Law Foundation
OF SILICON VALLEY

Advancing Justice
Housing | Health | Children & Youth

March 12, 2021

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County of Santa Clara
Behavioral Health Services Department
Mental Health Services Act (MHSA) Administration

RE: Law Foundation of Silicon Valley Comments on Mental Health Services Act (MHSA) Innovation (INN) Project-15: Community Mobile Response.

Dear Ms. Tirumalai:

The Law Foundation of Silicon Valley provides the comments below in response to the MHSA INN Project-15: Community Mobile Response. The Law Foundation supports a new and innovative Crisis Mobile Response (CMR), but encourage the Behavioral Health Department and Board of Supervisors to be thorough and thoughtful in creating a pilot that puts our communities experiencing mental health crises first, particularly paying close attention to the impacts of police response to our Black, Brown, and other communities of color.

I. Introduction

The Law Foundation of Silicon Valley, a nonprofit, nonpartisan legal services and social justice organization, was founded over 40 years ago and is based in Santa Clara County dedicated to advancing the rights of historically excluded and marginalized individuals and families across Santa Clara County and beyond through legal services, strategic advocacy, and educational outreach. The Law Foundation's Health program has an abiding interest in ensuring fair and due process and the promotion of the guaranteed rights of residents of Santa Clara County and California. Since its inception, the Health program has represented individuals in inpatient psychiatric facilities at due process and capacity hearings to protect their civil rights. Additionally, the Law Foundation has long fought to provides holistic legal services to people with mental health disabilities, including eviction defense and public benefits appeals. We serve communities who are historically excluded from health systems including Black, Indigenous, Latinx, Asian American and Pacific Islander, other people of color, LGBTQIA individuals and people experiencing homelessness. Our legal and policy advocacy is focused on supporting and advancing health equity for all.

We provide the following comments and suggestions to the Community Mobile Response proposal addressing community input, community collaboration, outreach, family involvement, best practices, and law enforcement involvement.

II. Community Input

For the CMR program to work, it's imperative that it have community buy in. Based on the written plan, multiple focus groups were held with a variety of stakeholders. What is unclear is how many people were involved in each of these focus groups and the breakdown of their racial, ethnic, gender identity, sexual orientation, national origin, and disability demographics.[1] It is unclear how many people with lived experience with mental health symptoms participated in the process.[2] For many people with childcare responsibilities, inflexible work hours, or disabilities that impact participation, they may not be able to participate in focus groups. Additionally, trust and public education are normally foundational components regarding increased participation for surveys of this manner and outlining how that was built clarifies context. Even within a focus group setting, some individuals may feel less comfortable speaking up. Were there any efforts made to solicit community input in other ways, such as asking health care providers or schools to send anonymous surveys?

To increase community input to assess the efficacy of the program using satisfaction surveys and a community advisory board we recommend using incentives to increase response rates and participation.[3] Absent meaningful incentives, it is unlikely these satisfaction surveys will yield much meaningful feedback. The current makeup of the CMR Workgroup Committee is predominantly people who work or volunteer in the mental health field.[4] To get more input from mental health consumers who are not as connected to the current system of care, the County may wish to consider some sort of incentive for community members to participate in quarterly meetings. Such incentives may help increase representation from historically excluded groups to ensure that their perspectives are being heard. Additionally, working directly with and taking direction from Black, Indigenous, Latinx, and other people of color community organizers who are skilled with building trust and power within communities is likely a helpful addition to considering next steps.

III. Community Education and Outreach

We support the CMR Program's plan of using Community Collaborators throughout the program process. Diverse community collaborators with lived experiences are critical for sharing program resources, facilitating training, and attending community events.

We have several recommendations regarding the Program's Outreach/Community Education Plans: (1) conduct outreach with diverse community groups and disseminate educational materials throughout the community, (2) partner with neighboring counties and cities to ensure

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[1] While some of the breakdowns suggest that at least one person from a certain community was consulted ie "Chinese Community," we are concerned that these groupings are too broad and are not nuanced enough to fully grasp what is happening within different communities. It also is important to explore these issues further to confirm that the research did not assume each community is monolithic and can be represented by a few voices.

