Mental Health San Francisco
Implementation Working Group
May 24, 2022
Call to Order/Roll Call
Scott Arai and Shon Buford’s last IWG meeting!

And also a big thank you to Philip Jones!
Vote to

Excuse Absent Member(s)

Decision Rule:

• Simply majority, by roll call
Meeting Goals

1. Receive brief monthly Director’s update
2. Receive an update and provide feedback on the Minna Project
3. Discuss and potentially vote on Crisis Stabilization Unit recs
4. Receive an update from the Controller’s Office on the Mental Health Service Center Options Analysis and provide feedback
5. Receive an update on the Street Crisis Response Team

All materials can be found on the MHSF IWG website at: https://www.sfdph.org/dph/comupg/knowlcol/mentalhlth/Implementation.asp
Reminder: Mental Health SF Domains

Mental Health SF Domains

Office of Coordinated Care
- Case Management and Navigation
- Overall Care Coordination
- Marketing / Community Outreach
- Inventory of Programs and Services

Street Crisis Response Team
- Pilot Phase
- Ongoing Implementation

Mental Health Service Center
- Centralized Access
- Pharmacy Services
- Transportation

New Beds and Facilities*
- Expanding Existing Models
- Drug Sobering Center
- Crisis Unit
- TAY

* (Mental Health and Substance Use Treatment Expansion)

Data and IT Systems
HR Hiring and Pipeline
Equity
Analytics and Evaluation

Marlo Simmons
Dr Angelica Almeida
Kathleen Silk
April Sloan
Eme Garcia
Yoonjung Kim
Max Rocha
Dan Kaplan
Jamila Wilson
Mike Wylie
Discussion Item #1

Remote Meeting Update

All materials can be found on the MHSF IWG website at:
https://www.sfdph.org/dph/comupg/knowlcol/mentalhlth/Implementation.asp
RESOLVED, as follows:

1. the State of California and the City remain in a state of emergency due to the COVID-19 pandemic. At this meeting, the IWG has considered the circumstances of the state of emergency.

2. As described above, because of the COVID-19 pandemic, conducting meetings of this body and its discussion groups in person would present imminent risks to the safety of attendees, and the state of emergency continues to directly impact the ability of members to meet safely in person.
Public Comment for Discussion Item #1

Remote Meeting Update

Steps:

• Call (415) 655-0001
• Enter access code 2491 802 4812
• Press ‘#’ and then ‘#’ again
Vote on Discussion Item #1

Remote Meeting “Findings”

Decision Rule:

• Simply majority, by roll call
Discussion Item #2

Approve Meeting Minutes

All materials can be found on the MHSF IWG website at:
https://www.sfdph.org/dph/comupg/knowlcol/mentalhlth/Implementation.asp
Public Comment for Discussion Item #2

Approve Meeting Minutes

Steps:

• Call (415) 655-0001
• Enter access code 2491 802 4812
• Press ‘#’ and then ‘#’ again
Vote on Discussion Item #2

Approve Meeting Minutes

Decision Rule:

• Simply majority, by roll call
Discussion Item #3

MHSF Director’s Update

Marlo Simmons

All materials can be found on the MHSF IWG website at:
https://www.sfdph.org/dph/comupg/knowlcol/mentalhlth/Implementation.asp
Public Comment for Discussion Item #3
MHSF Director’s Update

Steps:

• Call (415) 655-0001
• Enter access code 2491 802 4812
• Press ‘#’ and then ‘#’ again
Discussion Item #4

New Beds and Facilities: Minna Project Update & Feedback

All materials can be found on the MHSF IWG website at:
https://www.sfdph.org/dph/comupg/knowlcol/mentalhlth/Implementation.asp
A Different Process: Rapid Response

- Dashboard updated to include Minna Project
- Rapid nature of project required similar response from IWG
  - DPH met with members of IWG to develop understanding
  - Participating IWG members provided feedback of how to hone presentation to focus IWG feedback
  - IWG members gave initial feedback to DPH, to be summarized after DPH presentation

DPH Behavioral Health Residential Treatment Expansion Dashboard*

*https://sf.gov/residential-care-and-treatment
• Background

• Systems Gaps

• Program Overview and Models
  • Purpose
  • Program Scope
  • Site Overview
  • On-site Supportive Services

• Community Engagement

• Data and Evaluation

• Questions
BACKGROUND

• Many people in California prisons/jails have significant mental health needs
  □ CA prison inmates: 15% of men and 30% of women have SMI
  □ San Francisco county jail: 15% inmates treated for mental illness

• More than 50% of clients who are receiving services from Community Assessment & Services Center (CASC) have serious mental illness (SMI)
  □ Case manage 320 clients - 170 with SMI
  □ And of those with SMI, 50% are also chronically homeless
APD’S REENTRY DIVISION

• Design and implement a portfolio of reentry and rehabilitative services

• Operate 15 transitional housing programs (345 units)

