MENTAL HEALTH REFORM

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

UPDATE REPORT

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Executive Summary

In March 2019, Mental Health Reform in San Francisco launched with the mayoral appointment of Dr. Anton Nigusse Bland as director. Through this appointment, Mayor London N. Breed sought to identify solutions for behavioral health challenges faced by the City, especially those linked to increasing homelessness. With this charge, the Director of Mental Health Reform worked within the San Francisco Department of Public Health and with the broader behavioral health community to define the vision, goals, and target population for the reform effort. Building on this initial charter and framework, the Mental Health Reform team began to make recommendations in September 2019 and to take actions to launch transformative reform.

This status report provides an overview of the development and implementation of Mental Health Reform in San Francisco in its first year, detailing the initiation of the work, the identification of a target population, the engagement of the community, and recommendations for transforming the behavioral health system. Further, the report describes the complementary City initiative, Mental Health SF, legislation that aims to improve behavioral health services for people experiencing homelessness in San Francisco. Finally, the director outlines goals for the second year of Mental Health Reform.

Background

On any given day in San Francisco, thousands of people experience homelessness. While the Department of Public Health (DPH) is fully engaged on multiple initiatives to help those in need, and even as many City departments focus effort and investment on the issue, the population of people experiencing homelessness in San Francisco is growing. The Point-in-Time Count, conducted every two years by the Department of Homelessness and Supportive Housing (HSH), indicated a 17 percent increase from 2017 to 2019. This increase has been accompanied by deepening public concern, and the health needs of this expanding population are often chronic and complex. DPH is committed to protecting and promoting the health of all San Franciscans. When it comes to meeting the behavioral health needs of the most vulnerable people on our streets, the current infrastructure does not match the demand.

In March 2019, Mayor London N. Breed appointed a Director of Mental Health Reform, Dr. Anton Nigusse Bland, to develop strategies to improve San Francisco's approach to mental health and substance use treatment for adults experiencing homelessness. This assignment would be limited to two years, with an emphasis on leveraging existing efforts to make a measurable impact in the challenging environment. Dr. Nigusse Bland entered this role with extensive clinical expertise in caring for this patient population, as Medical Director of Psychiatric Emergency Services at Zuckerberg San Francisco General Hospital and, previously, Chief of Psychiatry at Contra Costa County Regional Medical Center. He is board-certified in both general psychiatry and addiction psychiatry. As a mayoral appointee, Dr. Nigusse Bland serves as a consultant to DPH while maintaining his faculty position with the University of California, San Francisco.

The table below outlines the core Mental Health Reform team supporting Dr. Nigusse Bland's work:

Name	**Title & Team Role**
Tomás J. Aragón, MD, DrPH	Director, Population Health Division (PHD); project advisor
Jeannie Balido	Project Management Improvement Office Coordinator; project advisor
Lauren Brunner, MPH	Program Coordinator, Mental Health Reform
Kelly Hiramoto, LCSW	Special Projects; project advisor
Jenna Lane	Behavioral Health Communications Specialist

During the project's first year, the Mental Health Reform team collaborated weekly with DPH leaders including, but not limited to, the Director of Health, Deputy Director of Health, Director of San Francisco Health Network, Director of Behavioral Health Services, Director of Whole Person Care, Director of Policy and Planning, and Director of Communications.

Defining the Project

Dr. Nigusse Bland began his work by meeting with stakeholders from the Department of Public Health, its Behavioral Health Services (BHS) division, and its network of community providers; the Department of Homelessness and Supportive Housing (HSH); Tipping Point Community Foundation and other philanthropic leaders; and others who work closely with people experiencing homelessness and/or people with behavioral health diagnoses. Through these conversations, Dr. Nigusse Bland developed a deep understanding of the City's priorities in the current landscape while capturing the collective expertise of the system serving this population. While San Francisco has many innovative practices and successes in caring for people experiencing homelessness, mental illness and substance use disorder, Dr. Nigusse Bland began to outline the ways that the City can and must do more to improve their quality of life. He also began to build consensus regarding the health system's strengths and opportunities to improve.

The Mental Health Reform team conducted a thorough review of the past 10 years of strategic planning processes on the topics of homelessness and behavioral health in San Francisco. The reports reviewed, and the common themes that emerged, are outlined in the table below.

Table 1: Behavioral Health Reports and Themes

Reports Reviewed	Common Themes
1. Homelessness and Behavioral Health; JSI – Tipping Point, 2019 2. BHS Performance Audit; BLA, 2018 3. Whole Person Care Stakeholder Discovery; WPC, 2018 4. Acute Adult Psych Recommendations; Mary Thornton, 2018 5. BHS External Quality Review Organization Report; FY1819 6. Justice that Heals Report, District Attorney, 2017 7. CARE Task Force; 2014 8. Hospital Council Mental Health Task Force; 2009 9. SFDPH Community Programs – Stakeholder Engagement Process, 2009	• Improve **linkages and care coordination** • Increase **intensive case management** through increased staffing and improved ability to step patients down to lower levels of care • Expand **field-based services** and improve technology for these outreach teams • **Increase co-location of services** (e.g., mental health at shelters and on streets, benefits and housing navigation) • Create a **database and/or tracking system** for behavioral health beds and wait times • Expand **harm reduction housing** for chronic alcoholism (managed alcohol programs) • Expand **data sharing**, increasing the ability to share information among providers and agencies in order to improve care coordination for shared clients

In consideration of the previous reports and interviews with key stakeholders, and in collaboration with DPH leadership, the Mental Health Reform team developed a two-pronged vision for the department and the people it serves.

> ***For our clients*:** People experiencing homelessness have low-barrier access to welcoming, high-quality behavioral health care that matches their needs.
>
> ***For our system of care*:** A system of care grounded in evidence-based practices that reduces harm, increases recovery, and is suited to efficiently deliver behavioral health services to people experiencing homelessness.

Accompanying this vision, the Director of Mental Health Reform established three core principles for this work: equity, transparency, and accountability. Armed with this vision and these principles, the team prepared to identify the target population and deliverables for the project.

Target Population

Through an in-depth data analysis, conducted in collaboration with the DPH Whole Person Care team, the Mental Health Reform team found that approximately 18,000 adults experienced homelessness in San Francisco in fiscal year 2018-19. These individuals were identified by the Coordinated Care Management System (CCMS), a DPH-operated system integrating 15 separate databases from DPH, HSH and the Human Services Agency (HSA). CCMS defines people as experiencing homelessness in the fiscal year if they either: 1) utilize a City service that indicates housing instability, for example, a City shelter, or 2) self-report homelessness while accessing health care services.