[2] CMR Report Page 18.

[3] *See* CMR Page 25; *see also* "Research suggests three main reasons [people participate in surveys]: altruism (e.g., the survey furthers some purpose important to the respondent, or the respondent is fulfilling a social obligation); survey-related reasons (e.g., respondents are interested in the survey topic, or find the interviewer appealing); and egoistic reasons (e.g., I like it; the money). . . .The role of incentives in motivating survey participation has been widely documented. . . money is more effective than non-cash incentives. . . . Incentives are also more effective in surveys where the response rate without an incentive is low." (*See* Singer, Eleanor and Mick P. Couper, *Do Incentives Exert Undue Influence on Survey Participation? Experimental Evidence,* J Empir Res Hum Res Ethics. 2008 Sep; 3(3): 49–56, **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2600442/**).

[4] CMR pp 29-30.

consistent messaging, (3) develop a social media strategy to target youth, and (4) translate all educational materials into the most common languages spoken in the areas where the program will be piloted.

First, the CMR program should conduct outreach and distribute educational materials with diverse groups throughout the county. Groups from different races, ethnicities, cultures, socio-economic, sexual orientations and religious backgrounds must be included. While the CMR Program plans for two pilot sites in San Jose and Gilroy, the Program should consider broadening outreach as many individuals live and work in different areas of the County.[5] The CMR Program should also distribute educational materials and host events at local homeless shelters, homeless encampments, colleges, board and care facilities, food banks, legal aid organizations, and other social services agencies. We recommend that community outreach publicize the new 3-digit crisis mental health phone number on billboards, bus stops, radio and television ads. Community outreach needs to be welcoming to individuals who may not traditionally seek mental health services. Again, we also recommend enlisting help of community organizers within different communities to help with this strategy.

Second, the program should partner with crisis mental health services in neighboring counties such as San Mateo and San Francisco to share strategies and resources on community outreach. Currently, several city police departments (e.g. San Jose[6] and Palo Alto[7]) are also considering pilot crisis mental health response programs. The CMR Program must ensure that community members are not confused about the different crisis response programs throughout the Bay Area. Using a consistent 3-digit number for mobile crisis throughout the region (e.g. 998) could help build community awareness. Even with a clear communication and public relations plan, the reality is, the community knows and will inevitably call 911 out of instinct and familiarity with the number. For that reason, it is imperative that our county's 911 operators are also properly trained to re-route these calls to the new crisis mental health number or can dispatch the CMR Team.

Third, the CMR Program must also develop a social media strategy and use a variety of platforms including Facebook, Twitter, TikTok, and Instagram to spread awareness about the program. Youth are less likely than adults to seek mental health treatment despite high levels of mental health diagnoses.[8] Ninety-seven percent of teens use a social media program.[9] Using social media can help reduce stigma and educate youth about the services offered in the CMR program.

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[5] It is our understanding that these areas were chosen as the pilot. We still have some concerns regarding whether a broader survey would demonstrate a difference in where the pilot should happen. Creating a program in an area that is likely already overly policed without integrating it into a broader policing strategy is likely something that community members would want to discuss.

[6] SJPD Begins Reimagining Mental Health Crisis Response, San Jose Police Dept., Oct. 15, 2020 https://www.sjpd.org/Home/Components/News/News/125/262.

[7] Sue Dreman, Palo Alto police to pilot psychiatric-emergency team https://www.paloaltoonline.com/news/2017/01/12/palo-alto-police-to-pilot-psychiatric-emergency-team

[8] Adams, S. H., Knopf, D. K., & Park, M. J. (2014). Prevalence and treatment of mental health and substance use problems in the early emerging adult years in the United States: Findings from the 2010 National Survey on Drug Use and Health. Emerging Adulthood, 2(3), 163-172.

