

MHSF Crisis Diversion Unit Recommendations (DRAFT for January 25, 2022 meeting)

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Second Discussion Group participants (2/8/22): Andrea Salinas (Captain), Monique Le Sarre (IWG Chair), Kara Chien, Steve Fields

Process

- **September- November 2021 IWG meetings on Crisis Diversion Unit:** see meeting [PowerPoints, minutes and recordings](#)
- **Issue Brief, Crisis Diversion Unit:** See [issue paper on IWG website](#)
- **November 9 IWG Crisis Diversion Unit recommendation brainstorm:** During the November meeting, the IWG brainstormed potential recommendations for the Crisis Diversion Unit (see [group brain storm in meeting minutes](#))

Principles group applied to all recommendations (from the framework)

For each recommendation, ask, “does this recommendation...”

1. Reflect evidence and/or community based best practices, data, research, and a comprehensive needs assessment.
2. Prioritize mental health and/or substance use services for people in crisis.
3. Provide timely and easy access to mental health and substance use treatment (low barriers to services).
4. Create welcoming, nonjudgmental, and equity- driven treatment programs/spaces where all individuals are treated with dignity and respect.
5. Utilize a harm reduction approach in all services. (*Harm reduction is a public health philosophy, which promotes methods of reducing the physical, social, emotional, and economic harms associated with drug and alcohol use and other harmful behaviors on individuals and their community. Mental Health SF shall treat all consumers with dignity and compassion, and shall provide care without judgment, coercion, discrimination, or a requirement that clients consumers stop engaging in specific behaviors as a precondition to receiving care.*)
6. Maintain an adequate level of free and low-cost medical substance use services and residential treatment slots, commensurate with the demand for such services.
7. Facilitate the integration of mental health and substance use services to ensure that individuals experience treatment as one seamless and completely coordinated system of care, organized around their individual needs.
8. Include sufficient resources to assure that workers associated with the project are paid a parity wage with public employees

9. Consider a continuum of services that range from low barrier and voluntary to conservatorship/involuntary services, when appropriate.

Draft Recommendations from the Discussion Group

NOTE: The following recommendations were developed in alignment with specific parts of the MHSF ordinance. Associated language related to the recommendations is indicated in *italics*.

Section (iv) Mental Health Urgent Care. Mental Health SF shall include a Mental Health Urgent Care Unit that shall offer clinical intervention for individuals who are experiencing escalating psychiatric crisis and who require rapid engagement, assessment, and intervention to prevent further deterioration into an acute crisis or hospitalization. Such facility may, but shall not be required to be, located at the Mental Health Service Center.

Overarching Goals/Vision for the Crisis Diversion Unit should include:

- A) As described in the MHSF ordinance provision of short-term voluntary sub-acute crisis stabilization mental health services.
- B) The program should align itself along the continuum of care with purpose of stabilization and abatement of symptoms for the purpose of readying an individual to engage in lower level of care treatment-the next step along the continuum of care the individual is ready to partake in for continued engagement in care, further stabilization and symptom management toward long term goal of health maintenance, maintenance of housing or linkage to stable permanent housing.
- C) The program should utilize a strength based, client centered approach to engaging individuals in their care and maximizing individual agency in their treatment planning decisions no matter where they lie along the continuum of readiness to engage in services.
- D) All individuals who wish to participate in an acute diversion program, residential dual diagnosis or substance use residential treatment should be referred and linked to that program with no gaps in their treatment plan of care. If a program is not available, individuals will receive an interim residential solution where they can be maintained on the wait list and tracked until the program bed becomes available.
- E) CDU staff must collaborate with the individual's outpatient mental health provider to ensure current treatment plan goals are supported and continuity of care.
- F) Initiate linkage to outpatient treatment if the individual is not already linked to a provider, be it a long-term provider or short-term linkage provider if there is no long-term outpatient treatment availability.

In order to achieve the recommended vision and goals we assert the need for the following program objectives:

1. This is a 24/7 facility that is able to take individuals that self-present, that are referred by their mental health provider, or emergency personnel. The length of stay should be up to 5 days for stabilization and the opportunity to engage in treatment.
2. The facility will be staffed by nurses and prescribers at all times, including options for telehealth during off peak hours. The prescriber will be able to complete a psychiatric assessment and start

an individual on medications if they are not already on a medication regimen. Should they present to the program without their medication there should be a mechanism through the CBHS pharmacy to obtain their medications quickly. Medical staff should participate in the development of the treatment plan and strategy to engage in treatment.