While the DPH estimate of 18,000 people experiencing homelessness in FY1819 may appear to conflict with San Francisco's Point-in-Time Count (8,035 people counted in January 2019)[1], the U.S. Department of Housing and Urban Development (HUD) details in its Annual Homeless Assessment Report to Congress that the full-year number is generally 2.5 times greater than the single-night count.[2]

Using the CCMS-defined 18,000 people experiencing homelessness as the base, the Mental Health Reform team analyzed the population's diagnostic epidemiology to understand the associated burden of behavioral health issues. The team found nearly 4,000 adults experiencing homelessness who also suffer with co-occurring mental health and substance use disorders. Specifically, in addition to homelessness, this group of 4,000 has a history of both psychosis and substance use disorder. Of this cohort, only 44 percent had

[1] http://hsh.sfgov.org/wp-content/uploads/FINAL-DRAFT-PIT-Report-2019-San-Francisco.pdf
[2] https://www.hudexchange.info/resource/5639/2017-ahar-part-1-pit-estimates-of-homelessness-in-the-us/

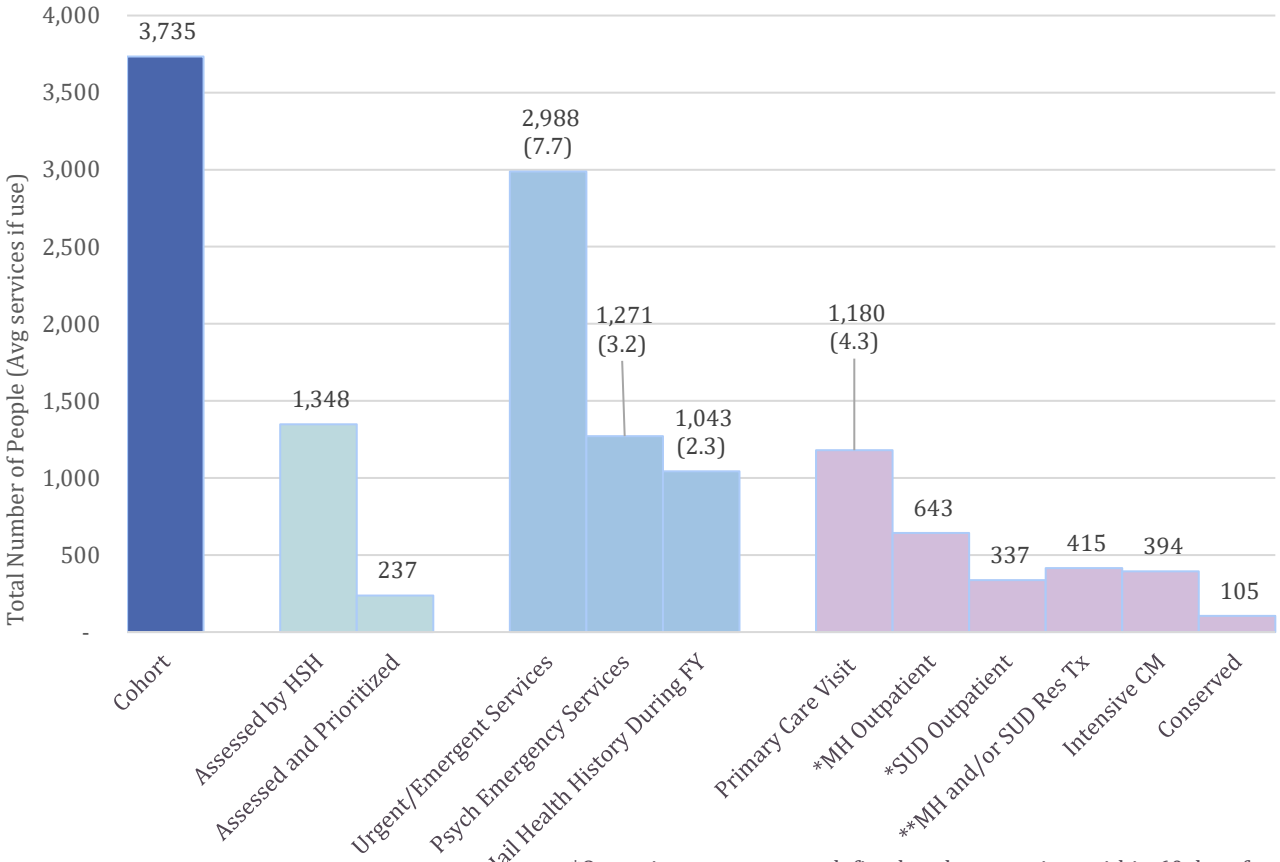
both DPH and HSH service records, meaning that more than half of the population had not accessed the two City systems most critical to their needs.

Adults Experiencing **Homelessness**
- History of **Psychosis** (such as schizophrenia and schizoaffective disorder)
- History of **Substance Use Disorder** (alcohol, opioid, cocaine and/or stimulant use)

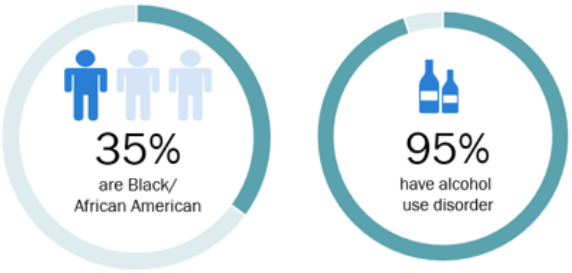
Upon further review of this population, the team found that health care utilization patterns (see *Figure A* below) did not match the needs of people living with this combination of conditions. For example, just 10.5 percent of the population had an intensive case manager (ICM) who helps behavioral health clients with complex needs. In other words, the people in greatest need of services were not using those services at the rates we would expect.

Selected data regarding service utilization patterns among the cohort of nearly 4,000 people is presented here. For a more detailed account of data regarding this population, see *Table 2* in the Appendix.

Figure A: Mental Health Reform Target Population FY1819 Service Utilization



*Outpatient engagement defined as three services within 60 days for mental health (MH), 30 days for substance use disorder (SUD)
**Residential treatment engagement is 30+ days of stay



In addition to the service utilization patterns, one of the most troubling findings about this group is the inequity of the burden of these diagnoses. Thirty-five percent of the population identifies as Black/African American, compared to 5 percent of the population of San Francisco. Another notable characteristic is that 95 percent of the cohort has a history of alcohol use disorder, which far exceeds the other common substance use disorders: methamphetamine use (54%) and opiate use disorder (29%).

The team concluded that this vulnerable population would be the focus of reform efforts and that solving for these highest-risk, highest-need individuals would improve access and flow throughout the behavioral health system. This marks the first time San Francisco has applied behavioral health diagnoses to its homelessness data and taken a population-level approach to solving the problems these individuals face.