[9] Mayo Clinic Staff, Teens and social media use: What's the impact?, https://www.mayoclinic.org/healthy-lifestyle/tween-and-teen-health/in-depth/teens-and-social-media-use/art-20474437

Finally, the program should translate all educational materials into the most common languages in the area where the program will be piloted. Currently, the program plans to translate all outreach and education materials and logos into the County's five threshold languages (p.18): Spanish, Vietnamese, Chinese, Tagalog, and Farsi. It is possible that the language needs in Gilroy differ from those in East San Jose and may include other languages than those needed county-wide. The Program team should research the most common languages in the pilot regions. The Santa Clara County Board of Supervisors has adopted a policy that seeks to ensure that all residents have meaningful access to County services and programs regardless of their English language proficiency.[10]

IV. Suggested Best Practices / Peer Involvement / Peer Support Workers

Peers can understand mental illness from experience and relate to mental health consumers in ways not duplicated in other clinical relationships. The experience gap between someone who has, for instance, experienced hearing voices, versus those who have not, is enormous. Peers may have insights into what to say and how to communicate with someone in a mental health crisis that is not available to those who lack this critical experience. The proposal lists titles of the mobile team members but does not specifically state whether any of these team members will be Peers.[11] Peer Support Workers should be included in the mobile teams and every effort should be made to determine what mental health symptoms the client is experiencing and to match the client with a mobile Peer Support Worker who has experienced similar symptoms. Efforts should also be made to match clients with Peers who are similarly demographically: age, gender identity, and ethnicity.

Particularly in the case of untreated, serious mental illness, the consumer's symptomology frequently taxes their familiar relationships and friendships, leaving the consumers isolated when they most need support. Mental health consumers need long-term, personal, supportive relationships within the mental health system that model and foster recovery. In addition to Peers being included on mobile teams, CMR should ensure referrals to organizations offering Peer Support will do so on a long-term basis.[12]

There are two additional reasons why integrating Peers into the system to the greatest extent possible is critical. First, mental health consumers often have mixed feelings about the mental health system as many have had negative experiences with involuntary hospitalization, seclusion, restraints and involuntary medication. These experiences break trust between the consumer and the system and cause consumers to avoid treatment. Peer Support Workers have frequently experienced the involuntary aspects of the system as well and are able to uniquely validate the consumer's feelings while remaining pro-treatment. Finally, Peers should be integrated into this new model to the greatest extent possible because Peer Support is effective. Studies show Peer Support greatly reduces rates of hospitalization; reduces number of inpatient days; increases utilization of outpatient services; and, lowers overall costs of care.[13]

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[10] County of Santa Clara, Language Access Guidelines and Procedures, https://www.sccgov.org/sites/oir/Documents/Language-Access-Guidelines-and-Procedures.pdf

[11] CMR page 14.

[12] CMR page 17.

[13] Evidence for Peer Support, Mental Health America, (Feb. 2017), https://www.mhanational.org/sites/default/files/Evidence%20for%20Peer%20Support_%20January%202017.pdf

V. Family Involvement

We appreciate that the plan recognizes that in many cases family members can help to make people experiencing crises feel more comfortable and supported. At the same, time we recognize that for some people their family members could be triggering. Even in cases where the family is not the source of the problem, people with mental health conditions should be given autonomy to make their own decisions about their treatment. We want to flag that the individual who is experiencing the crisis should be given the opportunity to decide whether they want family involvement in a private conversation outside of their family's earshot. Additionally, we would like to ensure that the individual in crisis can select support people to be involved who are not blood or legal relatives.[14]

VI. Law Enforcement Involvement

The proposed plan suggests "limited involvement" from law enforcement, however we recommend removing law enforcement altogether.[15] The purported purpose of the CMR plan is to reimagine how to address the mental and physical safety of those who are frequently put in danger by insufficiently trained officers. Having improperly trained law enforcement officers as a built-in "back-up" at the responder's discretion will inevitably lead to situations that are dangerous and life threatening to our community. Since 2015, law enforcement officers have shot more than 1,400 people with mental illness.[16] Additionally, studies do not show that bias training leads to changed behavior within law enforcement agencies.[17] We are especially concerned that Black and Latinx individuals with mental illness will be disproportionately impacted and the due to the lack of cultural competency, any interaction will be escalated.[18]

