Rafiki COALITION FOR HEALTH & WELLNESS

Your Friend in Health and Wellbeing

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October 1, 2021

Dear Mayor London Breed, Members of the Board of Supervisors, and Director Grant Colfax:

On behalf of the Mental Health San Francisco (MHSF) Implementation Working Group (IWG), I am pleased to share the IWG's Annual Progress Report pursuant to Ordinance 300-19 (File No. 191148). The report outlines the progress of the IWG to develop recommendations and inform the implementation and design of MHSF.

Despite the COVID-19 pandemic stretching our communities, public health and health care resources, and the growing mental health and substance use challenges for San Franciscans, this progress report describes the IWG's dedication and work to ensuring a well-informed and considered set of design and implementation recommendations for MHSF. The members of the IWG have developed an initial full set of recommendations for the Street Crisis Response Team and Drug Sobering Center, and they are in the process of building out recommendations for the remaining MHSF components.

The IWG's work on this project cannot be underestimated. Beginning in December 2020, the IWG has met monthly for 4-hour meetings, conducted discussions groups in between meetings, and provided valuable feedback as we develop these critical services. We are thankful to the DPH team, for their hard work in providing critical and timely information and data to ensure that the IWG is well informed. DPH MHSF program teams have attended multiple meetings and have been in direct dialogue with the IWG to discuss program elements, provide context for what is possible given the ordinance, and envision new approaches that can meet the needs of San Franciscans. We are appreciative of the City Performance Unit of the Controller's Office and their consultant, Harder+Company Community Research, for their project management, facilitation, and support to both the IWG and DPH.

Your crucial leadership and inclusion of community leaders in behaviorial health reform, as members of the MHSF Implementation Working Group, works to ensure that our City can meet the significant needs of this moment.

Sincerely,

Dr. Monique LeSarre
Executive Director, Rafiki Coalition Leadership
Chair, MHSF Implementation Working Group

October 2021

Mental Health SF Implementation Working Group

Progress Report

This progress report provides an update on the Implementation Working Group's progress to inform and develop MHSF. The report is organized to provide:

Background

On December 6, 2019, the San Francisco Board of Supervisors passed an ordinance (the Ordinance) amending the Administrative Code to establish Mental Health San Francisco (MHSF). This legislation is designed to increase access to mental health services, substance use treatment, and psychiatric medications to adult San Francisco residents with serious mental illness and/or substance abuse disorders who are homeless, uninsured, or enrolled in Medi-Cal or Healthy San Francisco. The Ordinance identifies five components:

1. Mental Health Service Center
2. Office of Coordinated Care
3. Street Crisis Response Team
4. Mental Health and Substance Use Treatment Expansion
5. The Office of Private Health Insurance Accountability

The Ordinance established a MHSF Implementation Working Group (IWG) to advise on the design, implementation, outcomes, and effectiveness of MHSF. However, the COVID-19 pandemic delayed the start of the IWG's engagement to late 2020. As the mental health and homeless crises in San Francisco grew more severe and concerning during this time, DPH moved forward with the design and implementation of some of the MHSF's program components. This included the Street Crisis Response Team and the Drug Sobering Center (part of New Beds and Facilities). When the IWG was convened in December 2020, these components were prioritized for IWG input.

Since December 2020, the IWG has met monthly, dedicating substantial time in and between meetings to develop recommendations for the Street Crisis Response Team and the Drug Sobering Center, and is currently developing recommendations for the remaining major MHSF components. This progress report summarizes its progress.

harder + co | community research

Implementation Working Group (IWG) Mandate

The IWG has the "power and duty" to advise the Mental Health Board, the Health Commission, the Health Authority, the Department of Public Health, the Mayor, and the Board of Supervisors on the design, outcomes, and effectiveness of MHSF to ensure its successful implementation. The IWG developed bylaws that govern its work and confirm the purpose and responsibilities (see full bylaws here):

- Advise the Mental Health Board or any successor agency, the Health Commission, the Department of Public Health, the Mayor, and the Board of Supervisors on the design, outcomes, and effectiveness of Mental Health SF;
- Evaluate the effectiveness of MHSF in meeting the behavioral health and housing needs of eligible participants, by reviewing program data;
- Review and assess the Implementation Plan that the Department of Public Health is required to submit to the Mayor and the Board of Supervisors;
- Conduct a staffing analysis of both City and nonprofit mental health services providers to determine whether there are staffing shortages that impact the providers' ability to provide effective and timely mental health services; and
- Prepare proposals for how to reduce the scope of services provided by MHSF if the cost of those services is estimated to exceed $150 million annually.