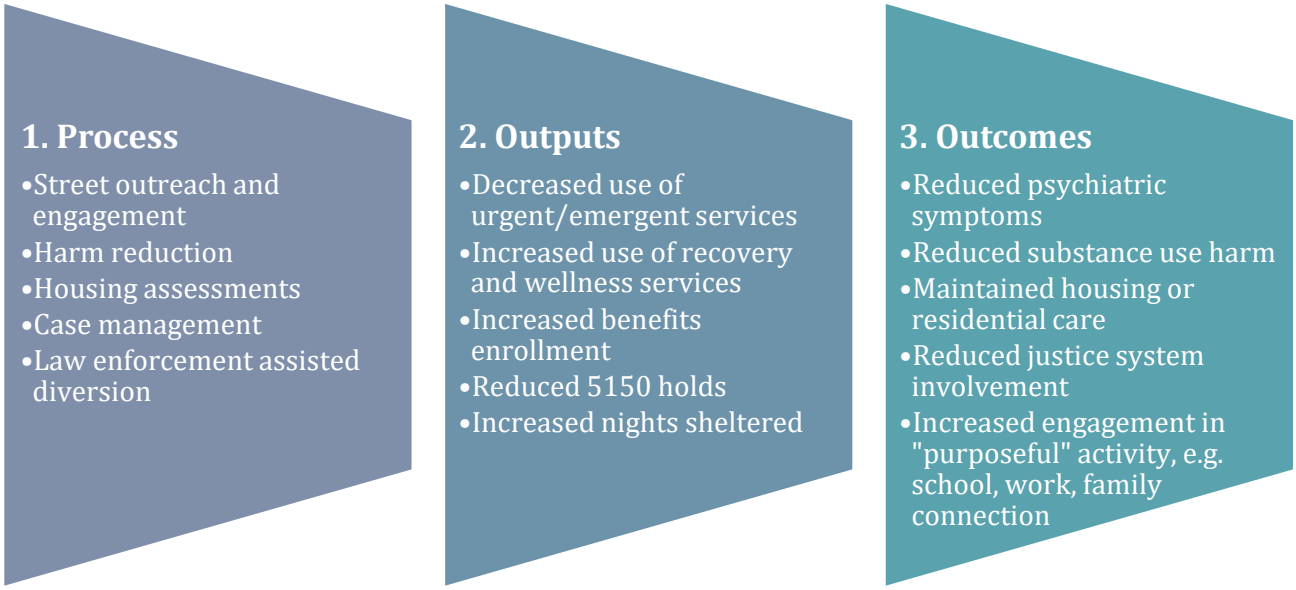
Evaluating the Reforms

Armed with the baseline data and the target population, the Mental Health Reform team developed an evaluation framework using the Results Based Accountability (RBA) methodology. In RBA, the strategies and measures stem from an overarching goal. In the case of Mental Health Reform, the goal is to ***improve the quality of life for adults experiencing homelessness with co-occurring mental health and substance use diagnoses in San Francisco*.**

The RBA framework seeks to answer the following questions:

1. How much was done? (Processes)
2. How well was it done? (Outputs)
3. Is anyone better off? (Outcomes)

The full RBA framework, shown in *Figure B* in the Appendix, demonstrates the processes, outputs, and outcomes that must be monitored and measured to reach the overarching goal of Mental Health Reform.



In the logic of this framework, by increasing and/or improving the activities listed in the process measures, we will see changes measured by the outputs, which ultimately lead to the desired changes in patient-level outcomes.

As part of a "Lean" strategic planning process with DPH leaders, Dr. Nigusse Bland identified five key metrics and targets for DPH to execute, in collaboration with other City departments, over a three-year period. These metrics and associated targets represent high-level indicators that, if achieved, would signify improvement in the lives of the 4,000 people in the target population.

The team is developing a full set of metrics to accompany these high-level targets and goals. As shown in *Table 3*, housing and residential treatment are key components to the health and wellness of this population.

Table 3: Mental Health Reform Targets and Goals by 2022

Metric	FY1819 Baseline	Target 7/1/21	Target 7/1/22
1. Increase the percentage of the target population assessed for housing.	36%	75%	90%
2. Increase the percentage of the target population retained in non-emergency behavioral health care (outpatient/residential mental health or substance use treatment).	29%	35%	42%

Metric	FY1819 Baseline	Target 7/1/21	Target 7/1/22
3. Reduce the percentage of target population who use urgent and emergent services and the frequency of use per person.	80% (7.7)	68% (6.6)	58% (5.6)
4. Improve quality of life and functioning, as measured by scores on mental health and substance use assessment tools.[3]	TBD	TBD	TBD
5. Increase the number of people who are placed in permanent supportive housing or other long-term placements (cumulative).	348	1,000	2,000

Housing is critical to a person's path to recovery. As proven in the groundbreaking "At Home/Chez Soi" trial for people experiencing homelessness and mental illness, an intervention that puts housing first with intensive case management (ICM) is more effective than treatment as usual.[4] In San Francisco, completing the HSH Coordinated Entry Assessment is the first step to access housing. In order to achieve this goal, DPH must partner closely with HSH to deliver this service to the community. For health care services, to mark progress, the outcomes data from treatment services must demonstrate both a reduction in the use of urgent and emergent services and an increase in the use of recovery and wellness services.

Engaging the Community

In addition to the series of individual meetings with key stakeholders, the Mental Health Reform team convened half-day engagement sessions with leaders from community-based organizations and DPH Behavioral Health Services (BHS). The objective of these sessions was to present and refine the vision and early recommendations for Mental Health Reform and to build consensus and engagement in the execution of the reforms.

[3] DPH is working to define this metric in a new way that fully captures improvements on the individual level for people who are in substance use or mental health treatment programs.

[4] Goering, P. N. et al. (2011). The At Home/Chez Soi trial protocol: a pragmatic, multi-site, randomised controlled trial of a Housing First intervention for homeless individuals with mental illness in five Canadian cities. *BMJ open*, *1*(2), e000323. https://doi.org/10.1136/bmjopen-2011-000323

The first meeting, held in September 2019, gathered executive leaders from 13 community-based organizations.[5] In this session, facilitated by Harder + Company, Dr. Nigusse Bland presented the vision, goals, objectives, target population and early recommendations for reform. Then, the group engaged in discussion and idea generation to identify how services could be strengthened for the target population. This conversation focused on short-term (six months) and long-term solutions that would improve quality of life for the population of 4,000 and public safety for all. The resulting themes included:

- Equity for the Black/African American community
- More harm reduction drop-in sites with expanded hours
- Client-centered service design and inquiry – ask clients what they want
- Provide more transportation services
- Align reimbursement payments with positive clinical outcomes
- Additional outreach and medical resources on the streets

Following the September engagement with community providers and to build on those ideas, the Mental Health Reform team organized an additional session with BHS executive leadership. In this meeting, BHS leaders identified promising and innovative resources and prioritized the emerging recommendations for reform. The resulting priorities, in order, were:

1. Provide tailored, innovative **services for Black/African American communities** to address inequities and disparities in health
2. **Centralize behavioral health intake** processes to improve client experience, system flow, and data analysis
3. Create more **harm reduction centers** and resources to build trust with the community and motivate people to engage in care
4. Provide improved and expanded **intensive case management services**
5. Expand the system's ability to provide mental health services through **telehealth**

The results of these two engagement sessions, coupled with the input from previous stakeholder processes, set the stage for the Director of Mental Health Reform's initial set of recommendations.

[5] See *Table 4* in the Appendix for a full list of participants and organizations.

Mental Health Reform Recommendations

Taking into consideration the current conditions, the target population, and the community engagement sessions, along with the guiding principles of equity, transparency and accountability, the Mental Health Reform team developed an initial set of recommendations in October 2019. These recommendations[6] aim to impact the lives of the 4,000 individuals experiencing homelessness, mental illness, and co-occurring substance use issues while improving public safety. Mayor Breed endorsed these recommendations and committed early budget investments to a subset of these initiatives, detailed in *Table 7*.

