Behavioral Health Services Accessing Care

San Francisco Department of Public Health

Community Engagement for Providers

DATE

Our Vision, Mission, and Key Strategies

Vision

For all San Franciscans to experience **mental and emotional well-being** and **participate meaningfully** in the community across lifespans and generations.

Mission

To provide **equitable**, effective substance use and mental health care and promote **behavioral health and wellness** among all San Franciscans.

Behavioral Health Services at a Glance

Largest provider of mental health and substance use prevention, early intervention, and treatment services in San Francisco. Civil service staff and contracted community partners deliver clinical services across the City.

100,000+ connections to prevention, care, and treatment

~21,000 people using Behavioral Health Services in FY 22-23 (Mental Health & Substance Use Disorder)

Top 5 Most Frequent Primary Diagnoses

- Depressive/Mood Disorders
- Substance Use Related Disorders
- Schizophrenic/Psychotic Disorders
- PTSD/“Severe” Stress Reaction
- Anxiety Disorders

Range of Behavioral Health Care Services

Prevention

(Early intervention)

100K+
contacts/year

Crisis

(Intervention for people experiencing a mental health emergency)

Mobile Crisis
2,700+ contacts/year

Street Crisis Response
12,000+ contacts/year

Crisis Stabilization and Urgent Care
2,500+ contacts/year

Access and Navigation

(Entry to care and coordination)

Services that help people get in and stay in care
5,000+ people/year

Behavioral Health Access Center
4,800+ contacts/year

Outpatient Treatment

(Primary and specialized care settings)

25,000 people/year received care for **substance use or mental health disorders in primary care**

5,000 people experiencing homelessness/year received care for **substance use or mental health disorders**

15,000 people/year in **specialized outpatient programs**

Residential Care, Treatment and Support

(Long-term care in a residential setting, including transitional housing for people who need support)

