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IMPLEMENTATION REPORT

Follow-up & Continuity of Care

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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.

Follow-up Implementation

This implementation brief focuses on a defining feature of the program that makes it unique from more traditional emergency response strategies: clinician follow-up focused on supporting continuity of care. Given that clinician follow-up is such a critical element of the program design, program partners were interested in learning more about clinician follow-up practices.[1]

Drawing upon substantial qualitative data collection that included conducting over 60 interviews, making 30 observations (including police ride-alongs and dispatch sit-alongs), and reviewing more than 50 program-related documents over the course of the pilot program's implementation, this research brief addresses the following questions:

What is follow-up focused on continuity of care and why is it important in the CWCRT Pilot Program?

How does clinician follow-up facilitate continuity of care?

What factors appear to facilitate clinician efforts to provide follow-up that supports continuity of care?

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

1. A version of these findings was initially shared with San Mateo County in October 2023.

What is follow-up focused on continuity of care and why is it important to the CWCRT Pilot Program?

Most of the mental health-related crises to which law enforcement respond are the result of chronic or complex factors. Resolving the acute crisis is critical, but in order to effectively address the factors contributing to the situation and reduce the likelihood of a recurrence, many of the individuals served by an emergency response team will need additional support in the days and weeks following a crisis.

Prompt, continuous, and coordinated care—what we refer to as "continuity of care"—is particularly important in optimizing the effectiveness of mental health treatment. Unfortunately, the ecosystem of mental health-related services does not often lend itself to this kind of system. Yet research suggests the most effective programs in supporting mental health are those that include an intentional focus on continuity of care (see, for example, Weaver et al., 2017; and Ruud & Friis, 2022).

The CWCRT Pilot Program's original "Theory of Change" included "continuity of care" as one of the program's core strategies (Gardner Center, 2024d). Over the course of implementation, program partners found that this language did not accurately describe this element of the program design, primarily because it implies that CWCRT clinicians provide a level of follow-up more akin to "case management." Rather, the pilot program seeks to improve continuity of care by ensuring that community members have at least one follow-up interaction with the clinician in the days or weeks following a co-response. Thus, for the purposes of framing this implementation brief, we have adopted the program partners' updated language, referring to this element of the program as "follow-up" with a focus on supporting continuity of care.

How does clinician follow-up facilitate continuity of care?

CWCRT Pilot Program partners originally expected that the program's capacity to improve continuity of care would be almost exclusively a function of the clinician's ability to follow up with a client within the first 72 hours following an initial co-response. However, our data indicate that while clinician follow-up is critical to facilitating continuity of care, its potential effectiveness is strongly linked to activities that occur before and during a co-response. Therefore, in order to describe the clinician follow-up in the context of the CWCRT Pilot Program, we need to situate it within the broader continuum of support that clinicians provide (see Figure 1).

Figure 1. Examples of CWCRT Clinician Activities Supporting Continuity of Care

During dispatch and prior to a co-response		
Listen to police radio, participate in dispatch process, participate in calls that could benefit from a co-response	Check personal clinical notes for any relevant background that could inform co-response	Check county health records to see if client is connected to county care provider(s)

During a co-response		
Interpret verbal and nonverbal cues, ask questions related to relevant history to provide insight into current situation	Evaluate level of threat to self/ others, develop a safety plan with the client	Attend to family/others present, help them understand what their client is experiencing, and how they can support their loved one
Complete paperwork with clinical notes that can be helpful to care team (e.g., PES)	Call Psychiatric Emergency Services (PES) to convey client is on their way, provide additional information, answer questions	Develop a plan for next steps with client/family including a follow-up call with the clinician

Following a co-response		
Explain to client/family which mental health services they can access given their insurance	Provide client/family with contact information for resources aligned with client needs and circumstances (e.g., insurance, access to transportation)	Encourage client to connect with their care team or, with client's permission, connect with someone on their care team to facilitate a warm handoff
Connect with PES and/or family following discharge, support client/family with the next step(s)	Serve as a thought partner to other care providers considering client's next best step	Assist other providers in locating the client (common with clients experiencing homelessness)
Help client/family navigate the system of support (e.g., apply for an identification card, persist when first attempt to get support is unsuccessful)	Care for the caregiver, ask family about their support system, help them understand and/or connect to relevant resources	Debrief with other CWCRT colleagues (dispatchers, officers, clinicians, program coordinator) to improve support of continuity of care

Note: Community Wellness and Crisis Response Team (CWCRT) clinicians employ strategies prior to, during, and following calls for service to facilitate continuity of care. Their strategies include, but are not limited to, the examples included in this table.

From the moment dispatch begins, clinicians engage in activities that support continuity of care. For example, if a clinician hears dispatch initiating a call for service to an individual with whom they have had prior contact, the clinician communicates this over the police radio and is then typically dispatched to join the response team.

During the co-response itself, clinicians assess the client, identify appropriate next steps, and help resolve the call in ways that lay the foundation for continued care. If the individual in crisis has loved ones present at the scene, the clinician also tends to take time to help them understand what they can expect in terms of next steps, answer any questions they might have, and provide them with guidance regarding how they can support their loved one.

