Mental Health SF Implementation Working Group
Final Meeting Minutes

April 27, 2021 │ 9:00 AM – 1:00 PM

This meeting was held by WebEx pursuant to the Governor's Executive Orders and Mayoral Emergency Proclamations suspending and modifying requirements for in-person meetings. During the Coronavirus Disease (COVD-19) emergency, the Mental Health San Francisco Implementation Working Group will convene remotely until the it is legally authorized to meet in person.

Note: The agenda, meeting materials, and video recording will be posted at the Mental Health SF Implementation Working Group website:
https://www.sfdph.org/dph/comupg/knowlcol/mentalhlth/Implementation.asp

1. Call to Order/Roll Call

The meeting was called to order at 9:05 am (estimated)

Committee Members Present: Dr. Scott Arai, Psy. D., Shon Buford, Kara Chien, J.D., Dr. Vitka Eisen, M.S.W., Ed.D, Steve Fields, M.P.A., Dr. Ana Gonzalez, D.O., Dr. Hali Hammer, M.D., Philip Jones, Dr. Monique LeSarre, Psy. D., Jameel Patterson, Andrea Salinas, L.M.F.T., Sara Shortt, M.S.W., Amy Wong.

Committee Members Absent: None.

2. Welcome and Review of Agenda

Dr. Monique LeSarre, IWG Chair, opened the meeting, welcoming the IWG members and the public to the meeting. Chair LeSarre reviewed the meeting goals and agenda, reviewed the MHSF components and group agreements.

3. Discussion Item #1: Meeting Minutes

Member Hammer resurfaced a question about whether or not public callers should be identified in the meeting minutes. Facilitator Jennifer James confirmed that given Deputy City Attorney Jon Givner's direction public callers will be identified if their names are stated when providing public comment. This is reflected in the March meeting minutes.

4. Public Comment for Discussion Item #1

No public comment.

5. Action on Discussion Item #1

Member Fields moved to approve the March 2021 meeting minutes; Member Eisen seconded the motion. Meeting minutes were approved by the IWG.

6. Introduction of New Director of MHSF and Behavioral Health

Dr Hillary Kunins joined the group to introduce herself and thank the group for their work. She was unable to stay the whole meeting, but noted her intention is to attend future meetings.

7. Discussion Item #2: Review Updates to Recommendation Principles

Chair LeSarre provided an update on the status of the recommendation principles review. Discussion group did not meet, and principles were not reviewed or finalized. A meeting will be scheduled for IWG members to work on these principles before the May IWG meeting. The principles were broadly used by the SCRT discussion group in developing recommendations specific to that MHSF component.

8. Discussion Item #3: Street Crisis Response Team Pilot Recommendations

Facilitator Jennifer James provided a reminder of how the Street Crisis Response Team fits in the overall MHSF framework. The charge of this workgroup is to advise on the design, outcomes, and effectiveness of various MHSF framework components – in this case, the Street Crisis Response Team (SCRT) and recommendations to the pilot phase. A reminder that these recommendations are for the pilot defined as citywide implementation with six teams. The results of the pilot and considerations about scaling and ongoing implementation will come back to this group in Fall 2021, pending sufficient data to evaluate how the city-wide rollout is going. IWG members will have a chance to further review and comment on the data then. Jennifer presented the diagram of the MHSF framework components as a reminder of the key programs/phases that are being designed or are underway by domain. The IWG will coordinate with other advisory bodies, such as Our City Our Home (Prop C), who hold responsibilities in recommending funding homelessness and behavioral and mental health programs.

Jennifer also provided a reminder on the Pilot Evaluation Questions. The key questions include: who is being served by the street team, how are the teams created, and how are they addressing inequities. Answers to those questions and other results will be part of the report back in Fall 2021 and will be shared with the IWG. Lastly, Jennifer provided a reminder of the roadmap and process it took to get to the review of SCRT recommendations being presented today.