2,500 beds, ranging in services

5,000-7,000 people/year

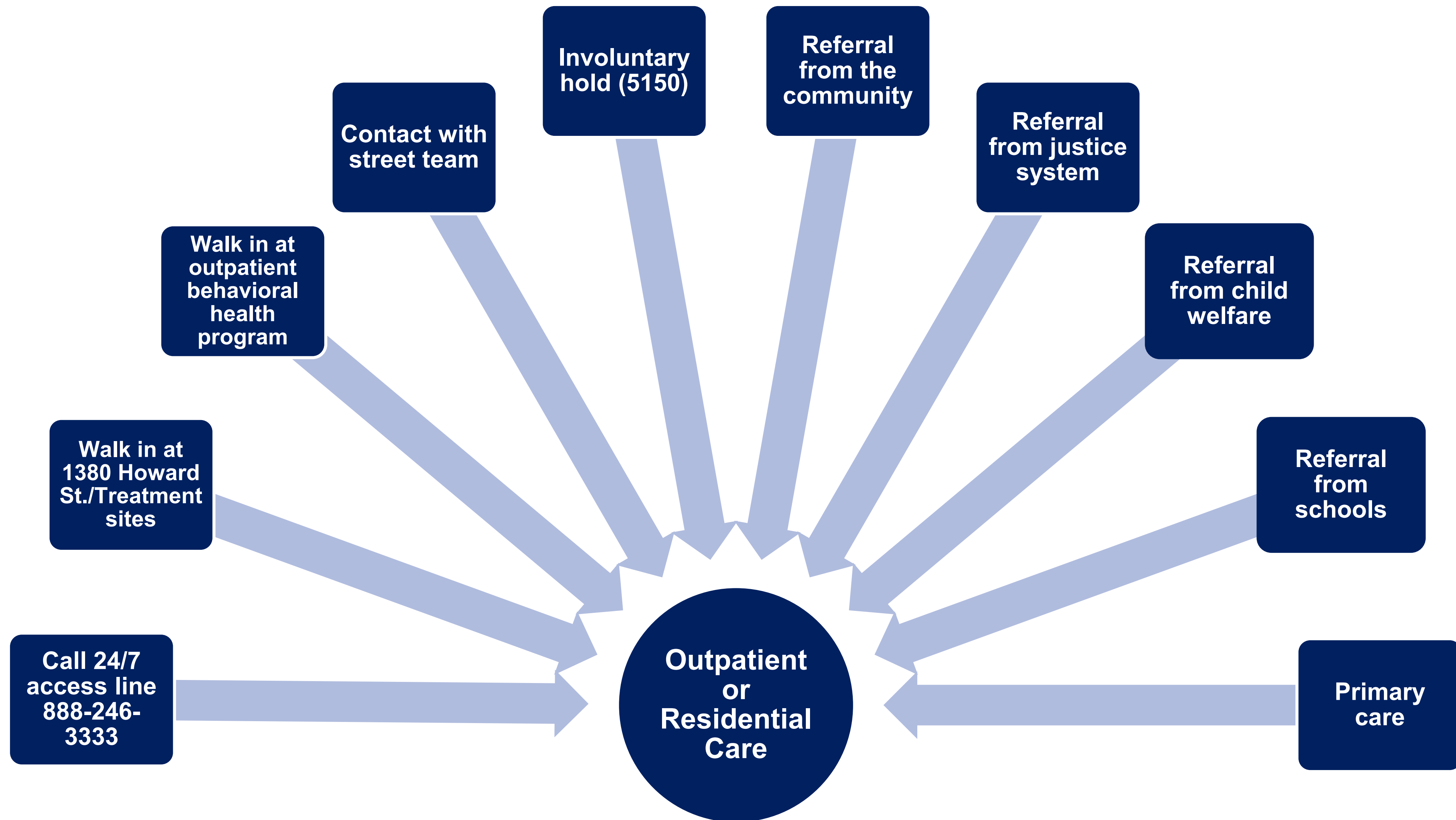
Get Support to Find the Right Service

Connect with a member of our team to receive an assessment, connection, referral, or general support navigating mental health and substance use care, including benefits enrollment.

- **Call the Behavioral Health Access Line 24/7 at 888-246-3333 or**
- **Visit the Behavioral Health Access Center**
  1st floor at 1380 Howard Street
  M-F 8am-7pm
  Sat-Sun 9am-4pm

Where DPH is Delivering Behavioral Health Care

How People Can Get Into Behavioral Health Care



Scenario 1: About Gerald

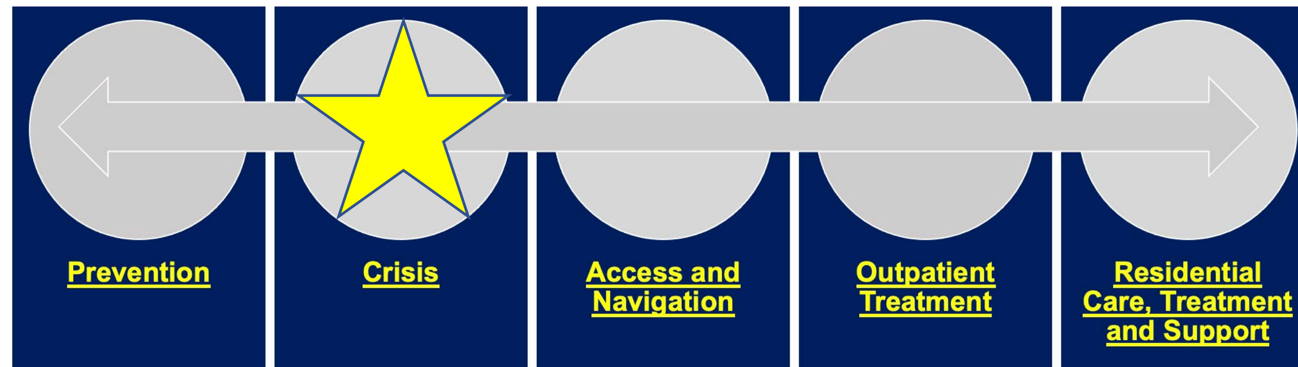
- Male
- 57-year-old
- Bipolar disorder
- Uses methamphetamine
- Currently unengaged in treatment
- Unhoused or marginally housed for the last 15 years
- Previously engaged in mental health treatment but only for a short period of time
- History of emergency department visits
- Has cancer but is not regularly receiving physical health care

Scenario: Crisis Encounter to Care Coordination

SCRT encounters Gerald after he is observed in distress on the street. SCRT assesses and transports Gerald to Dore Urgent Care and makes a referral to Office of Coordinated Care (OCC) for follow up.