Table 5: Mental Health Reform Recommendations October 2019

Improve Care Coordination	Optimize current intensive case management services to improve client outcomes.
	Expand intensive case management to serve more people in need.
	Expand assisted outpatient treatment to build on evidence-based practice.
	Provide telehealth to bring additional services to people outside of traditional care settings.*
	Create a team of behavioral health first responders to assist in police response to incidents on the streets.*
	Expand transportation services to improve client navigation and transitions of care.
Expand Service Sites	Expand drop-in hours at DPH's Behavioral Health Access Center.
	Create a new crisis stabilization unit to expand services into new neighborhoods.
	Create additional supportive housing sites to improve client recovery and meet demand.*
Increase Harm Reduction Services to Prevent Overdoses	Prevent overdoses through increased availability of naloxone.
	Implement a managed alcohol program for people with chronic alcohol use disorder.*
	Fund infrastructure to improve safety at harm reduction centers.
Develop the Behavioral Health Workforce	Conduct a market analysis to identify appropriate compensation of workforce.
	Develop a behavioral health clinical provider recruitment program to attract staff.
	Begin a scholarship program as an incentive to work in San Francisco's mental health safety net.
Bolster Public Awareness and Advocacy	Design and implement Mental Health First Aid to improve the general public's capacity to respond to people in need.
	Create a health system navigation media campaign to increase awareness of available services.
	Expand family and caregiver support services to support the families and advocates of people with mental illness and/or addiction.

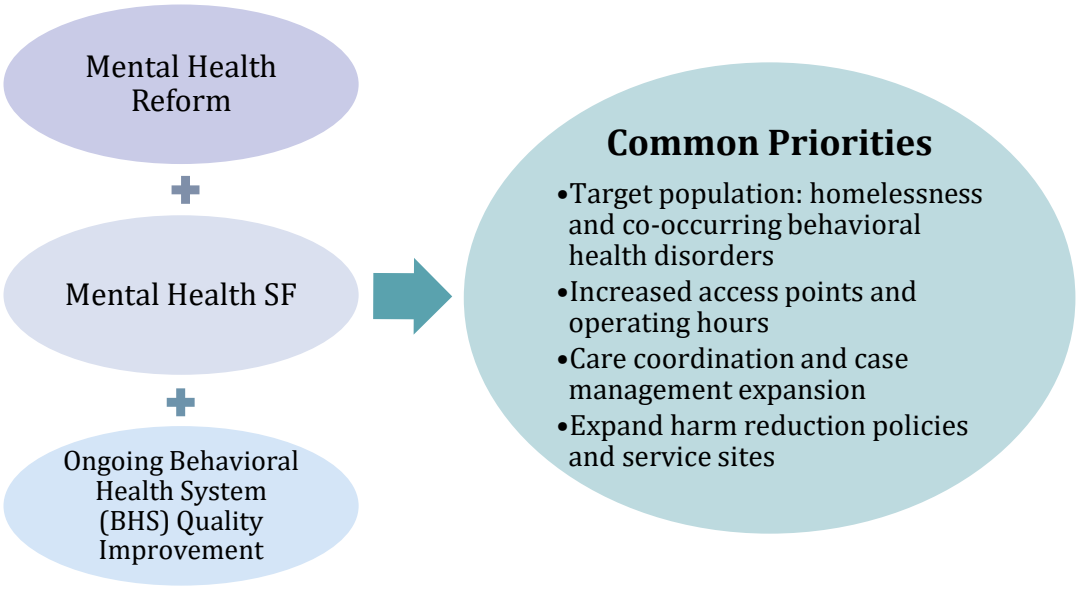
**Indicates shared priority with other City agencies such as HSH, dependent on effective interagency collaboration*.

[6] See *Table 6* in Appendix for full descriptions of recommendations.

Mental Health SF

In the fall of 2019, members of the San Francisco Board of Supervisors collaborated with the Mayor's office and DPH to refine and introduce legislation called Mental Health SF. The purpose of the legislation is to improve the delivery of behavioral health services in San Francisco, with a focus on adults experiencing homelessness. It includes a new, 24-hour Mental Health Service Center designed to provide urgent mental health care on demand, as well as a new Office of Care Coordination designed to track the need for behavioral health care and offer case management services.

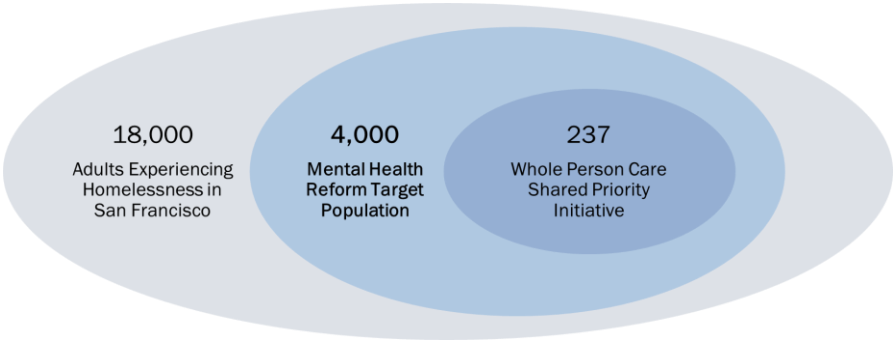
The vision for Mental Health SF evolved through a series of conversations including community stakeholders and care providers, the Board of Supervisors, the Mayor's office and DPH. The role of DPH staff was to offer detailed information regarding topic areas of interest, such as care coordination, to the original designers of Mental Health SF. Through this process, DPH and the Controller's Office conducted budget analyses for the legislation. As of December 2019, the estimated cost of implementing Mental Health SF was nearly $9 million in one-time costs and approximately $150 million annually. Potential funding sources, including a bond and a reformed business tax, have been identified. Per the legislation, the Mayor and Board of Supervisors will appoint a 13-person Implementation Working Group and DPH will hire a Director of Mental Health SF in 2020.



Mental Health SF and Mental Health Reform share many elements, and BHS is engaged in similar ongoing quality improvement work. Their common priorities will create a roadmap for budgeting and program enhancements in 2020 and beyond.

Milestones Summary

The Mental Health Reform team reached significant milestones in 2019 and early 2020 which provide the framework and foundation for future reform efforts and Mental Health SF. Other milestones symbolize a new era of transparency for DPH, such as the new behavioral health bed availability website, FindTreatmentSF.org. Some milestones are geared specifically toward the 4,000 people in the target population, such as the DPH, HSH and HSA shared priority list of 237 people. They are the first cohort to receive intensive interagency coordination services designed to successfully place them in permanent supportive housing or other stable residential settings. As of October 2020, roughly 56 percent of the shared priority list had been permanently housed.



The following table lists the most significant milestones for Mental Health Reform in its first year, in order of their public announcement and with planned implementation dates. These milestones were supported by significant investments of Mayor Breed and philanthropic partners; and provide a foundation for the City as it begins to plan for and implement Mental Health SF.

