MENTAL HEALTH CRISIS SERVICES ISSUE BRIEF

Mental Health San Francisco Implementation Working Group

I. OVERVIEW

Mental Health San Francisco, created through legislation (File No. 191148), calls for the development of a "Mental Health Urgent Care Unit" and expansion of crisis residential treatment services. Page 12, lines 10-14, and page 16, lines 19-20, state:

Mental Health SF Legislation (File No. 191148)

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.*

Mental Health and Substance Use Treatment Expansion*. (A) Crisis residential treatment services, including but not limited to, acute diversion, crisis stabilization, detoxification, and 24-hour respite care.*

San Francisco residents who are in a mental health or substance use crisis need acute care that can provide assessment, de-escalation, and treatment in a trauma-informed, recovery-oriented environment. Crisis facilities vary in scope, capability, and populations served, but all are intended to provide a safe and therapeutic alternative to a hospital emergency department (ED), inpatient psychiatric facility, or jail. Crisis services are also an important way to advance racial equity in access to behavioral health care.

As per the legislative language above, the Mental Health SF ordinance signed into law by Mayor London Breed in 2019 and supported by Proposition C funds provides an opportunity to both expand crisis service capacity and enhance the types of crisis services available. To inform the development of a potential urgent care unit and an expansion of crisis residential treatment services, the Department of Public Health reviewed acceptance rates and admissions data from across our acute and crisis care settings and identified gaps in our current system. In this issue brief, we introduce the concept of a Crisis Diversion Unit (CDU), which is in early design phase, as part of the Mental Health SF New Beds & Facilities domain. This brief identifies gaps, describes existing models and programs, and propose solutions for how to ensure access to high-quality crisis care for all San Franciscans. This work is being conducted under the New Beds and Facilities Domain of Mental Health SF.[1]

[1] https://sf.gov/residential-care-and-treatment

II. SAN FRANCISCO MENTAL HEALTH CRISIS SERVICES LANDSCAPE

The current array of crisis services available in San Francisco offers important entry-points for behavioral health care. The current mental health crisis receiving facilities operating in San Francisco include Psychiatric Emergency Services, Acute Diversion Units (ADUs), and Psychiatric Urgent Care. People in crisis also frequently enter non-specialty settings such as medical emergency departments and, all too often, jail. Facility definitions are provided below.

ZSFG Psychiatric Emergency Services (PES): Psychiatric Emergency Services at Zuckerberg San Francisco General is the primary provider of adult emergency mental health care in the City and County of San Francisco. The service is open 24/7 and sees approximately 8,000 patients per year, of whom approximately 20% are voluntary walk-in patients, with others primarily dropped off by police or ambulance. The goal of PES is to provide crisis stabilization. Services include complete medical and psychiatric assessment and evaluation services, and initial treatment, if appropriate. The staff, which includes physicians, nurses, and social workers, works closely with several community service providers to develop short and long-term treatment plans.

Progress Foundation Acute Diversion Unit (ADU)/ Crisis Residential: A community-oriented 24-hour non-institutional alternative to hospitalization for individuals who require non-hospital acute psychiatric care. The goal of ADUs is to reduce the utilization of acute psychiatric inpatient beds, either by diversion from inpatient placement or reduction of inpatient length of stay. ADUs in San Francisco can be accessed through inpatient psychiatry or psychiatric urgent care (see below). Services are designed (a) to reduce and stabilize crisis situations for individuals experiencing an acute episode or situational crisis, (b) to assess and augment the client's existing support system while encouraging the lowest possible level of psychotropic medication prescribed on an outpatient basis, and (c) to build skills for the client to move toward more independent living.