Following a co-response, clinicians employ strategies designed to connect clients to services aligned with their needs—another critical step toward improving continuity of care. One program partner describes the importance of support following a co-response in this way:

> *Crisis work by its nature is high acuity, short term, in and out. But … more times than not, the question is: "What's next? What support is in place? What systems are in place to support longer term well-being for the client?"*

Clinician follow-up is tailored to each individual and their specific circumstances. It typically involves connecting with the client, their family members, a member of their care team (e.g., emergency room staff, social worker, or case manager), and/or an agency that is equipped to address one of the key challenges they are facing (e.g., safe and stable housing).

The majority of follow-up happens within the first 48 hours after a co-response. Situations in which follow-up may extend beyond this timeframe may include the following scenarios:

> **A co-response concludes with a client being transported to psychiatric emergency services**. The clinician follows up with the client's family the day after the co-response, keeps the case open, and, after the client is discharged, follows up with the client, their family, and/or the agencies that will be supporting the client's next steps.
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> **A co-response concludes with a clinician facilitating the client's connection with a county or community-based resource (e.g., temporary housing, social worker**). Our data indicate that it is not uncommon for a client to engage with services for a period of time and then disengage. In some of these cases, clients reach out to the clinician directly for help reconnecting with services.
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> **A co-response involves a client who has a diagnosed but untreated mental health disorder in which the presenting crisis is resolved and the individual remains at home, often in the care of their loved ones**. In some of these situations, when the clinician calls to follow up a day or two after the initial co-response, neither the client nor their loved ones may be interested in connecting with resources for further support. A few weeks later, however, the client's loved ones may call the clinician seeking more information about available services and ask the clinician to facilitate a warm handoff to a county or community-based service provider.

What factors appear to facilitate clinician efforts to provide follow-up that supports continuity of care?

Our data highlight four factors that facilitate clinician efforts to provide follow-up that supports continuity of care:

Effective dispatch and co-responder team collaboration. Effective dispatch processes and co-responder team collaboration lay the foundation for effective follow-up. Thus, the factors that support dispatch and co-response also support follow-up and improve the program's capacity to improve continuity of care.

Clinicians' clinical and contextual expertise. Clinicians' clinical expertise expands the capacity of emergency response teams to understand the needs of an individual in crisis, but their contextual expertise—their working knowledge of available resources and their investment in developing and nurturing relationships with individuals throughout the local mental and behavioral health ecosystem—is equally important when it comes to the pilot program's capacity to support continuity of care.

Clinician discretion related to follow-up. One of the biggest factors contributing to the pilot program's ability to support continuity of care is how the general parameters for follow-up established by program partners leave room for clinician discretion. Given the variety of individuals and situations served by co-responder teams, follow-up looks different from case to case. As one clinician noted, "The flexibility to make that call from a clinical perspective is important. … [The client] may need three calls, or they may need some connection to services that they can't do by themselves; this kind of discretion for the clinician is important."

Mechanisms facilitating a clinician-community therapeutic alliance. One of the key conditions for providing effective care is creating a "therapeutic alliance," or a collaborative relationship among clinicians, caregivers, and clients. Some of these mechanisms include having clinicians wear civilian dress and drive regular passenger cars; structuring the clinician's role as a full-time position with a consistent schedule within a specific police department; and involving the clinician in community outreach activities such as community meetings, events, and homeless outreach teams. All of these promote clinician-community interaction and rapport building that lay the groundwork for a therapeutic alliance that facilitates follow-up focused on continuity of care.

Opportunities and Recommendations

The CWCRT Pilot Program's approach to following up with clients in ways that support continuity of care is still evolving, but it is clearer today than it was at the start of the pilot program. Notably, our data suggest clinicians build on the work they do during dispatch and co-response to engage in a variety of follow-up activities that focus on building:

- The client's capacity to connect to appropriate resources; and
- The county behavioral health ecosystem's capacity to provide coordinated care over time and across agencies and sectors.

Our data suggest clinicians are playing an important role in brokering individuals' access to community mental health services and resources. Clinicians are also shaping a holistic approach to public safety by developing relationships and serving as advocates connecting those in mental health crisis to critical services. The pilot program thus appears to be making progress toward its goal of improving not only continuity of care but also community utilization of mental health services and resources.

Yet the fundamental challenge related to follow-up and improving continuity of care continues to entail limitations in data practices and systems. Currently, police agency administrative data are insufficient to ascertain the number of follow-up encounters a community member experiences after being served by a co-responder team; the purpose or scope of those encounters; the degree to which they improved continuity of care; or the effect of any improvement on client outcomes.[2]

Improved data practices would support continuous learning, improvement, and evaluation of impact that could be meaningful within and across program partners and agencies involved and invested in the success of the CWCRT program. Solutions may include new or expanded data collection as well as new or expanded linking of data within and across agencies and sectors.

As program implementation continues or expands, accurate documentation of CWCRT clinician-provided follow-up will be crucial. As noted in the CWCRT Pilot Program Impact Report, indirect metrics suggest that continuity of care may be improving, but more systematic data collection and analysis are needed to speak directly to the relationship between follow-up, continuity of care, and program impact (Gardner Center, 2024e).

1. Data related to follow-up may be captured in clinicians' clinical notes; however, those are not included in or linked to police agency data.

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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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