Jennifer presented the consensus-based decision making process for passing recommendations and a reminder that the public can find the Planning Framework on the IWG website, in the January 26 meeting line. This process ensures that the consensus model is in line with public meeting legal requirements, such as the Brown Act.

Member Salinas presented recommendations and reminded public of the location of the recommendations on the IWG website (https://www.sfdph.org/dph/files/IWG/SCRT_Recommendations_group_summary_for_IWG_discussion.pdf). Chair LeSarre facilitated discussion.

Discussion:

Member Buford addressed Recommendation 3, Item B noting that although we want to meet people where they are, we need to be cautious that it isn't at the expense of the first responders. He would also like to see more public service announcements to address how to interact with houseless persons with humanity and compassion. He also recommended education for the public for when it is appropriate to utilize 911.

Member Fields responded to Member Buford: noted we are trying to find a new way for earlier intervention that doesn't automatically put into question whether law enforcement has to be on the team. If in fact there is an imminent threat to others, the purpose of the SCRT team is not to replace 911 calls. The discussion group posed the concern that this structure is too narrowly defined. SCRT is

an early intervention that doesn't need to involve law enforcement, open itself up to a 911 calls, or intervene if there is a threat.

Vice Chair Patterson highlighted the importance of making 3-5 questions available for operators to ask at the time of a call in order to determine the degree of violence.
Member Hammer reminded the working group that the goal is for the SCRT to respond behavioral crises and not involve law enforcement/law enforcement that is not needed . Emphasized the importance of making sure SCRT is not using a co-response model like Mobile Crisis.

Member Shortt recommended looking closely at whether weapons are being used as weapons or not.

Member Eisen reiterated that there is a lack of clarity around what is considered self-harming behavior and who decides that.

Member Jones noted that the recommendation states that the SCRT team should not respond to situations where there is imminent threat or danger, specifically a threat of violence with a weapon. Instead, another system, most likely the police, would respond. However, there are numerous cases where people pose some threat and some who don't pose any threat but are perceived as threatening by the police, typically because of racism or classism. The SCRT should be part of the process and be better equipped with the tools to address crises where there is a weapon or pose a threat instead of the police involvement. Member Jones would also like to keep in mind the IWG's reach within this issue and what they can address through these recommendations rather than factors out of their control.

Chair LeSarre would like to see structural racism addressed whether or not it is within IWG scope or not. She'd like the IWG to include a recommendation around responding from a de-escalation model that challenges racism and stigmatization of persons that are houseless or mentally ill. Chair LeSarre also suggested they receive some information on 311/911 incident calls.

Member Arai and Chair LeSarre highlighted the importance of a recommendation to improve dispatch training for 311/911 in order to discern what is actual vs perceived threats, discerning for structural racism and addresses the weaponizing of 911 calls.

Member Fields reminded the group of Recommendations 1 and 2 and that they will have more of a role to play in designing and implementing. The IWG was formed to advise the mental health board, department of public health, the health commission, SF health authority, and board of supervisors and not just reacting to DPH's hard work on setting up programs. If IWG is going to do that, we need to take into account what is embedded in the first two recommendations. According to those recommendations, this groups conversation could have been avoided by focusing on the pieces already in place rather than adding recommendations. IWG needs to contextualize their recommendations.

9. Public Comment for Discussion Item #3

- David Elliott Lewis: would like to see the SCRT create protocols and inform law enforcement that there is a process for referring 800 calls. The two teams SCRT and law enforcement need to work collaboratively.
- Caller 2: appreciated the IWG's recommendation of mapping the system given how many departments that don't talk to each other and crisis response teams there are. Would like to see DPH utilize empty rooms in SF General Hospital or Laguna Honda Hospital for people with brain injuries, chronic anebrias, and long term psych, dementia. Would like to see the city step up and use the resources available. If you want to cut the incidence of police violence, need a place for these people to go.

10. Action on Discussion Item #3

IWG did not move to the consensus voting/process on this item. A discussion group will reconvene before the May IWG meeting to make adjustments to the recommendations based on the discussion today.

Discussion Item #4: Broad MHSF Overview by Domain

Marlo Simmons provided an overview of MHSF by domain.