Progress Foundation Dore Urgent Care Center (DUCC): Provides up to 23 hours of service within the crisis stabilization framework, including (a) the capacity to intervene early in an escalating psychiatric crisis, (b) assessment and triage in a community-based setting, and (c) the option to transfer to crisis residential beds for those who would benefit from more intensive treatment that exceeds 23-hours or stabilization support. The goal of a psychiatric urgent care is to reduce demand on PES or individuals in psychiatric crisis who do not require involuntary confinement and mandatory treatment. Most clients are transferred from other providers (e.g., PES), 39% of clients are walk-in, and only 1-3% of clients are dropped off. Services are designed (a) to de-escalate and stabilize crisis situations for individuals experiencing an acute episode or situational crisis, (b) to assess and augment the client's existing support system, and (c) to determine the client's readiness and capability to return to the community. Data show 75% of clients may have co-occurring disorders that include mental illness and substance use as well as other chronic medical conditions, including those with mobility disabilities.

Table 1: Current Mental Health Crisis Care Services in San Francisco

	← *Higher Acuity*			*Lower Acuity* →
Program	Psychiatric Emergency Services	Dore Urgent Care Clinic	Acute Diversion Unit	*Hummingbird**
Location	1001 Potrero Ave (Mission)	52 Dore St. (SOMA)	Multiple locations	Potrero & Valencia (Mission)
Capacity	18 beds	12 loungers	44 beds	59 beds
How to access	Walk-in, drop-off (transferred from **medical emergency dept** during COVID)	Data pending	No drop-off; must have a psychosocial assessment, diagnosis, physical assessment, tuberculosis clearance	Drop-off and daytime walk-ins; overnight stays authorized and arranged in advance
Length of Stay	< 23 Hours	< 23 Hours	14-21 Days	14-21 Days
Available Services	Co-located with medical **emergency dept** + high acuity mental health care	Mental health care, mild substance use disorder	No physical care, mild substance use disorder; no prescriptions filled	Shelter + minor physical care
Restrictiveness	Locked	Unlocked	Unlocked	Unlocked

**Note: Hummingbird is not a crisis care facility but is included since PES discharges clients to this program.*

Crisis System Gaps Identified by SFDPH and Community Partners

Of the 18,000 people identified as homeless in FY18-19, approximately 4,000 had both psychotic and substance use disorders. Of those, 74% had a medical comorbidity and 80% had utilized an acute service (including PES, DUCC, Emergency Department, Sobering Center, Withdrawal Management, and Comprehensive Crisis Services). One of the most troubling findings about this group is the inequity of the burden of these diagnoses: while Black/African American compose 5% of San Francisco's overall population, they represent 35% of the population identified in the group.[2]

Following a crisis evaluation at PES, DUCC, and other settings, clients are often discharged to the street and are unable to engage in routine outpatient care, frequently returning to treatment in crisis soon thereafter. These clients are often dually diagnosed with mental health and substance use disorders, pre-contemplative regarding treatment, and experiencing homelessness. Half of PES visits are people in methamphetamine-induced psychiatric crisis.

Current residential programs will not admit clients who do not have capacity to consent to treatment or who have severe dual diagnosis. The Hummingbird sites at Potrero and Valencia are important destinations for clients seen by SCRT or discharged from PES – these programs primarily provide shelter, supportive services, and a path to stability and wellness for unhoused people struggling with mental illness and substance use.

[2] https://www.sfdph.org/dph/files/MHR/Mental_Health_Reform_Update_Report_FINAL.pdf

After reviewing these challenges with providers from PES, DUCC, SCRT, Comprehensive Crisis Services, EMS-6, Hummingbird, and others, we have identified **three critical strains on our mental health crisis system**: Inadequate capacity, overfull occupancy, and increasing demand.

Inadequate Capacity: According to the national Crisis Now guidelines, our system does not currently meet the recommended capacity of 42 "crisis receiving beds" based on San Francisco's population count.[3]

- We have a capacity of 12 spaces (limited to 8 available with COVID) at Dore Urgent Care Center (DUCC).
- This leaves us with a gap of 30 treatment spaces.

Overfull Occupancy: A system that is at 85% or higher occupancy may be unable to accommodate surges in volume.[4]

- PES is at capacity, especially during the COVID-19 pandemic
- DUCC is at or near capacity for at least 12 hours a day (between 10 am and 10pm) based on the arrival rate and length of stay in 2020 and 202).