• Housing Data FY 20/21
  ▪ 611 justice involved adults housed
  ▪ Reduced homelessness by 77,111 days
  ▪ 140 participants placed in permanent or stable housing
SERVICE GAPS

• Long wait to access permanent housing

• Challenges in accessing residential treatment programs
  ▪ Moderate to long wait to access dual diagnosis programs
  ▪ Highly structured programs that require compliance with state regulations

• High demand for more low-threshold programs for people
  ▪ May not be interested or ready for a structured program
PURPOSE

San Francisco Department of Public Health and Adult Probation Department are working in partnership to provide transitional living for justice-involved clients with behavioral health needs, focusing on providing wrap-around services for dually diagnosed clients.
• **Goal:** Improve quality of life and enhance recovery for clients with justice-involvement and mental illness and/or substance use disorder
  - Improve behavioral health of clients with justice involvement
  - Reduce repeated encounters with the justice system
  - Reduce homelessness
  - Increase transitional housing and treatment opportunities for people coming out of jail
  - Equity at the forefront of the program
OVERVIEW OF THE SITE

• Located at 509 Minna Street, San Francisco
• Used to be a commercial hotel; master leasing the property
• Newly remodeled
OVERVIEW OF THE SITE

• 75 units with private baths
• Treatment space
• Commercial kitchen and laundry facility
• Two dining rooms
ON-SITE SUPPORTIVE SERVICES

INDIVIDUALIZED SUPPORT SERVICES PROVIDED ON SITE IS THE KEY COMPONENT

DPH Clinical Services
• Clinical services
  ▪ Clinical assessment and review
  ▪ Case management
  ▪ On-site specialty MH outpatient services
  ▪ Medication management
  ▪ Individual therapy
  ▪ Group therapy

APD Supportive Services
• Property management
• Reentry case management services
• Program coordination, referrals and intakes
• On-site 12-step and support group
• Peer support
DYNAMIC PARTNERSHIP

• Department of Public Health – funding and clinical oversight
  ▪ UCSF Citywide Case Management Services

• Adult Probation Department – transitional housing and case management
  ▪ Westside Community Services
REFERRALS

• Accept referrals from: jail, BH Court, Parole/Probation Office, Pre-Trial Diversion, residential behavioral health programs, outpatient behavioral health services, hospitals, etc.
  ▪ Prioritize clients currently in the forensic system (jail, BH court, etc.)
  ▪ Receive clients graduated from a mental health residential treatment program who need ongoing support and stabilization
  ▪ Receive clients waiting for placement at a mental health residential treatment program
  ▪ Spanish monolingual clients

• Referrals can be made via the CASC website: https://www.reentriesf.org/minna (under construction)
ELIGIBILITY

• Eligibility Criteria:
  ▪ Experiencing homelessness
  ▪ SF resident
  ▪ History of justice involvement
  ▪ Mental illness and/or substance use disorder
  ▪ Independent in activities of daily living

• Expected average length of stay: about 1 year
HIGHLIGHTS

• Ribbon cutting ceremony is scheduled for June 9th, 2022.
• Phasing in of client admission through to October, starting May 2022.
• The Minna Hotel is budgeted under Proposition C (OCOH) to receive approximately $4.7 million annual operating funds, which includes master lease and on-site supportive services.
COMMUNITY ENGAGEMENT PLAN:  
PARTNERING TO ENHANCE CARE

• Positive feedback from the neighborhood:
  ▪ The local neighborhood community has been notified of the intent to situate the Minna Hotel as a community resource.

• Various stakeholders, including the BH court judges and staff, pre-trial diversion, jail and other partners, will be reached out in order to receive their inputs.

• Equity-related interviews or focus-group at CASC will be conducted to hear diverse voices from clients with SMI and/or SUD who have justice-involved history.
DATA AND EVALUATION

• The Minna Project will perform annual evaluations on
  ▪ Client benefit and satisfaction
  ▪ Transitions and connections to other services
  ▪ Racial equity

• Metrics will be aligned with other MHSF Key Performance Indicators, including measures of
  ▪ Increase in linkage to housing
  ▪ Reduction in jail time
  ▪ Reduction in repeated encounters with the justice system
  ▪ Increase in treatment opportunity

• We will also aim to measure impact across racial and ethnic groups to monitor how this program advances equity.
KEY QUESTIONS FOR CONSIDERATION

• What are key principles or design elements for the clinical services to consider/incorporate?

• Additional ideas to further support racial equity?

• What do you think are the priority measurable outcomes for behavioral health services?
Key Points Discussed

- Low threshold program
- Do not need to go through probation to have access
- Prioritizes Spanish-speaking/monolingual consumers (gap in service)
- Community engagement plan under way to hear from diverse voices who have justice involved history/suffering from mental illness/substance use
- A drug free site, but recognizes there will be drug use and people will be supported regardless
- Citywide patient services (Medi-Cal billing contractor)
- Client can stay from a month to as long as 2 years
- This will not be part of OCC - will be part of residential system of care
- Referral process managed by Westside, with DPH clinic review on a regular basis.