Upon receiving the referral, an OCC case manager meets with him at Dore Urgent Care. The case manager reviews Gerald's health history to better understand his behavioral health needs and learns that Gerald stopped using his psychiatric medication because he didn't like how it made him feel.

Gerald informs the case manager that a close family member recently passed away, which is contributing to his distress. He declines behavioral health care but agrees to receive help to find a navigation bed.



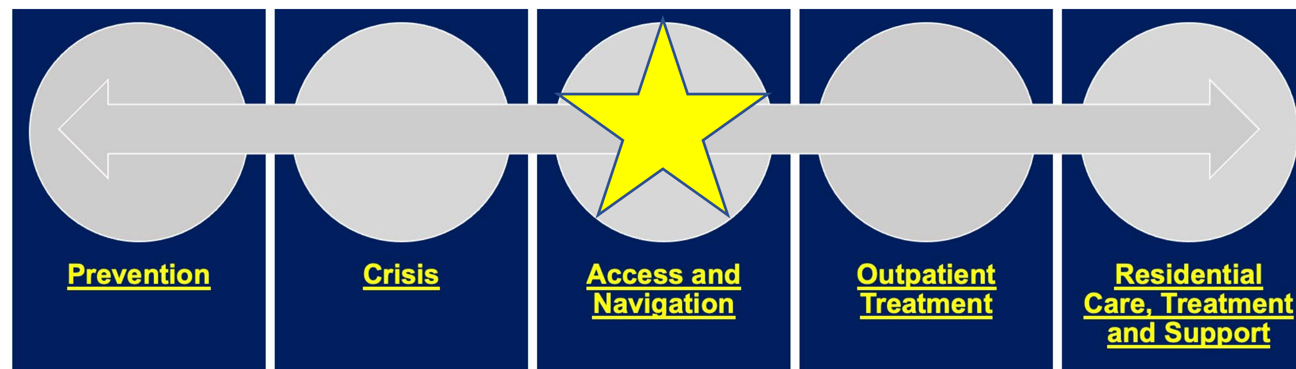
Scenario: Care Plan and Coordination

After visiting the navigation center with Gerald, the case manager offers to meet with him daily. Gerald agrees to meet twice a week and declines mental health care.

Finally, he agrees to develop a care plan with the case manager. He expresses that securing housing is his first priority, and that he is interested in receiving physical health care.

Although, he declines mental health care and says he's not ready to make a change in his drug use, which he says makes him feel better. He does agree to continue discussing mental health and substance use as a part of his care plan.

The case manager accompanies Gerald to a Coordinated Entry access point so he can be assessed for permanent supportive housing. The case manager also works with him to re-engage with his physical health providers.

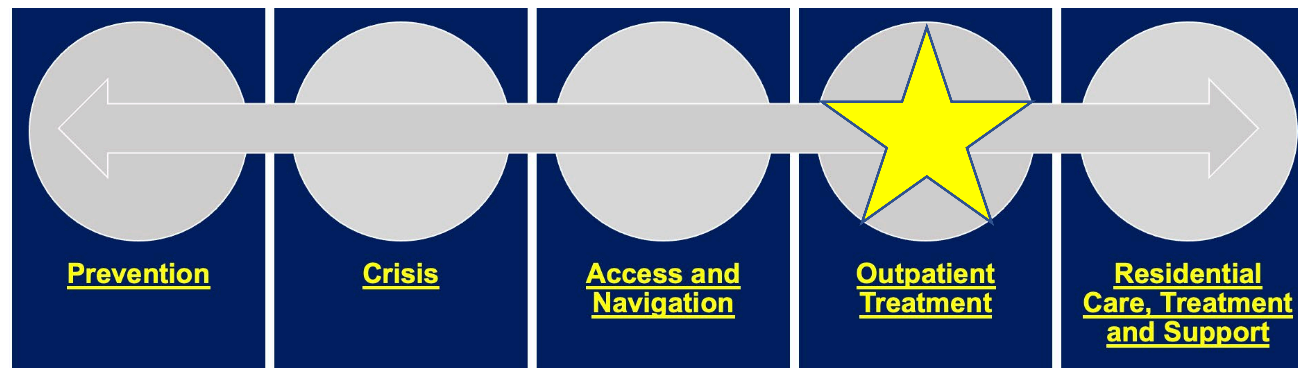


Scenario: Progress and Outcome

Throughout the seven months that the case manager engages with Gerald, progress is slowed when Gerald disappears for days or expresses a lack of willingness to engage. However, the case manager's persistent, regular engagement supports Gerald's continued interest in obtaining supportive housing, and increased interest in receiving cancer treatment.

