Call to Order/Roll Call
Meeting Goals

- Review survey feedback on process to date
- Discuss Street Crisis Response Team evaluation framework and IWG questions
- Craft Street Crisis Response Team’s initial 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 Components

Mental Health SF Components

- 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)
  - Bed Optimization Report Findings
  - Drug Sobering Center*
  - MH Urgent Care/Crisis Diversion Facility*

*service falls under Mental Health Service Center in legislation, DPH has organized under New Beds and Facilities for operational efficiency

Note: Office of Private Health Insurance & Accountability will be addressed at a later time.
Group Agreements

1. No one knows everything, together we know a lot
2. Listen actively, respectfully and for new information
3. Critique the idea, not the person
4. Step up/Step back
5. Speak from own experience; avoid generalizations
6. Focus on solutions that best create anti-racist, anti-sexist, anti-transphobic, anti-xenophobic, and promote a decolonized community
7. Use virtual meeting tools (camera, raise hand)
8. Allow the facilitator to guide the process

Mental Health SF Implementation Working Group

March 2021
Discussion Item #1

Approve Meeting Minutes

All materials can be found on the MHSF IWG website at:
https://www.sfdph.org/dph/comupg/knowlcol/mentalhlth/Implementation.asp
IWG Discussion: Reminder to raise your hand
Public Comment for Discussion Item #1

Approve Meeting Minutes

Steps:

• Call (415) 655-0001
• Enter access code 146 626 7818
• Press ‘#’ and then ‘#’ again
Vote on Discussion Item #1

Approve Meeting Minutes

Decision Rule:

• Simply majority, by roll call
Discussion Item #2

Review of IWG meeting survey results

All materials can be found on the MHSF IWG website at:
https://www.sfdph.org/dph/comupg/knowlcol/mentalhlth/Implementation.asp
Top Line Results

Meeting Experience to Date

- All respondents (n=6)
  - Agreed the issue paper is the best way to prepare IWG about DPH/MHSF programming
  - All read fully or skimmed the issue paper

- Most respondents (5 of 6)
  - Would be open to meeting twice a month for a couple of months

- Ranking of issues of interest/domains:
  1. Tie for Mental Health Service Center and Office of Coordinated Care
  2. Mental Health and Substance Use Treatment Expansion

Management of roll call
Facilitation
Presentation
Voting
Discussion for IWG members
Raising/Lowering of Hands
Decision 1: Meeting Frequency

Would you be interested in meeting twice a month for a period of time?
Decision 2: Meeting Options

1. Go deep: focus on one topic for a three-meeting sequence

Mtg 1: present issue
Between work: ask questions

Mtg 2: Discuss questions
Between work: develop draft recs (committee)

Mtg 3: Review and vote on committee recommendations

2. Go deep, but reserve time
Same as #1 (focus), but reserve time for updates on 4 other MHSF domains

3. Stack topics: keep two topics going during each meeting
Follow same general process as “deeply” but touch on 2 topics every meeting
Decision 3: Use of recommendation principles

Are the recommendations “good enough” to use for this process?

• Pilot these with the street team recommendation process?
Public Comment for Discussion Item #2

Post February meeting survey results

Steps:

• Call (415) 655-0001
• Enter access code 146 626 7818
• Press ‘#’ and then ‘#’ again
Discussion Item #3

Street Crisis Response Team Pilot Discussion

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

You are here!

- **February 23**
  - Street Crisis Response Team issue paper and presentation

- **March 10**
  - Additional data requests made and answered

- **March 23**
  - Craft initial recommendations

- **April 9**
  - Pro/Con to initial recommendations (homework)

- **April 21**
  - Ad hoc committee refines recommendation wording

- **April 27**
  - Review recommendations and vote

Mental Health SF Implementation Working Group
Street Crisis Team in Action

Click here for Video
• Pilot Evaluation
  • Harder + Company
  • Robert Wood Johnson Foundation Research Study
• Key Questions for Implementation Working Group
Planning and implementing continuous process improvement
PILOT EVALUATION

Pilot program evaluation, led by Harder + Company, key questions:

• Who is the Street Crisis Response Team serving, and what are the characteristics of those service calls?
• How effective is the Street Crisis Response Team in addressing the needs of the individuals it serves?
• What successes and challenges have Street Crisis Response Team members and community stakeholders observed in the implementation of the pilot program?