Increasing Demand: Demand for acute mental health services has grown in the face of the COVID pandemic, the meth and opioid crises, forest fires and other climate-related disruptions and displacements, and additional stressors.

- EMS reports the number of crisis calls are high and growing.

In our discussions with stakeholders, we also identified attributes of our priority patient population and system that should be addressed:

- High rates of co-occurring substance use disorder in our target population
- High rates of co-occurring physical illness in our target population
- 23-hours is not enough time to resolve most crises, especially for people with complex psychosocial needs
- Peer support roles in crisis settings are evidence based and strongly supported by the community
- The role for community paramedics in MH/SUD crisis response has continued to grow

III. CRISIS DIVERSION MODELS

Evidence-Based Models

The literature describes a wide variety of crisis receiving facilities, which vary in scope, capability, and populations served. All are intended to provide a safe and therapeutic alternative to hospital EDs, inpatient psychiatric facilities, or jail. Research has shown that crisis receiving facilities improve the following outcomes:

[3] https://crisisnow.com/wp-content/uploads/2021/03/Crisis-Resource-Need-Calculator-Website.xlsx
[4] Bagust A, Place M, Posnett JW. "Dynamics of bed use in accommodating emergency admissions: stochastic simulation model." BMJ. 1999; 319 (7203):155-158

- Reduced rates of inpatient psychiatric hospitalization[5]
- Reduced boarding of psychiatric clients in EDs[6]
- Reduced arrests[7]

In addition to crisis receiving facilities, community-based crisis diversion programs, often referred to as the "Living Room" model, have been shown to provide a safe place in the community for clients in mental crisis to seek low-threshold care.[8] This model provides 24/7 alternatives for less acute needs and often accept police drop-offs for clients who meet their admission criteria. They are typically unlocked and serve clients who are voluntary, non-violent, and motivated for help. Living Rooms offer a home-like environment with couches and artwork and are staffed predominantly by peer specialists, with limited coverage by a psychiatrist or other provider. They are especially helpful if psychosocial stressors are the main precipitants of the crisis. Living Room models may co-exist with higher acuity settings to coordinate and allow for internal triage so that crisis beds are reserved for people with higher acuity needs.

Examples of Crisis-Like Facilities in Other Locations

Low-threshold crisis centers for both mental health and substance use disorders have been successful in many counties throughout California and across the US. Two clinics typical of this care approach include Cherry Hill in Alameda County, Exodus Recovery in Los Angles, and Support and Connections Center in New York. Additional programs are reviewed below.

Alameda County – Cherry Hill: The Cherry Hill Detoxification Services Program consists of two complimentary substance use treatment services jointly located on the Fairmont Hospital grounds. Approximately 50% of Cherry Hill's clients also have co-occurring mental illness. Both programs are specifically designed to meet the needs of community partners including clinicians and law enforcement agencies. A central telephone screening process is used for both detoxification and sobering services. Cherry Hill's Sobering Unit is a 50-bed 24/7 facility that assists those needing immediate sobering services for a visit of <23 hours. Cherry Hill's Detox Unit is a "social model" 32-bed residential program serving clients withdrawing from the effects of alcohol or drug use, with an average stay of 4-6 days. In the Detox unit, clients are constantly monitored by trained staff and are referred for medical or psychiatric services as needed. Clients are then referred to appropriate level of treatment and supportive services, which may include housing, medical or psychiatric services, job training, etc.

https://www.horizonservices.org/cherry-hill-detoxification

Los Angeles – Exodus Recovery: The Eastside Urgent Care Center (EUCC) is located in the Boyle Heights area across from LAC-USC Medical Center. The EUCC offers a welcoming environment where individuals in crisis can be assessed 24/7 for stabilization services, medication evaluation and management, or hospitalization if necessary. The EUCC offers comprehensive care by an interdisciplinary team of physicians, Nurse Practitioners, nurses, and