Table 7: Mental Health Reform Milestones Through October 2020

Milestone	Milestone Description	Announcement Date	Planned Implementation
Define the Population	Used a population-level approach to behavioral health and homelessness by identifying the nearly 4,000 San Franciscans living with the combination of homelessness, serious mental illness, and substance use disorder.	September 2019	September 2019
Shared Priority Initiative	Streamline housing and health care through interagency collaboration with a "whatever it takes" approach to place the first 237 of the City's most vulnerable clients in housing or other safe settings.	September 2019	October 2019
Expand Access to Services	Expand the hours of the Behavioral Health Access Center (budgeted).	September 2019	Early 2021

Milestone	Milestone Description	Announcement Date	Planned Implementation
Psychiatric Respite Expansion	Tipping Point Community announces funding for an additional psychiatric respite center in the community.	September 2019	Early 2021
Overdose Prevention	Expand community access to and training in naloxone to reverse opioid overdose.	October 2019	Ongoing
Managed Alcohol Program	Endorsed managed alcohol programming as an evidence-based harm reduction tool to help people with chronic alcohol use disorder. This model was also recommended in the Tipping Point Community report, *Behavioral Health and Homelessness in San Francisco*. As part of COVID-19 response, DPH implemented a pilot managed alcohol program which has seen significant early success.	September 2019	Pilot managed alcohol program initiated in Spring 2020; Full scale program implementation TBD
Bed Availability Website	The Mental Health Reform team launched a public website, FindTreatmentSF.org, to display treatment capacity and daily availability for short-term, residential substance use treatment. Quality improvement work will be informed by the data shown in this new resource.	September 2019	December 2019
Drug Sobering Center	Endorsed recommendations from the City's Methamphetamine Task Force. Planning began immediately for one of the top recommendations, to open a resource equivalent to the City's alcohol sobering center for people sobering from drugs. The drug sobering center was originally scheduled to open in Spring 2020 but was delayed by the COVID-19 public health emergency.	November 2019	TBD
Expand Use of Telehealth	Developed a telehealth program for community access to buprenorphine and for mental health and substance use disorder treatment for alternate care sites during COVID-19 response. The protocols and infrastructure can be adapted to meet the needs of any residential setting (e.g. navigation centers, shelter-in-place hotels).	March 2020	Smart tablet devices deployed at Glide Street Outreach and Low Acuity Care Site October 2020

Milestone	Milestone Description	Announcement Date	Planned Implementation
Behavioral Health Bed Optimization Project	The Mental Health Reform team conducted a first-ever, in-depth quantitative analysis of the behavioral health system of care. Using bed simulation modeling methodology, the report recommends targeted investments to improve patient flow.	N/A	Report released June 2020
Street Crisis Response Team	The Mental Health Reform team is leading the planning and implementation of a pilot interdisciplinary team to respond to street-based behavioral health crises. This team will provide an alternative to police response. The next section provides additional detail on the innovative pilot program.	August 2020	December 2020

Looking Ahead

In its first year, the Mental Health Reform team helped lay the foundation for a transformation of the behavioral health care system in San Francisco so that it better serves the most vulnerable people on our streets. In its second year, the team expects to collaborate with City leaders and departments on the implementation of the Mental Health SF legislation, while also championing some of Dr. Nigusse Bland's own, complementary recommendations for reform that will enhance the work of Mental Health SF such as telehealth, robust behavioral health data tracking systems, a new crisis diversion facility, and Results Driven Contracting.

The second year of Mental Health Reform in San Francisco has been impacted by the COVID-19 public health emergency in many ways. Many DPH staff have been required to shift their attention and time to meet the demands of the public health emergency. Planning new programs has become more challenging due to physical distancing requirements and bleak budget outlooks. The population experiencing homelessness has also been disrupted, with shelters reducing capacity to prevent virus transmission. Despite these obstacles, DPH remains committed to Mental Health Reform and has pivoted recommendations and plans in a way that supports meaningful change in the new environment. The target population of nearly 4,000 people continues to be at the center of DPH reform efforts. The approach is designed to ensure the success of Mental Health SF, the transformation of BHS, and, most importantly, the stability and wellness of our population experiencing homelessness, mental illness, and substance use

disorder. Furthermore, in consideration of the growing incidence of overdose deaths in the City, these priorities also seek to respond to this public health emergency.

The Mental Health Reform team will continue to address the City's greatest challenge in its second year through the following:

1. **Improve the health and wellbeing of the 4,000 people experiencing homelessness with behavioral health needs.** DPH must implement targeted strategies with measurable outcomes to improve the health and wellbeing of the Mental Health Reform population. These are detailed in *Table 7*. Because HSH is the primary agency charged with placing residents in permanent supportive housing, achieving these goals will depend on effective partnerships between DPH, HSH and other City agencies.

Table 8: Key Performance Metrics and Strategies

Metric	Strategies
1. Increase the percentage of the target population assessed for housing.	• Establish performance measures for referral for housing through intensive case management services; 100% of clients in ICM should have a completed housing assessment • Collaborate with HSH to pilot Coordinated Entry assessments in residential mental health and substance use disorder treatment programs
2. Increase the percentage of the target population retained in non-emergency behavioral health care (outpatient and/or residential mental health or substance use treatment).	• Intensive outreach and engagement, including through new street crisis response team (detailed below), crisis diversion facility, and drug sobering center • Allocate at least 60% of new intensive case management through new Mental Health SF slots for target population • Implement active utilization of ICM to optimize capacity • Obtain technical assistance for Results-Driven Contracting to use performance data to actively manage contracts, including measuring outcomes, impacts, and/or cost-effectiveness
3. Reduce the percentage of the target population who use urgent and emergent services and the frequency of use per person.	• Intensive outreach and engagement through new crisis response team and new intensive case management slots allocated for population • Pilot Results-Driven Contracting to use performance data to actively manage contracts, including measuring outcomes, impacts, and/or cost-effectiveness

Metric	Strategies
4. Improve quality of life and functioning, as measured by scores on mental health and substance use assessment tools.	• Pilot Results-Driven Contracting to use performance data to actively manage contracts, including measuring outcomes, impacts, and/or cost-effectiveness
5. Increase the number of people who are placed in permanent supportive housing or other long-term placements (cumulative).	• Increase number from target population who are assessed for housing • Establish performance measures for referring participants in residential treatment programs to housing assessments

2. **Develop a behavioral health placement tracking system.** Create a uniform way to monitor and evaluate service demand, patient wait times and patient flow throughout behavioral health services. This data system will form the backbone of a seamless, transparent process for clients to be referred, authorized, and placed into behavioral health programs, benefiting the Mental Health Reform population as well as all behavioral health clients. This robust system must calculate demand and wait times and continue the use of FindTreatmentSF.org to drive better use of resources. Furthermore, this project must include a standing workgroup of community providers and DPH leadership to discuss current policies and procedures and how they can be refined to improve patient access. It must be a contractual obligation for community-based organizations to track demand and wait times through this new system.
3. **Expand and integrate the crisis response system.** While DPH offers a variety of crisis services, they currently lack sufficient coordination and may perpetuate inequities in the criminal justice system. DPH should align existing resources in a way that replicates a Crisis Now model; this approach can divert people with mental illness and substance use issues away from medical emergency departments and the criminal justice system and toward behavioral health treatment centers better suited to meet their health needs. This would complement ongoing work toward a March 2019 Health Commission Resolution, *Incarceration is a Public Health Issue*, and accomplish a goal of the Mental Health SF legislation. This work will strive to reduce inequities seen both in the criminal justice system and in the target population for reform. This redesign of crisis response will depend on three key elements:
    i. *Drug sobering center:* Mayor Breed and DPH continue to support drug sobering centers as an evidence-based model to help people who use drugs. Drug sobering centers will be a key component of the community-based response to the involvement of people with mental illness

and substance use disorders in the criminal justice system. In consideration of COVID-19, DPH must plan the safest way to design and open this type of setting.