3. The facility should be able to accept and treat individuals with complicated behavioral presentations, particularly those with co-occurring substance use disorders. As such there should be a high threshold for behaviors that occur in the context of emotional dysregulation. The program facility should be designed to accommodate individuals who need limited stimulation such as isolation rooms, and other quiet space for those who cannot tolerate much socialization.
4. Staff should be trained and competent in crisis management and de-escalation interventions, trauma informed care, harm reduction, and strength based case management.
5. In all instances where an individual desires, expresses willingness, or expressly requests further treatment or support in linking to resources for after care they should be referred and linked upon discharge. Staff should utilize a client centered approach to collaboratively craft appropriate disposition plans for all individuals who enter the CDU regardless of where the individual is willing to engage along the spectrum of care that meets their current expressed interest and presenting needs. For example, if the individual wants to transition to residential treatment services they should be linked, if the individual does not want further structured treatment but does not want to return to the street discharge to Hummingbird or a shelter/ navigation center bed, if they want to return to their encampment provide a relevant resource list.
6. Participation in the CDU services are optional. Clients can exit the program at any time. Punitive measures should not be taken if the client refuses to engage in treatment. Individuals cannot be suspended from services unless they present a health or safety risk to other participants and staff. However, should a situation arise in which a person presents a danger to themselves or others staff are obligated to conduct a 5150 advisement and Tarasoff reporting as the particular situation warrants.
7. The program should be able to accept individuals regardless of justice system involvement particularly individuals with 290's.
8. The program should be able to accept individuals who will need medical care for withdraw management from alcohol and opiates while they are in the program.
9. Transportation should be provided to individuals who are leaving the CDU to the next point of their treatment or other stabilization services. We understand the intention of this clause to be that BHS create a transportation service to assure that BHS clients are successfully linked to any programs along the continuum of care.

[Specific associated ordinance language: Part One: Section (v) Transportation. Mental Health SF shall provide prompt, accompanied transportation from the Mental Health Service Center to off-site treatment programs. Mental Health SF shall also provide transportation to individuals released from San Francisco County Jail and General Hospital's PES unit to the Mental Health Service Center]

10. We assert that it is in keeping with the above section and clause, and overall intent of the MHSF ordinance to more efficiently organize and provision services across the DPH spectrum of care that the CDU make available live bed availability in order to facilitate referrals from emergency responders and mental health providers.

[Specific associated ordinance language: SEC. 15.104. MENTAL HEALTH SF. (a) Findings (7) The inability to receive timely treatment has discouraged many people from accessing the services they need. Wait times for services are a major barrier to treatment, but the Department's BHS program as of 2019 lacks a systematic way to track the availability of spots in treatment programs in real time. AND Part Two: (A) Real-time Inventory of Program and Service Availability. The Office of Coordinated Care shall be responsible for conducting and maintaining an up-to-date inventory of available openings in all City-operated and City-funded mental health and substance use programs, and to the extent that data is practically available, in private, state, and federal facilities that offer mental health and substance use programs.]

11. BHS should provide the following data, collect additional data and analyze this data to improve service provision at the CDU, and continue to develop programs to meet the diverse needs of individuals who utilize BHS services:
- a. a map/diagram of the entire system of care to demonstrate where the CDU and other programs created by MHSF meet the mandate of the MHSF ordinance to create a seamless system of care.
 - b. In order to meet the standard of care outlined in MHSF, the CDU must maintain real time bed availability. This will facilitate the referral and linkage of individuals to the CDU by emergency responders and mental health treatment providers.
 - c. Prior to the CDU opening performance objectives must be developed and submitted to the IWG for review in order to ensure that the program is aligned with the intent of MHSF in creating a coherent system of care that maximizes efficiency, and ensures accountability to consumers and the community.
 - d. Data that must be collected that ensures the program is meeting performance objectives, measures program success and interconnection to the entire system of care includes:
 - 1) Individual length of stay,
 - 2) If a client leaves without linkage to further services or resources the reason why, for example not ready to engage, responsibilities to care for other individuals or pets, fearful, don't want to share a room with a stranger. This data should be collected and evaluated to determine future program design to address expressed needs of consumers. BHS can look to already existing program models to fill treatment gaps identified such partial hospitalization or intensive day treatment programs.
 - 3) If individuals are linked to a residential program, which program