[5] Little-Upah, et al.: The Banner psychiatric center: a model for providing psychiatric crisis care to the community while easing behavioral health holds in emergency departments. Perm J 17: 45–49, 2013.
[6] Zeller S, Calma N, Stone A: Effects of a dedicated regional psychiatric emergency service on boarding of psychiatric patients in area emergency departments. West J Emerg Med 15: 1–6, 2014.
[7] Steadman HJ, Stainbrook KA, Griffin P, et al.: A specialized crisis response site as a core element of police-based diversion programs. Psychiatr Serv Wash DC 52: 219–222, 2001.
[8] https://www.gjcpp.org/en/article.php?issue=15&article=74

therapists. Social services, referrals to community programs and resources, and discharge planning are included in the standard of care delivered at the EUCC.
https://www.exodusrecovery.com/l-a-eastside-ucc/

New York – Support and Connection Centers: In 2020, New York City launched two Support and Connection Centers, which function as Crisis Diversion Facilities in East Harlem and the Bronx. These community-based centers offer short-term clinical and non-clinical services to people with mental health and substance use needs and give police officers and EMS an alternative to avoidable emergency room visits or criminal justice interventions.
https://www1.nyc.gov/site/doh/about/press/pr2020/east-harlem-support-connection-center-opening.page

Beginning to Envision a Crisis Diversion Model for San Francisco

A new Crisis Diversion Unit (CDU) would build on the array of services currently available in San Francisco by expanding capacity to meet increasing demand and optimizing lower acuity settings to best meet the needs of the population. A CDU would be able to manage moderate/sub-acute mental health crisis and/or substance use crisis as well as moderate physical illness such as wound care, mild alcohol withdrawal and overdose. The specific details of a CDU model are still in development pending input from community stakeholders and the MHSF Implementation Workgroup.

Initial envisioning of a CDU would aim to include the following enhancements:

- Supports dual diagnosis, including mental illness, substance use, and minor physical healthcare needs
- A length of stay greater than 23 hours, ideally 3-5 days
- Accepts drop offs (e.g., SCRT, EMS-6, DPH Comprehensive Crisis Services, SFPD); may be designated as an EMS alternate destination in the future
- Strong peer support towards engaging with treatment and pursuing recovery
- Open 24/7 and accepts admissions around the clock
- Avoids multiple transfers between acute care settings
- Provides the least restrictive care option in an unlocked setting
- Strong linkage to Intensive Case Management and transitional residential services

Table 2: Future State Mental Health Crisis Care Services with the CDU

← *Higher Acuity*				*Lower Acuity* →	
Program	Psychiatric Emergency Services	**Crisis Diversion *(proposed)***	Dore Urgent Care Clinic	Acute Diversion Unit	**Hummingbird*
Location	1001 Potrero Ave (Mission)	**TBD**	52 Dore St. (SOMA)	Multiple locations	Potrero & Valencia (Mission)
Capacity	18 beds	**15-30 chairs/beds**	12 loungers	44 beds	59 beds
How to access	Walk-in, drop-off (transferred from **medical emergency dept** during COVID)	**Drop-off and walk-in**	Data pending	No drop-off; must have a psychosocial assessment, MH diagnosis, a physical assessment, tuberculosis clearance	Drop-off and daytime walk-ins; overnight stays authorized and arranged in advance
Length of Stay	< 23 Hours	**3-5 Days**	< 23 Hours	14-21 Days	14-21 Days
Available Services	Co-located with medical **emergency dept** + high acuity mental health care	**Mental health, substance use and physical care (wound care, mild alcohol withdrawal, etc.)**	Mental health care, mild substance use disorder	No physical care, mild substance use disorder; no prescriptions filled	Shelter + minor physical care
Restrictiveness	Locked	**Unlocked**	Unlocked	Unlocked	Unlocked

**Note: Hummingbird is not a crisis care facility but is included since PES discharges clients to Hummingbird.*

IV. BUDGET

The SF Crisis Diversion Unit is budgeted under Proposition C (OCOH) to receive approximately $3.2 million annual operating funds and can utilize the one-time Proposition C funds available for site acquisition and tenant improvements. A SF Crisis Diversion Unit is also anticipated to generate up to $1.5 million Medi-Cal reimbursable services which may supplement a total operations budget of over $4.5 million annually.