The IWG is comprised of a 13-member body appointed by the Mayor, Board of Supervisors, and the City Attorney (Figure 1) and positioned as a working group for the duration of six years. Members appointed a chair and vice-chair to facilitate the group's engagements at the January 2021 meeting. The Office of the Controller and their contractor, Harder+Company Community Research, supports the IWG in its administration, development of recommendations, and adherence to public meeting requirements. Deputy City Attorney Jon Givner provides consultation and advising to the IWG on conflicts of interest, contracting, the recommendations development process, and adherence to public meeting rules. All information considered and produced by the IWG is posted to the MHSF IWG website to promote transparency and in accordance with legal requirements.

Figure 1: IWG Membership

Name	Qualification	Appointed By
Dr. Scott Arai, M.D.	Residential Treatment Program Management and Operations	Mayor
Shon Buford	Peace Office, Emergency Medical Response, Firefighter (San Francisco Fire Department)	Mayor
Vitka Eisen, M.S.W., Ed.D	Treatment provider with mental health harm reduction experience (HealthRIGHT 360)	Mayor
Steve Fields, M.P.A.	Treatment provider with mental health treatment and harm reduction experience (Progress Foundation)	BOS
Dr. Ana Gonzalez, D.O.	DPH employee experience with treating persons diagnosed with both mental health and substance abuse (Behavioral Health, SFDPH)	Mayor
Phillip Jones	Lived experience	BOS
Monique LeSarre, Psy. D. (Chair)	Behavioral health professional with expertise providing services to transitional age youth in SF (Rafiki Coalition)	BOS
Jameel Patterson (Vice Chair)	Lived experience	Mayor
Andrea Salinas, L.M.F.T.	Treatment Provider with experience working with criminal system involved patients	BOS
Sara Shortt, M.S.W.	Supportive Housing provider	BOS
Amy Wong	Healthcare worker advocate	BOS
Kara Chien, J.D.	Health law expertise	City Attorney
Dr. Hali Hammer, M.D.	DPH employee with health systems or hospital administration experience (Primary Care Behavioral Health, SFDPH)	Mayor

The IWG is joined by a City Planning team (Figure 2) who supports the meeting planning and recommendation process as well as facilitates connections within and between DPH teams. This team is critical to ensuring that the appropriate subject matter experts and content are available at IWG meetings, recommendations made by the IWG are routed to the appropriate teams within DPH, and a feedback loop is created with the IWG to review progress toward recommendations.