IWG Principles

IWG recommendations and feedback consider:
1. Evidence and/or community based best practices
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. Ensure welcoming, nonjudgmental, and equity-driven treatment programs/spaces
5. Use a harm reduction approach
6. Ensure adequate level of free and low-cost medical substance use services and residential treatment slots
7. Integrate mental health and substance use services
8. Ensure workers associated with the project are paid a parity wage with public employees
9. Continuum of services
Minna Project Feedback

Share screen for virtual white board

(white board results will be posted in meeting minutes)
Public Comment for Discussion Item #4
Minna Project Update & Feedback

Steps:

• Call (415) 655-0001
• Enter access code 2491 802 4812
• Press ‘#’ and then ‘#’ again
Discussion Item #5

New Beds and Facilities: Crisis Stabilization Unit Recommendations

All materials can be found on the MHSF IWG website at:
https://www.sfdph.org/dph/comupg/knowlcol/mentalhlth/Implementation.asp
Reminder: Mental Health SF Domains

Mental Health SF Domains

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  - Pilot Phase
  - Ongoing Implementation

Mental Health Service Center
  - Centralized Access
  - Pharmacy Services
  - Transportation

New Beds and Facilities* (Mental Health and Substance Use Treatment Expansion)
  - Expanding Existing Models (Dashboard Updates & Rapid Response)
  - Drug Sobering Center
  - Crisis Unit
  - TAY

New Beds and Facilities* (Mental Health and Substance Use Treatment Expansion)

Data and IT Systems
  - HR Hiring and Pipeline
  - Equity
  - Analytics and Evaluation

Eme Garcia
Reminder of the Recommendation Roadmap

September 28-October 26*
IWG receives background and discusses

November 9*
IWG engages in white board session to source recommendation ideas

December
Discussion Group crafts recommendations

January 25*
IWG reviews Discussion Group’s work

March-May
Discussion Group refines recommendation wording

May 24 *
Review recommendations and vote

* Occurs during monthly IWG public meetings

Conflict of Interest key
- = step out
- = be vigilant
- = all can participate
Discussion Groups Key Takeaways

Takeaways specific to CSU

• The CSU has a sustainability plan, informed by data on how long people stay and Medi-Cal reimbursement rates.

• The unit is cost effective at 8 or 16 individuals due to staffing ratios.

Takeaways larger than CSU

• Need to map the continuum of care—both to identify gaps AND ensure effective referrals and supports (connection to OCC discussion group?)

• Need advocacy for underlying issues (e.g., housing, Medi-Cal reimbursements).
Share screen of recommendations
What is your level of agreement with the current Crisis Stabilization Unit Recommendations?
Public Comment for Discussion Item #5
New Beds and Facilities: Crisis Stabilization Unit
Recommendations

Steps:
• Call (415) 655-0001
• Enter access code 2491 802 4812
• Press ‘#’ and then ‘#’ again
Vote on Discussion Item #5

New Beds and Facilities: Crisis Stabilization Unit

Recommendations

Decision Rule:

- Simply majority, by roll call
5 Minute Break
Discussion Item #6

Mental Health Service Center: CON Options Analysis Briefing and Feedback

All materials can be found on the MHSF IWG website at:
https://www.sfdph.org/dph/comupg/knowlcol/mentalhlth/Implementation.asp
Mental Health Service Center

Update #2: Benchmarking + Service Crosswalk
Background

Service Center Benchmarking

Discussion

Crosswalk of Services

Jamboard Exercise

Discussion
Overview of Mental Health Service Center (MHSC)

What is the MHSC? What does the legislation require?
Reminder: Mental Health SF Domains

Mental Health SF Domains:
- Office of Coordinated Care
  - Case Management and Navigation
  - Overall Care Coordination
  - Marketing / Community Outreach
  - Inventory of Programs and Services
- Street Crisis Response Team
  - Pilot Phase
  - Ongoing Implementation
- Mental Health Service Center
  - Centralized Access
  - Pharmacy Services
  - Transportation
- New Beds and Facilities
  - (Mental Health and Substance Use Treatment Expansion)
- Expanding Existing Models
- Drug Sobering Center
- Crisis Diversion
- TAY

Data and IT Systems
HR Hiring and Pipeline
Equity
Analytics and Evaluation
Planned Deliverables

- **Crosswalk of Existing Services** -- Identify current services, remaining gaps compared to the legislation.
- **Benchmarking** – Research several other 24/7 service models, including program structure, demand, and key lessons learned.
- **Equity Assessment** – Work with DPH’s equity leads to ensure appropriate criteria are considered in the analysis.
- **Interviews with MHSF Stakeholders** – Share findings and solicit feedback on the analysis.
- **Options + Cost Analysis** – Provide three options for a MHSC roll-out, from a standalone to a virtual center approach. Provide cost estimates for each.
- **Project Summary** – Summarize project work in a Powerpoint deck.