V. COMMUNITY ENGAGEMENT PLAN

The SF Crisis Diversion Unit will be situated in a neighborhood with high Street Crisis Response Team and EMS call volumes so that it is best positioned to work in tandem with existing crisis services and serve as an alternative destination for persons in mental health crisis. The local neighborhood community will be notified of the intent to situate the SF Crisis Diversion Unit as a community resource through the Proposition I "Good Neighbor Policy" process[9] with ample time

[9] https://www.sfdph.org/dph/files/CBHSPolProcMnl/2.07-02-Good-Neighbor-Policy-072009.pdf

for community participation subsequent to notification. In addition, as part of the MHSF equity framework, mental health services clients will participate in the design and evaluation of the center through the DPH Client Council and other community-informed groups.

VI. ADRESSING RACIAL EQUITY AND INSTITUTIONAL RACISM

San Francisco Department of Public Health's Behavioral Health Services has identified the following racial health inequities for persons in need to behavioral health services and treatment:

- Adverse outcomes for people experiencing a behavioral health crisis who have contact with law enforcement
- Weaponizing of 911 against people of color
- Over-representation of people of color in the population experiencing homelessness
- Institutional racism that is often reflected by over-representation of incarcerated Black/African Americans
- High incarceration rates, unnecessary emergency room use, involuntary detentions for populations of color
- Other factors include: Uninsured or underinsured clients, homelessness, residents living below poverty level, behavioral health issues exacerbated by drug use and living situation"[10]

To address racial equity, the Department has committed to implement the following countermeasures, which will be prioritized when planning for expanded crisis services:

- Trauma-informed, behavioral health and medical response rather than a law enforcement response
- Deliver therapeutic de-escalation and medically appropriate response to person in crisis through a multi-disciplinary team
- Provide appropriate and targeted linkages and follow up care for people in crisis, including mental health care, substance use treatment, and social services
- Community based outreach for individuals served by the program and the communities where they live
- Ongoing community engagement and rapport building
- Integration of someone with lived experience on the team (both in terms of behavioral health services, but also representing communities being served) creating pathways to employment and allowing for more robust engagements"[11]

[10] https://sf.gov/sites/default/files/2021-07/1%20-%20Kunins%20-%20Health%20Commission%207.6.21-v11.cleaned%20%20-%20%20MM%20Comments.pdf

[11] https://sf.gov/sites/default/files/2021-07/1%20-%20Kunins%20-%20Health%20Commission%207.6.21-v11.cleaned%20%20-%20%20MM%20Comments.pdf

VII. DATA AND EVALUATION

The SF Crisis Diversion Unit will be operationalized as a pilot with quarterly and annual evaluations for the first year of operation. Evaluation will be designed in collaboration with consumers and neighborhood constituents to include: 1) participant and community satisfaction, 2) service quality, 3) safety, and 4) global contributions to MHSF goals, especially including improving access to essential crisis services at peak utilization hours (10am-10pm). Metrics will be aligned with other MHSF Key Performance Indicators, including measures of linkage to routine care and reutilization of acute services, and discharge destinations. We will also aim to measure impact across racial and ethnic groups to monitor how this program advances equity. At the end of the first year, a summary of the evaluation will be presented to the MSHF Implementation Workgroup for comment and feedback.

VIII. FUTURE DIRECTIONS

In order to advance the vision of the SF Crisis Diversion Unit as described above, SFDPH BHS will pursue the following next steps:

1. Seek input from the MHSF Implementation Workgroup
2. Seek input from community representatives
3. Seek additional input from city agency partners and local provider organizations
4. Identify additional data that demonstrate the need for additional crisis facility capacity
5. Identify a building that may be appropriate for the CDU
6. Explore regulatory options for licensure and required staffing levels
7. Determine operating expenses, reimbursement potential, and projected budget

Questions for the Mental Health SF Implementation Workgroup

1. As we begin planning for expanding crisis services, what advice or recommendations do you have for DPH?

2. Are there other models we did not discuss that we should consider?