Research Study funded by Robert Wood Johnson Foundation

• Three key outcomes post-crisis episode will be studied through this research study: linkage to outpatient mental health and substance use treatment, reutilization of crisis services, and assessment for housing placement.

Continuous Process Improvement

Act → Plan → Study → Do

[Diagram showing the cycle of Plan, Do, Study, and Act with arrows connecting each step.]
Key Evaluation Activities in Year 1 include:

- 2 Rounds of Qualitative Data Collection
- 2 Rounds of Quantitative Data Collection
- 3 Rounds of Reporting
- 3 Rounds of Community Engagement
Formative Implementation Interview Findings

- Reducing unnecessary police contact with clients
- Including peer approach to meet clients where they are
- Responding in a trauma-informed manner with cultural humility
- Continue pursuing diverse, experienced recruits
- Opportunity to increase role clarity in response process
- Promote ongoing service enhancement efforts
RESEARCH STUDY ON IMPACT OF STREET CRISIS RESPONSE TEAM

- Grant from Robert Wood Johnson Foundation, managed by Avalere Health
- Led by DPH researchers Dr. Matt Goldman (Project Director) & Dr. Phillip Coffin (Co-Project Director)
- BHS Research Program in collaboration with UCSF CTSG and PRISE Center
- Results expected to be published in late 2022

Quantitative Analysis of Impact of SCRT on Post-Crisis Outcomes
1. Outpatient mental health or substance use service utilization
2. Acute service reutilization (return to ED, PES, other crisis service)
3. Assessment for supportive housing or other long-term placement
4. Jail Entry

Equity Analysis - Stratify by Race/Ethnicity
1. What disparities exist at baseline?
2. What impact does SCRT have on potential disparities?

Qualitative Interviews with Recipients of SCRT Services
1. Baseline Engagement
2. SCRT Access, Assessment and Intervention
3. Post-Crisis Linkage
4. Client Experience
CLARIFYING QUESTIONS
KEY QUESTIONS FOR IMPLEMENTATION WORKING GROUP
1. If the team had additional resources, and were to respond to more calls for service beyond the “800Bs”, which types of calls should they prioritize?

2. How can the SCRT best be deployed in communities of color and other populations with distrust of law enforcement and other institutions?

3. How can SCRT best engage the community to support its clients using the strength of existing community-based networks?

4. SCRT is planning to have one team covering an overnight shift to enable 24/7 SCRT service coverage. What is your experience about the need for 24/7 coverage for this service?
1. IF THE TEAM HAD ADDITIONAL RESOURCES, AND WERE TO RESPOND TO MORE CALLS FOR SERVICE BEYOND THE “800B’S”, WHICH TYPES OF CALLS SHOULD THEY PRIORITIZE?

Additional call codes currently receiving law enforcement response could be considered for this program. For example, call code 801, "person attempting suicide" could be a well suited for SCRT response for the portion of these calls involving only ideation or other circumstances not requiring a "lights and sirens" response.

The Coalition on Homelessness and Human Rights Commission have also contemplated this question. The Coalition on Homelessness has recommended a “Compassionate Alternate Response Team (CART)” which could be a complementary solution to a subset of these additional call codes. For example, upon initial representative call data reviews, DEM has indicated that many of the 911 calls for service coded as “well-being” checks (code 910) present similarly to the needs of the code 800 calls. With additional staff training and further refined definitions of the call codes, some well-being check calls could be directed to SCRT while others could be directed to a homelessness response focused team such as CART. A comprehensive data analysis, essential to this exercise, will require additional resources to be identified.
2. HOW CAN THE SCRT BEST BE DEPLOYED IN COMMUNITIES OF COLOR AND OTHER POPULATIONS WITH DISTRUST OF LAW ENFORCEMENT AND OTHER INSTITUTIONS?

