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San Mateo County, California
Community Wellness and Crisis Response Team

Pilot Program: December 2021 through June 2024

by the John W. Gardner Center for Youth and Their Communities

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Overview

Many 911 calls fielded by police officers in the United States involve a mental health component, prompting cities and counties across the country to deploy new models of emergency first-response collaborations between police and mental health providers. For more than two decades, San Mateo County has used several models to address community mental health-related crises.

A combination of factors—including input from community organizations and constituents—has led county leaders to seek even more approaches to address mental health crises. To do so, the San Mateo County Executive's Office collaborated with the county's Behavioral Health and Recovery Services, StarVista (a nonprofit offering counseling and crisis prevention services), and police agencies within the county's four largest cities: Daly City, Redwood City, San Mateo, and South San Francisco.

In December 2021, this partnership began implementing the Community Wellness and Crisis Response Team (CWCRT) Pilot Program, which provides a mental health clinician co-responding with a sworn law enforcement officer to 911 calls for service involving someone experiencing a mental health-related crisis.

The county engaged Stanford's John W. Gardner Center for Youth and Their Communities to conduct an independent evaluation of its co-responder program implementation and outcomes.

Co-response Implementation

Prior to the implementation of the CWCRT Pilot Program, law enforcement's responses to mental health-related crises were relatively brief and circumscribed. While officers are trained to de-escalate and stabilize a crisis situation and determine whether an individual's risk of harm to self or others warrants further action (such as an involuntary psychiatric detention, or "5150" hold),[1] law enforcement's capacity to support someone experiencing a mental health-related crisis is limited. The theory underlying the CWCRT Pilot Program is that a co-responder team will improve the quality of care that individuals receive when calling 911 with a mental health-related emergency (Gardner Center, 2024d).

1. These actions are pursuant to section 5150 of the Health and Safety Code, which provides legal authority to detain a person involuntarily for assessment, evaluation, and treatment "when a person, as a result of a mental health disorder, is a danger to others, or to themselves; or is gravely disabled due to a mental disorder," defined as being unable to provide for their own basic needs such as food, clothing, or shelter.

During the early stages of implementation, program partners were interested in learning more about the roles of law enforcement and clinicians during a co-response.[2] Drawing upon qualitative data collection that included conducting over 60 interviews and 30 observations (including police ride-alongs and dispatch sit-alongs), as well as reviewing more than 50 program-related documents over the course of the pilot program's implementation, this research brief addresses questions about the implementation of co-responder teams, specifically:

> **How do law enforcement officers and mental health clinicians collaborate when they are part of a co-responder team?**
>
> **How do members of law enforcement and clinicians experience the co-responder model?**
>
> **What factors facilitate implementation of co-responder teams?**

This brief accompanies two additional research briefs describing the pilot program's other core implementation elements of dispatch and follow-up (Gardner Center, 2024b, 2024c).

How do law enforcement officers and mental health clinicians collaborate when they are part of a co-responder team?

Our data provide evidence that the general protocol for a co-response is as follows:

Law enforcement ensures the safety of a situation. In the majority of responses, when a co-responder team is dispatched to a call, a law enforcement officer and a mental health clinician will drive their own cars to the location of the emergency (clinicians' cars are unmarked). If law enforcement is concerned with the safety of the situation, they may ask the clinician to "stage," meaning they will ask the clinician to position themselves close to—but not at—the scene and await further instruction before joining the emergency response.

The clinician assesses the individual in crisis. While the law enforcement officer is establishing the safety of the situation, the clinician typically reviews any available background information and speaks with others at the scene who can provide a health history of the individual in crisis. Once the officer indicates that the situation is safe, the clinician approaches the individual in crisis and law enforcement allows the clinician and the individual being served to have some degree of privacy during their conversation while still attending to the safety of all present. During their interaction with the individual, the clinician gathers information to assess the level of risk the individual poses to themselves or others and makes a recommendation regarding the appropriate approach to resolve the call.