ii. *Crisis diversion facility:* DPH should implement a crisis diversion facility either through repurposing a current program or developing a new site. Crisis diversion facilities are an evidence-based model replicated across the nation; they provide specialized mental health and substance use treatment to stabilize people in crisis, reduce unnecessary and costly emergency room use and jail stays, and increase access to critical health and support services for vulnerable community members who often suffer from structural inequities. This facility would succeed through collaboration with community partners, including the new street crisis response team, SFPD, EMS-6 and Homeless Outreach Team. This facility will differ from existing crisis centers by offering a 72-hour length of stay, which will enable stronger connections to case management and/or referrals to residential treatment programs.

iii. *New street-based crisis response team:* In alignment with Mental Health SF legislation and Mayor Breed's commitment to developing alternatives to law enforcement responses to people in crisis, a street-based crisis response team is under development. The Mental Health Reform team, in collaboration with its implementation partners, is coordinating the launch of this pilot program by December 2020. The model of care for this team is informed by national best practices and customized to the needs of San Francisco. The team will be comprised of a community paramedic from the San Francisco Fire Department, a behavioral health clinician, and a peer health worker with relevant lived experience. The team will be supported by a care coordinator from the Office of Coordinated Care, responsible for follow up and linkage support. This team will complement the mobile crisis response work of DPH Comprehensive Crisis Services, which primarily serves children, youth and individuals who are housed. The new street-based crisis response team will respond with trauma-informed behavioral health interventions, in lieu of, or in collaboration with, the San Francisco Police Department. This team will begin as a pilot in areas of San Francisco where the highest volume of 9-1-1 calls for mentally disturbed persons originate. The pilot model shall be expanded over time and based on the evaluation of promising practices.

4. **Expand telehealth with a focus on sustained access to remote psychiatry and addiction services.** Prior to the COVID-19 emergency, DPH was developing small pilot programs to test the use of telehealth for people experiencing homelessness, especially for addiction treatment services. Mental health and substance use services can be delivered effectively without physical contact. Federal regulatory changes have made the provision of these services more flexible and reimbursable,

including the ability to start new patients on buprenorphine, a medication for opioid use disorder, through a telephone visit. By increasing telehealth services, DPH hopes to make an impact on decreasing avoidable deaths from drug overdose by making it easier to access care.

DPH should broadly expand its telehealth programming, recognizing its ability to not only protect patients and providers in the time of COVID-19, but also as a workforce multiplier to help bring services to the population rather than waiting for clients to come into four-walls clinics for services. This expansion should include training and equipping outreach teams and first responders with technology to provide telepsychiatry, with a goal of providing more tele-buprenorphine on the streets and in settings accessible to people experiencing homelessness such as residential treatment and navigation centers.

Telehealth helps bring services directly to clients while reducing the cost of care. The use of telehealth will amplify the impact of initiatives included in Mental Health SF legislation, such as the street crisis response team and the Mental Health Service Center. This solution will be particularly impactful for the Mental Health Reform target population of 4,000 people, many of whom have little to no engagement in the behavioral health system of care despite their documented needs. Environments where access to telehealth and tele-buprenorphine should be expanded:

- Shelter-in-place sites, shelters, and navigation centers
- Substance use disorder and mental health residential treatment centers, Hummingbird psychiatric respite
- Street outreach teams including DPH Street Medicine and Community Health Response Team, Felton Engagement Specialist Team (FEST), Glide, SF AIDS Foundation

To increase the accountability and performance of DPH's contracted programs, new programs should use the Results-Driven Contracting (RDC) model to measure their health and social impact for clients. In this model, community-based organizations track a standardized set of process and outcome measures and base their contracts on goals set collectively. RDC has proven to be a powerful tool to drive program impact and community health improvements for people experiencing homelessness in Seattle, Denver, Los Angeles, Santa Clara County and Alameda County. The Harvard Kennedy School Government Performance Lab is conducting research on cities' procurement and contracting practices, and providing technical assistance to midsize cities to implement Results-Driven Contracting strategies for their most important

services.[7] The redesign of the crisis services continuum and the new programs that are generated from Mental Health SF are an opportunity to test this model and improve outcomes for our community.

In pursuing these strategies throughout its second year, the Mental Health Reform team will continue to gather and amplify community expertise and promote collective action to improve behavioral health care for people experiencing homelessness, mental illness, and substance use disorder. The team's technical support will help build the department's capacity for sustaining improvements and providing more effective services. The team will disseminate widely the learning that occurs throughout this process, so that other divisions of the San Francisco Department of Public Health can benefit from adopting the most promising of these strategies. The principles of equity, transparency, and accountability will continue to guide the work, leading San Francisco's behavioral health system closer to its ideals and bringing high-quality care to the most vulnerable San Franciscans when they need it.

[7] Harvard Kennedy School Government Performance Lab. (2018). *Results-Driven Contracting Solutions Book: How Cities Are Improving the Outcomes of High-Priority Procurements*. https://hwpi.harvard.edu/files/govlabs/files/rdc_solutions_book.pdf

Appendix

Table 2: Baseline Data for 4,000

Grouping	Data Element	FY1819 Percent of Population
Demographics	Race and ethnicity	Black/African American (35%) White (33%) Latino (11%) all other races (9%) unknown (12%)
	Age distribution	Ages 18-29 (11%) Ages 30-39 (23%) Ages 40-49 (26%) Ages 50-59 (28%) Ages 60+ (12%)
	Gender	Male (68%) Female (28%) Transgender (1%)
Health Services Utilization	All urgent and emergent services[8]	80%; 7.7 visits per person if use
	Psychiatric emergency services (PES)	34%; 3.2 visits per person if use
	5150 Visits to PES	22%; 1.8 visits per person if use
	Emergency Department	65%; 6.4 visits per person if use
	Sobering Center	6%; 11.2 visits per person if use
	Primary Care Visit	32%; 4.3 visits per person if use
	Mental Health Non-Urgent Engagement[9]	41%
	Substance Use Non-Urgent Engagement[10]	25%
	Mental Health Residential Treatment (>30 days)	8%
	Substance Use Residential Treatment (>30 days)	6%
	Jail Health	28%
	Intensive Case Management	11%
	Conservatorship	3%
Diagnoses (any history)	Psychosis	100%
	Alcohol Use Disorder	95%
	Depression	79%
	Medical Elixhauser Condition[11]	74%
	Chronic Pulmonary Disease	27%
	Methamphetamine Use (or other stimulants)	54%
	Opiate Use	29%
	HIV/AIDS	12%
Housing & Benefits	Length of Homelessness	0-2 years (17%) 2.1-5 years (14%) 5.1-13 years (30%) Over 13 years (40%)
	Assessed by HSH Coordinated Entry	36%
	Prioritized by HSH Coordinated Entry	6%

[8] Includes Psychiatric Emergency Services, Emergency Department, Psychiatric Urgent Care, Sobering Center, Withdrawal Management, Comprehensive Crisis Services

[9] Engagement defined as three services within 60 days for mental health

[10] Engagement defined as three services within 30 days for substance use treatment

[11] The Elixhauser Co-morbidity Index is a research tool to predict early mortality among inpatients. It is a set of 31 co-occurring conditions that contribute to early mortality.