Planned Delivery Date = June 30
The MHSF legislation specifies the Service Center provide 6 key services.

**Assessment of Immediate Need**
Assess a patient’s need for immediate medical treatment refer as necessary and appropriate.

**Psychiatric Assessment, Diagnosis, Case Management, and Treatment**
Provide onsite consultations, diagnosis and/or referral, create a treatment plan, prescribe medications, and assign case mgmt./care.

**Pharmacy Services**
Stock and provide mental health + substance use medications at a reasonable cost 7 days a week.

**MH Urgent Care**
Clinical intervention for those experiencing escalating psychiatric crisis and require rapid engagement, assessment, and intervention.

**Transportation**
To other service sites.
From Jail and ZSFGH.

**Drug Sobering Center**
Clinical support and beds at appropriate level of care for individuals experiencing psychosis due to drug use.
Benchmarks

How do other jurisdictions provide 24/7 entry to behavioral health services? Is there overlap with the proposed MHSC?
BENCHMARKING

Methodology

Project team met with 6 jurisdictions.

Comparable Health Systems

- California Association of Public Hospitals Lists 12 counties with public hospitals
- County Behavioral Health Directors Association recommendations
- Out-of-state jurisdictions with known comparable systems
- Total = 12 municipalities

Desk Research into 24/7 Services

- Team conducted a web review of mental health programs similar to MHSC at municipalities.
- Identified 6 municipalities with MHSC-like programs.

Interviewed Jurisdictions

Interviewed 3 types of roles:
- County Behavioral Health Directors
- Directors of Call-Centers
- Directors of Drop-in Services

Also spoke with 1 vendor.
Santa Clara County

Operates a 24/7 call center and a drop-in urgent care.

Call Center—BHS Call Center
- County-operated.
- Services Provided— Operates individual call lines for mental health and substance use. Both lines provide initial screenings, counseling, and referrals.
- Staffing—Skilled screeners conduct initial screenings for both lines. Clinicians take mental health crisis calls and certified counselors take substance use calls.

Drop-In Services—Urgent Care
- County-operated.
- Services Provided— Psychiatric evaluation, diagnosis and treatment. Brief medication management, referral to services and community resources, phone consultations with clinical staff.
- Staffing—Clinical staff, Licensed Practitioners of the Healing Arts (LPHA's), and doctors. Languages spoken: English, Mandarin, Spanish, Korean, Farsi, Vietnamese
New York City

Operates 24/7 virtual model offering call/text/chat services.

Call Center—NYC Well

- **Vendor-operated.**

- **Services Provided**—Crisis counseling, information and referrals to services, and suicide prevention. Translation service to provide care in 200+ languages. All communications are anonymous unless client is being referred to care. Referrals can be made to a particular clinic, mobile crisis teams, or a number of nonprofit providers. Dispatch of mobile crisis teams occurs from 8am-8pm for individual care in the home.

- **Staffing**—Counselors and peer support staff

- **Origins**—Grew out of a suicide prevention hotline. Plans to evolve with the introduction of 9-8-8
Operates a call center (24/7) and walk-in clinic (extended hours).

**Call Center—BH Crisis Intervention Line**
- **County-operated.**
- **Services Provided**—Needs assessment of individual, referral to Cascadia health services or alternative resources.

**Drop-In Services—Cascadia Health and Planned Resource Center**
- **Vendor-operated.**
- **Services Provided**—Cascadia Health provides mental health, addiction recovery, primary care resources. They operate Multnomah’s urgent walk-in clinic with counseling services, access to prescriptions, and referrals. Cascadia mobile crisis teams are utilized for direct care.
- **Next Steps**— Opening a multi-story Behavioral Health Resource Center Fall 2022. Contracted Staff. Non-crisis space with basic care services (laundry, showers, etc.) and connection to resources, housing and mental health services. Partially funded through local bonds.
Los Angeles County

Operates a call center and 7 drop-in urgent care centers. (both 24/7)

Call Center—ACCESS Center

- County-operated.

- Staffing—Clinical and non-clinical staff with crisis and referral skillsets; licensed clinical supervisor.

- Origins—In operation since 1980s; now merging with 9-8-8 line.

Drop-In Services—Urgent Care Centers

- Vendor-operated.

- Services Provided—Crisis intervention, linkage, housing connections, and therapeutic transportation. Clients can stay for up to 24 hours.

- Staffing—Psychiatrists, nurse practitioners, licensed case workers, peer support staff, nurses to administer medications, and certain specialists (housing or case manager).

- Origins—First center opened in 2003; most have been open for <5 years.
Orange County

Operates a 24/7 in-person care center. Minimal drop-ins, with most clients sourced from law-enforcement drop-offs.