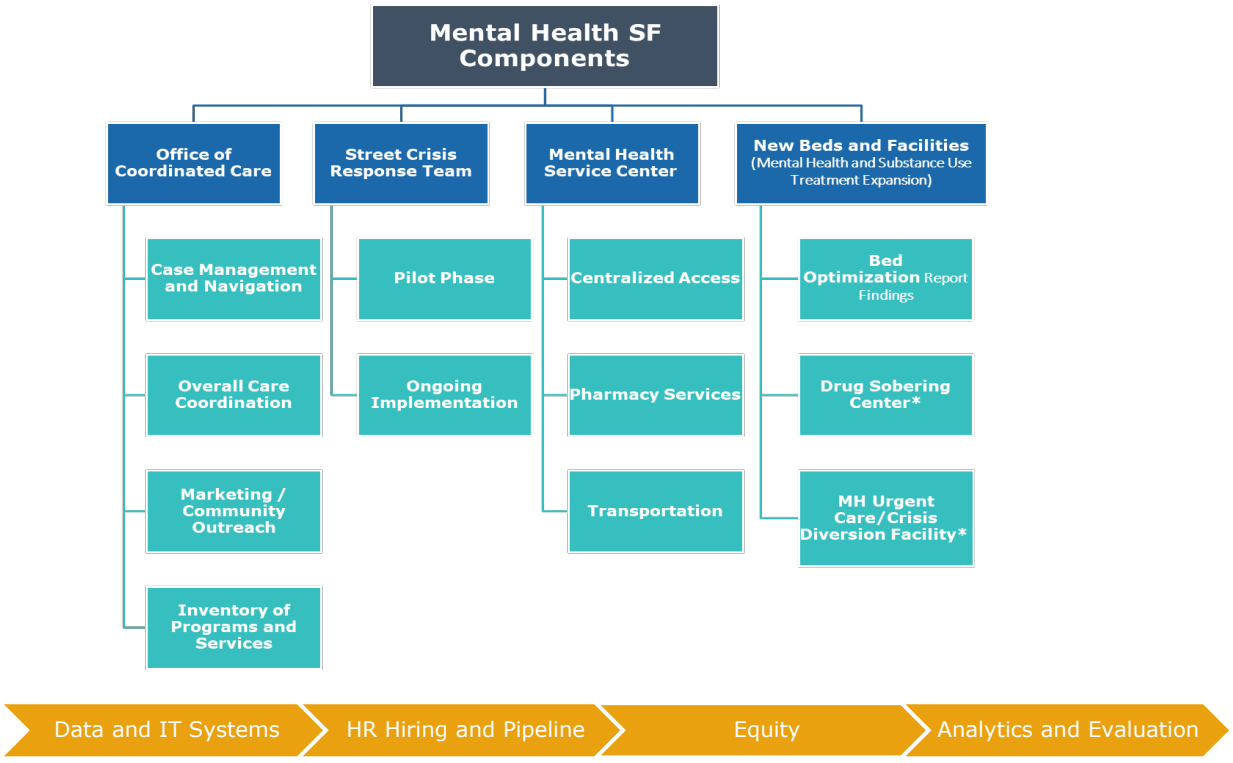
Figure 2: City Staff

Department	Name	Title
City Planning Team: planning and administrative/analytical support for IWG meetings		
DPH	Marlo Simmons	Deputy Director, Behavioral Health Services, MHSF Liaison
DPH	Sneha Patil	Director, Office of Policy and Planning
Office of the Controller	Heather Littleton	Project Manager, City Performance Unit
Office of the Controller	Catherine Omalev	Senior Analyst, City Performance Unit
Supporting Departments: departmental consultation, as needed, at IWG meetings		
Department of Public Health	Dr. Hillary Kunins	Director, Behavioral Health Services and MHSF
Department of Homelessness and Supportive Housing	Dedria Black	Deputy Director, Programs
Human Services Agency	Christine Lou	Senior Policy Analyst
Department of Aging and Adult Services	Christine Lou	Senior Policy Analyst
Office of City Attorney	Jon Givner	Deputy City Attorney

MHSF Components

The Ordinance identifies five MHSF components. DPH and Behavioral Health Services executives and subject matter experts developed an internal governance structure to manage MHSF. They refined and built out the MHSF components, organizing them as displayed in Figure 3. This diagram shows major programmatic components (dark blue boxes) and includes foundational elements (gold arrow), such as Data and IT systems, HR Hiring and Pipeline, Equity, and Analytics and Evaluation, that support across components' implementation.

Figure 3: Structure for the Components and Subcomponents of MHSF



There are some differences in the working organizational structure of MHSF than what is called out in the legislation. Minor changes include titling (The Crisis Response Street Team was renamed "Street Crisis Response Team") and the domain focused on Mental Health and Substance Use Treatment Expansion is being called "New Beds and Facilities". However, more substantive differences in the organizational structure are of note:

- The Office of Private Health Insurance Accountability is the fifth MHSF component and is not pictured in Figure 3. DPH reports that while the Ordinance requires the creation of an Office of Private Health Insurance Accountability, funding for this component has not been identified and planning for this effort will be addressed at a later time.
- The Controller and the Department of Human Resources (DHR) staffing analysis of City and non-profit mental health service providers to determine whether there are staffing shortages that impact the providers' ability to provide effective and timely mental health services was not pursued in 2021 due to departmental capacity issues with COVID-19 response. However, the City Planning team will work with the IWG, the Controller, and DHR to scope and prioritize this work in the near future.

MHSF Budget Overview

The initial funding for MHSF components was provided by Proposition C, which was approved by voters in 2018 and imposes additional business taxes to fund a significant increase in new residential care and treatment beds, programming, capacity, and coordination for mental health and substance use services to better serve people experiencing homelessness and those transitioning into permanent supportive housing. This fund, otherwise known as the Our City, Our Home Fund, is set annually and managed by a separate oversight committee. Below is a high-level overview of the budget with a detailed table (Figure 4) of anticipated funding by MHSF component.

The Our City, Our Home funds approved for FY21-22 and FY22-23 include a blend of ongoing annualized spending, a one-time capital acquisition, and improvement costs specifically related to MHSF:

$93M in ongoing, annualized spending
($50.9M approved as FY20-21 spending plan; $42.2M for new, ongoing programs)

$130M for rehab sites
(Residential care and treatment beds/services)

$4.2M Mental Health Service Center capital improvements
(Across FY20-23)

Starting in FY21-22, approximately $55 million of Our City, Our Home funds will be allocated to further support the key MHSF domain areas. These new Proposition C investments build on existing department resources and staffing deployed to support the implementation of MHSF. Figure 4 outlines how those funds are used by MHSF component across fiscal years.