Gerald is successfully placed in permanent supportive housing and begins treatment for cancer. Once housed, Gerald tells the case manager that he would like to enter a mental health treatment program.

The case manager connects Gerald to an Intensive Outpatient Program where a multi-disciplinary team reviews his care plan, communicates with OCC, and implements the plan. An Intensive Outpatient Program case manager takes over and begins to meet with Gerald at least twice a week.



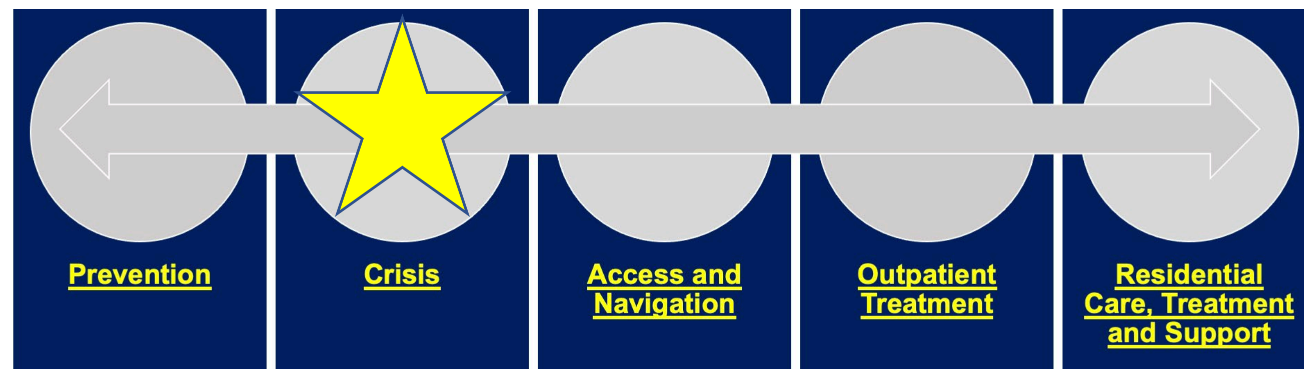
Scenario 2: About Joanna

- Female
- 37-years-old
- Bipolar disorder
- Uses methamphetamine and fentanyl
- Currently unengaged in treatment
- Unsheltered for many years
- Encountered in Joint Field Operations and referred to BEST Neighborhoods

Scenario 2: BEST Neighborhoods Follow Up

Joanna is staying in an encampment. She is highly disorganized and has a lot of belongings. She exhibits disorganized thought process, manic features. She is encountered by the Healthy Streets Operations Center (HSOC).

The HSOC team refers Joanna to the BEST Neighborhoods behavioral health team, which is part of the Office of Coordinated Care.



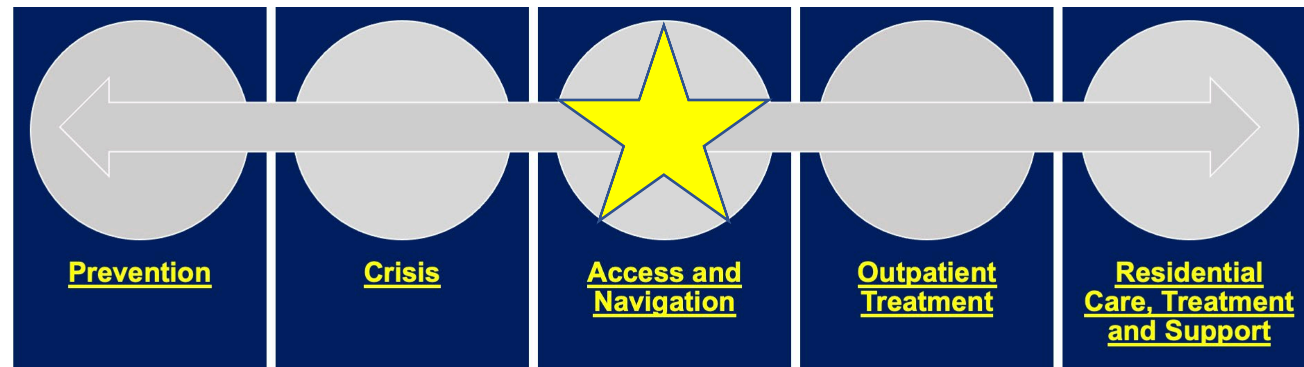
Scenario 2: BEST Neighborhoods to Street Medicine