**In-Person Services—BeWell OC**
- **Public, private, and CBO partnership.**
- **Services Provided**—Substance Use Disorder Unit, Drug Sobering Center, Crisis Stabilization Unit, Crisis and Substance Abuse Residential Services.
- **Staffing**—Licensed clinicians, nursing, CRP, alcohol and drug counselors, mental health providers, and physical health providers.
- **Origins**—Initiated by a coalition concerned public and private sector experts, as well as faith-based hospitals.
- **Next Seps**—Expanding to a 100+ acre site focused on TAY and families.
Riverside County

Operates a call-center and 3 drop-in urgent care centers. (both 24/7)

Call Center—CARES Line
  - County-operated.
  - Services Provided—Behavioral health screenings and referrals. System-wide beds tracked in real-time and can be assigned during the call.
  - Staffing—Licensed CTs, drug and alcohol counselors, paraprofessional case managers, counselors, and peer mentors. In-person during the day, remote at night.

In-Person Services—Mental Health Urgent Care Centers
  - Vendor-operated.
  - Services Provided--Immediate crisis intervention support, medication services, and linkage to other services and benefits. Clients sourced via drop-ins, crisis response teams, and law enforcement.
  - Staffing—Mental health providers, nurse practitioners, and peer staff with lived experiences. Fluent in English and Spanish.
Key Lessons from Benchmarking

Common themes emerged from the 6 jurisdictions interviewed.

24/7 Models are Common
Many different counties offer some form of a drop-in center, be it virtual, brick-and-mortar, or some combination of the two.

Demand Fluctuates
Demand generally remains strong from 4am to 11pm. Can increase overnight demand through law-enforcement or crisis team drop-offs.

Marketing is Key
Lack of marketing can cause confusion about what the center is, while too much marketing can increase demand to the point that staff are overburdened.

Staffing
CSU-mandated staffing ratios can be a challenge to meet and bilingual staff with specific credentials can also be hard to find. Peer support staff is common and valuable.

Funding
Most programs rely heavily on MediCal; private-insurance reimbursements can be a challenge to secure.

None Have Pharmacies
Many offer limited medications, though supported the idea of having a pharmacy.
What stood out to you?

Do other jurisdiction’s mix or model of services match that of SF’s MHSF goals? Are there elements of other jurisdictions SF should incorporate into the MHSC?
To what extent is San Francisco currently meeting the Service Center requirements in the legislation?
Where are there potential opportunities to scale programs?
Two Ways to Conduct a Crosswalk

Program-Specific Crosswalk(s)
More in-line with the Legislation’s intent to develop a convenient one-stop shop for services, we compare the MHSC legislation to specific BHS programs:
- CDU/CSU
- BHAC
- Dore Urgent Care Center
- Tenderloin Linkage Center

System-Wide Crosswalk
Compare each service called out for by the MHSC legislation to the City’s landscape of BHS programs.

<table>
<thead>
<tr>
<th>Do BHS Programs Meet MHSC Requirements?</th>
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</thead>
<tbody>
<tr>
<td>Meets</td>
</tr>
<tr>
<td>Partially Meets</td>
</tr>
<tr>
<td>Does Not Meet</td>
</tr>
</tbody>
</table>
## Crisis Diversion/Stabilization Unit

Envisioned program has closest operating model to MHSC legislation.

<table>
<thead>
<tr>
<th>MHSC Requirement</th>
<th>Addressed?</th>
<th>How it Satisfies MHSC Reqt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment of Immediate Need</td>
<td></td>
<td>Assessed by care team upon entry</td>
</tr>
<tr>
<td>Psychiatric Assessment, Diagnosis, Case Mgmt, and Treatment</td>
<td></td>
<td>Will receive full MH, SUD, and Medical assessment, diagnosis, and crisis management treatment</td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td></td>
<td>Medications administered onsite, but not dispensed</td>
</tr>
<tr>
<td>MH Urgent Care</td>
<td></td>
<td>Original basis for CDU</td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
<td>Accompanied transit to next point of treatment, but not from Jail or ZSFGH</td>
</tr>
<tr>
<td>Drug Sobering Center</td>
<td></td>
<td>Can initiate treatment for drug-induced psychosis</td>
</tr>
</tbody>
</table>
### Behavioral Health Access Center

Not as comprehensive as the MHSC, nor does it operate 24/7.

<table>
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<th>How it Satisfies MHSC Reqt</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment of Immediate Need</td>
<td></td>
<td>Centralized access point for low to high-barrier needs</td>
</tr>
<tr>
<td>Psychiatric Assessment, Diagnosis, Case Mgmt, and Treatment</td>
<td></td>
<td>Consultations with licensed healthcare professionals (including psychiatry); only initial treatment planning</td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td></td>
<td>Medications administered onsite, hours recently extended</td>
</tr>
<tr>
<td>MH Urgent Care</td>
<td></td>
<td>Clinicians onsite to assess and refer treatment</td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
<td>Not available through BHAC</td>
</tr>
<tr>
<td>Drug Sobering Center</td>
<td></td>
<td>Provides referrals, but is not a sobering center</td>
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</table>
### Dore Urgent Care Clinic (DUCC)

A non-institutional alternative to acute psychiatric care.