Figure 4: MHSF Budget (FY20-21, FY21-22, FY22-23)

MHSF Components	FY20-21	FY21-22	FY22-23
Office of Coordinated Care *Purpose*: Provide case management and linkage services to clients. Streamline and organize the delivery of mental health and substance use services across the City			
Expansion of Case Management • Coordination and Oversight • TAY Care Coordination • Bed Tracking System	$4.2M	$9.7M	$10.0M
Street Crisis Response Team *Purpose*: Provide interventions and connections to ongoing care for people who experience behavioral health crises on the streets of San Francisco			
Seven core response team field staff • Program supervision and management • Pilot program evaluation • Vehicles, supplies & engagement materials • Staff training	$6.2M	$11.8M	$12.3M
Mental Health Service Center[1] *Purpose*: Expand Behavioral Health Access Center (BHAC) hours and other improvements - a first step toward the creation of a centralized drop-in Mental Health Services Center			
BHAC Hours Expansion • Pharmacy Expansion	$0.9M	$3.8M	$5.9M
New Beds and Facilities[2] *Purpose*: Residential care and treatment expansion – Prop C funding supports approximately 350 additional beds*			
Drug Sobering • Psych SNF • Locked Subacute (LSAT) Board & Care • Crisis Diversion • Mental Health Residential • Residential Step-Down • TAY Residential Beds • Managed Alcohol Program • Co-op Housing • Client Transportation	$4.8M	$30.3M	$30.9M
Total Ongoing Proposition C Budget	**$16.2M**	**$55.5M**	**$59.0M**

Other key Proposition C investments that align with the goals of MHSF, but are not specific to the MHSF-legislated components, to provide care for persons experiencing homelessness include:

$13.2M in overdose response
(additional treatment meds, contingency planning, new street-based response team)

$7.7M for behavioral and physical health services
(in shelters and permanent supportive housing)

$6.8M for transgender and Transition Age Youth
(behavioral health support on the street, in shelters and drop in-centers)

[1] Proposition C invests $4.2 million for Mental Health Service Center capital improvements across the FY20-23 budgets.
[2] Proposition C also invests $130 million in one-time funding to acquire sites for residential care and treatment programs. The one-time capital acquisition is to be spread in the following budgets: FY20-21 $7.7M, FY21-22 $76.8M, and FY22-23 $45.5M.

IWG Approach

During the initial meetings, the IWG developed a shared process to develop thoughtful, well considered recommendations for MHSF components. The elements of this approach are described here.

IWG Approach to Developing Recommendations

The IWG uses a flexible, iterative meeting topic schedule that prioritizes pressing issues related to MHSF identified by DPH and the IWG. DPH strives to connect MHSF efforts to other DPH projects and planning processes, through both the sequencing of meeting topics and bringing in information from other concurrent efforts. The initial recommendation development process for each MHSF component is anticipated to be covered between four to five IWG meetings. The process extends over multiple meetings to allow sufficient time to develop a shared understanding of the program, brainstorm recommendation ideas, and refine recommendations. In between IWG meetings, "discussion groups" are sometimes convened of interested IWG members to refine group work into draft recommendations for consideration at IWG meetings. These discussion groups are no more than six people in accordance with the Brown Act. Figure 5 provides an overview of the general recommendations development process.

Figure 5: The IWG Recommendation Development Process

Once recommendations are approved, they are routed to the appropriate DPH team for review and consideration as the components are developed, implemented, and refined. DPH teams are asked to report back to the IWG about other implementation updates regarding the status of IWG recommendations. We anticipate that during future scheduled update sessions, new recommendations may be considered, and DPH may ask new questions for advisement by the IWG.

The IWG recommendation process is guided by two key considerations: recommendation principles and consensus-based decision making.

Recommendation Principles

The IWG developed the following principles, in part adapted from the Ordinance, to ensure that the recommendations are aligned with the Ordinance and with keeping with the values of this group. They are applied as a screener by discussion group members who organize and refine the IWG's recommendations. These principles ensure that each recommendation does the following:

1. Reflects evidence and/or community based best practices, data, research, and a comprehensive needs assessment.
2. Prioritizes mental health and/or substance use services for people in crisis.
3. Provides timely and easy access to mental health and substance use treatment (low barriers to services).
4. Creates welcoming, nonjudgmental, and equity-driven treatment programs/spaces where all individuals are treated with dignity and respect.
5. Utilizes a harm reduction approach in all services.[3]

[3] Harm reduction is a public health philosophy, which promotes methods of reducing the physical, social, emotional, and economic harms associated with drug and alcohol use and other harmful behaviors on individuals and their community. MHSF shall treat all consumers with dignity and compassion, and shall provide care without judgment, coercion, discrimination, or a requirement that clients consumers stop engaging in specific behaviors as a precondition to receiving care.