Law enforcement and clinician collaboratively resolve the call. Once the clinician has completed their assessment, the law enforcement officer and the clinician come to an agreement about how to resolve the call. When the co-responder team initiates an involuntary psychiatric detention, the clinician typically completes paperwork required as part of initiating the hold, and law enforcement completes the required police report (typically discussing and/or reviewing their notes with one another prior to submission). If loved ones of the individual in crisis are present, the clinician will help them understand the team's decision, provide resources to support their loved one over the following days and weeks (including the clinician's contact information), and make a plan to follow up.

2. A version of these findings was initially shared with San Mateo County in March 2023.

Our data suggests this co-response protocol provides an effective framework that leverages the unique strengths of officers and clinicians during an emergency first response. For example, one officer described being part of a co-responder team dispatched when a parent called 911 for support with their young adult son, who was experiencing a mental health-related crisis. The son had locked himself in the family home and the parent was outside. Upon arriving at the scene, the officer determined that the individual in crisis did not pose an immediate safety threat to themselves or to others. The clinician then communicated with the person inside the home via the family member's telephone. The individual in crisis ultimately opened the door to the residence of their own accord and continued their conversation with the clinician.

This particular call did not result in a 5150 hold. Instead, the clinician worked with the individual to create a safety plan, provided the parent with guidance about how to support their loved one—including information on how to access mental health services—and set up a follow-up phone call. Law enforcement noted that if the clinician had not been part of the response team, they may not have been as effective in communicating with the individual in distress. This could have led to a forced entry into the home and/or the initiation of a 5150 hold that could have added to the individual's distress, added to the parent's distress, and potentially escalated the situation. Instead, the co-responder team effectively de-escalated the situation and resolved the call in ways that optimized the outcome for the individual in crisis and their loved one.

In describing situations like this, a clinician said, "I feel like every single piece … involved us doing things together, which … [shows] the perfect way a co-response model should work." Similarly, community members who interact with the pilot program observe the value of having both law enforcement and clinicians present during a co-response. One school administrator who had interacted with co-responder teams on multiple occasions shared:

> *I do think we need the police officer, because in [one] situation he actually removed a razor blade from a student that [they were] hiding and so we need that … but [the clinician] is that sort of softer, the person that says, "We understand what you're going through…" So it is important. I think that having both people there is really important.*

Co-responder teams also appear to follow this protocol in situations that do not include 5150 holds. For example, one officer shared the story of a car accident involving a parent (driver) and two children (passengers), in which the parent was fatally injured. In describing the clinician's role during the co-response, the officer said, "she took the kids and created stability [and] support—something our officers wouldn't have had the bandwidth to do. I hear stories like that daily."

While co-responder teams tend to quickly reach agreement about how to resolve a call, differences between law enforcement and clinician approaches to gathering and interpreting information can complicate this process in certain situations, particularly in the early stages of program implementation and/or the early months of a new hire (either law enforcement or clinician).

Many situations in which co-responder teams struggle to reach agreement involve differences in their perceptions about the threat an individual in crisis presents either to themselves or to others. For example, an individual in crisis may move erratically or suddenly in the direction of the co-responder team. Such movements could be an indication of dementia, substance use, a mental health disorder, or aggression/threat; law enforcement may have reasons for heightened safety concern and take the lead on restraining the individual. In other situations, the co-responder team may decide there is no need to restrain the client and the clinician can take the time needed to further evaluate the client, learn about their connections to community resources, and identify the next best step to optimize the client's

safety and well-being. In either case, the co-responder team will typically debrief the call to talk through their different perspectives in more detail. These conversations, which may take place informally with those directly involved in the co-response or more formally with additional colleagues and/or supervisors, provide both law enforcement and clinicians with more insight into each other's practice and improve their capacity to collaborate efficiently and effectively in the field.

Thus, while each call is unique and requires an individualized response, our data indicate that the protocol for a co-response provides an effective framework for law enforcement and clinician roles, responsibilities, and meaningful collaboration during a co-response.