When the BEST Neighborhood team finds Joanna, she expresses that she is uninterested in shelter, substance use, mental health, or medical services. Although, she agrees to have the team come back to meet with her again.

The team follows up at least three times a week to get to know Joanna and build trust. After several weeks, Joanna opens up to the team about her mental health challenges. The team offers and she agrees to a visit with a street-based psychiatrist.

The psychiatrist assesses Joanna's mental health and recommends psychiatric medications. Joanna expresses openness to medications but is also concerned about being on the streets and taking medications that could make her less alert and compromise her safety.

The team revisits the idea of shelter, which she agrees to, and the team helps her move into a shelter placement.

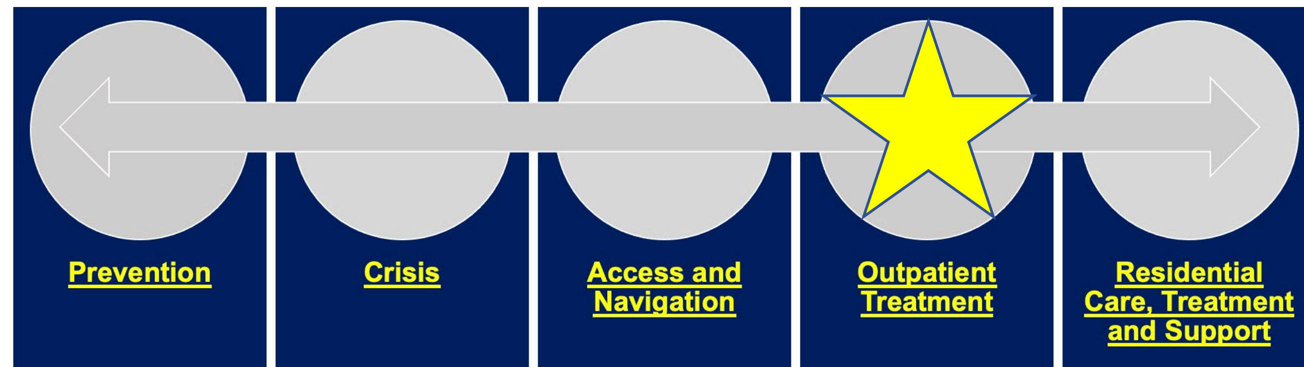


Scenario 2: BEST Neighborhoods to Intensive Outpatient

The psychiatrist, with the daily support of the Office of Coordinated Care Registered Nurse, starts Joanna on medication and provides medication support. Joanna continues to decline treatment for her substance use disorder, and the team continues working on building motivation to make changes in her substance use.

BEST Neighborhoods also begins working to obtain permanent supportive housing for Joanna. As Joanna becomes more stable in her shelter and on medications, BEST Neighborhoods transitions her care to an Intensive Outpatient Program.

The Intensive Outpatient Program takes over her care plan and mental health treatment and support Joanna with her move to permanent supportive housing. Joanna is now adherent with her medications and has reduced her distressing street behaviors.