6. Maintains an adequate level of free and low-cost medical substance use services and residential treatment slots, commensurate with the demand for such services.
7. Facilitates the integration of mental health and substance use services to ensure that individuals experience treatment as one seamless and completely coordinated system of care, organized around their individual needs.
8. Includes sufficient resources to assure that workers associated with the project are paid a parity wage with public employees.
9. Considers a continuum of services that range from low barrier and voluntary to conservatorship/involuntary services, when appropriate.

Consensus-Based Decision-Making

The group uses a consensus-based decision-making process. In a public process like this one, groups that reach mutual agreement in the form of consensus decisions are generally viewed more favorably than decisions made by majority vote as it means the whole group has agreed to endorse the recommendations it is putting forward. Furthermore, majority voting may have a polarizing effect on a group as it sets up a win/lose solution, rather than promoting trust. To support consensus within the boundaries of the public process, the IWG implements a hybrid model that strives for unanimity along a "gradients of agreement" (Figure 6) with a tie breaker of majority vote if unanimity is not reached. Components for our hybrid consensus model includes the following:

- Ensures that every IWG member has a voice in decisions
- Appreciates that there are degrees of agreement along a continuum – from whole-hearted endorsement to support with reservations
- Recognizes that a dichotomous yes/no engenders fundamental problems of accurately and authentically conveying the extent of support/nonsupport of a proposal

Figure 6: Gradients of Agreement

Process for decisions:

Step 1: Record proposal on a "flip chart" or virtual meeting platform

Step 2: Check to ensure everyone understands the proposal

Step 3: Ask for final revisions in the wording of the proposal

Step 4: Each member registers their level of agreement (Figure 6)

Step 5: If any 1s or 2s are documented, discuss and clarify concerns. Facilitators adjust proposals as needed and repeat Steps 1-4.

If after two discussion rounds and votes, there is not consensus for all members to get to a level of agreement of #3-5 (i.e., *I see issues, but can live with it*, *I'm fine with this as is*, or *I love this!*), the IWG uses a simple majority yes/no vote. All concerns, considerations, and dissenting views are recorded to ensure dissenting perspectives are shared alongside IWG recommendations.

Recommendations: Progress to Date

The IWG is following an ambitious planning calendar to develop recommendations for all MHSF components by the Spring of 2022 and to submit Implementation Recommendations Report to policymakers by May 2022. The IWG will continue to meet beyond this preliminary calendar to advise on MHSF's implementation and is expected to terminate by September 2026.

The IWG has also received updates on the MHSF budget from the DPH Budget Director as well as the evaluative framework from the Analytics and Evaluation team to inform their work and provide comment. As the calendar in Figure 7 below shows, the design "D" process for each component spreads across four to five months depending on the level of complexity. The update "U" identifies the anticipated schedule for when DPH teams return to the IWG to provide a status on recommendations, general updates on the component's programming, and new design and implementation questions for the IWG to consider.

Figure 7: IWG Meetings and MHSF Component Topics Calendar through FY21-22

MHSF Component	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Spring
Street Crisis Response Team	D	D	D	D					U					
New Beds & Facilities (NB&F): Drug Sobering Center			D	D	D	D						U		
NB&F: Psychiatric SNF, Rehabilitative Board and Care, Mental Health Rehabilitation, Psychiatric SNF, Residential Care Facilities						D	D	D	D	D				U
Office of Coordinated Care (OCC)							D	D	D	D	D			
Mental Health Service Center (MHSC): Crisis Diversion Program; 24/7 access planning; Behavioral Health Access Center improvements								D	D	D	D	D		
A&E: metrics update				U							U			

To date, the IWG has developed recommendations for two MHSF components – Street Crisis Response Team and the Drug Sobering Center, and is developing the remaining MHSF components.

Street Crisis Response Team Recommendations

The purpose of the Street Crisis Response Team (SCRT) component of the MHSF legislation is to provide a rapid, trauma-informed response to calls from people experiencing behavioral health crises in public spaces in order to reduce law enforcement encounters and unnecessary emergency room use. SCRT is a collaboration between DPH, the San Francisco Fire Department (SFFD), and the Department of Emergency Management (DEM) to provide the most appropriate clinical interventions and care coordination. Each team includes one community paramedic, one behavioral health clinician, and one behavioral health peer specialist. The legislation required the following, summarized design elements:

- A city-wide crisis team led by the Department that operates 24 hours per day, seven days per week.
- A marketing strategy that ensures that the public is familiar with the specific telephone number to call to engage the SCRT (by dialing 311 or, in the case of emergency, 911).
- Coordinate with the Office of Coordinated Care (yet to be designed) to assign case managers as needed to establish Trust and rapport with individuals who refuse to access services and who are not eligible for conservatorship.
- Coordinate with all outreach teams aimed at meeting the needs of people experiencing homelessness to share information and be guided by data, best practices, and past experience.

