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IMPLEMENTATION REPORT

Dispatch

October 2024

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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Create knowledge.
Ignite change.

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.

Dispatch Implementation

This research brief addresses research questions about the program's dispatch implementation. The CWCRT program's "Theory of Change" (Gardner Center, 2024d) focuses on the co-responder model as a strategy that would be deployed via 911 dispatch to support individuals during a crisis with a known or suspected mental health component.

Given that the dispatch of a co-responder team is such a critical element of the program design, program partners were interested in learning more about dispatch practices in the context of the pilot program. This research brief addresses the following questions designed at the outset of the CWCRT program:

How are co-responder teams dispatched?

How do those who implement the program experience dispatch?

What factors appear to facilitate dispatch?

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

How are co-responder teams dispatched?

The dispatch process for deploying CWCRT co-responders begins with a request for service. Such requests originate from a variety of sources, including:

Community members who call 911 and non-emergency police department phone lines.
Community members may call to request assistance with many types of emergencies or non-emergencies that may or may not include a mental health component.

Community members who call a clinician's direct phone line.
Community members seeking support for a mental health-related concern may call the clinician directly. Sometimes, either the clinician or the caller (at the clinician's prompting) contacts dispatch to initiate a call for service.

Community member "walk-ins" or in-person queries for assistance.
Community members may walk into a police department seeking assistance with a range of situations. After speaking with the front desk staff, mental health clinician, and/or police officer, this encounter may result in one party calling dispatch to initiate a call for service.

Officer requests.
The program design also allows the officer at the scene to determine an incident to be program-eligible even if not initially deemed so by a dispatcher. In those cases, officers contact dispatch to request the city's mental health clinician, if available.

While available administrative data do not denote which calls originate from each of these sources, interviews with program partners suggest the majority of co-responder dispatches originate from calls to 911 or non-emergency police phone lines.

Criteria informing decision to dispatch a co-responder team

As the first point of contact with callers, dispatchers listen for cues indicating the call would be well-served by a mental health clinician's involvement. At the start of the pilot program, dispatchers often listened for specific words or phrases to prompt dispatch of a co-responder team, such as a reference to a mental health diagnosis, erratic behaviors (e.g., hallucinations or delusions), suicidal ideation, or a request for assistance conducting a mental health assessment (typically originating from schools or care facilities). However, as officers, clinicians, and dispatchers became more familiar with the types of calls that are well-served by a co-responder team, the dispatch process has evolved.

First, dispatchers' criteria for engaging a co-responder team have expanded beyond listening for specific words or phrases to include:

Consideration of additional information regarding the individuals involved in the call.
For example, a call may come in requesting a welfare check at a particular address. Dispatch's query of the police department database reveals an individual at the address has had prior contact with the department's co-responder team, which may then prompt a CWCRT dispatch.

Consideration of the needs of others involved in the situation.
For example, a car accident may not initially prompt a co-response, but when it becomes apparent the accident involves a critical or fatal injury, dispatchers may send the clinician as part of the response team to support the injured party's loved ones.

Second, dispatchers rarely make dispatch decisions in isolation, but rather in collaboration with officers and clinicians. Drawing upon their diverse expertise, the group then determines whether a co-responder team is needed. For example, a caller may not say anything to indicate there is a mental health component to their situation. However, upon hearing the call dispatched over the police radio, the clinician may recognize the call involves someone with whom they have had previous contact through an encounter that would not appear in police agency records (e.g., from the city's homeless outreach team). In such cases, the clinician will communicate over police radio to let the responding officer and dispatcher know of their prior contact with the individual. In these situations, the officer will typically respond by asking the clinician to join the response team and the dispatcher will attach the clinician to the call.

We also find that while dispatch decisions are informed by dispatchers, clinicians, and police officers, it is ultimately the officer who determines whether a clinician will join a response team, since the officer bears responsibility for ensuring the safety of all parties involved in an emergency response. Even so, we find no evidence suggesting officers are barriers to co-responder dispatch; to the contrary, our analyses suggest officers generally prefer responding to calls as part of a co-responder team.

In addition to observing the many factors informing a decision to dispatch a co-responder team, we also observe a few considerations that inform a decision not to dispatch a co-responder team:

Safety.
Dispatchers do not immediately dispatch a co-responder team if there is a credible safety concern for anyone involved in the call, including community members, clinicians, officers, and other first responders.

Fire/medical response.
Dispatchers do not typically send a clinician when a call consists primarily or exclusively of a fire or significant medical situation. There are exceptions, but the majority of fire/medical calls to which police are dispatched will not be served by a co-responder team.

Resources.
Only one full-time clinician works with each police agency; dispatchers, officers, and clinicians are mindful of dispatching co-responder teams to situations that can benefit most from the presence of a mental health clinician. For example, if a non-emergency call comes in regarding a "welfare check" or a "suspicious incident" without any indication the situation involves a mental health concern, a dispatcher may first send an officer to respond and learn more about the situation before deciding whether to dispatch a clinician.

Overall, in emergency situations we find dispatchers will send a co-responder team when there is some indication that those involved could be well-served by the immediate support of a clinician. In non-emergency situations, dispatchers, clinicians, and officers all contribute to decision-making. Our current findings suggest all involved believe this collaborative process works well.

How do those who implement the program experience dispatch?

Data suggest dispatchers and officers appreciate opportunities to engage a skilled mental health clinician to support community members who are in distress. Overall, they perceive co-responder dispatch processes going "very smoothly," noting it is similar to their experience dispatching other special units (e.g., chaplains). In terms of clinician availability and response, clinicians have a number of additional responsibilities (e.g., required paperwork, professional development, clinical supervision, follow-up after a co-response) that impact the time they are available to be dispatched. Even so, most program partners feel that having one full-time clinician on duty at a time allows them to meet current demand; a clinician is rarely needed in two places at once. Partners agree, however, that it would be helpful if co-responder teams could be available 24/7.