- 4) If individuals are linked to another community resource such as Hummingbird, navigation center, shelter and which program.
- 5) Recidivism should be tracked, and for those individuals that return multiple times over the course of a year identify what is preventing them from engaging in treatment post discharge.
- 6) If individuals are referred to an outpatient treatment clinic, which program. If they are already enrolled in an outpatient program what is the follow up plan with their provider.

[Specific associated ordinance language: SEC. 15.104. MENTAL HEALTH SF. {13} A 2018 audit of BHS conducted by the San Francisco Budget and Legislative Analyst ("2018 BHS Audit") found that under the then-current system, which was still operative in 2019 BHS does not systematically track waitlist information for mental health and substance use services. Waitlists, when they are maintained, are generally kept by the individual service providers and not aggregated or evaluated by BHS. Because BHS does not compile and track waitlist data in a format that allows for analysis of point-in-time capacity or historical trends, there is limited information about BHS capacity across all mental health and substance use services. (16)To remedy many of the problems discussed above, Mental Health SF is intended to create a seamless system of care where no one will fall through the cracks.]

12. The county should explore avenues at the state level to change existing Medi-cal reimbursement rules so that the county can bill Medi-cal for services provided at the CDU beyond 23 hours of client stay. We should look to our local elected state officials to sponsor such legislation. Legislators such as Scott Weiner have been big advocates for expanding avenues to treatment.
 - a. If on the state level medi-cal reimbursement beyond 23 hours for crisis stabilization treatment cannot be amended to cover up to 5 days crisis stabilization coverage the program should be developed as a hybrid model of crisis stabilization/ADU in order to cover operational costs of such a program.
13. Given the stated intent of the MHSF legislation (see below in italics) it is imperative that the CDU and all programs created by the MHSF ordinance are situated along a spectrum of care with the vision of stabilization and long term housing placement. It is an undisputed fact that individuals require stable permanent housing if they are to effectively engage in healthcare. In 1998 DPH created the Direct Access to Housing Program, expressly to meet the need of unhoused individuals with complex medical needs: co-occurring mental health, substance use disorder and medical needs. As MHSF re-emphasizes this joint charge of DPH and HSH it is imperative that there be greater coordination and collaboration between both departments and providers of said departments, and reporting to the MHSF Implementation Working Group and the Prop C Oversight Committee. Further, up to this juncture the MHSF programs being created appear to be thus far entirely funded by Prop C. There must therefore be greater coordination in the planning and implementation of new programs between MHSF IWG and OCOH oversight committee. As such it is necessary that a joint meeting be scheduled between the two bodies as soon as possible.

[Specific associated ordinance language: SEC. 15.104. MENTAL HEALTH SF. (3) According to the City's Point-in-Time Count conducted in January 2019, there are about 8,000 people experiencing homelessness in San Francisco on any given night. But over the course of an entire year, many more people experience homelessness. According to the Department's records, in Fiscal Year 2018-2019, the Department and/or the Department of Homelessness and Supportive Housing ("HSH") served about 18,000 people experiencing homelessness. Of those 18,000 people, 4,000 have a history of both mental health and substance use disorders. (4) These 4, 000 people are in critical need of help, as evidenced by their high use of urgent and emergency psychiatric services. They have the highest level of service needs and vulnerability, and require specialized solutions in order to reach stability and wellness. The Department and HSH agree that people experiencing homelessness with both mental health and substance use disorders are the most vulnerable members of our community and require immediate attention and care coordination. (15) To stop the cycle of people going from residential treatment programs back to the street, the City must create additional long-term housing options, including cooperative living opportunities and permanent supportive housing (or people living with mental illness and/or substance use. Studies have shown that providing patients with long-term housing options dramatically reduces substance use relapse and supports patients through continued recovery.]