Discussion:

Member Fields expressed concern around the narrowness of the expansion of treatment services and wondered about whether DPH is no longer engaging in recovery work, as the work wasn't mentioned. 4 out of 5 facilities introduced as part of the New Beds and Facilities response are institutional settings or non-recovery or rehab based settings and these settings have a very difficult time working with people who are dually diagnosed. Marlo Simmons responded reaffirming that there are many conversations happening around each of these levels of care proposed and all with the goal of rehabilitation. Member Fields responded that only one of the facilities (Crisis Diversion Facility) generates Medi-Cal yet, so these facilities are not only expensive but institutional. They are going in the wrong direction when referring to continuum of care and are inconsistent with the governor's proposal of funding a continuum of residential treatment services in the community. It seems like a philosophy to move to institutional settings instead of treatment settings. Because MHSF is about the whole system, it needs more examination and more current response to mental health services and would like to see more creativity with recovery based services outside of the system of care. Marlo Simmons agrees and would like to delve into that more.

Vice Chair Patterson would like to see more safe places for people who have experienced domestic violence and would like to see more therapeutic living environments as people tend to be referred to more healthy living environments for recovery outside of San Francisco. He would like to introduce more of those environments for recovery available within the City itself and within these new beds and facilities.

Member Salinas asked a question about whether the residential step-down program has dual diagnosis beds or just side beds. Marlo Simmons confirmed that they are side beds, but would like to see the work as a system not have a this or that and is hoping the system has more integration. In regard to Intensive Case Management (ICM) and out-patient expansion, Member Salinas made note of the necessary changes to caseloads to do more outpatient case management work and the caseloads will be much more acute. Would like to know what the projected changes would be to ICM case manager caseloads or outpatient caseloads and how DPH would address the hiring challenges.

Member Wong is concerned about where people are to go for recovery services, re-emphasizing the importance of helping people feel safe, receive treatment, and heal. Member Wong also emphasized the need for street outreach workers to not only serve as a mediator between the police, but also be culturally aware/sensitive to avoid misinterpretation.

Member Eisen spoke to the residential step-down program; 90% of people who access those services are houseless. 150 beds are only a fraction of what is needed for recovery/treatment and these beds are a low level of care. Would also like DPH and the IWG to open their minds to more low barrier low threshold services in addition to the Drug Sobering Center. None of these programs will be successful if nonprofit workers without a compassionate wage.

Member Jones and Chair LeSarre stressed the importance of location and who will be able to access programs and areas that are more in need when it comes to resources like these new beds and facilities.

11. Public Comment for Discussion Item #4

- David Elliot Lewis: there is no way to avoid working with the police as of right now. Also hoping as SCRT expands access to more satellite or mobile access centers (pop up mobile vans or pop-up tents brought into neighborhoods that are underserved in terms of mental health access). It would be great to talk about creating pop up or mobile options.
- Nate Pharrell: thanked the IWG and SCRT for all the work they've done and digging into important considerations. Highlighted that the success of this program relies on its workforce and there is a mandate in the legislation to address this question. Would like to see more dedicated time to discuss and really talk about issues around workforce – turnover, recruitment, staffing shortages, contracts, pay rates. Feels strongly that this group should discuss these issues more directly than sporadically. Would like to know when SCRT and IWG plan to set aside time to address this and if there is an update from the Controller's Office on their staffing analysis.
- Sarah Larson: would like to see more language in MHSF components for those with dementia and chronic brain injury. There are really no treatment facilities for people with brain injuries – these are often coupled with drug use or mental illness and this requires a different kind of therapeutic process. Very difficult to get people in conservatorship who are violent or confused and we don't have enough care for people with dementia. Applauded the IWG for a much more organized and focused meeting than the last. Feels like there is movement happening and congratulated the group.

12. Discussion Item #5: Drug Sobering Center Overview & Discussion

Dr. David Pating provided an overview of MHSF component, The Drug Sobering Center.