In order to address the needs and concerns of communities with widespread distrust of law enforcement, SCRT may need to identify and create pathways to deploy the SCRT independent of 911. Because developing new call-center infrastructure requires significant resources, this could be achieved through leveraging existing crisis call lines (e.g., SF Suicide Prevention line, Comprehensive Crisis Services) who could develop workflows to deploy SCRT as needed. Other programs, such as Maricopa County in Arizona, indicate crisis call centers can reduce the need for deploying mobile teams while still providing therapeutic intervention to clients in need.
3. HOW CAN SCRT BEST ENGAGE THE COMMUNITY TO SUPPORT ITS CLIENTS USING THE STRENGTH OF EXISTING COMMUNITY-BASED NETWORKS?

It is essential that SCRT builds on the strengths of existing community-based resources and trusted community members to maximize program sustainability and impact. Identifying opportunities to promote an individual’s resiliency within their communities by integrating existing networks, such as churches and community-based organizations, would yield positive outcomes for both clients of SCRT and concerned community members. The role of Office of Coordinated Care staff, and the types of strategies they employ in their care coordination work, are a potential opportunity for collaboration.
4. SCRT IS TARGETING TO HAVE ONE TEAM ON AN OVERNIGHT SHIFT TO ENABLE 24/7 COVERAGE. WHAT IS YOUR EXPERIENCE ABOUT THE NEED FOR 24/7 COVERAGE FOR THIS SERVICE?

During the hours between 11pm and 7am, code 800 calls decrease dramatically, with the average call volume during these hours approximately 65 percent lower according to DEM data from 2019. At the same time, options for referral to services will be much more limited during these hours than during the day. Furthermore, hiring and retaining staff to provide coverage for these service hours is expected to be more challenging and costly. A financial analysis of this difference in cost will be provided once available.
1. If the team had additional resources, and were to respond to more calls for service beyond the “800Bs”, **which types of calls should they prioritize**?

2. How can the SCRT best be deployed in communities of color and other populations with **distrust of law enforcement and other institutions**?

3. How can SCRT best **engage the community** to support its clients using the strength of existing community-based networks?

4. SCRT is planning to have one team covering an overnight shift to enable 24/7 SCRT service coverage. What is your experience about the **need for 24/7 coverage for this service**?
Discussion Item #4

Craft Initial Street Crisis Response Team Pilot Recommendations

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

You are here!

February 23
Street Crisis Response Team issue paper and presentation

March 10
Additional data requests made and answered

March 23
Craft initial recommendations

April 9
Pro/Con to initial recommendations (homework)

April 21
Ad hoc committee refines recommendation wording

April 27
Review recommendations and vote
Public Comment for

Any other matter within the Jurisdiction of the Committee not on the Agenda

Steps:

- Call (415) 655-0001
- Enter access code 146 626 7818
- Press ‘#’ and then ‘#’ again
Housekeeping

- Website for the IWG
  - [https://www.sfdph.org/dph/comupg/knowlcol/mentalhlt h/Implementation.asp](https://www.sfdph.org/dph/comupg/knowlcol/mentalhlt h/Implementation.asp)
- Meeting materials
- Final bylaws uploaded
- Next Meeting Date and Time
  - 4\textsuperscript{th} Tuesday of the month: 9:30 AM - 12:00 PM
  - April 27, 2021
- Meeting Minutes Procedures
  - Draft minutes in the next two weeks
  - Approved meeting minutes will be posted
Adjourn
IWG Roles & Duties

- **Advise** the Mental Health Board, Health Commission, Department of Public Health, Mayor, Board of Supervisors, and San Francisco Health Authority, on the **design, outcomes, and effectiveness** of Mental Health SF