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<tbody>
<tr>
<td>Assessment of Immediate Need</td>
<td></td>
<td>Assessed upon entry</td>
</tr>
<tr>
<td>Psychiatric Assessment, Diagnosis, Case Mgmt, and Treatment</td>
<td></td>
<td>Provides assessment and triage. Clients can receive care up to 23 hours; case management not provided</td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td></td>
<td>Does not stock a pharmacy. Medications administered on site</td>
</tr>
<tr>
<td>MH Urgent Care</td>
<td></td>
<td>Original intention of DUCC</td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
<td>Coordinates but does not provide transportation to and from the clinic</td>
</tr>
<tr>
<td>Drug Sobering Center</td>
<td></td>
<td>Provides low acuity services, but is not a sobering center</td>
</tr>
</tbody>
</table>
# Tenderloin Center (TLC)

A less clinical and behavioral health-focused site than the MHSC.

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</thead>
<tbody>
<tr>
<td>Assessment of Immediate Need</td>
<td><img src="" alt=" " /></td>
<td>Voluntary referrals available, but not core focus of Center</td>
</tr>
<tr>
<td>Psychiatric Assessment, Diagnosis, Case Mgmt, and Treatment</td>
<td><img src="" alt=" " /></td>
<td>Teams of clinicians and specialists not available onsite to develop treatment plans</td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td><img src="" alt=" " /></td>
<td>Does not stock a pharmacy</td>
</tr>
<tr>
<td>MH Urgent Care</td>
<td><img src="" alt=" " /></td>
<td>Not an urgent care facility</td>
</tr>
<tr>
<td>Transportation</td>
<td><img src="" alt=" " /></td>
<td>Transport services from the center to other sites, no transport to the center</td>
</tr>
<tr>
<td>Drug Sobering Center</td>
<td><img src="" alt=" " /></td>
<td>Offers safe space for substance use, but does not have a medical focus</td>
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## System-wide View

<table>
<thead>
<tr>
<th>MHSC Requirement</th>
<th>Existing Programs</th>
<th>In-Development</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BHAC</td>
<td>TLC</td>
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<td></td>
<td></td>
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<tr>
<td>Mental Health Urgent Care</td>
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<td>Transportation</td>
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<td>Drug Sobering Center</td>
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Jamboard Activity

What of the organization or elements of the crosswalk need revision?
Are any key programs missing from the system-wide view?
Share screen for virtual white board

(white board results will be posted in meeting minutes)
System-wide vs. Program view

What are the pros and cons of these different approaches?
Which programs are the best candidates for expansion?
Options Analysis @ June 28th Meeting

Interviews with IWG volunteers and BHS SMEs will continue to inform options analysis.

CON will prepare three options for the MHSC.

**01 Stand-Alone Center**
- A full-service MHSC facility staffed and otherwise depicted in the MHSC portion of the legislation.

**02 Multi-Location Center**
- Meeting the MHSC goals listed in the legislation through a combination of several service locations and centers.

**03 Virtual Center**
- Offering services called for in legislation through a distributed/decentralized system.
Public Comment for Discussion Item #6

Mental Health Service Center: CON Options Analysis Briefing and Feedback

Steps:

- Call (415) 655-0001
- Enter access code 2491 802 4812
- Press ‘#’ and then ‘#’ again
Discussion Item #7

Street Crisis Response Team Update

All materials can be found on the MHSF IWG website at:
https://www.sfdph.org/dph/comupg/knowlcoi/mentalhlth/Implementation.asp
Reminder: Mental Health SF Domains

Mental Health SF Domains

- Office of Coordinated Care
  - Case Management and Navigation
  - Overall Care Coordination
  - Marketing / Community Outreach
  - Inventory of Programs and Services

- Street Crisis Response Team
  - Pilot Phase
  - Ongoing Implementation

- Mental Health Service Center
  - Centralized Access
  - Pharmacy Services
  - Transportation

- New Beds and Facilities*
  - Expanding Existing Models (Dashboard Updates & Rapid Response)
  - Drug Sobering Center
  - Crisis Diversion
  - TAY

Dr Angelica Almeida
Kathleen Silk
April Sloan
STREET CRISIS RESPONSE TEAM
GOAL AND STRATEGIES

Goal: Provide rapid, trauma-informed response to calls for service to people experiencing crisis in public spaces in order to reduce law enforcement encounters and unnecessary emergency room use.

1. Identify 9-1-1 calls that will receive behavioral health and medical response rather than law enforcement response.

2. Deliver therapeutic de-escalation and medically appropriate response to person in crisis through multi-disciplinary team (paramedic + behavioral health clinician + peer).

