato where a large portion of their calls derive. MCRT also might add substance use counselors to their team. If this occurs, they would be able to expand the types of call to which they respond.

The benefits to everyone in Marin County cannot be understated. These teams would alleviate police, fire, MCRT, and smooth out the systemic barriers to getting mental health workers onto CFS that do not require law enforcement or EMS. Shifting MCRT's focus to the broader county and creating collaborations between all the first responders as the mental health arm of the first response system is expanded will benefit the residents of Marin County, immensely.

Vehicles

CRISIS Consulting has provided guidelines for how the vehicles could be laid out. Typically, Ford Transit or Mercedes Sprinter vans are used. Fords are preferred because they are more cost efficient at the outset and for maintenance throughout their lifespan.

One option is to utilize the new Ford Electric Transit. These vans are the same as normal transits but are fully electric. A fully electric vehicle will save immensely on gas and maintenance. They have a short range, however, and so two vans will need to be purchased. While one is being used, the other will be charging. While this may sound expensive, even if a fuel van is purchased, there will still need to be two vans, a primary and a backup. Ford Transit and Mercedes Sprinters experience frequent service interruptions due to mechanical and electrical failures.

The vans are typically stocked with supplies such as food, water, medical gear, an AED, blankets, feminine hygiene products, and more. There are safety features of these vehicles that are added in the upfitting process. These safety features include a reinforced plexiglass barrier between the patient compartment and the crew compartment. It is advised to cover the patient compartment windows with plexiglass barriers in case of attempts of self-harm against the window glass. Other safety features are listed in the guidelines provided by CRISIS Consulting.