Figure B: Mental Health Reform Evaluation Framework

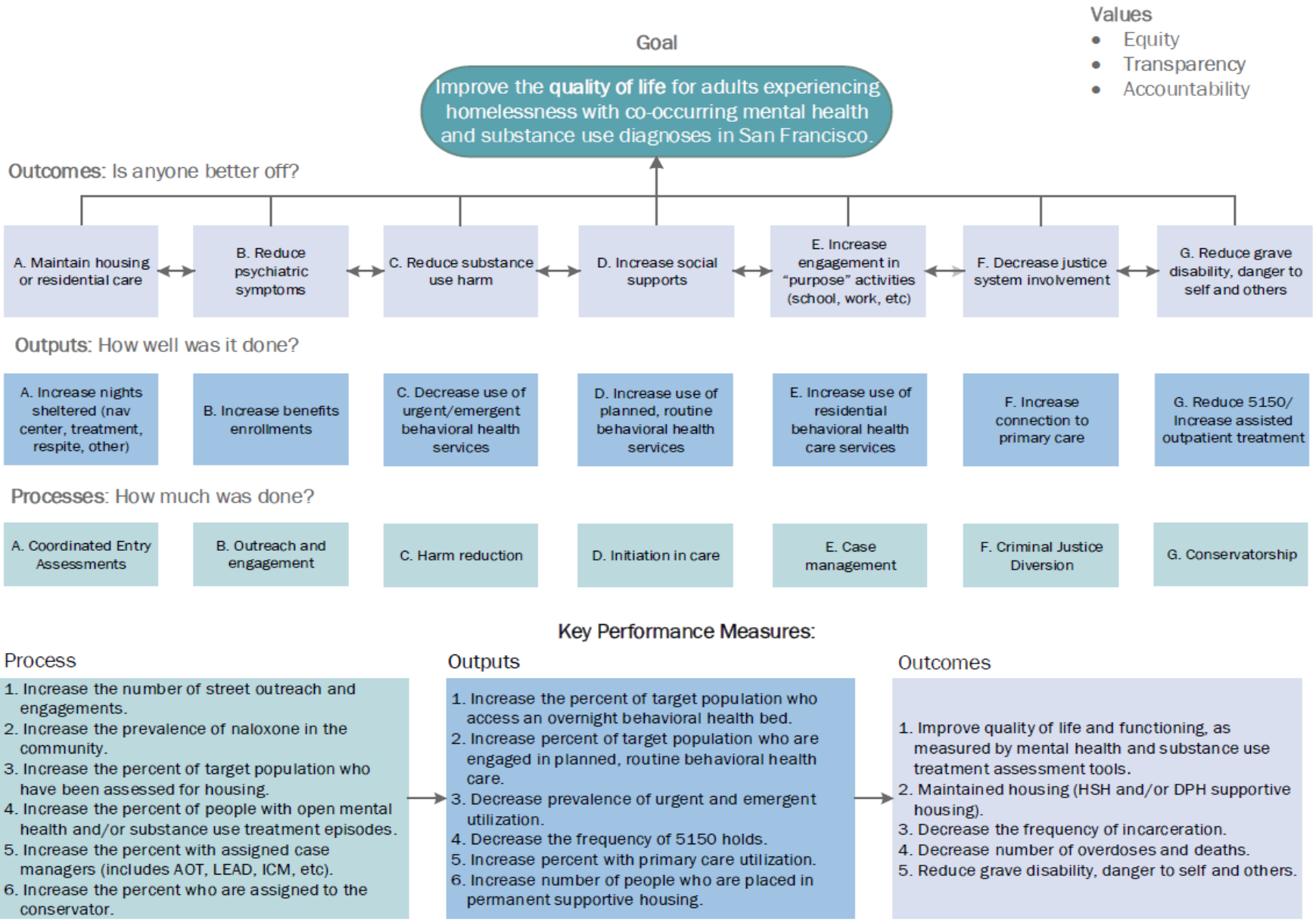


Table 4: Community Engagement Session Participants, September 11, 2019 and October 29, 2019

Community Provider Engagement Session Participants	
Name	**Organization**
Louise Foo	Conard House
Al Gilbert	Felton Institute
Tomiquia Moss	Hamilton Families
Timothy Evans	Hamilton Families
Jeannie Little	Harm Reduction Therapy Center
Nicole Ibarra	HealthRIGHT 360
Simon Pitchford	Homebridge
Lauren Calderon	Hyde Street Community Services
Richelle Slota	Mental Health Board of SF
Terezie Bohrer	Mental Health Board of SF
Brett Andrews	PRC/Baker Places
Steve Fields	Progress Foundation
Jorge Wong	RAMS
Sabra Matovsky	SF Community Clinic Consortium
Marlo Simmons	SFDPH
Fumi Mitsuishi	UCSF Citywide

Behavioral Health Services Engagement Session Participants (DPH staff)
Angelica Almeida
Edwin Batongbacal
Jessica Brown
Shirley Cai
Garrett Chatfield
Cynthia Chinn
Farahnaz Farahmand
Michelle Geiger
Shirley Giang
Matthew Goldman
Ana Gonzalez
Hamilton Holt
Lisa Inman
Alexander Jackson
Michelle Long
Judy Martin
Michelle Meier
Imo Momoh
Craig Murdock
David Pating
Nanalisa Rasaily
Monica Rose
Deborah Sherwood
Marlo Simmons
Irene Sung
Kimberly Voelker
Diana Yee