DPH developed a pilot SCRT, based on public health data and through engagement with community based programs, DPH programs working with similar populations, other city agencies impacted or engaged in the issue, behavioral health consumer focus groups, and other citywide committees and working groups (see Issue Brief). The first team was launched in November 2020, the second on February 1, 2021, and additional teams began in Spring 2021 with citywide geographic coverage as of Summer of 2021.

The IWG began reviewing this information via an issue brief in February 2021 and a SCRT preliminary evaluation report. DPH specifically asked the IWG the following questions to consider as they developed recommendations:

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. Starting March 31, 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?

Through the process outlined in Figure 5, the IWG developed the following recommendations (see Figure 8). In late October 2021, DPH is due to report back to the IWG on SCRT's progress as well as their response and status to the IWG's recommendations.

Figure 8: IWG SCRT Recommendations

Street Crisis Response Team Recommendations

1. A mapping of all current crisis response programs must be undertaken, for example SCRT, Homeless Outreach Team (HOT), EMS-6, Mobile Crisis, Comprehensive Crisis Services, High Intensity Care Team, and other teams unknown to the IWG members. No new MHSF street crisis programs should be planned, implemented, expanded until after the mapping is completed, and proposed programs shall be brought to the MHSF IWG for review prior to launch.

    A. The strategic vision for each program should be clearly defined, including problem(s) the program targets for change, target population, goals and objectives. Also include visual representation of the mapping, with all program components, and their relationship to each other within the system of care. Clearly defining programs is a necessary measure to improve utilization of BHS funding, accountability, and accessibility to San Franciscans.

    B. Data on each program should be collected to answer: How many requests for service does each program currently receive per month? How many requests for services do they have the capacity to respond to per month? Provide data on how many total individuals served, including unduplicated individuals.

    C. An assessment of the collection of programs as a whole should be conducted to identify any redundancies and/or contradictions between these programs.

    D. The evaluation should undertake an analysis of current gaps in crisis response services and the adequacy of funding levels for services across the continuum of crisis services.
        i. The evaluation will include data from the evaluation of current crisis response teams, including under resourcing of current programs.
        ii. The evaluation of current service gaps must also include input from those most impacted to determine the current unmet needs in our crisis services. Specifically, the evaluation should include the voices of consumers of mental health services, the loved ones of mentally ill in San Francisco, and service providers across the spectrum of mental health care.

2. Once gaps in service are identified, BHS shall undertake a restructuring of current crisis services as needed. Based on this restructuring, a final set of recommendations for the implementation of SCRT can be made by BHS and the MHSF IWG.

    A. The final recommendations shall be informed by the following:
        i. MHSF mandate Section (3), parts (A) and (B), listed above.
        ii. All MHSF Governing Principles, with specific attention to (7) Integrated Services, (8) Coordinated Communication, (9) Culturally Competent Services, and (10) Data-and-Research Drive.
        iii. Mayor's Office mandate to create a public health intervention to policing for persons who are mentally ill.
        iv. The needs of those directly impacted by mental illness in San Francisco.
        v. Initial data provided by pilot of SCRT.

    B. SCRT shall, if deemed needed, submit an updated strategic vision, goals, and objectives.

Street Crisis Response Team Recommendations

3. In the interim, while the above steps are undertaken, in order to address current implementation challenges and to minimize inefficient use of Prop C funds, we assert the following: current implementation of SCRT is too narrow. As such, the following recommendations are proposed for SCRT in the interim:

   A. As SCRT has the stated goal of "reducing law enforcement encounters", SCRT should expand their scope to respond to all 800a and 800b calls for "Mentally Disturbed Person". Even in situations where there are "weapons", or perceived threats involved, there is still need for mediation to de-escalate the crisis rather than respond with lethal force as is the norm now.

   B. Respond from a de-escalation model that challenges racism and stigmatization of persons that are houseless and struggling with mental health challenges. Please make available which model of de-escalation and mediation the team is being trained to use.

   C. The following SCRT call code criteria currently in use should be eliminated:
      i. Person must not be displaying self-harm behaviors.
      ii. Person does not pose an imminent threat to themselves, others, or property.