- **Evaluate the effectiveness** of Mental Health SF in meeting the **behavioral health and housing needs** of eligible participants

- **Review and assess the Implementation Plan** that is required to be submitted to the Mayor and the Board of Supervisors

- By July 2020, conduct a **staffing analysis** of City and nonprofit mental health services providers with the Controller and the DHR to determine whether there are staffing shortages, and make recommendations regarding salary ranges and working conditions to address any staffing shortages that impact timely and effective service delivery
IWG Roles & Duties (continued)

- Submit **annual progress reports** to the Board of Supervisors, the Mayor, and the Director of Health by October 1.

- By June 1, 2021, submit to the Board, the Mayor, and the Director of Health **final recommendations concerning the design** of Mental Health SF, and any steps that may be required to ensure its successful implementation.

- If the annual cost of implementing Mental Health SF exceeds $150 million (as adjusted for CPI), submit to the Board, the Mayor, and the Director of Health recommendations **for how to reduce the scope of services** provided by Mental Health SF in order to reduce.
## Appendix: Deliverable Dates

<table>
<thead>
<tr>
<th>Ordinance Deliverable</th>
<th>Original Date in Ordinance</th>
<th>Proposed Adjusted Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>IWG Annual Progress Report: Every year, IWG submits progress report to BOS, Mayor, and Dir of Health</td>
<td>Starting October 1, 2020</td>
<td>October 1, 2020 is cancelled. Next report: October 1, 2021</td>
</tr>
<tr>
<td>IWG Final Design/Implementation Recs Report: The IWG submits “its final recommendations concerning the design of Mental Health SF, and any steps that may be required to ensure its successful implementation” to the BOS, Mayor, and Dir of Health</td>
<td>June 1, 2021 (This original date assumes the IWG has met for over a year)</td>
<td>May 2022 to allow enough time for the IWG to cover MHSF topics and provide recommendations.</td>
</tr>
<tr>
<td>DPH Annual implementation plan (services, finance resources, what is infeasible to deliver)</td>
<td>Feb 1, 2021 (and annually thereafter) to Mayor and BOS - (this original date assumed the IWG has met 10+ months)</td>
<td>April 1, 2021 - light progress report given COVID and budget. First full implementation plan will be presented in Feb 2022.</td>
</tr>
</tbody>
</table>
Appendix: Ordinance Components