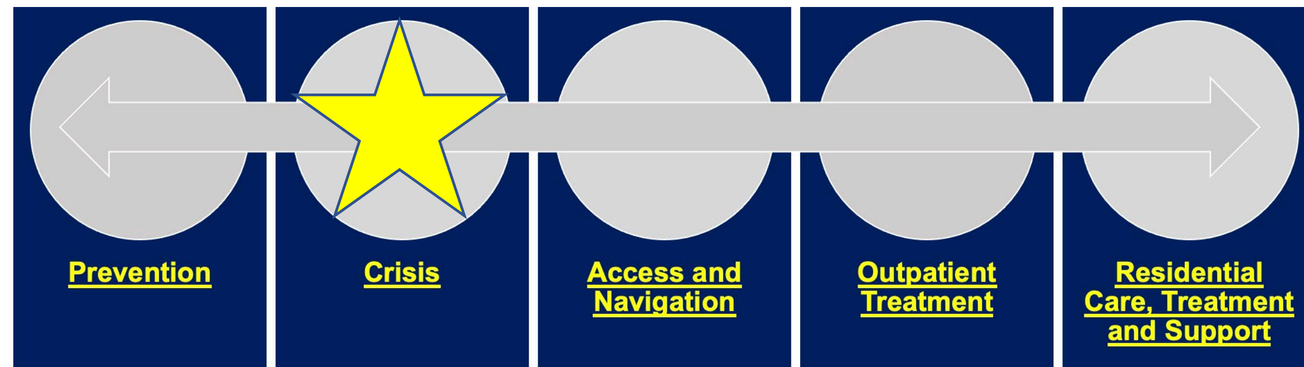
Scenario 3: About Ronald

- Male
- 63-years-old
- Uses alcohol
- Currently not in treatment
- Unsheltered for many years

Scenario 2: SCRT to BEST Neighborhoods

Ronald uses alcohol in public, screams and yells at neighbors, and panhandles in public places. Ronald is encountered by the Steet Crisis Response Team (SCRT) because of a neighbor calling 911.

SCRT makes a referral to the Office of Coordinated Care for follow up. The BEST Neighborhoods behavioral health team locates and engages with Ronald.

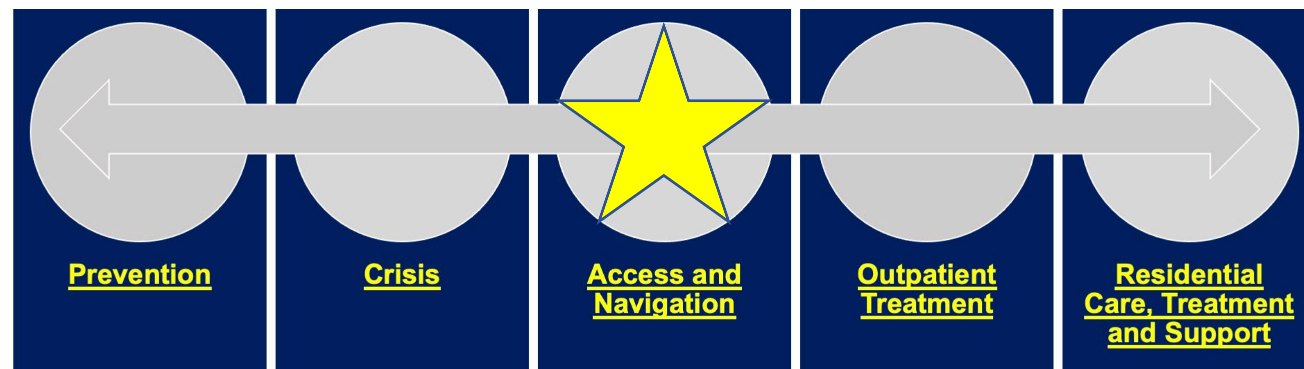


Scenario 2: BEST Neighborhoods to Managed Alcohol Program

The BEST Neighborhoods team locates Ronald and begins to engage with him. He is initially uninterested in services but agrees for the team to visit him again.

The team visits him three to four times a week. His primary interest is finding housing. The team coordinates with SFHOT to provide a housing assessment for permanent supportive housing and works with him to find shelter in the meantime. He is hesitant about going into shelter due to some of the rules but also expresses interest in reducing his alcohol use.

The team suggests the Managed Alcohol Program (MAP) as an option. He agrees to give it a try. With the help of the BEST Neighborhoods team, Ronald is admitted into the Managed Alcohol Program and preparation for a permanent supportive housing placement continues.



Scenario 3: Stability and Permanent Supportive Housing

Ronald stabilizes significantly in the Managed Alcohol Program. He no longer exhibits distressing street behaviors, reduces his alcohol consumption, and engages with OCC case managers, who visit him less frequently now that he has stabilized significantly.

He moves into a permanent supportive housing program with services that include a representative payee, IHSS, on-site nursing and case management. His care plan is taken over by the on-site case manager, but the Office of Coordinated Care can help with worsening of symptoms.