3. Provide appropriate linkages and follow up care for people in crisis, including mental health care, substance use treatment, and social services.
## Current Coverage and Hours

<table>
<thead>
<tr>
<th>Region</th>
<th>Hours</th>
<th>Launch Date</th>
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<tbody>
<tr>
<td>Tenderloin</td>
<td>0900-2100</td>
<td>Launched 11/30/2020</td>
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<tr>
<td>Mission/Castro</td>
<td>0700-1900</td>
<td>Launched 2/1/2021</td>
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<tr>
<td>Bayview</td>
<td>1100-2300</td>
<td>Launched 4/5/2021</td>
</tr>
<tr>
<td>Waterfront/Chinatown/North Beach</td>
<td>0700-1900</td>
<td>Launched 5/10/21</td>
</tr>
<tr>
<td>Park/Richmond/Sunset</td>
<td>0600-1800</td>
<td>Launched 6/14/21</td>
</tr>
</tbody>
</table>
DATA – APRIL & CUMULATIVE

Crisis Calls Handled by SCRT

April: 735
Cumulative*: 9,260

800-B Calls that Received SCRT Response**

April: 60%
Cumulative: 47%

Average Response Time

April: 17 min
Cumulative: 16 min

Client Engagements

April: 278
Cumulative: 4,525

Engagement Outcomes: Cumulative

- Crisis resolved on scene: client remained safely in community: 61%
- Client transported to hospital: 15%
- Client linked & transported to social or behavioral setting: 13%
- 911s Initiated on scene: 6%
- Other: 5%

*A single client engagement may result in multiple outcomes.
### Office of Coordinated Care Follow Up Rate

<table>
<thead>
<tr>
<th></th>
<th>April</th>
<th>Cumulative</th>
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<tbody>
<tr>
<td>Connections to Care: Cumulative</td>
<td></td>
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</tr>
<tr>
<td>Connected with existing provider or treatment facility</td>
<td>34%</td>
<td></td>
</tr>
<tr>
<td>Direct client follow up</td>
<td>31%</td>
<td></td>
</tr>
<tr>
<td>Unable to locate individual</td>
<td>25%</td>
<td></td>
</tr>
<tr>
<td>Individual declined support</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
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</tr>
</tbody>
</table>
UPCOMING MILESTONES

• SCRT's 7th Team will launch Summer 2022!

• SCRT's switch from police dispatch to EMD (Emergency Medical Dispatch) is scheduled for Summer 2022. This transition helps achieve SCRT's goal of eliminating police response to behavioral health calls.

• The Office of Coordinated Care (OCC) now provides support 7 days a week. The team includes behavioral health clinicians and health workers dedicated to follow up and care coordination for SCRT clients.

• The teams continue to focus on equity in their work. All staff participate in twice yearly equity surveys. Data are reviewed by leadership and shared with staff. These data will help inform upcoming equity trainings for staff and management teams. SCRT continues to prioritize equity when hiring and onboarding new staff.
EMERGENCY MEDICAL DISPATCH (EMD)

• EMD stands for Emergency Medical Dispatch. This is the dispatch procedure used by EMS and will not change the types of calls SCRT is responding to. SCRT is currently using police dispatch and the switch will aid in removing police response to behavioral health calls.

• SCRT and EMS will take over an estimated 11,000 calls/year (this is subject to change and has shown signs of increasing in recent months and includes calls that are already handled).

• This is part of fulfilling SCRT's larger role in SF crisis response.

• There is an anticipated increase in call volume including the potential for indoor calls (80% of calls are anticipated to remain outdoors). Examples of indoor calls include shelters, indoor public spaces such as malls, SROs, and private residences.

• SCRT will be co-responding with ambulances for some calls.

• Teams will continue to have a geographic focus, but also dynamically dispatch to the closest available team.
EMD PREPARATION & TRAINING

• Teams began training at the end of 2021 (this was then postponed due to a delay in move to EMD) and continued trainings this month in anticipation of the EMD transition this summer, which has been communicated with front line staff.

• Trainings include both didactic and experiential learning. Some topics include:
  • General EMD Introduction
  • Situational and Spatial Awareness
  • Team Safety
  • Advanced De-escalation Strategies
  • Responding Indoors & Working with Families
  • Case Scenario Guidelines
  • EMD Call Codes and Dispatch Changes
  • Vignettes & Case Scenarios
CALL VOLUME

• SCRT is responding to around 60% of 800B calls
• The last year has seen an almost 50% increase in call volume
  • If volume had stayed the same as previous years, SCRT would be handling almost 90% of 800B calls
  • Based on national data, each SCRT team is anticipating responding to 5-8 calls per shift, allowing 7 teams to handle and estimated 13,000-20,000 calls a year
• The transition to EMD dispatch (Summer 2022) will result in all 800B calls being removed from police dispatch. These calls will be handled by SCRT or an ambulance.
SCRT Call Volume by Month
HEAT MAP (JANUARY — MARCH)
HARDER CO. YEAR ONE EVALUATION

• SCRT responses are primarily reaching unique individuals. Eighty-one percent of SCRT clients have had a single SCRT encounter.