Discussion:

Chair LeSarre posed a few questions around whether there will be locker/storage space and space for animals at the center and whether or not this center will replicate the project currently at the SF General. If it isn't affiliated, would there be a way to gather data on what was learned through the project and what they might be able to offer as insight for the Drug Sobering Center. Dr. Pating confirmed that the center has pet capacity, one private room for people who would like more privacy.

Chair LeSarre also asked what protocol would be in place for evaluating persons who are sleeping/nodding vs those who are actually overdosing. Dr. Pating noted that if overdoses were to occur, they would have Narcan on site and all staff will be trained and offered feedback on protocols that are in development and to reach out to their team to discuss further.

Member Salinas posed a question about whether or not people who have wounds related to IV drug use will be evaluated and treated given that there is no nurse on site at this center. Dr. Pating confirmed that they've talked extensively with street medicine and they confirmed that the need to manage street crisis is less and have arranged with EMS to get their support if a crisis does arise. If there is a need for direct nursing care, the Drug Sobering Center's plan is to call the hospital. If there is an open wound, they facilitate an emergency room visit. There will be an EMT on site who would properly dress the wound and care for scratches and would probably call a non-emergency ambulance.

Vice Chair Patterson sees this center as a step in the right direction for polysubstance use. Vice Chair Patterson also brought up the benefits in the current push for decriminalization or legalization of drugs in San Francisco because it is more than a crisis, it is a plague. To combat that plague, drugs should be legalized. Also need to survey vacant spaces in the City and this brings an opportunity to looking at culturally competent alternative methods to combating drug use – meditation, acupuncture, Native American treatments in addition to the medical side. When looking at drug use, it is a psychological and chemical imbalance. Vice Chair Patterson also highlighted that there is a

substance use community, those who have been in the community, and they should be more involved in the conversation in order to not reinvent the wheel but expand it – peer support is key to substance use treatment. Dr. Pating responded confirming their commitment to a peer support workforce, engaging people with lived experience and hope to have a demographic that reflects the community that the Drug Sobering Center is serving. They've established close alignments and relationships with the Harm Reduction Center, Sixth Street Harm Reduction Center, and AIDS Health Foundation and other centers in the neighborhood to make sure everyone in the neighborhood who serves this community knows the Drug Sobering Center is here and would be willing to work as a partner.

Member Chien posed a question about what the difference is between Hummingbird Respite or Alcohol Sobering Center on Mission St. Dr. David Pating responded confirming that the Drug Sobering Center will not require as high level of nursing staff as the Alcohol Sobering Center as opioid withdrawals are not as life threatening as alcohol withdrawals. There are fundamental issues around making the greatest use of the MHSF money with the greatest impact. The Drug Sobering Center has learned a lot from the Hummingbird model.

Member Jones asked Dr. Pating how they would approach drug use within the facility (if people have drugs in their possession or if they are actively using in the facility) and for people who are high users and at potential risk of overdose or drug related complications in the future, having some continuum of care so that their needs are addressed and they are able to use drugs in the safest way with the least amount of harm. Will this be used as a gateway to treatment services or is the center limited to the services they offer at the facility? Dr. Pating confirmed this is gateway to treatment while meeting people where they are at by making treatment available to them if/when they would like it.

13. Public Comment for Discussion Item #5

- David Elliott Lewis: Strong support for the Drug Sobering Center. Would like to make sure that once this center starts running that they take into consideration the different needs of those who use different drugs – stimulants vs cocaine vs depressants and the behavior associated with the use. Recommended that the center designate separate areas for those using different drugs for better management of those client populations and the different withdrawal efforts. Would also like to see the Drug Sobering Center be transparent and open with the community with what they learn, since it will not be an easy process, as it may require them to make tough calls on who to provide care to.

14. Discussion Item #6: Public Comment on any matters within the Working Group's jurisdiction not on the agenda

- No public comment.

15. Adjourn

The next meeting will be on Tuesday, May 25th, 2021 from 9:00 AM - 1:00 pm.

Meeting adjourned at 1:02 PM.