   D. Improve dispatch protocols to SCRT:
      i. An alternative number to 911 should be established. There were widespread recommendations from members of the IWG for a non-911 call line access to SCRT. In addition, the MHSF administrative code calls to establish 311 as an access line to the Street Crisis Response Team.
      ii. Improve dispatch training for 311/911, in order to discern what is actual or perceived threats. Training should include instruction in discerning for structural racism to address and eliminate the weaponizing of 911 calls.
      iii. When police respond to a call, create policies and procedures that establish when police can and should defer/transfer response to the SCRT team. Police should track and provide data of numbers of calls they deferred/transferred to ensure that SCRT services are appropriately utilized.
      iv. DPH and IWG needs data from 311/911 on their protocols for triaging calls, and data of all 800 calls received with which entities they were triaged/directed to in order to recommend future improvements to dispatch.
      v. Public service announcements to San Franciscans to make them aware of SCRT. Public education should include instruction on how people can navigate their interactions with houseless persons to improve compassion and humanity. Public education must include information of when it is appropriate to utilize 911, versus calling non-emergency number to dispatch SCRT and potentially other crisis services when that number goes live.

Drug Sobering Center Recommendations

The Drug Sobering Center (DSC) is part of San Francisco's response to the overall increase in street drug use and specifically the spike in methamphetamine use in recent years. The proposed center will promote substance use services and social support through targeted engagement. This DSC is under the "New Beds and Facilities" MHSF component, and the legislation required the following, summarized design elements:

- Include at least one Drug Sobering Center that offers clinical support and beds at a clinically appropriate level of care for individuals who are experiencing psychosis due to drug use.
- Coordinate with the Mental Health Service Center (yet to be designed) to provide clinically trained psychiatric services for patients with dual mental health and drug use diagnoses.

Similar to the SCRT, DPH began developing the DSC concept prior to the IWG's convening. The DSC is one of the first of its kind in San Francisco and in the nation. When DPH brought the issue paper to the IWG to begin the recommendation development process, the DSC location and program operator were already in place. The location of the center was identified in District 6, which has one of the highest concentrations of overdose mortality in San Francisco. DPH clinical and operational leads determined that the 17,000 square foot space was the best fit of available properties within the city. The final remodel will include the DSC on the first floor with other DPH and MHSF programs that interface with Drug Sobering Center clients and staff (e.g., Street Medicine, Office of Coordinated Care, Street Crisis Response Team) on the second floor. The provider HealthRIGHT 360 is engaged to operate the program for 18-months to allow DPH time to evaluate the new model and review best practices for this new innovative service.

The DPH DSC team asked the IWG to consider two key questions:

1. The Drug Sobering Center is a pilot which will be evaluated along four dimensions: 1) contribution to MHSF global outcomes, 2) Drug Sobering Center services and utilization, 3) quality; and 4) satisfaction. What other outcome measures would the IWG deem important or essential in evaluation of this program as pilot?
2. How should the Drug Sobering Center be evaluated in the context of rapidly changing patterns of community drug use?

Through the recommendation development process, the IWG addressed these two questions and identified a number of other recommendation considerations. The recommendations (Figure 9) are organized in four key groupings, generally aligned in response to the issue paper sections.

Figure 9: IWG Drug Sobering Center Recommendations

Drug Sobering Center Recommendations

Recommendations related to DPH's direct questions

The Drug Sobering Center is a pilot which will be evaluated along four dimensions: 1) contribution to MHSF global outcomes, 2) Drug Sobering Center services and utilization, 3) quality; and 4) satisfaction. What other outcome measures would the IWG deem important or essential in evaluation of this program as pilot?

How should the Drug Sobering Center be evaluated in the context of rapidly changing patterns of community drug use?

The IWG recommends that:

1. The DSC include information/data related to addressing and combating the Opioid pandemic and better tie the evaluation of success to its overall impact the program has on reducing overdose deaths.
    A. Data sets collected should include #ODs reversed on-site, # of Harm Reduction supplies distributed (Narcan/Fentanyl test strips), # offered/accepted SUD Tx)

2. Evaluation criteria for "success" of DSC is not clearly defined. Current data collected (e.g., # admits and what service provisions were accessed) focuses on short term goals. To better inform expansion of the DSC pilot, data should also include:
    A. How many clients were offered and linked to services such as ICM/CM, Housing Supports, SUD Treatment? How long do people stay?
    B. How are pre-mature exits measured? (# of clients redirected because they did not meet the minimum admission criteria of "Directable, non-violent, and medically stable")
    C. Where did they go?

3. A mapping of all current Sobering Center programs must be undertaken. For example, people under the influence from alcohol can be taken to a Sobering Center, Medical Detox, Social Detox; people experiencing mental health crises can be taken to PES or diverted programs such as DUCC and ADUs., and any other programs unknown to the IWG members. No new MHSF Drug Sobering Centers (outside of the currently planned center to open in Fall) should be planned, implemented, expanded until after the mapping is completed, and proposed programs shall be brought to the MHSF IWG for review prior to launch.
    A. The strategic vision for each program should be clearly defined, including problem(s) the program targets for change, target population, goals and objectives. Include visual representation of the mapping, with all program components, and their relationship to each other within the system of care. Clearly defining programs is a necessary measure to improve utilization of BHS funding, accountability, and accessibility to San Franciscans.