• Team member skills and the SCRT approach are well positioned to meet the presenting health needs of clients.

• The SCRT provides a host of psychological supports and educational resources for clients, ensuring they are safe and secure before planning for future service interventions.
## Ultimate Client Dispositions

<table>
<thead>
<tr>
<th>Disposition</th>
<th>Percent</th>
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<tbody>
<tr>
<td>Remain in community</td>
<td>59%</td>
</tr>
<tr>
<td>Non-ambulance transport to resources</td>
<td>14%</td>
</tr>
<tr>
<td>Ambulance transport</td>
<td>15%</td>
</tr>
<tr>
<td>Walked away after brief encounter</td>
<td>11%</td>
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<tr>
<td>Declined transport against medical advice</td>
<td>1%</td>
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</table>

*Most clients are not transported to medical facilities, but are either transported by SCRT to resources in the community (e.g. Hummingbird, DORE, congregate shelter, shelter in place hotel, SF Sobering center) or remain safely in the community where they receive direct resources.*
## Direct SCRT Interventions

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Percent</th>
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<tbody>
<tr>
<td>Provided psychoeducation/resources</td>
<td>70%</td>
</tr>
<tr>
<td>Worked with family/support system</td>
<td>68%</td>
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<tr>
<td>Provided peer support</td>
<td>65%</td>
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<tr>
<td>Motivational interviewing</td>
<td>26%</td>
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<tr>
<td>Used de-escalation techniques</td>
<td>24%</td>
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<tr>
<td>Coordinated care with providers</td>
<td>23%</td>
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<tr>
<td>Other intervention&lt;sup&gt;22&lt;/sup&gt;</td>
<td>30%</td>
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<tr>
<td>Supported coping skills</td>
<td>16%</td>
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<tr>
<td>Made safety plan</td>
<td>13%</td>
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</tbody>
</table>

For those who remain in the community:

- Psycho-Educational Resources: 70%
- Worked with family/Support System: 67%
- Peer Support: 64%
- Motivational Interviewing: 24%
- De-escalation: 22%
Public Comment for Discussion Item #7
Street Crisis Response Team Update

Steps:

• Call (415) 655-0001
• Enter access code 2491 802 4812
• Press ‘#’ and then ‘#’ again
Public Comment for
Any other matter within the jurisdiction of the Implementation Working Group not on the agenda

Steps:
• Call (415) 655-0001
• Enter access code 2491 802 4812
• Press ‘#’ and then ‘#’ again
## Anticipated IWG Meeting Topics 2022

### IWG Domains

<table>
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<tr>
<th>Topic Area</th>
<th>Jan</th>
<th>Feb</th>
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<td>Street Crisis Response Team</td>
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<td>New Beds &amp; Facilities (NB&amp;F):</td>
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<td>NB&amp;F: Expansion of Existing Models</td>
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**Deliverable:** IWG Annual Progress Report

**Deliverable:** IWG Implementation Report

### Other Intersecting Departments/Projects/Briefings

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<tr>
<th>Topic</th>
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<td>CON: Citywide Street Outreach Briefing (SCRT, SFHOT, SORT, etc.)</td>
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<td>HSH: Housing Briefing</td>
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<td>DPH MHSF Budget Update</td>
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*D=Design   U=Update*
Housekeeping

• Next Meeting Date and Time
  o 4th Tuesday of the month 9:00AM-1:00PM
  o June 28, 2022

• Volunteer to be part of the TAY Discussion Group!

• Meeting Minutes Procedures
  o [https://www.sfdph.org/dph/comupg/knowlcol/mentalhlt h/Implementation.asp](https://www.sfdph.org/dph/comupg/knowlcol/mentalhlt h/Implementation.asp)
  o Draft minutes in the next two weeks
  o Approved meeting minutes will be posted

• MHSF IWG e-mail address for public input:
  MentalHealthSFIWG@sfgov.org
Adjourn
Member Meeting Attendance (per Bylaws)

Member Absences
Any member who misses three regular meetings of the Working Group within a 12-month period without the express approval of the Working Group at or before each missed meeting will be deemed to have resigned from the Working Group ten days after the third unapproved absence.

Excused Absences
The Working Group may vote to excuse an absent member from a Working Group meeting. If the Working Group does not take such a vote at the meeting or at a previous meeting, then the minutes shall note that the absence is unexcused.
DPH Bed Continuum of Care

**Short-Term Care**
- Emergency and urgent care
- Low barrier
- Immediate
- No authorization required
- Walk-ins accepted

**Respite Care**
- Safe environments
- Low barrier
- Encourage treatment

**Transitional Care**
- Planned therapeutic and treatment services
- Skill building

**Long-Term Care**
- Specialized support
- Safe environments to support stabilization