How do law enforcement and clinicians experience the co-responder model?

Pilot program partners consistently report positive experiences with the co-responder model. Clinicians value law enforcement's ability to secure the situation before they interact with an individual in crisis and officers value the clinician's expertise, particularly if there is a question about whether to pursue an involuntary psychiatric detention. In addition, emergency room staff and county/community providers of mental health-related services appreciate the co-responder model, noting that the information clinicians gather during the initial emergency response informs and improves their ability to understand the situation and develop an effective treatment plan.

While the focus of the CWCRT Pilot Program is to improve experiences and outcomes for community members, our data suggest that program partners experience improvements in law enforcement's practices not only when they are part of a co-responder team, but also more broadly. Law enforcement across all four pilot cities report that their on-scene collaboration with clinicians is teaching them new ways of engaging with individuals experiencing a mental health-related crisis and they are implementing some of those strategies even when they are part of officer-only response teams. One officer described it this way:

> *With the clinician there … I can kind of see how she was doing things … there were some extra questions she would ask or maybe spending more time [talking to a person in crisis] than I would. So that's been a good thing for me. She's not there on [one of my shifts], so I'm starting to use some of the questions, and some of the things that she sees. … And so I'm picking up on some of the language that she uses, some of the things that she was looking out for, that she notices with people that I noticed too, but I wasn't able to articulate it until I read it on her [report]. … So that's been great, it's kind of opened my eyes to a lot of different ways of handling things.*

Law enforcement officers mention other benefits, as well. For example, they describe experiencing a sense of relief when their department's mental health clinician is on duty. In the words of one officer:

> *I knew [the pilot program] would be helpful. I didn't realize it would be as helpful, I guess, if I could say that. It's been … I mean, I have a lot of anxiety when she's off, when I know she's not working, you know? … That's always the thing, "Is [our clinician] working?" Because [mental health crises are] just a daily thing.*

Several law enforcement officers posit that when they are feeling less anxious, they are more likely to respond skillfully not only to co-response calls but also to other calls as well. Some shared that when they experience less work-related stress, they experience improvements in their working relationships, friendships, and marriages; they wonder if, over time, this might improve their mental health and reduce their chances of burnout.

While program partners generally report positive experiences with the co-responder approach, they are also quick to note that these experiences were not realized immediately. Implementing co-responder teams involves a learning curve during which both law enforcement and clinicians develop an understanding of each other's approaches to gathering and interpreting information. For example, during the first months of program implementation, a clinician observed that—as part of their effort to assess suicidality of an individual in crisis—law enforcement tends to ask individuals if they are thinking of "harming" themselves; the officer would interpret an affirmative response as an indication of high or imminent risk of suicide that might prompt a 5150 hold. The clinician, on the other hand, understands that thoughts of self-harm do not necessarily include suicide, so they would ask different questions to gain a more accurate understanding of the level of threat and identify other options to resolve the call.

Further, when it comes to determining the most appropriate resolution to a call, there is evidence that—in comparison to officer-only teams—co-responder teams expand the options available for resolving an emergency response. One clinician put it this way:

> *I think I have a lot more resources than the officers [do], and I think that's the biggest piece. … A lot of times I can go out and I can work with the family and get different resources out to the family and provide connections to different options. … I think that that's the biggest shift is that not everybody needs to go to the hospital. That's not the only option anymore.*

Our data indicate that it takes time for law enforcement to adjust to these different options. As a senior member of law enforcement observes:

> *In the beginning, there were times when I would get a call from an officer on the scene during a co-response, and they would say "I am not sure how this call is going to go; normally at this point we are doing X and we're not doing that yet." Essentially they were concerned that the clinician was taking their response in a different direction and they weren't totally comfortable with that. … As it turned out, … when they stopped to check in, they discovered that they were actually on the same page, it was just that [the clinician's] approach … looked different than ours.*

During the first few months of implementation, it took law enforcement officers and clinicians time to talk through these differences, which resulted in extending the average time response teams spent on-scene. Over the course of just a few months, however, co-responder teams began to collaborate more efficiently, being mindful of the time spent on an individual call without sacrificing the value of the clinician's contribution to the response. With that said, officers and clinicians adapted quite quickly: within just six months of implementation, we observe changes in collaborative capacity corresponding with a decrease in time spent on-scene.