4. Data on each program should be collected to answer: How many requests for service does each program currently receive per month? How many requests for services do they have the capacity to respond to per month? Provide data on how many total individuals served, including unduplicated individuals.
    A. An assessment of the collection of programs as a whole should be conducted to identify any redundancies and/or contradictions between these programs.
    B. The evaluation should undertake an analysis of current gaps in Drug Sobering Center type services and the adequacy of funding levels for services across the continuum of crisis services.
    C. The evaluation of current service gaps must also include input from those most impacted to determine the current unmet needs in our crisis services. Specifically, the evaluation should include the voices of consumers of substance use disorder and mental health services, their loved ones, and service providers across the spectrum of mental health care.

Drug Sobering Center Recommendations

Recommendations related to DSC services provided

The IWG recommends that:

1. Individual and peer support and counseling should include adjunctive/non-traditional therapies and activities such as yoga, meditation, books, and other gentle activities to engage clients while coming down.

2. Harm reductions supplies, such as Narcan and Fentanyl test strips, are generously distributed.

3. The proposed services list indicates that the DSC will provide clients with "**referrals** to community based providers for primary medical care, outpatient mental health and substance use services…" The IWG recommends the DSC should also have immediate on-site access to resources such as Office of Coordinated Care for connections to Housing Supports, Psychiatry services to prescribe and/or re-fill client Rx., and any County Placement team authorizations necessary to access treatment beds (e.g., Detox, TAP, MH Transitions/Placement teams).

4. DSC have storage space for client belongings.

5. DSC develop protocols for support, including referral to appropriate services or other sites of care, for clients with families and/or those who have pets.

6. A warm hand off for those under age 18 and/or any who cannot currently be served by the DSC.

7. All clients receive an offer to have staff assist in developing a wellness/safety plan that includes phone numbers and contact information for access to 24-hour community programs and resources.

8. There be policies and protocols in place that the DSC provide a warm-handoff to access points to support such as Case Management and/or residential/outpatient treatment.

Recommendations related to DSC community engagement

The IWG recommends that the DSC:

1. Better define "community" to ensure participants themselves are included feedback gathering process.

2. Broaden community outreach efforts to engage varying and diverse cultural and non-English speaking communities that have been historically under-represented.
    i. African American radio and news
    ii. AAPI communities
    iii. Outreach efforts utilizing Social Media platforms (FB/IG/Twitter) can be targeted and provided in different languages

3. Partner with other community service providers that work directly with high risk SUD such as DOPE Project and SF AIDS Foundation for outreach efforts.
    i. Education on Harm Reduction philosophy

4. Outreach to CBOs and DPH outpatient service centers to understand how to get a client into the center.

Recommendations related to DSC components already established by DPH (Location and Contractor)

The IWG recommends that the DSC:

1. Explore alternative locations that are not geographically tied to high-use areas.

2. Address pay discrepancy between DPH and CBOs in implementing programs and promote DPH and CBO workforce stability.

Next Steps

The IWG has made great progress in developing a thoughtful, iterative process that allows sufficient time to develop informed recommendations. This next reporting period will include the following focused next steps:

- **Finish initial implementation recommendations for all MHSF components**. The IWG will continue to participate in monthly long format meetings and in-between meeting discussion groups to develop initial recommendations for the key MHSF components. These will be completed by Spring 2022 (see initial recommendation timeline, Figure 7). All initial recommendations will be summarized in a May 2022 report to the Board of Supervisors, Mayor, and the Director of Health in accordance with the Ordinance to provide "its final recommendations concerning the design of Mental Health SF, and any steps that may be required to ensure its successful implementation."

- **Provide advice and recommendations to DPH as programs are implemented**. The IWG will also begin to receive updates from DPH about the recommendations developed to date. We anticipate that initial recommendations will continue to be refined or amended as the feedback loop between DPH and the IWG about MHSF component recommendations is implemented. An important part of this ongoing conversation will focus on how the department is addressing equity in access and outcomes.

- **Partner with DPH to foster community engagement**. There are a number of community engagement activities underway across the City. In keeping with the value of honoring community time, the IWG will not overburden communities with engagement that can already be addressed through other existing processes. However, there will be important opportunities to engage community as the remaining MHSF components are developed and to provide ongoing opportunities for the community to inform and provide feedback regarding MHSF implementation. A community engagement plan will be developed in Fall of 2021. Further, DPH plans to ensure meaningful stakeholder engagement in the development of all new MHSF programs and initiatives.