Since the onset of the program, dispatchers and clinicians have experienced a reduction in the number of calls coming from individuals who call 911 frequently (e.g., multiple times/day or week) seeking support for mental health-related concerns. Dispatchers attribute this shift to co-responder teams being more effective at supporting callers who struggle with complex and/or chronic mental health challenges. They posit that as community members' needs are better understood and addressed, they rely less on 911 to access support. According to one dispatcher:

> *There was one person that used to always call. … He [had a complex mental health diagnosis]. … The only thing we can do is either put him on a hold, a 5150 hold … but then after 72 hours … they put him back out there, [and we] get a call, literally, right when they get released from the hospital, he's calling again. … So the officer goes back out there, they 5150 him again. … But ever since the mental health clinician came, I don't know exactly what she's been doing, but definitely I've been hearing less and actually stopped hearing from him for a couple months. … We still hear from him, but way less frequently.*

Dispatchers and officers also perceive clinicians as building dispatchers' capacity in ways not anticipated at the program's inception. For example, during a large storm in January 2023, a clinician stopped by the dispatch center to offer support in case people called in need of emergency shelter. Dispatchers were already receiving such calls, but when they tried to get in touch with the local inclement weather shelter, they were being sent straight to voicemail. Before ending her shift, the clinician provided the dispatchers with the contact information for an individual who would answer their calls and help them connect community members with beds.

What factors appear to facilitate dispatch of co-responder teams?

Our data suggest four factors that facilitate dispatch of co-responder teams:

Police/dispatch precedent for working with additional units.
Officers and dispatchers were already accustomed to working with additional units (e.g., chaplains, EMTs); thus, police agencies quickly adapted processes already in place to then facilitate the dispatch of co-responder teams.

Police chiefs championing the pilot program.
When the program first launched, the police chiefs involved each championed the effort. This set the tone and expectation for supporting CWCRT dispatch throughout each police agency's chain of command.

Formal and informal mechanisms supporting collaboration among clinicians, officers, and dispatchers within each agency.
Formal mechanisms that support collaboration include locating clinicians' offices at their respective police agencies; including them in each police agency's "morning lineup" that orients officers to their shifts; and enabling clinicians to lead professional development or training for the officers in their agencies. Informal mechanisms include unscheduled conversations to pre-brief or debrief calls, quick check-ins, ride-alongs with police officers, dispatcher sit-alongs, and a variety of other efforts to consult each others' expertise. All of these efforts contribute to the ease and efficacy of collaboration related to dispatch.

Opportunities for learning and improvement across all four cities.
In the early stages of the pilot program's implementation, there were no formal mechanisms in place to help dispatchers across all four cities share best practices about the dispatch of co-responder teams. Over time, CWCRT partners created opportunities for these conversations, fostering collective learning and improvement.

Opportunities and Recommendations

During the CWCRT Pilot Program's implementation, the primary challenge of dispatching co-responder teams was that of data collection. At the onset of the pilot program, CWCRT partners were interested in tracking both "requests" (i.e., the calls for which dispatch requested a co-responder team) and "responses" (i.e., the calls actually served by a co-responder team).

While police agencies have consistently documented calls to which a co-responder team was dispatched during the pilot program, there is some evidence that they may have been less consistent in documenting all requests for co-responder teams, regardless of whether a clinician responded.

Failure to document all requests for CWCRT co-responders is likely explained by situations in which the dispatcher knows the clinician is not on duty and a co-responder team is therefore not available. Unfortunately, given these inconsistencies in data collection, we cannot make confident claims about the degree to which requests for clinicians met or exceeded availability during the pilot program.

Preliminary findings suggest there are two crucial reasons to better document community need for mental health clinicians. First, accurate counts of the number of calls that would benefit from the presence of a clinician would help establish the need for the CWCRT program broadly by geography, time of day, day of week, and time of year. Understanding patterns of need—both within and across cities—would provide program partners with the information they need to appropriately staff the program for each city and for the county more generally. For example, if cities and police agencies find the CWCRT program important and useful, accurately documenting all clinician requests, regardless of whether a clinician responds, helps city and county leaders advocate for more resources if demand for clinicians exceeds availability.

Second, documenting which kinds of calls most often correspond with requests for a co-responder team would help provide more nuanced insight into program impacts. Although it may seem obvious that clinicians respond mostly to incidents with a clear mental health component, our data suggest that clinicians are also responding to individuals experiencing distress related to many co-occurring factors, including substance use and lack of housing.

There are many different ways program partners can improve dispatcher data collection practices. One strategy to more accurately document mental health calls for service is to target specific days and weeks in which dispatchers and officers prioritize attention to recording co-response requests, helping ensure a focused yet highly accurate count of calls for a limited amount of time (e.g., prioritizing CWCRT-related calls for 5–10 days). These focused data collection efforts can then be considered a "snapshot" of clinician need in a typical day or week without imposing an indefinite expectation on dispatchers and police officers who have many other responsibilities requiring their focus and attention.

Since sharing early implementation findings among CWCRT partners, dispatch managers have taken steps to review data collection protocols and consider options such as the point-in-time data collection approach described above. As the program expands to additional cities, we anticipate that attention to dispatch—including both how and when co-responder teams are dispatched and how this is tracked—will continue to be a priority for CWCRT partners.

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About the Gardner Center

Stanford's Gardner Center conducts research in partnership with school districts, nonprofits, foundations, and government agencies to generate practical solutions that advance equity for young people and their communities.

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