Having a mental illness is not a crime. Experiencing suicidal ideation is not a crime. Having a substance use diagnosis is not a crime, yet, too often police officers are the first responders to mental health emergency calls – a response that criminalizes mental illness and increases fear, trauma, stigma, shame, and mistrust. A system that allows law enforcement officers to appear on the scene will likely do nothing other than increase the risk of an altercation and a tragic outcome. If the CMR plan is to work effectively, there can be no police involvement. Relatedly, are the currently budgeted amount and staff allocations adequate to offer full services twenty-four hours-a-day, seven days-a-week? I f there is only one licensed program manager for the team who can write 5150s, will this lead to more police calls after standard business hours?[19]

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[14] For example, many LGBTQ individuals create chosen families whose support can be vital in addressing healthcare emergencies. (*See "We Just Take Care of Each Other": Navigating 'Chosen Family' in the Context of Health, Illness, and the Mutual Provision of Care amongst Queer and Transgender Young Adults*, Nina Jackson Levin, Shanna K. Kattari , Emily K. Piellusch, and EricaWatson, Department International Journal of Environmental Research and Public Health (Oct. 2020) https://www.mdpi.com/1660-4601/17/19/7346)

[15] CMR page 16.

[16] https://www.washingtonpost.com/graphics/investigations/police-shootings-database/

[17] "NYPD Study: Implicit Bias Training Changes Minds, Not Necessarily Behavior" NPR, Sept 10, 2020, *available at* https://www.npr.org/2020/09/10/909380525/nypd-study-implicit-bias-training-changes-minds-not-necessarily-behavior.

[18] Black, Disabled and at Risk: The Overlooked Problem of Police Violence Against Americans with Disabilities, TIME, June 25, 2020, *available at* https://time.com/5857438/police-violence-black-disabled/. The article outlines that it is important to understand disability framing specifically from Black and other people of color by stating ""Disability is commonly understood through a white and wealth privileged lens," says Lewis, the lawyer with HEARD, who helps disabled people facing violence and incarceration across the country."

[19] CMR page 15.

Additionally, the plan proposes emergency medical technicians (EMTs) as part of the response team.[20] Often EMTs are trained to call police in crisis situations and do not have proper crisis training. Having responders who may be associated as a usual first responder often associated with the police, may lead to further escalation of the crisis and the client's mistrust of the CMR team.

Instead, as we've suggested, the use of purposeful, deliberate, patient, empathic interventions in a crisis is needed, and is a complex skill that takes years not hours of training and practice. None of which means the necessary inclusion of law enforcement. The proposal suggests that if law enforcement is needed, officers trained in Crisis Intervention Training (CIT) be dispatched.[21] A master's degree in social work, for example, requires at least 900 hours of supervised field experience in addition to two years of course work, whereas CIT training is considered complete in a matter of hours. No law enforcement officer responding to a mental health crisis will be better equipped to handle that situation than a trained mental health professional. Just this fall, on October 26, 2020 two Philadelphia police officers responded to a call of a man experiencing a mental health crisis. Instead of engaging in any form of crisis stabilization, or de-escalation, the officers fired multiple shots killing Walter Wallace, Jr.[22] The police responding to Mr. Wallace's family's call likely escalated the situation leading to Mr. Wallace's death. And this murderous history is deeply entrenched in policing Black communities as Eleanor Bumpers, a Black womxn with a history of mental illness, was shot and killed by NYPD officer Sullivan while attempting to assist the marshals in her eviction.[23]

Most upsetting among the general population is the incorrect perception that people with mental illness are so dangerous and out of control that only police are equipped for the job. This is far from accurate, according to the American Psychiatric Association, most people with mental illness are not violent, not criminal and not dangerous.[24] In fact, people with mental illness are more likely to be victims of crime, and "rhetoric that argues otherwise will further stigmatize and interfere with people accessing needed treatment."[25] If this program is to be truly innovative we need to take a radical step away from law enforcement and other public first responders including EMT/paramedics and fire departments.