Overall, our data indicate that across the four participating cities and the variety of situations served by co-responder teams during the pilot program, program partners experience that—in comparison to officer-only response teams—co-response teams are able to conduct a much more sophisticated assessment of an individual in crisis, develop a more

nuanced understanding of the circumstances surrounding the situation, identify a wider range of options for resolving the call, and more effectively engage the individual in crisis (and often their loved ones) in making a plan for next steps to connect with appropriate resources.

What factors facilitate implementation of co-responder teams?

Our data suggest several factors facilitate effective collaboration during a co-response:

Clear roles and responsibilities. Given the variety and complexity of the calls to which officers and clinicians are dispatched, understanding of and respect for each other's roles, responsibilities, and expertise is a key factor facilitating co-responder team collaboration. Our data also suggest that visible differences that reflect their distinct roles (e.g., uniformed officers arriving at the scene in a police car and clinicians in civilian dress arriving at the scene in a regular passenger car) effectively convey the differences in their roles to community members, which further supports co-responder team implementation.

Cross-sector leadership and implementation support. Another key factor that contributes to the success of the co-responder approach is the cross-sector leadership and support for co-responder teams, including law enforcement, each of the four participating city governments, the County Executive's Office, County Behavioral Health and Recovery Services (BHRS), and StarVista (the nonprofit responsible for hiring, training, supervising and supporting CWCRT clinicians). Cross-sector leadership and support are critical at every level, from the CWCRT Advisory Group overseeing program design and implementation at a high level, to the CWCRT Working Group supporting implementation on a more operational level, to the police captain or clinician supervisor who takes time to debrief a specific call with a co-responder team.

Mechanisms that promote formal and informal collaboration. Physical proximity alone does not ensure meaningful cross-disciplinary collaboration. Program partners intentionally employ a number of mechanisms to promote and strengthen collaboration between law enforcement officers and clinicians. Strategies promoting formal collaboration include locating clinician offices within their respective police departments, integrating clinicians into department routines such as the morning lineup, and engaging in shared professional development. Less formal mechanisms include, in the words of many program partners, "establishing good lines of communication" like seeking (and welcoming) frequent, informal, impromptu check-ins or conversations about past calls or more general topics about supporting individuals experiencing a mental health-related emergency.

Opportunities and Recommendations

We highlight one key opportunity that comes through in all of our research: the importance of improving data practices and systems to understand the holistic and long-term impact of co-responder teams. Specifically, we invite those implementing co-responder teams to consider how to improve data collection about call resolution.

Our data suggest that one of the potential benefits of a co-responder team is that it can tap into a wider range of options to resolve a call than an officer-only response team. Unfortunately, the data available to understand the full scope of these options and how they might correspond with different outcomes of interest are limited. As it stands, police agencies document certain outcomes (e.g., arrest, involuntary psychiatric detention) and clinicians document others (e.g., creation of a safety plan, connection to services, follow-up calls). These data collection activities

by officers and clinicians are conducted separately, without permissions to view or combine the data, and are not connected to long-term outcomes for the individuals served. As the program continues and expands, improving the breadth and depth of data about call resolutions will allow for more meaningful research and evaluation efforts.

The promising news is that our findings show co-responder teams collaborate effectively to support community members who request police assistance for a mental health-related emergency. As documented in the related Impact Report (Gardner Center, 2024e), this resulted in significant benefits, reducing involuntary psychiatric detentions and the number of 911 calls with a mental health component. Our observations point to the key factors that can bolster effective collaboration during co-responses, especially as additional cities and counties contemplate implementing this model.

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