1) Mental Health Service Center

2) Office of Coordinated Care

3) Crisis Response Street Team

4) Mental Health and Substance Abuse Use Treatment Expansion

5) Office of Private Health Insurance Accountability
# Appendix: IWG Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Qualification</th>
<th>Appointed By</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scott Arai, Psy. D.</td>
<td>Residential Treatment Program Management and Operations</td>
<td>Mayor</td>
</tr>
<tr>
<td>Shon Buford</td>
<td>Peace Office, Emergency Medical Response, Firefighter (San Francisco Fire Department)</td>
<td>Mayor</td>
</tr>
<tr>
<td>Vitka Eisen, M.S.W., Ed.D</td>
<td>Treatment provider with mental health harm reduction experience (Health Right 360)</td>
<td>Mayor</td>
</tr>
<tr>
<td>Steve Fields, M.P.A.</td>
<td>Treatment provider with mental health treatment and harm reduction experience (Progress Foundation)</td>
<td>BOS</td>
</tr>
<tr>
<td>Ana Gonzalez, D.O.</td>
<td>DPH employee experience with treating persons diagnosed with both mental health and substance abuse (Behavioral Health, SFDPH)</td>
<td>Mayor</td>
</tr>
<tr>
<td>Phillip Jones</td>
<td>Lived experience</td>
<td>BOS</td>
</tr>
<tr>
<td>Monique LeSarre, Psy. D.</td>
<td>Behavioral health professional with expertise providing services to transitional age youth in SF (Rafiki Coalition)</td>
<td>BOS</td>
</tr>
<tr>
<td>Jameel Patterson</td>
<td>Lived experience</td>
<td>Mayor</td>
</tr>
<tr>
<td>Andrea Salinas, L.M.F.T.</td>
<td>Treatment Provider with experience working with criminal system involved patients</td>
<td>BOS</td>
</tr>
<tr>
<td>Sara Shortt, M.S.W.</td>
<td>Supportive Housing provider</td>
<td>BOS</td>
</tr>
<tr>
<td>Amy Wong</td>
<td>Healthcare worker advocate</td>
<td>BOS</td>
</tr>
<tr>
<td>Kara Chien, J.D.</td>
<td>Health law expertise</td>
<td>City Attorney</td>
</tr>
<tr>
<td>Hali Hammer, M.D.</td>
<td>DPH employee with health systems or hospital administration experience (Primary Care Behavioral Health, SFDPH)</td>
<td>Mayor</td>
</tr>
</tbody>
</table>
The SCRT received a call about a person walking in and out of the streets, throwing trash. The fire and sheriff’s departments were on the scene but requested SCRT help with the person’s mental health issues. The team found the client in an agitated, paranoid state. The clinician used active listening and de-escalation techniques to engage the client, who reported using fentanyl earlier in the day. She expressed that she was very cold and wanted coffee, so the clinician offered to get the coffee. As they waited for the coffee and the conversation continued, the client told the clinician about her bipolar and psychosis diagnoses and about her case manager. The team referred the client back to that provider.
Within the first month in operation The Street Crisis Response Team had its first repeat engagement. Over the course of one week the team engaged with a young male in his 20's that was reported to be naked in the community. Each time the team was dispatched to the location they tried continuously to get the client to stop for even one second to have a conversation and each time the client quickly said no thank you and ran off. On the third or fourth time being dispatched out to this unclothed individual I was able to follow him a block and he surprisingly accepted food that I was offering him. As I handed him the snack I thought that this might be my chance to get him to stop for a second and talk. To my surprise he responded to a few questions and lingered longer than he had in past engagements before running off again. This was witnessed by the other members of the team. We debriefed for a minute before trying to engage one more time and came to an agreement that since he looked willing to talk to me that I would do my best to try and engage with him again and try and get him to put on some clothing. We found him talking to himself down an alley off Van Ness Ave, and I walked down to try and talk again... while my team members tried their best to remain unseen but within sight in case I needed assistance. Even though the conversation was confusing and didn’t make much sense to me he still took the clothes I was offering and put on the underwear and shirt and even took a new blanket. Ultimately, he declined services but felt that the repeated compassionate care that the team showed and maybe the relative heart of the peer he was able to receive was a win indeed.

-Michael Marchiselli, Peer Counselor, Street Crisis Response Team
SCRT APPENDIX: ALIGNMENT WITH OTHER MHSF PROGRAMS

Office of Coordinated Care (OCC)
- The SCRT model includes a team of care coordinators assigned to SCRT responsible for following up with existing providers and/or clients with whom SCRT engages within 24 hours of contact with the team. The care coordinator will function as a part of the OCC and will support clients in navigating the system and aim to reduce readmission to crisis services.

Crisis Stabilization Unit
- The establishment of a new low-barrier resource to accept clients in a behavioral health crisis as an alternative to Psychiatric Emergency Services and in addition to Dore Urgent Care Clinic is a critical linkage resource for the SCRT.

Drug Sobering Center
- The establishment of the new Drug Sobering Center will enable clients encountered by SCRT who use drugs – especially methamphetamine – to safely recover from intoxication.

Intensive Case Management (ICM) Expansion
- ICM is a community-based complement of services to help clients obtain housing and achieve an optimum quality of life through developing plans, enhancing life skills, addressing health and mental health needs, engaging in meaningful activities and building social and community relations. This service would benefit a subset of the clients with whom SCRT engages in addition to other forms of case management.