Table 6: Mental Health Reform Recommendations October 2019

	Mental Health Reform Recommendation	Recommendation Description
A. Improve Care Coordination	Optimize current intensive case management services to improve client outcomes.	Supplement current intensive case management (ICM)-level programming (serving approximately 1,200 clients) to provide a care experience on par with full-service partnership (FSP) programming. Key distinctions between FSP and ICM are clinician-client ratios and provision of non-mental health supports, including flexible funding for food, childcare, housing, and respite care. Implement active utilization management as part of this optimization.
	Expand intensive case management to serve more people in need.	Fund expansion of full-service partnership (FSP)-level programming with Assertive Community Treatment Team mode for intensive case management (ICM), which will provide high-quality treatment to an additional 1,000 individuals assessed as high needs/high vulnerability. Resources should be allocated specifically with additional modality to treat co-occurring substance use issues. *To achieve the department's equity aims, 30% or more of the individuals enrolled in this program should identify as Black/African American.*
	Expand assisted outpatient treatment to build on evidence-based practice.	Expand capacity of Assisted Outpatient Treatment to provide services for an additional 150 high-concern individuals each year. This program has demonstrated ability to improve the quality of life of participants and support them on their path to recovery and wellness, as well as prevent decompensation and cycling through acute services (e.g., psychiatric hospitalization) and incarceration.
	Provide telehealth to bring additional services to people outside of traditional care settings.	Establish a mobile technology/telehealth connection between street outreach team members (HSH, EMS-6, and DPH), navigation/shelter health workers, and the Behavioral Health Access Center (BHAC) for on-demand assessments of clients' behavioral health needs in the community. This should divert clients from going to the BHAC before referral/placement in a residential treatment setting. If a bed resource is unavailable, the client can be assessed for wait-list status and a plan for follow-up developed with outreach workers to support the client in the interim.
	Create a team of behavioral health first responders to assist in police response to incidents on the streets.	Behavioral Health First Responders Team with = transport for clients. The response team includes one paramedic, one behavioral health clinician, and one peer health worker. The team will be deployed in response to 911 or 311 calls for individual safety concerns (e.g. suicidal ideation). This team will decrease the amount of law enforcement response to mental health emergency cases. By making trained professionals available for emergency response, the quality of care provided is improved. It will also minimize the stigmatization of patients with psychiatric problems.
	Expand transportation services to improve client navigation and transitions of care.	Expand transportation escort services for clients who are traveling between City-operated programs and facilities. This escort service should incorporate the expertise of peer support workers. Peer support providers are a distinct provider type for the delivery of counseling and other support services to Medicaid-eligible adults with mental illnesses and/or substance use disorders.

Table 6: Mental Health Reform Recommendations October 2019

	Mental Health Reform Recommendation	Recommendation Description
B. Expand service sites	Expand drop-in hours at DPH's Behavioral Health Access Center.	The Behavioral Health Access Center (BHAC) staff assess clients' needs, help them enroll in benefits such as Medi-Cal, find placements in treatment programs, and connect them to services like medical screenings and primary care. BHAC will be redeveloped as a single point of access for behavioral health, benefits, and evaluation for Coordinated Entry (housing).
	Create new crisis stabilization unit to expand services into new neighborhoods.	Establish a second 24-hour Crisis Stabilization Unit (CSU) site north of Market Street. This site should have 18 beds for direct admissions/transfers from local emergency departments and can be paired with flexible capacity of up to an additional 10 beds as a sobering site destination for methamphetamine users. Given that individuals can present under the influence, the CSU would require clinical and security staff consistent with Psychiatric Emergency Services at ZSFG.
	Create additional supportive housing sites to improve client recovery and meet demand.	Additional supportive housing sites where there is priority placement for clients with mental illness and addictions. Within this expansion, emphasize the integration of persons with mental illness with other populations in supported housing, avoiding their segregation. An estimated 15% set-aside for persons with mental illness or addictions is recommended.
C. Reduce Harm	Prevent overdoses through increased availability of naloxone.	Increase the availability of naloxone by installing vending machines in high-risk, high-need areas and increasing its presence in SROs. The goal would be to have a naloxone dispenser available wherever there is an automated external defibrillator (AED) present in the city. Following a demonstration period, this may require a policy-level change to mandate organizations to have rescue kits available. Furthermore, establish an oversight committee to review policies at residential sites contracted by City agencies, to assess for policies that impede overdose response and establish accountability for implementation of overdose prevention plans.
	Implement a managed alcohol program for people with chronic alcohol use disorder.	DPH should design and implement a managed alcohol program as an innovative, evidence-based solution for people with chronic alcohol use disorders. Expert consensus is to establish a managed alcohol program for chronic, heavy alcohol users with dispensation of alcohol on premises. This is most like the evidence-based models currently in use in Ottawa, Canada. In such a setting, residents must commit to not consume alcohol outside of the program.
	Fund infrastructure to improve safety at harm reduction centers.	A growing number of individuals are being driven toward the use of illicit drugs (i.e. opioids) in settings with little or no clinical support, such as public restrooms. We will partner with community-based organizations that operate drop-in centers in high-risk, high-need areas to fund facilities infrastructure improvements that help mitigate against harm of injection drug use. These funds can support import of technology that helps monitor for signs of overdose (e.g., motion sensors in restrooms, increased visibility in toilet facilities).

Table 6: Mental Health Reform Recommendations October 2019

	Mental Health Reform Recommendation	Recommendation Description
D. Develop the behavioral health workforce	Conduct a market analysis to identify appropriate compensation of workforce.	The growing behavioral health provider shortage threatens SF Health Network members' ability to obtain timely high-quality healthcare. Conduct a market survey analysis to determine range of wages for master's-level social work clinicians and psychiatrists. In order to incentivize recruitment of a high productivity workforce, set community-based organization salaries at 75th percentile. In circumstances where salaries cannot be effectively changed, explore options for loan repayment incentives as an indirect compensation measure.
	Develop a behavioral health clinical provider recruitment program to attract staff.	The Clinical Provider Recruitment Program will provide salary subsidies up to $125,000 to recruit highly qualified and seasoned master's-level (or higher) clinicians and medical providers as civil servants employed by the San Francisco Health Network. For individuals who are employed by entities contracted with the Department of Public Health, create an opportunity for loan repayment grants of up to $3,000 per month for up to five years of service. *To achieve the department's equity aims, 30% or more of the individuals awarded these grants should identify as Black/African American.*
	Begin a scholarship program as an incentive to work in San Francisco's mental health safety net.	Establish the San Francisco Mental Health Safety Net Scholarship Program to provide funds for full-tuition scholarship for individuals at UCSF School of Medicine, chosen by the medical school based on financial need and a commitment to serve vulnerable populations. *To achieve the department's equity aims, 30% or more of the individuals awarded these scholarships should identify as Black/African American.* These scholarships should be modeled after the National Health Service Corps which incentivizes students to commit to working in areas with vulnerable populations and sets terms to maintain those commitments. The program will also fund up to four UCSF Psychiatry Residency Trainees who elect to enter civil service positions within the City providing care for underserved populations. These individuals would begin receiving loan repayment grants of up to $3,000 per month for up to five years. Participating resident-trainees would incur a public service commitment of one year for every 12 months of grant funding received.
E. Bolster Public Awareness and Advocacy	Design and implement Mental Health First Aid to improve the general public's capacity to respond to people in need.	Implement Mental Health First Aid training for community bystanders to help community members recognize the early signs and symptoms of mental illness and substance misuse and respond to overdose. Community members will learn how to listen without judgment, respond to and help someone in distress until they can get the professional care they may need.
	Create a health system navigation media campaign to increase awareness of available services.	Initiate a Health System Navigation media campaign to address client and caregiver concerns about how to access services and where to go to seek help. Behavioral health access sites should be highlighted, and resource information distributed in multiple modalities including television, radio, and print media.
	Expand family and caregiver support services to support the families and advocates of people with mental illness and/or addiction.	Partner with local advocacy agencies, such as National Alliance for Mental Illness (NAMI) to expand Family/Caregiver Support Services. NAMI Family-to-Family is a free, 12-session educational program for family, significant others and friends of people with mental health conditions. It has been shown to significantly improve the coping and problem-solving abilities of the people closest to a person with a behavioral health condition.