VII. Additional Recommendations

a. Critique and Analysis of the Current Mobile Crisis Response Team

The CMR pilot proposal provided no critique of the current Mobile Crisis Response Team (MCRT) in Santa Clara County. How much has been spent on the current program? How successful was the program? As the County looks to spend twenty-five million dollars on this proposal an evaluation and assessment on what worked and didn't work, as well as the cost of prior attempts at Mobile crisis. Was there any cost savings associated with MCRT? Has there

[20] CMR page 14.
[21] CMR page 16.
[22] https://www.nytimes.com/article/walter-wallace-jr-philadelphia.html
[23] A short history of Black women and police violence, Generocity, June 12, 2020, *available at* https://generocity.org/philly/2020/06/12/a-short-history-of-black-women-and-police-violence/.
[24] https://www.psychiatry.org/newsroom/news-releases/apa-condemns-loss-of-life-from-gun-violence-disputes-link-to-mental-illness
[25] *Id*.

been an analysis of how the CMR program can create cost-savings from the county budget through treatment over hospitalization and incarceration?

b. Program Assessment

When assessing the success of the program, we hope that the county will compare the rates of use and reduction in use of jail and hospitalizations to both pre-COVID and post-COVID rates. As the proposal explains, there was a significant increase in MCRT calls and 5150s in 2020.[26] However, 2020 posed unique challenges for our community including job loss, financial insecurity, loss of loved ones, fear of a pandemic, and social isolation. The level of need for CMR services may vary depending on the trajectory of the COVID emergency and our economy. As a result, we hope that any assessment of the need for and efficacy of the program factors in these environmental issues.

c. The CMR Team Must be Culturally Responsive and Representative

We appreciate the plan's aims to have members of the call center and CMR team who are representative of the communities being served, are culturally responsive, include mental health consumers, and include multiple language capabilities. To achieve these goals, we recommend compensating all members of the team for their services and expertise, even in planning. Given significant disparities in income for Black, Indigenous, and other People of Color (BIPOC) communities and the fact that the neighborhoods this project is targeting are largely lower income, many people from these communities would be unable to volunteer their time to assist with the call center or as part of the CMR team.[27] Moreover, regardless of their income, the expertise that BIPOC people bring to this effort is invaluable. If compensated, these roles would be more likely to get well-qualified applicants who fulfill the program's goals of reflecting the communities served.

Research shows that high-quality mobile crisis response teams can result in significant cost savings.[28] Should the county wish to maximize these cost savings, it should invest in having enough paid staff on the CMR team who meet its aims of being culturally and linguistically responsive and including peer support.

d. Follow-Up to Provide Linkages to Services.

We commend the plan to follow up with clients twenty-four to seventy-two hours after CMR interventions to link them to follow up services. One thing to consider is whether, "face-to-face engagement may be warranted or even necessary when the individual cannot be reached by phone."[29]

In conclusion, we appreciate the initial efforts to create a space that starts to reimagine less policing for crisis intervention. However, for the reasons outlined above, we believe there is

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[26] CMR page 11.
[27] CMR page 13.
[28] SAMHSA's *National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit* cites research showing that "mobile crisis intervention services can reduce costs associated with inpatient hospitalization by approximately 79 percent." p. 19 https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf.
[29] (*See* https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf p. 21).

more to be done to truly create a space where the most vulnerable members of the community feel safe and seen during crisis interventions. We are available to discuss any of the points made and encourage you to work with BIPOC organizers for next steps in additional outreach to the community.

Respectfully Submitted,

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Abre' Conner, Directing Attorney
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